The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)

Participant Manual

Course 1

Clinical Care for Women with Substance Use Disorders

1st Edition, 2020

COLOMBO PLAN

DAP
Drug Advisory Programme

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Acknowledgments

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United States	Shelly F. Greenfield, MD, MPH
United States	Hendrée Jones, Ph.D.,
United States	Dr. Karol Kaltenbach
United States	Laurie Krom
United States	Shirley Mikell
United States	Patricia (Pat) Stilen
United States	Deborah (Deb) Werner, MA
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ONDCP	Nataki MacMurray
Colombo Plan/DAP	Gayathri Jayasooriya

Disclaimer

The substance use disorder treatment interventions described or referred to herein are the views of the authors and do not necessarily reflect the official position of INL or the U.S. Department of State. The guidelines in this document should not be considered as substitutes for individualized client care.

1st Edition
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CONTENTS

Part I—Participant Orientation

Part II—Training Modules

Part III—Appendices

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PARTICIPANT ORIENTATION

The problem

Women around the world who use drugs face challenges that increase their vulnerability to gender-based violence, economic discrimination, human rights violations, physical and mental comorbidities, high rates of incarceration, and intense stigma from many spheres of society. Such discrimination, as well as perceived and enacted stigma, act as significant barriers to treatment and encourage the continued victimization of women who use drugs. Traditionally, more men than women use drugs. In the last few decades, countries have recognized that the numbers of female drug users continue to increase as do the repercussions of drug use for women. As the numbers of female drug users continue to expand, it is important to understand gender-specific etiological factors, phenomenology, course and outcome, and to implement effective prevention, treatment, recovery and social re-integration strategies on a national and international level.

Among the world population, 2% of individuals have been reported to have an alcohol or an illicit drug use disorder (that may include s, cocaine, amphetamines and/or cannabis).

In 2016, globally, alcohol or drug use disorders were twice as common in men (2.4%) as in women (1.2%)[1]

Treatment Barriers and Clinical Needs Unique to Women

The reasons for women's initiation of drug use include critical incidents such as coercion to use drugs by drug-using intimate partners, multiple family factors, the need for self-medication, multiple complex social/environmental factors, life stresses, sex work, relationship issues, physical, sexual and emotional abuse, and peer pressure.

Women tend to start using drugs at an older age than men, yet, women often develop a substance use disorder more quickly than men do. Psychological factors, psychiatric comorbidities, especially childhood and more recent physical, sexual and emotional abuse are key issues that must be addressed in an integrated way during treatment. Sociocultural factors, including the fact that society expects a woman to be a wife, a mother, caretaker, sexual partner, and nurturer, can influence how women use drugs and how they respond to treatment.

Unlike men, women tend to experience greater medical, physiological and psychological impairment earlier in their drug use life course. When women enter treatment for substance use disorders they often present with a more severe clinical profile than men, despite lesser frequency and quantity of substance use.

1. Source: Hannah Ritchie and Max Roser (2020) - "Drug Use". Published online at OurWorldInData.org. Retrieved from: 'https://ourworldindata.org/drug-use' [Online Resource] BibTeX citation

Certain structural, social, and personal barriers are considered responsible for low rates of treatment-seeking among women. While women comprise one third of individuals who use drugs, they comprise only one fifth of the in-treatment population. Women encounter significant systemic, structural, social, cultural and personal barriers to accessing substance use disorder treatment. At the structural level, obstacles for women include a lack of childcare services as well as prejudicial and stigmatizing attitudes from treatment providers and other societal members. Often, residential treatment programs do not allow women to bring their children to treatment; this can result in women having to make the gut-wrenching choice between parenting and treatment. Studies that have examined gender differences in substance use disorder treatment retention and completion show inconsistent results. On a social level, women's roles as the economic provider, home tender, childcare giver or other responsibilities may prevent women from seeking or engaging in treatment. On a personal level, the fear, guilt, stigma and shame may inhibit women for getting the help they need.

Generally, studies focusing on the association of treatment completion and outcome have indicated that treatment completion is associated with better outcomes, irrespective of gender. The sensitivity to women's special needs and problems is critical to treatment success and some of the specific issues related to outcome include: Co-occurring psychiatric disorders, history of victimization, therapist-patient gender matching, and social factors. Both men and women benefit from the substance use disorder treatment and gender alone is not a predictor of outcome. However, certain characteristics of individuals, sub-groups of individuals, and treatment approaches may have a differential impact on treatment-related outcomes by gender. Both the WHO and UN have given attention to the unique needs of women treated for substance use disorders while pregnant and while incarcerated.

Pregnant women in need of treatment for substance use disorders may avoid treatment due to fear of involvement of legal authorities or other social consequences. However, if pregnant women remain untreated, there are risks for negative health outcomes for the mother and child. Some of the factors that motivate women to enter treatment are pregnancy, parenthood and a partner's entry into treatment. Overall, two factors that significantly aid in predicting the treatment outcome for women are co-occurring diagnoses and a trauma history. Thus, programs that address these issues have a better chance of helping women have meaningful positive drug treatment outcomes.

The unique issues of women for recovery and social re-integration include peer support groups, on-site 12-step meetings, and social outings. For example, women may benefit more from women-only meetings, support groups and social outings than they will in mixed-gender activities. On-going social support, economic opportunity, parenting and child care support are needed to help provide women the tools to be successful in treatment and recovery. In some cultures women may not be given the autonomy to consent to treatment. They may be forced into treatment by family or prevented from accessing or remaining in treatment due to family norms. Women in all cultures deserve the right to make choices about their health and well-being.

Another issue that engenders women's success in treatment is the use of women-only programs. Women who participate in such programs report being better understood and

can more easily relate to other female peers. Some women report that they feel unsafe or are harassed in mixed-gender programs. In women-only programs, women report that the availability of individual counseling, the absence of sexual harassment and the provision of childcare services are important components for success. Women are best served through a strength-based approach that includes normalization and structure, biopsychosocial safety, and social connection.

In summary, women respond best to a women-centered approach to treatment, on-site childcare, co-occurring disorder treatment and trauma or sexual abuse counseling. Treatment programs should also provide women with skills, knowledge and support to enable them to maintain their change in substance use behavior when they return to their home and community. The ultimate goals of the treatment process are to enable women to take control of their lives, improve their physical and mental health, engage in healthy relationships with their children, families and communities, and finally, to engage in meaningful activities that help them feel connected to self, others, and community.

INL's Response

The Bureau of the Narcotics and Law Enforcement Affairs (INL) has been a pace-setter in addressing gender as part of a comprehensive, integrated and balanced approach to drug treatment. In 2009, INL led the charge by creating a women-centered treatment curriculum entitled "Guiding the Recovery of Women (GROW)." However, given the breadth and depth of the evolving science and emerging clinical evidence regarding women, INL recognized the need for a new cutting-edge, skills-based curriculum which empowers practitioners with the most up-to-date practical knowledge and skills to provide the highest quality treatment to women.

In early 2018, the Expert Working Group (EWG) Meeting on Addressing Substance Use Disorders in Women was organized by the Colombo Plan on behalf of INL and included substance use disorder treatment experts from Romania, Peru, Vietnam, United Arab Emirates, Puerto Rico, Pakistan, the Republic of Georgia, India, Australia, and the United States. This distinguished international panel of experts mapped the content for the new curriculum after which it was fully developed, piloted-tested, and refined during 2018 and 2019. This four-course specialized curriculum for addressing women's treatment needs is now being offered globally through the Colombo Plan's Universal Treatment Curriculum (UTC) series.

Providing Evidence-Based Specialized Care to Women with Substance Use Disorders:

Titles of the four Courses of the Specialized Women's Treatment Curriculum:

- Course 1: Clinical Care for Women with Substance Use Disorders
- Course 2: Trauma Responsive and Family-Centered Care for Women and their Children
- Course 3: Caring for Women with Substance Use Disorders across the Lifespan and in Specialized Circumstances

- Course 4: Creating and Implementing a Women-Responsive Substance Use Disorder Treatment Model of Care

The four-course women's treatment curriculum addresses the following topics:

- Basic theories and concepts guiding the treatment of women who have substance use disorders
- Legal and ethical issues in providing treatment to women with substance use disorders
- Important aspects of creating a women-responsive therapeutic treatment context
- How to identify substance use disorders among women
- How to create and implement a comprehensive assessment of the female patient
- Creating and implementing Individualized care plans for women: Development, initiation, monitoring, and completion
- Methods to help female patients stabilize and withdraw from substances
- Components of a comprehensive drug treatment program for women
- Approaches to caring for the dually-diagnosed female patient
- Care in specialized circumstances (e.g., Obstetrical aspects of care of the pregnant woman with substance use disorders and helping women with substance use disorders care for their drug exposed newborn and caring for incarcerated women)
- Approaches to empower women to enhance parenting skills
- Trauma responsive treatment for women
- Case management for women
- Recovery oriented system of care for women
- Keys to developing a comprehensive care model for women

The specialized curriculum for addressing substance use disorders in women consists of the following four courses:

- Course 1: Clinical Care for Women with Substance Use Disorders
- Course 2: Trauma Responsive and Family-Centered Care for Women and their Children
- Course 3: Caring for Women with Substance Use Disorders across the Lifespan and in Specialized Circumstances
- Course 4: Creating and Implementing a Women-Responsive Substance Use Disorder Treatment Model of Care

Goals and Objectives for Course 1

Training goals

Participants will acquire:

- Knowledge of what makes treating women for substance use disorders different from treating men
- Tools and strategies to identify, assess, and treat women for substance use disorders

Objectives

- Name at least three ways women differ from men in terms of substance use disorder treatment needs
- Demonstrate ways to screen and assess women for substance use disorders
- Identify key elements in a comprehensive women-specific substance use disorder treatment process

Getting the most from your training

- Participate actively. Discuss your views openly, ask questions and don't be afraid to make mistakes.
- Listen to the contributions of other participants as they bring them insights based on their rich experience
- Review the Participant Manual after each day's training to assimilate information provided and clarify your understanding further. Read through the information to be covered the next day too!
- Think about the ways in which you can incorporate training inputs into your work.
- Enjoy yourself. Have fun!! The training programme is designed to make learning fun.

U.S. DEPARTMENT OF STATE
MODULE 0


MODULE - 0
U.S. DEPARTMENT of STATE

Congratulations!

"As a participant in this training, you are part of a rapidly growing global community of substance use professionals"

U.S. DEPARTMENT of STATE 0.2 MODULE - 0

How is this global community of substance use professionals expanding?

In the last decade, a growing number of people are:

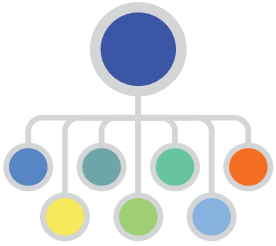
- ✓ being trained
- ✓ being credentialed
- ✓ studying at universities with specialized addiction programs
- ✓ operating in the context of a larger drug control system
- ✓ adhering to science and research-based approaches
- ✓ joining professional substance use associations
- ✓ networking through professional associations

U.S. DEPARTMENT of STATE 0.3 MODULE - 0

Who are the members of this global community of substance use professionals?

Individuals working worldwide in the substance use prevention and treatment fields in government, non-governmental organizations, civil society, and the private sector

Organizations that act as portals or "doorways" for individuals to join the global community



U.S. DEPARTMENT of STATE 0.4 MODULE - 0

ISSUP INTERNATIONAL SOCIETY OF SUBSTANCE USE PROFESSIONALS

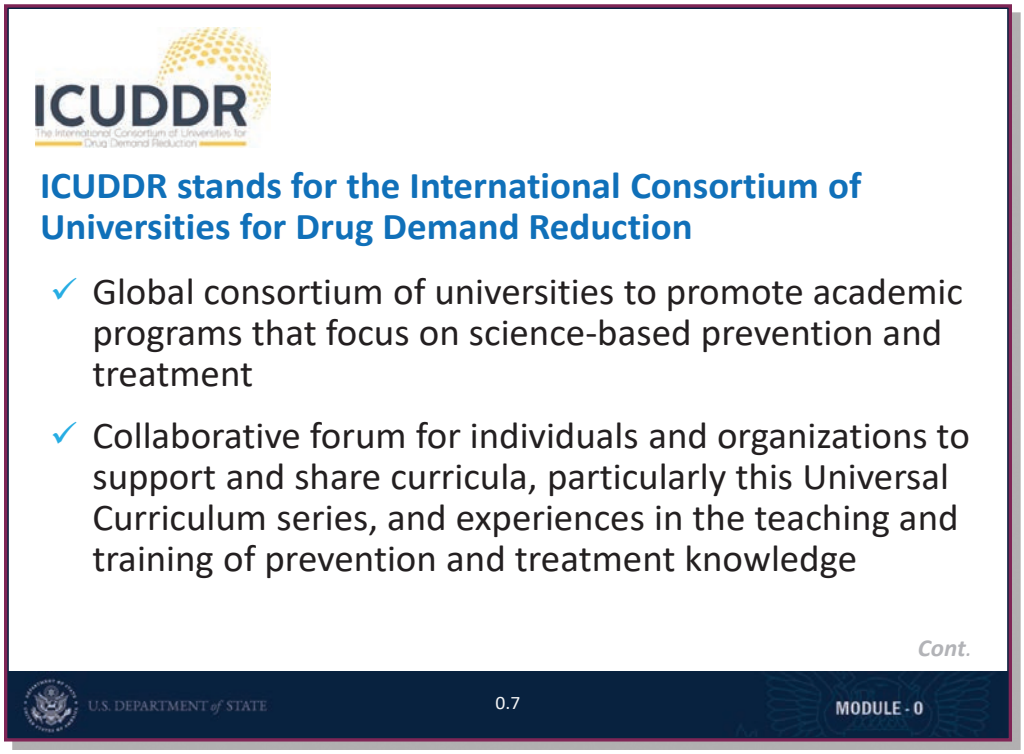
ISSUP stands for the International Society of Substance Use Professionals

- ✓ ISSUP was launched by INL in 2015 as a global, not for profit, non-governmental organization to professionalize the global prevention and treatment workforce.
- ✓ ISSUP provides members with opportunities to share knowledge, exchange experiences, and stay abreast with current research in the field

Cont.

ISSUP stands for the International Society of Substance Use Professionals

- ✓ There are more than 10,000 ISSUP members worldwide
- ✓ Join one of ISSUPs four levels of membership for free at: www.issup.net
- ✓ You can earn credit for this and other courses with ISSUP


ICUDDR
The International Consortium of Universities for Drug Demand Reduction
ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction
✓ Global consortium of universities to promote academic programs that focus on science-based prevention and treatment
✓ Collaborative forum for individuals and organizations to support and share curricula, particularly this Universal Curriculum series, and experiences in the teaching and training of prevention and treatment knowledge
Cont.
U.S. DEPARTMENT of STATE
0.7
MODULE - 0

ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction

Learn about specialized addiction programs at universities worldwide at www.icuddr.com

THE COLOMBO PLAN | Global Centre for Credentialing and Certification

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

- ✓ The hours that you put into this training can be logged at GCCC and qualify you for exams and professional credentials
- ✓ GCCC credentials will help accelerate your career by indicating your passion and commitment to high standards

Cont.

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

Learn about how to apply the latest in research-based prevention and treatment at: www.globalccc.org

U.S. DEPARTMENT of STATE 0.10 MODULE - 0

Who funds and supports this global community of substance use professionals?

The U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) which is funded by the U.S. taxpayer

U.S. DEPARTMENT of STATE 0.11 MODULE - 0

Where does this global community of substance use professionals meet?

- ✓ Digitally- through ISSUP and its networks and
- ✓ Face to face – through trainings, on university campus settings, and at conferences held at the global, national regional and local levels

U.S. DEPARTMENT of STATE 0.12 MODULE - 0

How does this global community of substance use professionals operate?

In the context of a larger international drug control environment that includes:

- United Nation's three international Drug Control Treaties or "Conventions"
- Commission on Narcotic Drugs (CND)
- International Narcotics Control Board (INCB)

U.S. DEPARTMENT of STATE 0.13 MODULE - 0

What are the key international organizations which operate in the context of this larger drug control environment?

DAP	The Colombo Plan Drug Advisory Program (DAP)
	The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS)
AFRICAN UNION	The African Union Commission (AUC)
UNODC	The United Nations Office on Drugs and Crime (UNODC)
World Health Organization	The World Health Organization (WHO)

ISSUP INTERNATIONAL SOCIETY OF SUBSTANCE USE PROFESSIONALS

How can I participate in this global community of substance use professionals?

The easiest way is to become an active member of ISSUP!

- ✓ Register for free on the ISSUP website at www.issup.net
- ✓ Click on the "Apply for Membership" icon
- ✓ Select one of four levels of membership -all are free!
- ✓ Begin networking with others on an ongoing basis

It takes only a few minutes to register and you can immediately connect with over 10,000 ISSUP members worldwide!

What are the benefits of being an active member of this global community of substance use professionals?
You can:

- ✓ Stay informed
- ✓ Implement best practices
- ✓ Access training and mentoring
- ✓ Turn training into credentials
- ✓ Access job postings
- ✓ Access up-to-date research
- ✓ Join a professional network
- ✓ Interact with other professional networks

0.16

MODULE - 0

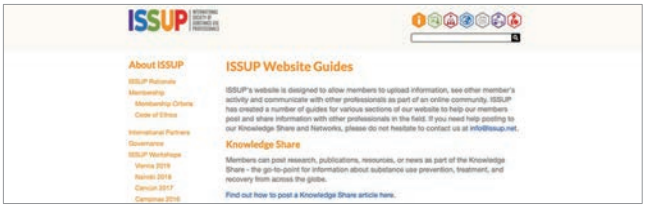
CALL TO ACTION

Next Steps

1. Join ISSUP at www.issup.net
2. Complete this training to earn credit
3. Send your credit hours to GCCC at www.globalccc.org

Participate in ISSUP

- Post on ISSUP: Find easy instructions for how to post on the ISSUP website
- Engage ISSUP's Networks: Connect with colleagues and broaden your impact



U.S. DEPARTMENT of STATE 0.17 MODULE - 0

CEREMONIAL WELCOME AND MODULE 1


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
CEREMONIAL WELCOME
DAP
Drug Advisory Programme

Introductions

- Divide into pairs
- Learn the following things about your partner:
  - Name
  - What position he or she holds in the treatment program
  - One good thing that has happened to the person in the last year
- Take a total of 10 minutes (5 minutes per person)
- Then introduce the person to the group

1.2

Ground Rules

Together we will develop a list of rules to maintain a positive and respectful learning environment

1.3

Pre-Test

- 30 minutes is allocated to complete the test
- Remember to complete the training evaluation

1.4

How is the WISE Curriculum Organized?

- **Course 1:** Clinical Care for Women with Substance Use Disorders
- **Course 2:** Trauma Responsive and Family-Centered Care for Women and their Children
- **Course 3:** Caring for Women with Substance Use Disorders across the Lifespan and in Specialized Circumstances
- **Course 4:** Creating and Implementing a Women-Responsive Substance Use Disorder Treatment Model of Care

1.5

What is Course 1 About?

- It provides a review of:
  - Module 1: Core competencies needed to help women and what makes women unique compared to men in their illness trajectory
  - Module 2: Basic theories and concepts
  - Module 3: Legal and ethical issues
  - Module 4: The important aspects of creating a women-responsive therapeutic treatment environment
  - Module 5: How to identify substance use disorders among women
  - Module 6: How to create and implement a comprehensive assessment
  - Module 7: How to create and implement individualized care plans
  - Module 8: Components of a comprehensive substance use disorder treatment program
  - Module 9: Approaches to caring for women with co-occurring disorders
  - Module 10: Case management for women

1.6

What the WISE Course Offers

An Evidenced-Based Understanding of How to Treat Women with Substance Use Disorders

- What are the unique issues for women versus men and what they mean for treating women
- How to identify, assess, and treat women for substance use disorders

Participants will acquire:

- Knowledge of what makes treating women for substance use disorders different from treating men
- Tools and strategies to identify, assess, and treat women for substance use disorders

1.7

How this Course Fits into the Complete UTC Curriculum

- This course is one of the specialty courses of the UTC
- It builds upon a number of UTC courses, including both basic and advanced courses

1.8

Overall WISE Curricula Aims and Objectives

Aim:

- To increase providers' capacity to identify, assess and effectively treat women who have substance use disorders

Objectives:

1. Name at least three ways women differ from men in terms of substance use disorder treatment needs
2. Demonstrate ways to screen and assess women for substance use disorders
3. Identify key elements in a comprehensive women-specific substance use disorder treatment process

Course 1

1.9

Overall Curricula Aims and Objectives (Cont.)

Objectives (Continued):

5. Articulate the elements of trauma informed care for women
6. Identify the elements of attachment-based parenting and how they apply to family-centered care for women and their children

Course 2

7. Identify at least three ways substance use disorders affect women across the life span and three ways to respond
8. Articulate the unique considerations, treatment needs and ways to respond to women with substance use disorders in specialized circumstances

Course 3

9. Identify the key aspects to address when creating and implementing a women-responsive substance use disorder treatment model of care

Course 4

1.10

Key Documents

Note that there is a document from 2004 that is a toolkit for working with women who have substance use disorders

https://www.unodc.org/docs/treatment/Toolkits/Women_Treatment_Case_Studies_E.pdf

1.11

The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)

Course: 1

Clinical Care for Women with Substance Use Disorders

Module 1: Core Competencies Needed to Help Women and What Makes Women Unique Compared to Men in Their Illness Trajectory

DAP
Drug Advisory Programme

Learning Objectives: Module 1

- Recognize the core competencies needed to help treat women for substance use disorders
- Identify three ways women are uniquely affected by different substances
- Articulate three issues that differ in women's trajectory of substance use initiation, problem development, treatment and recovery from men's

1.13

Introduction: Core Competencies

- Women need multi-sector/multidisciplinary care through the lifespan
- A framework of human rights must be employed in treatment
- The role of relationships in the lives of women is critical to treatment and recovery (intrapersonal and interpersonal and systems)
- Women are best served by a strengths-based, trauma-responsive, culturally responsive treatment culture

1.14

Introduction: Why Focus on Women?

- Women deserve, and can benefit from, treatment for substance use disorders
- International Narcotics Control Board devoted Chapter 1 of their report in 2016 to women
- The report summarized that compared to men, women:
  - Are highly stigmatized
  - Experience more violence
  - Are less likely to receive treatment for substance use disorders
  - Women deserve, and can benefit from, treatment for substance use disorders
  - Lack access to gender-specific treatment
  - Are being incarcerated at higher rates = devastating effects on children
- While gender itself may not predict treatment outcome, there are gender-specific factors that influence treatment outcomes in women

(Greenfield et al., 2007 Drug Alcohol Dep 86, 1-21;
https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ebook.pdf)

1.15

The National Treatment Agency for Substance Misuse, 2010: EFFECTIVE TREATMENT CHANGING LIVES www.nta.nhs.uk

Introduction: Why Focus on Women? (cont.)

- Gender equality is a right.
- Women are not only more affected by the problems, but also possess ideas and leadership to solve them.
- Gender discrimination holds too many women back, and holds our world back too.
- Women experience substance use disorders in somewhat different ways than men.

1.16

Introduction: History of Women's Treatment

- The birth of gender-specific treatment began in the 17 and 1800's
- Women have been targeted by the promotional machinery of licit and illicit drug industries for centuries.
- The first gender-centered treatment was seen in the 1800's with special programs for women
- There is a long history of stigma and discrimination, and the resulting invisibility and "voicelessness" of women suffering from and recovering from substance use disorders.
- There is also the assumption that women's lives can be changed within programs created by and for men.

1.17

Break

15 minutes

1.18

Introduction: Defining Terms

- Substance use disorder, not abuse and dependence
- Use of person first language
- Patient not client – honors the need for professional help to be treated for and recover from a substance use disorder
- Sex—differences based on biology
- Gender—differences based on culturally defined roles for men and women
- Gender responsive
- Trauma-informed and Trauma-responsive

This course focuses on cisgender individuals

(Covington SS and Bloom SL. Moving from Trauma-Informed to Trauma-Responsive A Training Program for Organizational Change, 2018)

1.19

Introduction: What is Culture?

- Culture is complicated
- Culture is NOT Race
- Construct of Race and Bias

Karina A. Forrest Perkins, CoE PPW Webinette #4, July 12, 2016

1.20

Introduction: What is Cultural Competence?

- Cultural Competence:
- "refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time"
- It has also been called "a set of behaviors, attitudes, and policies that . . . enable a system, agency, or group of professionals to work effectively in cross-cultural situations"
- How does gender specific care fit into this definition?

Karina A. Forrest Perkins, CoE PPW Webinette #4, July 12, 2016

1.21

Language Matters

Stigmatizing Language	Preferred Language
abuser	a person with or suffering from, a substance user disorder
addict	person with a substance user disorder
addicted infant	infant with neonatal abstinence syndrome (NAS) infant with substance withdrawal
addicted to [alcohol/drug]	has a [alcohol/drug] use disorder
alcohol	person with an alcohol use disorder
clean	abstinent
clean screen	substance-free
crack babies	substance-exposed infant
dirty	active using
dirty screen	testing positive for substance use
drug abuser	person who uses drugs
drug habit	regular substance use
experimental user	person who is new to drug use
lapse/ relapse/ slip	resumed/ experienced a recurrence
medication-assisted treatment (MAT)	medications for addiction treatment (MAT)
opioid replacement /substitution	medications for addiction treatment (MAT)
pregnant opiate addict	pregnant women with an opioid use disorder
prescription drug abuse	non-medical use of a psychoactive substance
recreational or casual user	person who uses drugs for nonmedical reasons
reformed addict or alcoholic	person in recovery
relapse	reoccurrence of substance use or symptoms
slip	resumed or experienced a reoccurrence
substance abuse	substance use disorder

Adapted from: The Rhetoric of Recovery Advocacy: An Essay On the Power of Language W.L. White; E.A Salsitz, MD., Addiction Medicine vocabulary; Substance Use Disorders: A Guide to the Use of Language Prepared by TASC, Inc. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS), rev. 4.12.04

1.22

Exercise: Person-First Language in Action

- Small group exercise:
- Divide into groups of 4-5 participants
- Write a list of stigmatizing words or phrases that you hear or have heard about women with substance use disorders
- Now, for every word or phrase you wrote down, develop a counter statement or person-first language to use instead
- The groups have 12 minutes to develop both lists
- Each group has 3 minutes to present

1.23

Substance Use Among Women: The Numbers

- Women and girls make up about 1/3 of the people who use drugs in the world
- Males have higher prevalence of use of most substances than women
- 3.8 million women are estimated to inject substances globally
- Some sub-groups of women have higher rates of injecting drug use than others
- 6.3 million women have an amphetamine use disorder
- 4.7 million women have an opioid use disorder
- 2.1 million women have a cocaine use disorder
- In Southeast Asia and Oceania women have a high prevalence of amphetamine use: 31%
- In Oceania women have a high prevalence of opioids: 25%
- Cocaine use disorder in Latin America and North America 22%

ThematicChapter-WomenAndDrugsINCB.pdf; Lev-Ran S, Le Strat Y, Imtiaz S, Rehm J, Le Foll B. Am J Addict. 2013 Jan;22(1):7-13.
Le *et al.* Drug Alcohol Depend. 2015;150:46-53

1.24

Women Experience Substance Use Disorders Differently Than Men

Sex and gender differences influence the lives and experiences of individuals.

Social, cultural and structural factors drive women's increased issues:

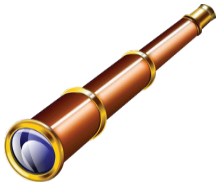
- higher unemployment/economic dependence on others
- living in poverty can affect mental health
- risk of incarceration- leads to continued poverty
- risks for violence - physical, sexual and emotional abuse
- risks of HIV, Hepatitis C and other negative health consequences

ThematicChapter-WomenAndDrugsINCB.pdf

1.25

Telescoping

- The amount of time between initial use and the development of physiological problems is shorter for women than men.
- The amount of time between initial use and the severity of the problems that develop from use of alcohol and drugs is shorter for women than men.



(review Greenfield et al, 2010; Hernandez-Avila CA et al., 2004; Hser YI et al., 1987; Randall CL et al., 1999) Piazza et al., 1989; Khan et al., 2013; Lewis, Hoffman, & Nixon, 2014

1.26

Substance-related Health Issues

- Use of licit or illicit drugs stresses the human body
- True for both women and men
- However: Women have some different physiological responses to drugs, and greater risk for health-related issues

(eg., Greenfield, 2003; McHugh et al., 2017)

1.27

Ways Substance Use Disorders Differ Between Women and Men

- Physical effects- Women experience negative physiological consequences sooner with less use than men
- Women have more medical, psychiatric and social consequences of substance use than men
- Treatment needs of women are different than men.
  - Co-existing psychiatric disorders
  - Parental Stress
  - Trauma History
  - Specific Barriers
- In some countries, fewer women than men overdose
- When given help, women can respond to treatment better and have better outcomes than men.

(https://www.unodc.org/docs/treatment/UNODCWHO_2016_treatment_standards_E.pdf; eg., Greenfield, 2003; McHugh et al., 2017)

1.28

Lunch

60 minutes

1.29

Alcohol and Health Effects on Women

Alcohol is one of the five (5) leading causes of morbidity and mortality worldwide.

Women compared to men:

- Are more susceptible to alcohol-related organ damage
- Develop damage at lower levels of consumption over a shorter period of time
- Experience an increased severity, greater number, and faster rate of development of health-related complications
- Develop alcohol use disorders in less time than do men: telescoping

1.30

(Chisholm et al., 2004; Piazza et al., 1989)

Stimulants and Health Effects on Women

- Hormonal changes across the menstrual cycle have a strong effect on stimulant drugs
- The phase of the menstrual cycle matters
- Overall, women who use cocaine report more positive subjective drug effects, including greater euphoria and desire to use, while physiological responses to the drug did not change
- Psychoactive effects of methamphetamine (also known and ecstasy) are more intense for women than men
- Prevalence of energy drink misuse is increasing

(Evans S et al., 2002; McCance-Katz et al. 2005; Liechti et al. 2001)
(Mayo et al., Psychopharmacology (Berl). 2019 Aug;236(8):2413-2423)

1.31

Opioids and Health Effects on Women

- No menstrual cycle differences in women's subjective experience or physiological reaction to opioids
- Women using heroin or methadone do experience menstrual abnormalities, particularly amenorrhea or an irregular menstrual cycle
- Deficits in sexual desire and performance are also consequences of heroin use
- Amenorrhea and other symptoms often make women believe they are permanently sterile, a fear that can be lessened with education
- Women are at first more sensitive to overdose than men; yet, after a few years are more likely than men to survive.

(https://www.drugabuse.gov/drugs-abuse/opioids)
(Gjersing and Bretteville-Jensen, 2014)

1.32

Cannabis and Health Effects on Women

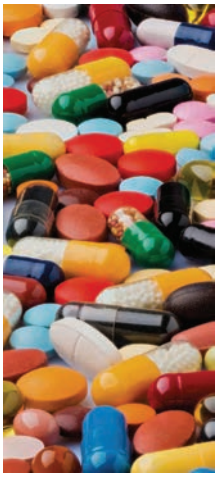
- Studies on cannabis have focused specifically on gender differences
- Findings suggest that the effects of cannabis do not vary markedly across the menstrual cycle
- Men appear to be more sensitive to the analgesic effects of cannabis than women
- Women show greater improvements in appetite with cannabis compared to men but other outcomes, including ratings of nausea or quality of life measures were not different

(https://www.drugabuse.gov/publications/drugfacts/marijuana)
(Strasser et al, 2006)

1.33

Prescription and Over the Counter Medications and Health Effects on Women

- Women are significantly more likely to use and misuse prescription medications
- Over-the-counter (OTC) medications include cold remedies, antihistamines, sleep aids, and other legally obtained nonprescription medications.
- Misuse of these medications can result in serious medical complications for those with eating disorders
- Complications can involve the gastrointestinal, neuromuscular, and cardiac systems and can be lethal.
- Many prescription and OTC medications interact negatively with alcohol and drugs.



1.34

(Simoni-Wastila 2000; Kamimori et al. 2000; https://www.drugabuse.gov/publications/drugfacts/over-counter-medicines).

Tobacco and Health Effects on Women

- Compared to men, women who smoke show higher disease risk regardless of smoking level or intensity
- Women who smoke:
  - Have an increased risk of peptic ulcers
  - Have an increased risk of menstrual issues
  - Are more likely to be diagnosed with cancer
  - Have a higher risk for delayed conception and infertility
  - Have an increased risk for ischemic stroke
  - Are more likely to have premature decline in lung function, chronic obstructive pulmonary disease, and coronary heart disease
  - Have an increased risk of developing cataracts and macular degeneration
  - Reach menopause at a younger age
  - Have lower bone densities and an increased risk for hip fracture after menopause

1.35

(Mucha et al. 2006; https://www.drugabuse.gov/publications/drugfacts/cigarettes-other-tobacco-products)

Dangers of "Energy Drinks"

Concerning effects include:

- Heart skipping a beat or beating too fast
- Hands shaking
- Agitation or feeling restless
- Stomach problems
- Chest pain
- Dizziness
- Tingling or numbing of the skin
- Can't sleep Respiratory distress Headaches

1.36

Gunja N, Brown JA. Energy drinks: health risks and toxicity. Med J Aust 2012; 196 (1): 46-49.

Women: Increased Vulnerability with Substance Use Disorders

- Both genders are vulnerable to substance use disorders– but women may show more severe psychiatric, medical, and employment problems.
- Among women who seek treatment, the age of onset of regular use does not show gender difference – but women who use opioids, cannabis, and alcohol enter treatment sooner after onset.
- Findings suggest the existence of an increased vulnerability in women to the adverse consequences of use of these drugs.

1.37

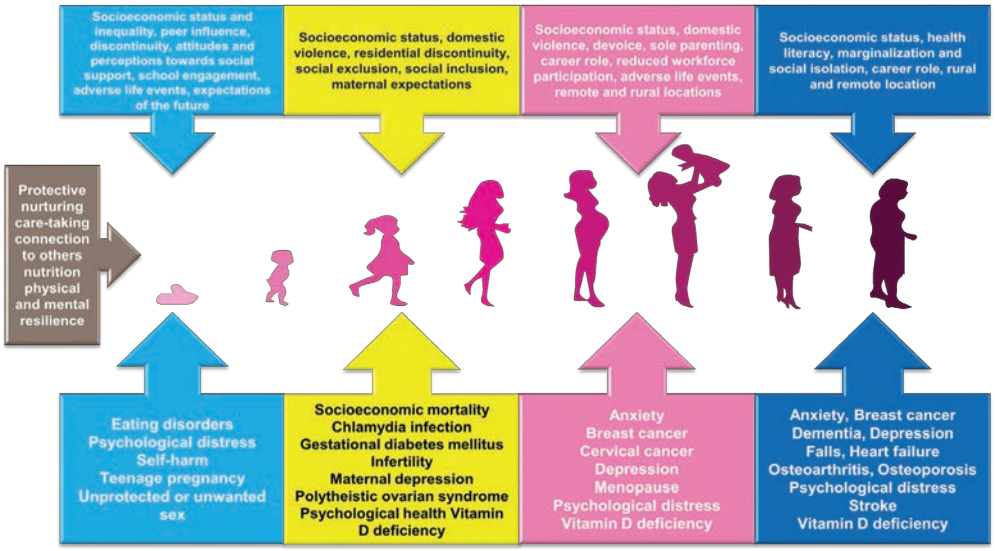
(Hernandez-Avila et al., 2004)

What Does Substance Use Disorder Look Like In Women?

- Initiation of drug use
- How she obtains her drugs
- Where she uses her drugs
- How she recovers from drug use
  - Untreated substance use disorder places a woman at risk for multiple adverse consequences

1.38

Social Determinants of Health for Women Across the Lifespan



Risk and Protective Factors for Girls and Women: Substance Use

- Timing matters- at younger ages, the sex differences of substance use are less than later in life
- The media reinforces a casual attitude toward socializing using tobacco, alcohol, and cannabis, as well as glamorizing a thin-body-type ideal
- Messages normalizing drug use are equally harmful for boys and girls, but girls have an added burden of conforming to the standards of a thin-obsessed society
- Peer influence appears to be equal for girls and boys for substance use
- Girls are less likely to use drugs and alcohol illegally if they have warm, close relationships with their parents or caretakers
- In contrast to adolescence, risk for drug use disorders in women is substantially reduced during pregnancy

1.40

(Kumpfer KL, et al., 2008; Kendler KS, et al., 2017)

Exercise: Apply New Knowledge in Action

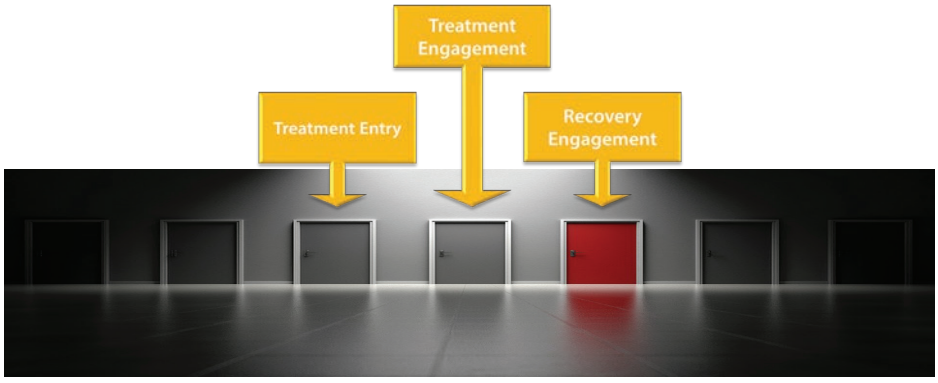
Small group exercise:

- Divide into groups of 4-5 participants
- Develop a 3 minute presentation using a visual where you show why women need gender-specific treatment- be creative!
- Remember to use the non-stigmatizing language in the earlier slides
- The groups have 15 minutes to develop the presentation
- Each group has 5 minutes to present

1.41

Barriers and Strengths: Treatment and Recovery for Women

Barriers for women occur at many points on the treatment and recovery continuum and women and providers can overcome them



(McHugh et al., Clin Psychol Rev. 2018 Dec;66:12-23)

1.42

Barriers to Treatment Entry for Women

Barriers = reasons individuals do not utilize specialized treatment services or do not modify target behaviors

Interpersonal and Intrapersonal

- Psychiatric disorders (mood, eating, anxiety, and post-traumatic stress disorders)
- Trauma issues
- Do not see the need for treatment

Sociocultural

- Discrimination and stigma
- Family is not supportive

Structural and Systemic

- Lack of treatment available
- Economic
- Lack of childcare

(eg,Brady and Ashley, 2005)

1.43

Break

15 minutes

1.44

Treatment Engagement: Barriers

- Intrapersonal
- Interpersonal
- Sociocultural
- Structural

1.45

Treatment Engagement Barriers: Intrapersonal

Intrapersonal

Individual factors including:

- health problems
- psychological issues
- level of cognitive functioning
- motivational status
- treatment readiness

(eg, Grella, & Joshi, 1999; Grella et al., 1999; Greenfield et al., 2007; Ashley et al., 2003)

1.46

Treatment Engagement Barriers: Interpersonal

Interpersonal

Relational issues including:

- significant-other relationships
- family responsibilities
- family dynamics
- availability of support systems

(eg, Grella, & Joshi, 1999; Grella et al., 1999; Greenfield et al., 2007Brady and Ashley, 2005)

1.47

Treatment Engagement Barriers: Other People

Significant others may impact women's treatment seeking, recovery, and relapse

- Women may have less support from family members and/or partners for seeking treatment
- Partners with substance use disorders may only be supportive of women's treatment seeking if they themselves are in treatment

(eg, Jones et al., 2011)

1.48

Treatment Engagement Barriers: Relationships

Relationships are an important aspect of drug use treatment for women

- Role as caregivers
- Relationship with the treatment provider
- If attention is given to establishing and maintaining relationships with women while they are in drug treatment, they are more likely to enter, engage in, and complete treatment

1.49

(Jones and Kaltenbach, 2013)

Treatment Engagement Barriers: Women's Roles

- Women are more likely to encounter obstacles during treatment than men as a result of caregiver roles, gender expectations, and socioeconomic hardships
- Drug-using women have greater needs for treatment services due to
  - pregnancy
  - child care issues
  - roles as caregivers
- Women often face more economic barriers to entering and staying in treatment than do men

(eg, Jones and Kaltenbach, 2013)

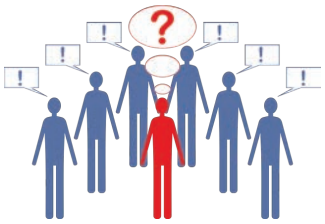
1.50

Treatment Engagement Barriers: Sociocultural

Sociocultural

Social factors including:

- cultural differences
- role of stigma, bias, and racism
- societal attitudes
- disparity in health services
- attitudes of healthcare providers toward substance-using women



(eg, Grella, & Joshi, 1999; Grella et al., 1999; Greenfield et al., 2007; Brady and Ashley, 2005)

1.51

Treatment Engagement Barriers: Structural

Structural

Treatment program characteristics including <u>not being:</u>

- Women-centered and women-sensitive
- Trauma informed

in policies and procedures, program design and treatment restrictions

(eg, Grella, & Joshi, 1999; Grella et al., 1999; Greenfield et al., 2007Brady and Ashley, 2005)

1.52

Treatment Engagement Barriers: Systemic

Systemic

Larger systems including:

- Governmental agencies that generate public policies and laws
- Businesses including health insurance companies
- Environmental factors

(eg, Grella, & Joshi, 1999; Grella et al., 1999; Greenfield et al., 2007; Brady and Ashley, 2005)

1.53

Treatment Engagement: Strategies

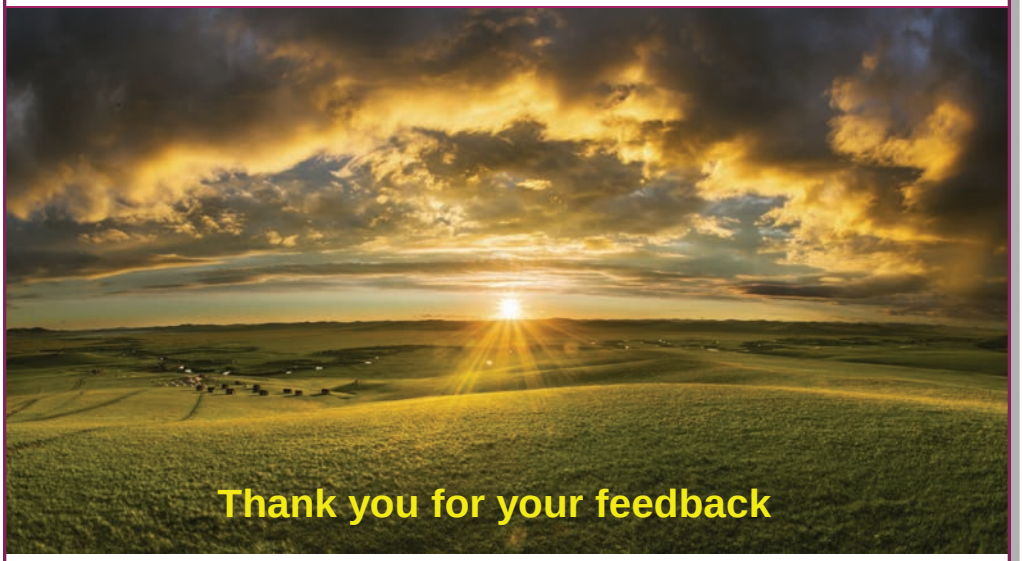
- Treatment engagement strategies are now recognized as important not only to attract potential patients to treatment but also to maintain them in treatment longer
- Such strategies begin at intake and extend across the continuum of care
- Women offered services during intake are more likely to utilize such during treatment
- Three core engagement strategies that are particularly beneficial for women
  - outreach services
  - pre-treatment intervention groups
  - comprehensive case management

"Women often prefer women staff to work with at all stages of the treatment and recovery process"

(Comfort et al., 2000)
(e.g., Hatchett and Park, 2004; Liddon, Kingerlee, and Barry 2018)

1.54

Day 1 Wrap-Up



1.55

Treatment Engagement: Outreach

Three components to outreach:

1. Identify and address a woman's most urgent concerns
2. Empathize with the woman's concerns and ambivalence
3. Assist the woman in navigating the health service systems

- Outreach results in a greater likelihood of contact with treatment services by women. Three factors influence this likelihood:
  - level of readiness
  - trauma history
  - support system

(eg, Melchior A et al., 1999)

1.56

Treatment Engagement: Pre-Intervention Treatment Groups

- Early identification and intervention may prevent more significant substance use-related consequences
- Pre-treatment intervention sessions are typically designed to:
  - provide personalized or structured feedback about substance use
  - convey information regarding available treatment services
  - utilize strategies to enhance motivation to enter treatment
- Women-focused pre-treatment is designed to address certain psychosocial barriers to treatment entry, particularly stigma
- Pre-treatment can be perceived as treatment rather than an initial step

(Green et al., 2007; Ford, Green et al., 2007)

1.57

Treatment Engagement: Case Management

- Case management helps bridge the gap between services and agencies
- With the wide range of services often warranted for most women, comprehensive case management that involves medical and social case management is an essential ingredient

(see Jones and Kaltenbach, 2013 for additional information)

1.58

Improving Engagement and Retention: Strategies

- Develop Relationships Early
- Manage or Eliminate Waiting Lists
- Use Motivational Strategies
- Place Reminder Phone Calls, Text Messages, or Email
- Provide Continuous Feedback
- Ensure a Positive Environment – Physically and Emotionally
- Engage Women's Partners
- Address Co-occurring Disorders
- Engage Women in Improving Services

(Research to Practice Brief. National Infants Assistance Resource Center. UC Berkeley;; Jones and Kaltenbach, 2013)

1.59

Improving Engagement and Retention: Therapeutic Relationships

Develop Relationships Early

- Screening, Assessment, and Intake should be seen as the beginning of the therapeutic relationship, and not as a prelude to "treatment admission"
- Have continuity of staff who are interacting with the woman
  - Support throughout contact with the agency is a key component in both treatment engagement and treatment retention.

(Jones and Kaltenbach, 2013)

1.60

Improving Engagement and Retention: Interim Services

Manage or Eliminate Waiting Lists

- Failure to enter treatment is often directly related to having to wait to enter treatment.
- Patients who have to wait for services may develop the belief that the agency has little or no interest in them or their problems.
- Agencies need to change their practices so that waiting lists are eliminated, or wait times are short.

(Jones and Kaltenbach, 2013)

1.61

Improving Engagement and Retention: Address Ambivalence

Use Motivational Strategies

- Motivational Interviewing is a brief, directed intervention intended to explore a patient's ambivalence.
- Motivational Interviewing has a toolkit of techniques that can be used to increase both treatment engagement and treatment retention.

(Jones and Kaltenbach, 2013)
(Korcha et al., Counselor (Deerfield Beach). 2015;16(3):62–69)

1.62

Improving Engagement and Retention: Explore Barriers

Understand and Address Individual Barriers

- Each patient will have her own individual barriers to treatment
- It is critical to treatment retention that the interventionist work with the patient to find ways to address her particular set of barriers
  - *Case management skills can help the interventionist work effectively with his or her patient*

(Jones and Kaltenbach, 2013)

1.63

Improving Engagement and Retention: Feedback

Provide Continuous Feedback

- Review progress
- Revisit goals
- Provide feedback

(Jones and Kaltenbach, 2013)

1.64

Improving Engagement and Retention: Environment Matters

Ensure a Positive Environment – Physically and Emotionally

- The agency environment tells your patients how you value them
- The environment should allow for privacy, should be well lit with soothing colors, and should be structured to allow for social interaction
- If it is not possible to provide child care services, then there should be a play area set aside for the children
- Staff who interact with patients at any level should be positive and supportive

(Jones and Kaltenbach, 2013)

1.65

Improving Engagement and Retention: Role of Partners

Engage Women's Partners

- Partner support is one of the single most effective ways to increase the likelihood of treatment retention
- If the partner also uses substances, it is critical to obtain services for him or her
- Partners, husbands and family may have conflicting feelings about the women getting treatment. Education about the treatment process can be helpful.
- In some cases, if the partner or other family blocks access to treatment, women can have better treatment outcomes if they separate from them. She needs support in this process but it can be the best for her health and well-being

(Jones and Kaltenbach, 2013)
(Jones et al., 2011)

1.66

Improving Engagement and Retention: Mental Health Matters

Address Co-occurring Disorders

- Women who use substances often have a multiplicity of needs given their backgrounds
- They have very often experienced neglect, physical and sexual abuse
- As a result, they very often have need of mental health services
  - *Trauma-informed services have been shown to work best for this population*

(Jones and Kaltenbach, 2013)

1.67

Improving Engagement and Retention: What Women Think Matters

Engage Women in Improving Services

- In addition to the interventionist soliciting feedback from her patients, the agency should solicit feedback from its consumers
- Create a Consumer Advisory Board of past and current patients to provide feedback on how the agency can best meet its patients' needs, and where it can make improvements in its services.
  - *It is important to let patients give input on the services they receive and to adjust services based on this collective input.*

(*Research to Practice Brief*. National Infants Assistance Resource Center. UC Berkeley).

1.68

Summary of Engagement and Retention for Women

- The therapeutic partnership is a process in which the interventionist and patient communicate on a regular basis regarding the goals of treatment, and how these goals might best be met
- Engagement does not mean than a patient simply enters treatment
- Likewise, retention does not mean that a patient remains in treatment
- Rather, Treatment Engagement and Retention are processes that reflect on commitment to partnership with the patient on the part of the agency and interventionist to see her treatment needs are met
- Engagement and retention are the two building blocks of treatment success

1.69

Health and Wellness for Women

- Difference between drug abstinence and recovery
- Recovery includes taking and maintaining control of life in health, environment, economy, attitude, social stability and purpose the promise of recovery must offer more than the removal of alcohol and other drugs from one's life. For the person staring into the abyss, the promise of recovery to a life of meaning and purpose may be far more potent than the promise of recovery from addiction.

(https://www.samhsa.gov/recovery)
(http://www.williamwhitepapers.com/pr/dlm_uploads/Quotes-from-William-White-Co-authors-2018.pdf)

1.70

Engaging Women: Wellness

- The absence of disease is not health
- If happiness is on the other side of success, we will never get there
- Positive brains perform better
- Becoming more positive in the present results in better performance
- Re-wire the brain for happiness

Every day for 21 days:

- **Write down three new things you are grateful for**
- **Journal gratitude – 1 positive experience that happened in the last 24 hours**
- **Get physical exercise**
- **Practice meditation**
- **Do something nice for others**

1.71

Exercise: Identify Ways to Improve Treatment Engagement with Women

Please divide into groups of 4-5 participants

Factor	Barriers	Solutions
Intrapersonal		
Interpersonal		
Sociocultural		
Structural		
Systemic		

Group 1: Intrapersonal
Group 2: Interpersonal
Group 3: Sociocultural
Group 4: Structural
Group 5: Systemic

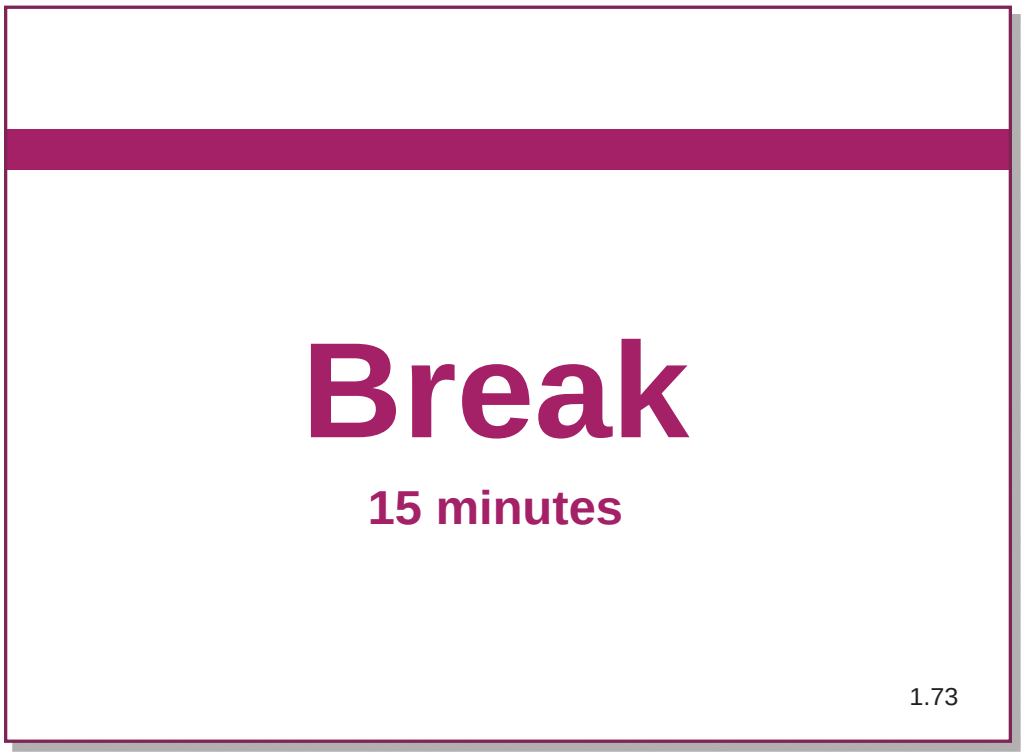
With your group, use the slides to identify specific barriers that exist in your treatment center for women and specific actions you can take to help women overcome these barriers

There are 12 minutes devoted to completing the handout

Each group will have 3 minutes to present their summary

HANDOUT: Exercise-Identify ways to improve treatment engagement with women

1.72


Break
15 minutes
1.73

Applying the International Standards to Women's Treatment

- Principle 1: Treatment must be available, accessible, attractive, and appropriate for needs
- Principle 2: Ensuring ethical standards in treatment services
- Principle 3: Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services
- Principle 4: Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders
- Principle 5: Responding to the needs of special subgroups and conditions
- Principle 6: Ensuring good clinical governance of treatment services and programs for drug use disorders.
- Principle 7: Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated

Note that this document contains a specific section devoted to women and pregnant women

1.74

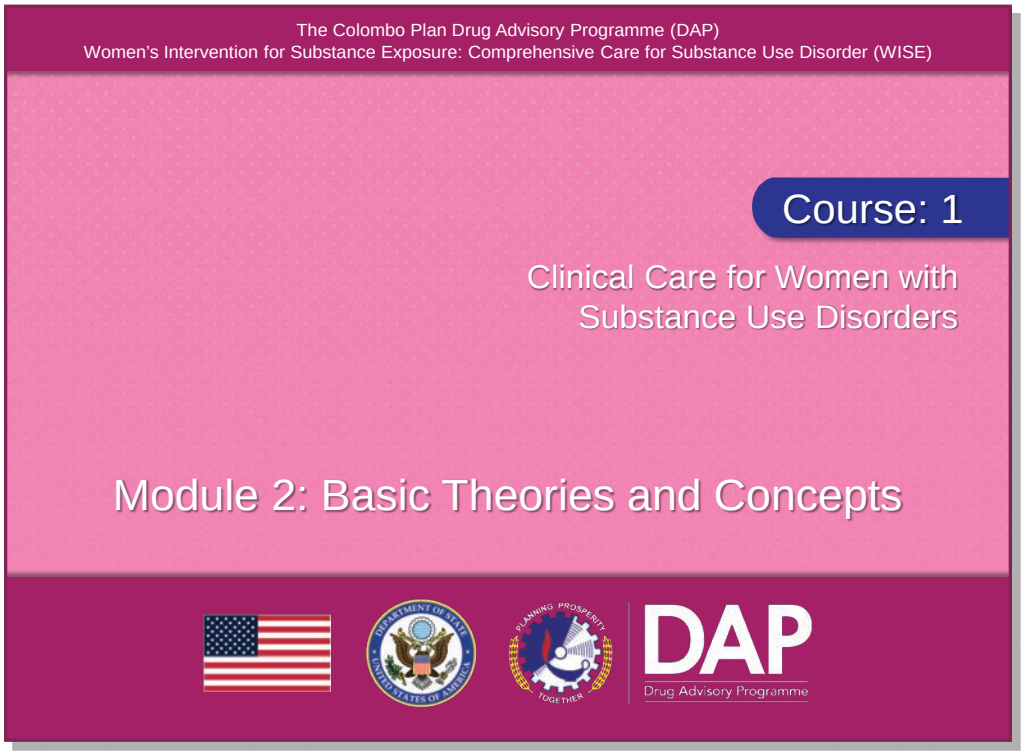
Summary of Learning Objectives: Module 1

- Recognize the core competencies needed to help treat women for substance use disorders
- Identify three ways women are uniquely affected by different substances
- Articulate three issues that differ in women's trajectory of substance use initiation, problem development, treatment and recovery from men's

1.75

MODULE 2

BASIC THEORIES AND CONCEPTS


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 2: Basic Theories and Concepts
DAP
Drug Advisory Programme

Learning Objective: Module 2

- Examine how the different theories underpin effective treatment for women with substance use disorders

2.2

Treatment That is Based on Theory and Evidence

- Research shows that substance use disorders are not a single dimension for women
- Substance use disorders are part of an individual's history and the social, economic and cultural factors that create her life
- "If treatment is to be effective, it must…take the context of the women's lives into account"

(eg, Jones and Kaltenbach, 2013)

2.3

Multiple Theories Guide Treatment

- **Behaviorist learning theories**
  - Four tenets of learning
    - learning being demonstrated by a change in behavior
    - the primary role of the environment in shaping behavior
    - the principle of contiguity
    - the principle of reinforcement
- **Cognitive learning theories**
  - Learning involves central constructs and new ways of perceiving events
  - Problems, like substance use disorders, are the result of maladaptive ways of thinking, distorted attitudes, and misperceptions of oneself and others
- **Social learning theory**
  - Transition between behaviorist learning theories and cognitive learning theories. This theory focuses on learning that occurs within a social context.
  - Observation, modeling and imitation
  - Maladaptive behaviors, such as substance use, are learned behaviors - suggests that the treatment would teach the patient with a substance use disorder new more adaptive behaviors
  - Concept of expectancies

2.4

(eg, Skinner, 1971, Rotter 1982,Gross, 1992, Ormrod, 1999, Jones and Kaltenbach, 2013)

More Key Concepts to Guide Treatment

Concept of Substance Use Disorders

- Disorder versus disease
- Substance use disorder as a neglect of self

Concept of women's psychological development

- Growth fostering relationships
- Substance use disorders and relationships

Trauma

- Complex relationship with substance use disorders
- Three stage model for trauma recovery
- Attachment Theory
- Concepts explaining an emotional bond between child and caregiver

2.5

(eg, Covington 2008; Suleiman 2008; Herman 1992)

Three Stage Model for Trauma Recovery

Stage 1

- Safety
  - When entering treatment a primary need is safety- women feel unsafe in their body and unsafe in relation to others
  - Providers help women with substance use disorders to feel physically and psychologically safe in treatment.

Stage 2

- Remembrance and mourning
  - Mourning of the self destroyed by trauma
  - Providers help women with substance use disorders to acknowledge and process the loss and grief in their lives.

Stage 3

- Reconnection
  - Developing a new self and creating a new future
  - Providers help women with substance use disorders to plan for the future, practice new self-connection and connection with others.

(eg, Herman J Trauma and Recovery, 1992)

2.6

Gender-Responsive Treatment: Grounded in Core Components

1. Addresses women's unique experiences
2. Is trauma informed
3. Uses relational approaches
4. Is comprehensive to address women's multiple needs for wellness

(see document for original citations and references: https://www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf Greenfield & Grella, 2009).

2.7

Women Need Gender-Responsive Treatment

- Gender Responsive - addresses factors that are more frequently seen in women and may affect women's treatment outcomes
- Women tend to have better treatment outcomes if they are in a women-only treatment program rather than a mixed-gender program
- A women-centered program is defined as having everyone in the program working to take into account the issues that women face in their lives
- Each patient is seen to have her own unique strengths and vulnerabilities and treatment serves to promote her strengths and reduce vulnerabilities.

(see document for original citations and references: https://www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf Greenfield & Grella, 2009).

2.8

Elements of Effective Women's Treatment

- Adequate treatment period is crucial
- Individual & group counseling (women only)
- Co-occurring disorders treated in an integrated way
- Medication as needed
- Empowerment Model and Strengths Perspective
- Recovery is a long-term process & frequently requires multiple treatment episodes

2.9

(Jones and Kaltenbach, 2013)

Exercise: Putting Evidence into Practice for Women

Small Group Exercise

- Divide into five groups and select and apply one or more theories to the case that is assigned to your group. Add in your own details to the case. Groups have 15 minutes to discuss and summarize what theories they would use and how they would be applied. There will be 5 minutes per group for the presentation.
- Case 1: A woman 25 years of age is brought to treatment by her husband. He is with her in the waiting room, reviews the health form she completes and gets upset when you tell him he cannot come into the exam room with her and you. You notice on her screening form that she reports depressed mood.
- Case 2: A woman 19 years of age comes to treatment due to family concerns. She is very underweight, sad, has scars on her wrists. She starts to cry when you ask her what brought her to see you today.
- Case 3: A woman age 35 comes to treatment. Her husband has red eyes, slurred speech and she is clearly afraid of him. Her two children (ages 10 and 6) cling to their mother's leg. She has a black eye that is healing.
- Case 4: A 56 year old woman comes to the health clinic complaining that she cannot sleep. She smells of alcohol. She has bruises on her neck. She says her family does not know she came to the clinic and she needs to leave in an hour.
- Case 5: A 44 year old woman says she wants to lose weight. Her partner left her and she has no money and no job. She needs energy to get her life back together. Her pupils are large and do not constrict with light. She is aggitated.

2.10

Summary of Learning Objective: Module 2

- Examine how the different theories underpin effective treatment for women with substance use disorders

2.11

Lunch

60 minutes

2.12

MODULE 3

LEGAL AND ETHICAL ISSUES


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 3: Legal and Ethical Issues
DAP
Drug Advisory Programme

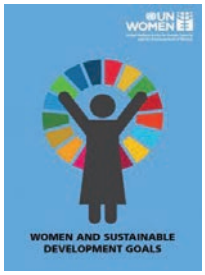
Learning Objectives: Module 3

- View women's treatment for substance use disorders through a human rights perspective and cultural conversation points
- Apply the UTC 8 ethical decision making framework to treating women for substance use disorders
- Articulate ethical principles that apply to the treatment of women for substance use disorders

3.2

View of Women's Treatment: Lens of Human Rights and Culture

- The 2030 sustainable development goals will only be accomplished if women have equitable access to the tools they need to thrive



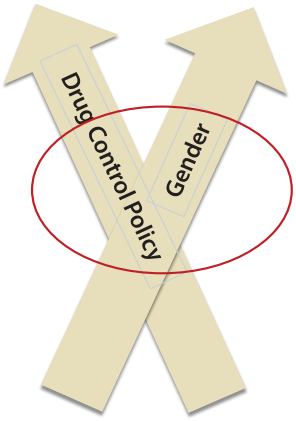
"The complex interplay of culture and health—
as well as the influence of differing attitudes toward, definitions of, and beliefs about health and substance use among cultural groups—affects the psychosocial development of women and their alcohol, drug, and tobacco use and abuse."

(SAMHSA, 2009, pp. xxi–xxii)

3.3

View of Women's Treatment: Policy and Gender Equality

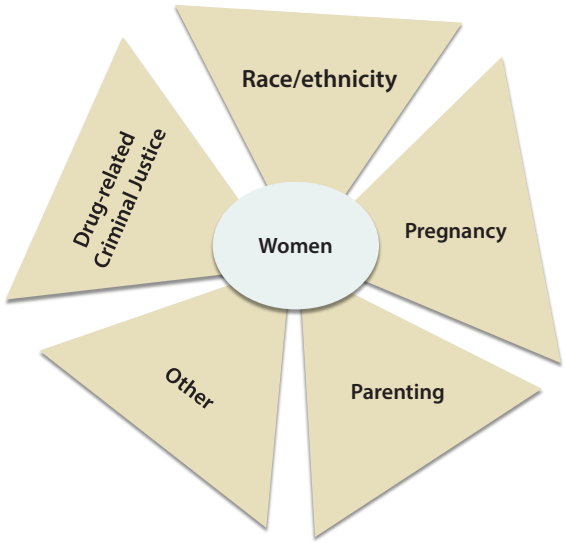
- Women's rights and gender equality are rarely seen in drug policy
- Public health effects of drugs are gender specific
- Women's specific needs are often ignored in treatment
- 2016 Report of the International Narcotics Control Board focused on women and UN General Assembly on Drugs member state committees agreed to bring a gender perspective into drug polices and programs



Pinkham S. et al., Adv Prev Med 2012; Azim T et al., Int J of Drug Policy 2015; https://www.unodc.org/documents/ungass2016/Contributions/UN/Gender_and_Drugs_-_UN_Women_Policy_Brief.pdf; https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ChapterIV-Recommendations.pdf

3.4

View of Women's Treatment: Intersection of Ethics and Policy Issues



3.5

Exercise:Thinking About What We Know and Need to Know

Small Group Exercise

- Divide into groups of 4-5 participants. Groups have 15 minutes to discuss what they know and what they need to know about how the following factors influence the treatment of women for substance use disorders in their community. We will have a general large discussion for 15 minutes about the issues.

Issue	What we know	What we need to know
How does citizenship play a role in treatment access and delivery?		
How does religion play a role in treatment access and delivery?		
How does the law play a role in treatment access and delivery?		
How does race and/or ethnicity play a role in treatment access and delivery?		
What are the other factors that play roles in treatment access and delivery for women?		

HANDOUT: Exercise-Thinking about what we know and need to know

3.6

Ethical and Professional Responsibilities of Providers

- Adhere to established professional codes of ethics
- Adhere to laws and agency regulations
- Interpret and apply information from current counseling and substance use disorder treatment research
- Recognize the importance of individual differences
- Conduct self-evaluation of professional performance
- Obtain appropriate continuing professional education
- Participate in ongoing supervision and consultation
- Develop and use strategies to maintain holistic health

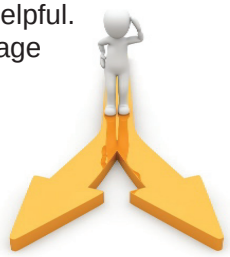
3.7

(Gallon, S L & Porter, J (2011). Performance Assessment Rubrics for the Addiction Counseling Competencies. Portland, OR: Northwest Frontier ATTC)

Women's Treatment: Ethical Decision Making

When providing treatment to women, there are many ethical issues that arise. Examples of issues include relationship dynamics, parenting, family dynamics/relationships, women's safety, working relationships with social and child protective services

Use of a decisional framework to approach cases can be helpful. The UTC 8 Ethics for Addiction Professionals, Resource Page 3.1. Ethical Decision-Making Model can be used here.



1. Whose interests are involved? Who can be harmed?
2. How may primary stakeholders be involved or harmed?
3. Whose interests, if any, are in conflict
4. What universal values can be applied?
5. What laws, standards, policies, historical practices, or cultural teachings could or should guide you in this situation?

(Adapted from White, W. L., & Popovits, R. M. 2001)

3.8

Women's Treatment: Ethical Considerations

Bioethical principles and decision making in the care of women with substance use disorders

- Respect for persons
- Beneficence
- Compassion
- Honesty
- Justice
- Autonomy- can be viewed in different ways in different cultures

The presence of conflicts shows that mere knowledge of ethical principles is not adequate preparation for clinicians working with the complex issues that naturally emerge in the care of women with substance use disorders.

(Roberts LW, Dunn LB, .2003)

3.9

Women's Treatment: Ethical Issue Domains

Domains of Ethical Conflicts:

1. Voluntarism
2. Beneficence, compassion, and reducing risk
3. Confidentiality and truth-telling
4. Respect for persons and justice
5. Informed consent

Proactive policy-level and systemic action steps can be taken to enhance the ethical caliber of care.

Such efforts will help ensure that women who have substance use disorders will be cared for in a manner that is respectful, beneficent, compassionate, honest, and just.

(Roberts LW, Dunn LB,.2003)

3.10

Exercise-Apply the UTC 8 Ethical Decision Framework to Cases with Women's Treatment

Large Group Exercise

Please divide into 4-5 groups and turn to the hand out which includes various cases that pose ethical dilemmas. The handout also includes the ethical decision framework to our discussions.

We will discuss the cases for 15 minutes in smaller groups and then have a large group discussion for 15 minutes more.

HANDOUT: Exercise-Apply the UTC 8 Ethical Decision Framework to Cases with Women's Treatment

3.11

Summary of Learning Objectives: Module 3

- View women's treatment for substance use disorders through a human rights perspective and cultural conversation points
- Apply the UTC 8 ethical decision making framework to treating women for substance use disorders
- Articulate ethical principles that apply to the treatment of women for substance use disorders

3.12

Break

15 minutes

3.13

MODULE 4

THE IMPORTANT ASPECTS OF CREATING A WOMEN-RESPONSIVE THERAPEUTIC TREATMENT ENVIRONMENT


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 4: The Important Aspects of Creating A Women-Responsive Therapeutic Treatment Environment
DAP
Drug Advisory Programme

Learning Objectives: Module 4

- Identify at least three factors that are needed for a positive therapeutic environment for women
- Articulate three ways to help women feel physically and psychologically safe in a mixed-gender treatment setting

4.2
2

Treatment Environment Matters

- Treatment needs to be approached from the complete context of a woman's life
- Need to create an environment that fosters safety, respect and dignity
- Women recover in an environment that creates healing-
- Keys to healing are:
  - Safety
  - Mutuality
  - Empowerment

4.3

(eg, Covington 2008)

Keys to Ensuring and Maintaining A Safe Healthy Atmosphere for Women

1. Availability
2. Only make promises that will be kept
3. Listen to your patients
4. Keep the patient informed
5. Address complaints
6. Be helpful
7. Train all providers, staff, and administrators to be always helpful
8. Take the extra step
9. Maintain a positive attitude
10. Be patient
11. Regularly review the clinic's physical environment
12. Be respectful

(see document for more references and citations Jones and Kaltenbach, 2013)

4.4

Gender Dynamics in Treatment Settings

- Benefits of women helping women
- What to do if you have only a few women among men
  - Give time and space for women
  - Acknowledge the bias towards men
  - Talk about what is needed for physical and psychological safety- have ways to report and respond to unsafe behavior
  - Have resources for women's health –mental and physical
- Connecting women to resources
- Gender sensitized staff- staffing pattern matters
- Assessments and treatments can still be gender-responsive

4.5

(https://store.samhsa.gov/shin/content/SMA16-4979/SMA16-4979.pdf)

When Treatment Is Not Trusted: Women Will Not Enter or Stay

- Women are a hidden and under-recognized population of people with drug use disorders.
- Outreach from social workers and trusted community representatives can be helpful in reaching women
- Screening and assessment tools for substance use disorders and other mental health issues for women are available
- Consider the unintended consequences of labelling with diagnoses
- Take the time needed to build rapport and a solid trusting relationship
- Empowering increases the chances of a successful outcome

4.6

(https://www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf)

Exercise: Identify Ways to Improve the Treatment Context

Divide into groups of 4-5 participants

Develop specific ways to improve your assigned items

Group 1: ♦ Availability ♦ Only make promises that will be kept and ♦ Listen to your patients

Group 2: ♦ Keep the patient informed ♦ Address complaints ♦ Be helpful - even if there's no immediate pay-off in it

Group 3: ♦ Train providers, staff, and administrators to be helpful ♦ Take the extra step ♦ Maintain a positive attitude

Group 4: ♦ Be patient ♦ Review the clinic's physical environment ♦ Be Respectful

There are 15 minutes devoted to the group work and 3 minutes per group to present the summary of your discussion.

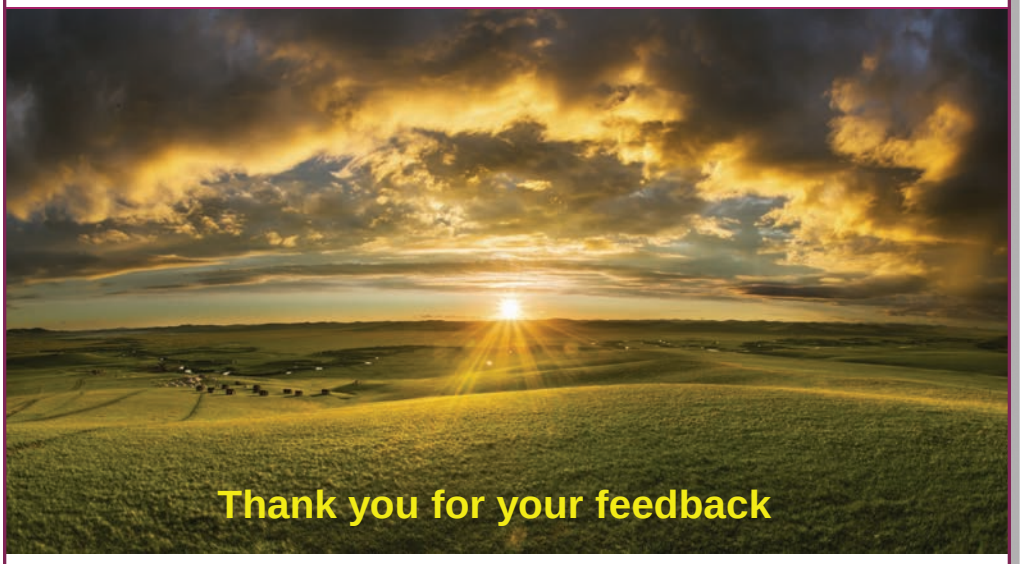
4.7

Summary
Learning Objectives: Module 4

- Identify at least three factors that are needed for a positive therapeutic environment for women
- Articulate three ways to help women feel physically and psychologically safe in a mixed-gender treatment setting

4.8

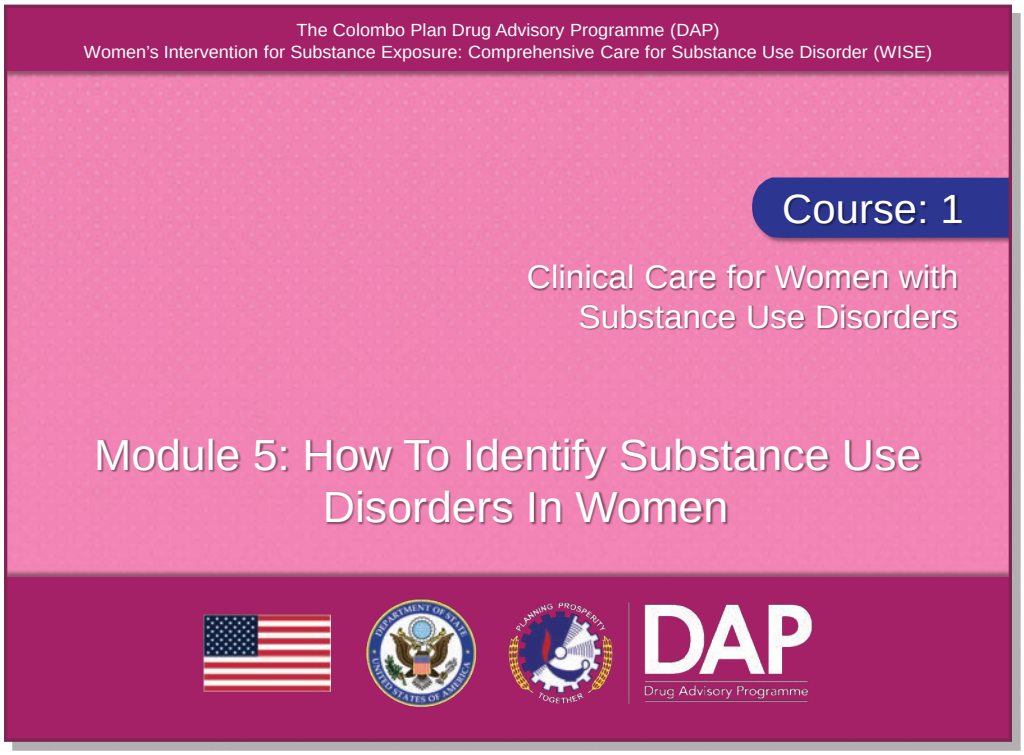
Day 2 Wrap-Up



4.9

MODULE 5

HOW TO IDENTIFY SUBSTANCE USE DISORDERS IN WOMEN


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 5: How To Identify Substance Use Disorders In Women
DAP
Drug Advisory Programme

Learning Objectives: Module 5

- Identify key issues in the selection and administration of screening instruments
- Demonstrate basic screening rapport with women

5.2

Screening: What is it and Why Universal?

- Screening is different than assessment
- In 2001, the Institute of Medicine called on clinicians to implement universal screening for health risk behaviors, including substance use disorders, with appropriate follow-up and referral.
- Screening for substance use with a validated tool should be an essential component of routine health care beginning in adolescence, with the goal of early intervention and referral for treatment prior to the development of serious morbidity.
- Negative attitudes toward women struggling with alcohol and drug dependence may contribute to screening avoidance by providers.
- Selective screening based on “risk factors” perpetuates discrimination and misses most women with problematic use

(https://aspe.hhs.gov/system/files/pdf/158971/SBIRTbarr.pdf)

5.3

Screening: Why is it Important?

- Identifying women who have a substance use disorder as early as possible is important to get them appropriate care and make referrals to specialized treatment.
- Screening is the first step on the path of treatment
- Continued use of substances is common among women until they are treated. Need to look at poly-substance use as the rule not the exception.

5.4

Screening: Differs From Urine Testing

Category	Screening with an instrument	Urine Testing
Purpose	To detect possible illness indicators	To establish presence/absence of a recent substance use
Test method	Simple, quick, acceptable to patients and staff	May take days for results and must be GC/MS or other confirmed test
Positive result threshold	Generally chosen towards high sensitivity not to miss potential disease	Chosen towards high specificity (true negatives). More weight given to accuracy and precision
Cost	Cheap, benefits should justify the costs since large numbers of people will need to be screened to identify a small number of potential cases	Higher costs associated with test; cost may be justified to establish specific result

* All Require Informed Consent and Neither are a Diagnosis of A Substance Use Disorder. GC, gas chromatography; MS, mass spectrometry
Adapted from: https://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/screening-diagnostic-case-finding

5.5

Screening: Tool Selection

- Instruments tested with women:
  - Alcohol: Tolerance, Annoyed, Cut-down, Eye-opener (T-ACE)
    - 4-item scale used to screen for risky drinking during pregnancy, defined as the consumption of 1 ounce or more of alcohol per day while pregnant
  - Tolerance, Worried, Eye-opener, Amnesia, K[C]ut-down (TWEAK)
    - 5-item scale developed originally to screen for risky drinking during pregnancy
  - Substance Use Risk Profile-Pregnancy Scale (SURP)
    - 3-item scale used to screen for hazardous substance use by pregnant women
  - ASSIST
  - NIDA Quick Screen

(https://store.samhsa.gov/shin/content//SMA18-5054c/SMA18-5054.pdf
http://www.who.int/substance_abuse/activities/assist/en/
https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen)

5.6

Screening: Tool Selection (cont.)

Tool		Sensitivity	Screens for	Validation
ASSIST	8 Initial questions with follow up/lengthy	54%-97% Sensitive	Specific drugs of use, EtOH and tobacco	Cross-nationally/WHO screening tool.
	Discriminates between casual use/use disorders	50%-96% Specific		Not for prenatal patients
AUDIT-C	3 Questions/ approximately 1-2 min	67%-95% Sensitive 85% Specificity Positive predictive value 92%-100%	EtOH use	For prenatal patients Sensitivity varies widely in different studies
CRAFFT	Validated for use for patients aged 15-24 six Questions/ approximately 2-3 min	76% Sensitivity 94% Specificity	EtOH and drug use	Recently for prenatal patients
Substance Use Risk Profile Pregnancy Scale	3 Questions/ approximately 2 min	91% Sensitivity 67% Specific	EtOH and THC	Recently developed Specifically for prenatal patients
T-ACE	4 Questions/ approximately 1-2 min	69%-88% Sensitivity 1%-89% Specificity	EtOH only — for heavy use	For prenatal patients
TICS	2 Questions/<1 min	80% Sensitivity 80% Specificity Negative predictive value 92.7%	EtOH and drug use	Easy to implement in primary care setting
TWEAK	5 Questions/ approximately 1-2 min	71%-91% Sensitivity 73%-83% Specificity	ETOH only — effective for heavy use	For prenatal patients

5.7

(Goodman DJ, Wolff KB, 2013)

Screening: Barriers

Female Patient	Provider
Fear of discrimination or judgment Previous bad experience with health care provider Fear of legal issues They don't consider their use problematic	"My patients don't use drugs" "I don't have time" "I won't get paid" "I don't know what to do if they screen positive"

5.8

Screening: Overcoming Barriers

Female Patient		Provider	
Fear of discrimination or judgment Previous bad experience with health care provider Fear of legal issues They don't consider their use problematic	Trust of provider can overcome fear and past experiences Having time to talk about ambivalence	"My patients don't use drugs" "I don't have time" "I won't get paid" "I don't know what to do if they screen positive"	Knowledge and tools Ways to get reimbursed or feel rewarded for helping Having tools to refer or provide brief help

5.9

Screening: Setting, Roles and Responsibilities

- Screening for substance use should always occur with a woman alone
- Some instruments are designed to be administered verbally by a health care provider; others can be self-administered if the patient can read
- How the questions are asked tends to be more important than who is asking
- A screening protocol is a smoother process if there is general acceptance from everyone on staff
- Practical issues to consider in choosing which instrument

5.10

(Goodman DJ, Wolff KB. 2013)

Screening: Tips for Informed Consent Before Taking Biological Samples for Tests

- The woman should be asked to provide informed consent for urine, blood, or saliva screenings for substance use.
- Oral consent is often used, but a signed form is preferred.
- The healthcare professional should review with the woman:
  - Risks and limitations of each type of test.
  - Need for confirmatory testing for any positive results.
  - The process and meaning of test results before specimen collection.
  - Local legal implications of testing.
- Have a written protocol for what happens after a positive screen.

(Goodman DJ, Wolff KB. 2013; https://store.samhsa.gov/shin/content//SMA18-5054c/SMA18-5054.pdf)

5.11

Exercise: Practice Screening Role Play

- As a large group discussion-
- How will you introduce the screen?
- What will you tell the woman about what is done with the results?
- How will you ask the questions?
- What other information do you need to share with her?
- Divide into pairs
- Take turns being the patient and the screener
- Discuss what it was like to be the patient and screener
- Total exercise time 30 min

HANDOUT: Practice Screening Role Play

5.12

Summary
Learning Objectives: Module 5

- Identify key issues in the selection and administration of screening instruments
- Demonstrate basic screening rapport with women

5.13

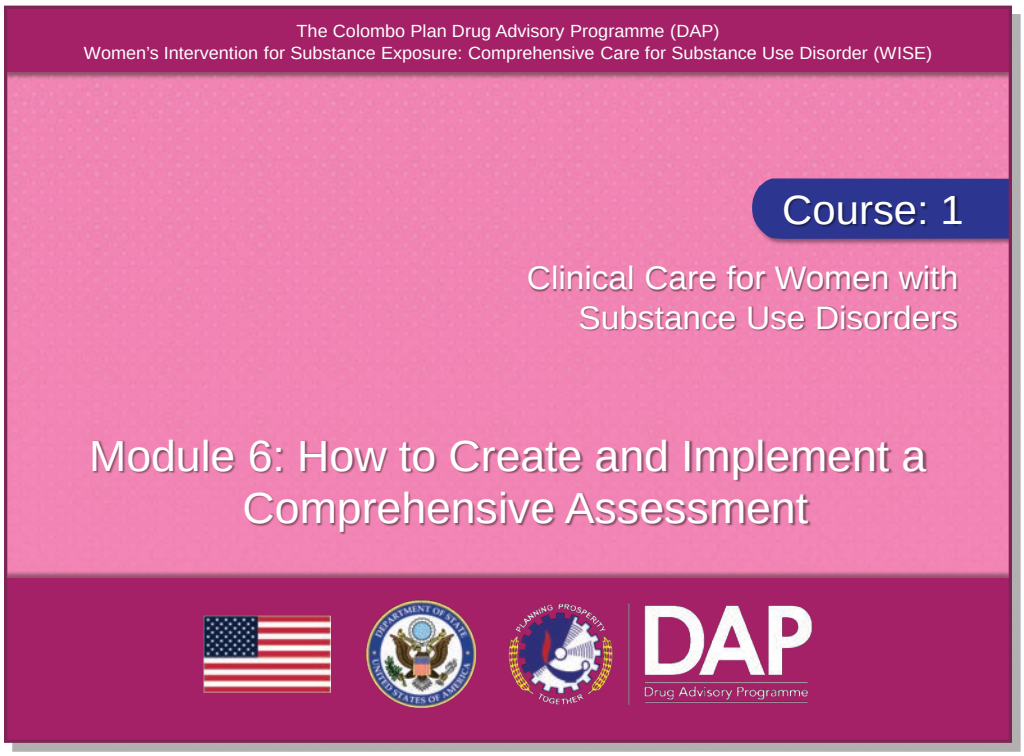
Break

15 minutes

5.14

MODULE 6

HOW TO CREATE AND IMPLEMENT A COMPREHENSIVE ASSESSMENT


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 6: How to Create and Implement a Comprehensive Assessment
DAP
Drug Advisory Programme

Learning Objectives: Module 6

- Identify key issues in the selection and administration of assessment instruments
- Demonstrate basic assessment rapport with women

6.2

Assessment: A Multiple Time Event That is Important

- Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.
- Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.
- Provides measure of progress over time.

Part 5 Elements of comprehensive women-specific assessment (Objective 4)

6.3

Assessment: Establish Rapport, Trust and Safety

- The success of an assessment is dependent on the extent to which the woman trusts you- what will you think of her, what will you do with her intimate life details and what are the ramifications or consequences to her if she trusts you with the information.
- Before the assessment, it is important to obtain her informed consent
- Other tips to establish safety and trust include:
  - Practice a non-judgmental approach
  - Let her know that the assessment result may lead to more questions or even a family assessment
  - Talk about the limits of confidentiality

6.4

(Gallon, S L & Porter, J (2011). Performance Assessment Rubrics for the Addiction Counseling Competencies. Portland, OR: Northwest Frontier ATTC)

Assessment: Data Sources and Breadth

- Data systematically gathered – from the woman and from other available records and individuals that are appropriate to talk to (with her informed consent)
- Data should include current and historic:
  - Substance use
  - Physical health (including reproductive)
  - Mental health
  - Treatment history
  - Social, environmental, and/or economic factors
- Look for and respond to substance toxicity, intoxication, and withdrawal
- Respond to aggression or danger to self and/or others

6.5

(Gallon, S L & Porter, J (2011). Performance Assessment Rubrics for the Addiction Counseling Competencies. Portland, OR: Northwest Frontier ATTC)

Assessment: Barriers and Overcoming Them

Female Patient		Provider	
Fear of discrimination or judgment	Trust of provider can overcome fear	"I don't have time"	Ways to have the simplest and most effective tool
Fear of legal issues	Keep the assessment limited to only the specific issues that can inform treatment	"I won't get paid"	Get reimbursed or feel rewarded for helping
Embarrassment	Take time to talk about ambivalence		
Takes too much time			
They don't consider their use problematic			

6.6

Assessment: Validated Tools

Addiction Severity Index (ASI) is the most widely used substance use assessment instrument in both research and clinical settings.

- Semi-structured interview
- High levels of reliability and validity across genders, races/ethnicities, types of substance use disorders, and treatment settings

ASI-F: The ASI-F is an expanded version of the ASI; several items were added relevant to the family, social relationships, and psychiatric co-morbidities.

- Additional items ask about homelessness; sexual harassment; emotional, physical, and sexual abuse; and eating disorders.

*Make sure to also include measures of the patient's strengths, abilities and preferences

(McLellan et al. 1980; Comfort and Kaltenbach 1996; CSAT 1997)

6.7

Assessment: Domains to Include

Measure problems in domains of life that are harmed by substance use:

- Medical
- Psychological- victimization
- Drugs
- Alcohol

Health- physical and mental

- Employment
- Legal
- Family and social - children

Social Functioning

(McLellan et al., 1985;. McLellan et al., 2006; Cacciola et al., 2011)

6.8

Assessment: Aspects of Physical Health for Women

Physical health assessment can include, but does not have to be limited to:

- Overall current physical health- all body systems
- Health history and presence of disease
- Infections and infectious diseases (i.e. TB, HEP, HIV)
- Chronic diseases (diabetes, high blood pressure, etc.)
- Dental needs
- Physical challenges that impact daily life
- Developmental status
- Pregnancy history and status

6.9

Assessment: Aspects of Mental Health for Women

Mental health assessment usually includes asking about (at a minimum):

- Depression
- Anxiety
- Post-traumatic stress disorder
- Eating disorders
- Cutting/self harm
- Suicide
- History of abuse, trauma, neglect
- Cognitive or learning disabilities
- Other major psychological disorders

6.10

Assessment: Aspects of Social Functioning for Women

Assessment of social circumstances includes gathering information about the following:

- Food sufficiency
- Access to clean water
- Living conditions
- Family members- children, elders, siblings, partner/husband
- Peers/friends
- Support systems
- Religious or spiritual beliefs and practices
- Educational status
- Employment status (paid and unpaid work and responsibilities)
- Other activities/interests
- Legal system involvement
- Access to transportation
- Access to health care services, etc.

6.11

Exercise: Assessment - Develop Domains to Include for Women in Your Community

- Break into 5 groups and develop a list of components that you want to make sure are covered in an assessment for a woman who screened positive for substance misuse
- There are 15 minutes devoted to completing the assignment and then each group has 5 minutes to report their summary.
- Group 1= Physical Health (excluding drug use)
- Group 2= Mental Health
- Group 3= Demographics, family, friends, supports and social issues
- Group 4= Legal Issues
- Group 5= Drug use

6.12

Lunch

60 minutes

6.13

Assessment: Roles and Responsibilities

- Assessment should always occur with a woman alone
- How the questions are asked tends to be more important than who is asking
- Practical issues to consider in choosing which instrument to use include ease of administration, the amount of time the tool takes and if it must be purchased
- The woman should be asked to provide informed consent for assessment
- Review with the woman:
  - Risks and limitations of the assessment
  - Local legal implications of answering
  - Her ability to refuse to answer questions
  - Have a written protocol for what happens after the assessment
  - Give her the results and let her know what they mean

6.14

Assessment: Areas of Attention

Professionals using assessment tools should pay careful attention to the following areas of concern:

- Gather specific information: Assessment tools should seek out specific information needed.
- Follow-up to assess progress: Frequency of use of assessment tools may vary, but some follow-up should be used throughout the intervention in order to track progress or document new information.
- Communication style. Communication style is essential to the success of an assessment.
- Scoring and interpretation matter. Proper scoring and interpretation of scoring will inform the provider of unique challenges and areas to focus on with the woman.
- Accurate recording of information will improve the intervention. The data recorded is only valuable when the information is documented accurately and then used to create the treatment plan.

6.15

Assessment: Cultural Considerations

- Ethnicity and culture
- Acculturation and language issues
- Socioeconomic status
- Cognitive and learning disabilities
- Strengths
- Coping styles
- Spirituality

(see document for original citations and references: https://www.ncbi.nlm.nih.gov/books/NBK83253/; Paniagua 1998)

6.16

Culturally Responsive Assessment

- Instruments should be used that have been adapted and tested on women
- Most instruments have not been tested on women across cultural groups, and caution should be taken in interpreting the results.
- Assessor need to discuss the limitations of instruments they use with patients
- Acculturation levels can affect screening and assessment results.
- Even though a woman may speak the language well, she may have trouble understanding the subtleties of questions
- Interviews should be conducted in a patient's preferred language by trained staff members or an interpreter from the woman's culture (not a family member).
- All of the above bullets pertain to screening too

6.17

(see document for original citations and references:
https://www.ncbi.nlm.nih.gov/books/NBK83253;Gopaul-McNicol and Brice-Baker 1998)

Culturally Responsive Assessment: Hints

Helpful Hints:

- Take a non-confrontational and non-judgemental approach
- Develop rapport
- Be honest and provide information
- Emphasize confidentiality

Part 5 Elements of comprehensive women-specific assessment (Objective 4)

6.18

Culturally Responsive Assessment: Be Prepared

What you will need:

- Copy of the instrument you will be using
- Pen to record the answers
- Calendar with days, weeks and months
- Response cards to match the instrument
- Tissues
- Water, light snacks

Part 5 Elements of comprehensive women-specific assessment (Objective 4) 6.19

Assessment: Informs the Treatment Plan

- The assessment identifies specific strengths of the woman and other social supports which can become a part of the treatment plan.
- It facilitates the development of a written summary that:
  - Determines the severity of the use
  - Identifies factors that contribute to or are related to substance misuse
  - Identifies the woman's strengths, needs, abilities and preferences for help
  - Identifies a corrective treatment plan to address the problem areas
  - Details a plan to ensure that the treatment plan is implemented and monitored to its conclusion
  - Makes recommendations for referrals to other agencies or services as needed

6.20

After The Assessment: Talking Points

- Help the woman in identifying the effects of substance use on her current life problems
- Talk with her about how ready she may be for treatment
- Review the treatment options appropriate for her
- Develop with her an initial action plan about how she will get to treatment and what she needs to do before she starts
- Based on the initial action plan, take specific steps to initiate an admission or referral and ensure follow-through.

https://pixabay.com/en/family-women-holzfigur-figure-2730602/

(Gallon, S L & Porter, J (2011). Performance Assessment Rubrics for the Addiction Counseling Competencies. Portland, OR: Northwest Frontier ATTC)

6.21

Assessment: Who Assesses Matters

- The assessor should be a well-trained professional experienced with women
- The assessor should have sufficient training in the tools used
- The assessor should also be familiar with the local slang terms for particular drugs
- There should be a clearly designated lead person for collecting, gathering, summarizing, and interpreting the screening and assessment data
- The person who is the assessor should seek appropriate supervision and consultation about assessment and challenging issues
- The assessor should document assessment findings and treatment recommendations

(Gallon, S L & Porter, J (2011). Performance Assessment Rubrics for the Addiction Counseling Competencies. Portland, OR: Northwest Frontier ATTC)

6.22

Exercise: Introducing an Assessment to a Woman

Divide into pairs

Develop a script that includes all of the pertinent points in the assessment module slides to introduce the assessment to the woman and tell her what is going to happen and how her information will be used- 10 min

Discuss the scripts as a large group and modify your scripts- 10 min

Then practice the revised script in a pair- 3 min

Then, reverse so that each partner gets an opportunity to introduce the assessment- 3 minutes

Discuss as a large group- 5 minutes

6.23

Summary
Learning Objectives: Module 6

- Identify key issues in the selection and administration of assessment instruments
- Demonstrate basic assessment rapport with women

6.24

MODULE 7

HOW TO CREATE AND IMPLEMENT INDIVIDUALIZED CARE PLANS


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 7: How to Create and Implement Individualized Care Plans
DAP
Drug Advisory Programme

Learning Objectives: Module 7

- Identify key issues in the development and revision of treatment plans
- Demonstrate basic ability to develop a treatment plan for a woman who has a substance use disorder

7.2

What is a Treatment Plan?

A treatment plan is a written agreement between the patient and practitioner that describes:

- Problems to address
- Goals
- Objectives
- Intervention

Also can be described as a “road map” for a patient to follow

A treatment plan works best when it is a collaborative document that reflects the strengths and treatment plans that the woman desires and values

(Tuten, Jones et al., 2011)

7.3

Key Provider Competencies in Treatment Planning

- Use the assessment information to guide the treatment planning
- Explain assessment findings to the woman
- Examine treatment options in collaboration with the woman
- Prioritize with her needs in the order they will be addressed in treatment
- Formulate mutually agreed on and measureable treatment goals and objectives
- Develop appropriate strategies for each treatment goal
- Coordinate treatment activities and community resources
- Develop a mutually acceptable treatment plan and ways to monitor and evaluate progress
- Reassess the treatment plan at regular intervals or when indicated by changing circumstances

(Gallon SL, Porter J ,2011)

7.4

Treatment Planning: Knowing Community Resources Helps

- Relationships with civic groups, agencies, professionals, governmental entities, and the community helps
- Continuously assess and evaluate referral resources to determine their appropriateness
- Know when to have the woman self-refer versus when to have a counselor refer
- Match referrals to the woman's needs
- Explain clearly the necessity for and process of referral – increases follow-through
- Exchange relevant information with the agency or professional to whom the referral is being made in the confines of confidentiality rules and regulations and generally accepted professional standards of care
- Regularly evaluate the outcome of the referral- gather feedback from the woman

7.5

(Gallon SL, Porter J ,2011)

Introducing the Treatment Plan Process to the Woman

Key Points

1. The patient needs to feel that the plan is hers
2. The patient needs to be involved in the creation of the plan
3. Touch on each issue of her concern and the concerns of the provider (they do not always match) - have a preliminary plan for addressing each issue
4. Start quick work on a few, not all, issues at the same time
5. Make sure to highlight her strengths and successes at all points- every interaction should note strengths

7.6

(Tuten, Jones et al., 2011)

Break

15 minutes

7.7

Treatment Planning and Plan: Key Parts

1. Challenge statements
2. Master problem list
3. Prioritizing problem statements
4. Writing goals
5. Writing objectives
6. Writing interventions

Develop a cumulative strengths list that is added to with each interaction.

(Stilen P, Carise D, Roget N, Wendler A, 2007)

7.8

Treatment Planning and Plan: Challenge Statements and The List

What is a challenge?
A challenge is identified based on the assessment

What is the Master Challenge List?
Data collected during the assessment process is organized, interpreted, and reformulated into problem areas by the provider

Date Identified	Assessment Domain	Problem	Status	Date Resolved
	Alcohol/Drug	She reports several or more episodes of drinking alcohol to intoxication in past month.		
		She reports regular, lifetime use of alcohol to "intoxication." She reports tobacco use since age 15. She smokes 20 cigarettes/day		
		The patient reports using cocaine in past month.		
	Medical	She has a chronic medical problem that interferes with her life		
	Family/Social	She is not satisfied with how she spends her free time		
		Reports having serious problems with family members in the past month		
		She is troubled by family problems and is interested in treatments		

(Stilen P, Carise D, Roget N, Wendler A, 2007)

7.9

Treatment Planning and Plan: Domains

- Medical
- Employment
- Alcohol and/or other substances
- Legal
- Family/social
- Psychological
- Make sure to address crisis and safety needs first!

(Stilen P, Carise D, Roget N, Wendler A, 2007)

7.10

Treatment Planning and Plan: Prioritizing Challenge

- A Master Challenge List includes all of a patient's possible problems regardless of services available at the agency.
- Some challenges need to be addressed more urgently; in other words, some challenges will be deferred while others are addressed immediately. Patients need to help determine their most pressing challenges.
- Selecting only those challenges requiring immediate attention is the next step in the treatment planning process.
- The Master Challenge List is a dynamic document that should be revisited and revised often during treatment. Challenges will be resolved and new ones identified as the patient moves through treatment.

7.11

(Stilen P, Carise D, Roget N, Wendler A, 2007)

Treatment Plan: Goals Address Problem Areas

Goal: ***A statement of the condition you expect to change***

- Goals are created to address each challenge statement
- Goals are statements that describe in broad terms what the patient will learn from treatment.
  In other words, goals are a behavioral outcome statement.

Goals often involve the counselor working with the patient to achieve the goal

7.12

(Tuten, Jones et al., 2011)

Treatment Plan: How to Set Goals to Address Challenge Areas

Measureable

Achievable

Results-focused

Self-check goals by asking the following questions:

- Does the goal address the challenge statement?
- Will the patient be able to understand the goals as written? Is it free of clinical jargon?
- Is the goal statement clearly stated in a complete sentence?
- Is the goal attainable during the active treatment phase?
- How confident would you feel negotiating this goal with a patient? Will the goal be agreeable to both patient and staff?

7.13

(Tuten, Jones et al., 2011)

Treatment Plan: SMART Objectives

Specific
Measureable
Achievable
Results-focused
Time sensitive

Specific:
Make objectives specific and concrete

Measureable:
How will you know when objectives is achieved?

Achievable:
Can the patient reasonably be expected to meet objectives?

Results-focused:
The outcome for the objectives should be clear

Time-sensitive:
A timeframe for completing the objectives should be specified

(Tuten, Jones et al., 2011)

7.14

Treatment Plan: SMART Objectives-Example

Specific
Measureable
Achievable
Results-focused
Time sensitive

Example:

The patient will complete art therapy and trauma coping modules each week she is in the treatment program.

The first exposure to these modules will be accomplished by Wednesday, the 19th of October.

(Tuten, Jones et al., 2011)

7.15

Treatment Plan: SMART Objective- Another Example

Specific
Measureable
Achievable
Results-focused
Time sensitive

Example:

Depression

Patient will be able to report that she was able to verbalize sadness to family or peer at least one time per week as measured by self-report.

Increase involvement in activities with peers from 2 times to 5 times per week as measured by self-report and staff observation.

(Tuten, Jones et al., 2011)

7.16

Treatment Plan: SMART Objective- Another Example

Specific
Measureable
Achievable
Results-focused
Time sensitive

Example:

Anxiety

Patient will verbally identify fears, concerns, and anxiety at least one time per session.

Patient will show a decrease in anxiety from the baseline score om the ASI.

Patient will demonstrate positive self-talk at least one time per session.

Patient will practice relaxation techniques in the trauma coping module each time it is presented.

(Tuten, Jones et al., 2011)

7.17

Treatment Plan: SMARTER

7.18

Treatment Plan: SMARTER Objective Reinforcing

Specific
Measureable
Achievable
Results-focused
Time sensitive
Ensure
Reinforcement

Ensure that treatment plan includes objective that are reinforcing to the woman

- **Intention is to help the patient learn *new behaviors***
- **Treatment plan should not be all work**
- **Should include enjoyable activities that improve life functioning while meeting the objective**

(Tuten, Jones et al., 2011)

7.19

Treatment Plan: Objectives and Interventions

After the challenge is identified and the goals are established, the next part of the treatment plan is to develop objectives and interventions

Objectives are defined as what the patient will do to meet those treatment goals.

Interventions are defined as what the staff will do to assist the patient

(Tuten, Jones et al., 2011)

7.20

Treatment Plan: Breaking Goals Down into Objectives and Interventions

A seemingly simple goal can be broken into smaller steps or objectives that will help the patient to reach the goal.

One way to start thinking about objectives is to ask the following about the goal:

- How
- What
- Where
- When

Each objective may have barriers and the counselor can help the patient think through specific, concrete ways to overcome the barriers, and some of these may involve interventions on the part of the counselor

(Tuten, Jones et al., 2011)

7.21

Treatment Plan: Putting It Together

Case Example

Asa is a 19 year old woman who has been using opium every other day since age 7.

Parents introduced Asa to opium to help with sleep and reduce hunger.

Asa meets the criteria for depression and post-traumatic stress disorder.

Asa also cannot identify letters of the alphabet.

(Tuten, Jones et al., 2011)

7.22

Exercise: Use the Assessment To Develop A Treatment Plan

- Large group exercise to complete a treatment plan together
- We will review and identify the areas on the assessment that are concerns
- Then we will formulate treatment goals and objectives and interventions
- There are 45 minutes devoted to this group activity

See Resource page 7.23 (treatment plan blank and completed)

7.23

Treatment Plan: Hints for A Successful Start

Helpful Hints:

- Have the patient's chart and completed intake, screening and assessment forms with you when making the treatment plan.
- The treatment plan should be made ***with*** the participant, not for the participant.
- The treatment plan is an active document that gets reviewed and updated at each contact. Statements are non-judgemental.
- Avoid jargon statements.
- Use complete sentence structure when writing Problem Statements.

7.24

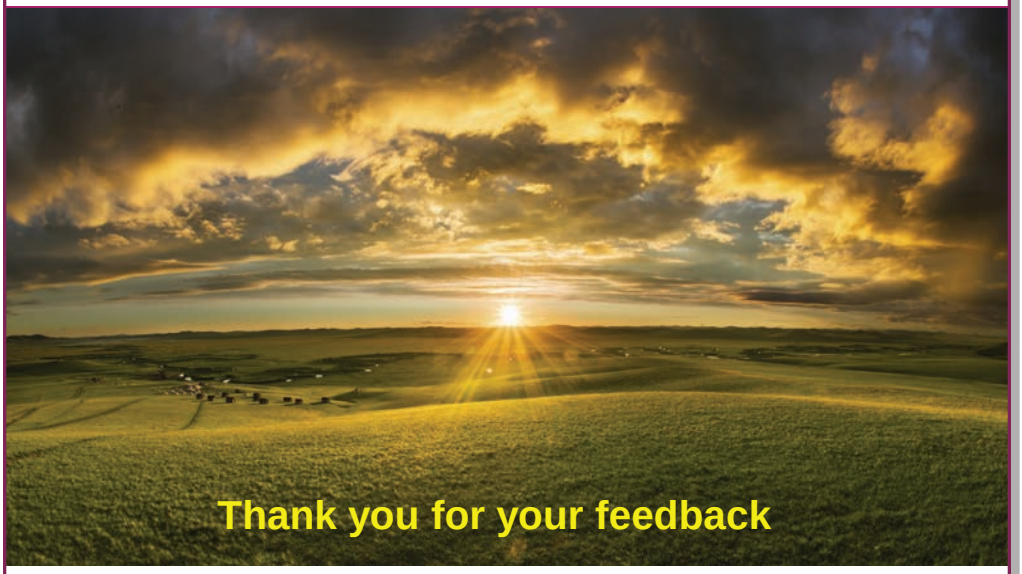
Treatment Plan: Expectations of Providers

- Establish a helping relationship with the woman.
- Facilitate the woman's engagement in the treatment and recovery process.
- Promote her knowledge, skills, and attitudes that all contribute to a positive change in substance use behaviors.
- Encourage and reinforce actions determined to be beneficial in progressing toward treatment goals.
- Recognize how, when, and why to involve her significant others in enhancing or supporting the treatment plan.
- Adapt counseling strategies to the individual characteristics of the woman.

(Gallon SL, Porter J, 2011)

7.25

Day 3 Wrap-Up



7.26

Treatment Plan: Considering The Woman's Relationships in the Process

- Understand the characteristics and dynamics of families, couples, and significant others affected by substance use- hers or others in her life.
- Facilitate the engagement of selected members of the family or significant others in the treatment and recovery process.
- Assist families, couples, and significant others in adopting strategies and behaviors which sustain recovery and maintain healthy relationships.
- Provide those in the woman's life that she identifies with needed education about substance use and its effects and related treatment.
- Provide the woman and her significant others/family with life skills, including but not limited to stress and anger management, relaxation, communication, assertiveness, and refusal skills.

7.27

(Gallon SL, Porter J, 2011)

Revising the Treatment Plan: Collaborating with the Woman

Using monitoring tools on a schedule that reflects patient needs to track progress:

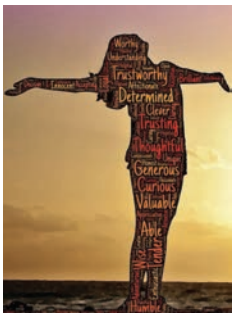
- Assessment
- Urine testing
- Counseling sessions
- Communication with patient

7.28

Revising the Treatment Plan: Affirm the Positive

Affirm and promote positive outcomes:

- Focus on the goals the patient has achieved and offer verbal praise
- Review treatment plan at each visit



(Tuten, Jones et al., 2011)

7.29

What if She is Not Meeting Her Treatment Goals?

- Identify barriers
- Offer resources to help overcome barriers
- Break goals into smaller steps
- Work with patient to set more attainable goals

(Jones and Kaltenbach 2013)

7.30

Breaking Goals Into Smaller Goals

Specific
Measureable
Achievable
Results-focused
Time sensitive

Smaller steps

Example:

The woman will complete art therapy and trauma coping modules each week she is in the treatment program.

The first exposure to these modules will be accomplished by Wednesday, the 19th of October.

The woman will complete 1 trauma coping module in the next 2 days.

The module will be completed by Wednesday, the 20th of October.

(Tuten, Jones et al., 2011)

7.31

Exercise: Practice Revising the Treatment Plan

- Divide into pairs to revise one part of the treatment plan (the trainer will assign you your section to revise)
- There are 15 minutes devoted to this pairs work
- We will then have a large group discussion for 15 minutes about the treatment plan revisions

HANDOUT: Use the treatment plan form that was used in the previous exercise

7.32

Treatment Plan: The Importance of Documentation

- It only counts if it is written down
- Documentation shows knowledge of accepted principles of patient record management
- Protect patient rights to privacy and confidentiality in the preparation and handling of records, especially in communication of patient information with third parties
- Record treatment and continuing care plans progress
- Document treatment outcome, using accepted methods and instruments in neutral and supportive language

(Gallon SL, Porter J, 2011)

7.33

Treatment Plan: The Importance of Documentation

Case notes are the narrative portion of the patient's treatment record; the "story" of what has occurred during the beginning, middle, and ending phases of treatment.

Case notes also provide a connection to the treatment plan.

A counselor not familiar with a patient's case should be able to read the case note section of the treatment record and understand exactly what has occurred in treatment.

Tx Plan Reflected in Documentation?

Client quote →	**S: "My husband has the children and he will not let me see them until I am a year drug free"**
Physiological observations? →	**O: Tearful at times; gazed down and fidgeted with scarf.**
Problem statements, testing results, ASI severity ratings, non-judgmental professional assessment →	**A: Client feels strongly that family is important in her recovery process. She is motivated to actively parent her children and is looking to resolve conflicts with his ex-wife.**
Goals, Objectives, Interventions →	**P: Addressed Tx Plan Goal 2, Obj. 3, Int. 4. Address Tx Plan Goal 3, Obj 1 in next 1:1 session.**

121

(Stilen P, Carise D, Roget N, Wendler A 2007)

7.34

Treatment Plan: Completion

- The treatment plan must eventually come to a close
- Transitions in care need to be discussed and prepared for
- The patient should also be an active participant in her aftercare planning
- The treatment plan completion should include a formal recognition of the patient on leaving the program

(Jones and Kaltenbach, 2013)

7.35

Summary
Learning Objectives: Module 7

- Identify key issues in the development and revision of treatment plans
- Demonstrate basic ability to develop a treatment plan for a woman who has a substance use disorder

7.36

Break

15 minutes

7.37

MODULE 8

COMPONENTS OF A COMPREHENSIVE SUBSTANCE USE DISORDER TREATMENT PROGRAM FOR WOMEN

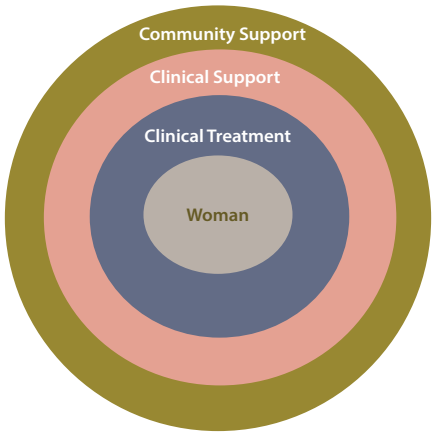

The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 8: Components of A Comprehensive Substance Use Disorder Treatment Program for Women
DAP
Drug Advisory Programme

Learning Objectives: Module 8

- Identify the key components of a comprehensive care program for women
- Articulate strengths and gaps in the local services for women and develop initial steps to take action to fill a service gap

8.2

Components of Comprehensive Care for Women with Substance Use Disorders

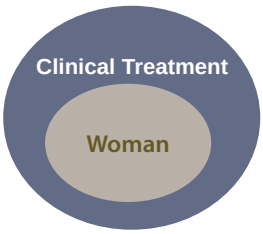


8.3

Components of Comprehensive Care for Women with SUD- Clinical Treatment

Clinical Treatment:

- Outreach, engagement & pre-treatment services (being responsive to need)
- Screening
- Brief Intervention
- Intake
- Assessment
- Crisis intervention
- Treatment Planning
- Detoxification
- Pharmacotherapy
- Counseling and education (individual)
- Group therapy for women (Women's Recovery Group)
- Relapse prevention monitoring
- Medical services for whole health
- Trauma services
- Case management
- Mental health services
- Drug use monitoring
- Continuing care



8.4

What is Outreach?

It can be:

- Providing food and clothing in an area frequented by people using intravenous drugs
- Bringing a mammography van into a rural area without a hospital
- Handing out STD pamphlets and condoms at a coffee shop that is popular with teens
- Training individuals to provide health education in their own communities
- They all involve reaching out – but the type and degree of outreach depends on an effort's purpose, goals, and target population.

(http://ctb.ku.edu/en/table-of-contents/implement/access-barriers-opportunities/outreach-to-increase-access/main)

8.5

Why Conduct Outreach for Women?

- Identifying new women in need of help
- Linking them to appropriate services to help
- Improving access to services like OB and primary healthcare
- Reaching women who do not want to access services or who may not be aware of services
- Observing and understanding women, drug-sharing culture, drug use networks and risk taking behaviors
- Gathering information from the field which can be used for effective planning, expanding outreach, meeting possible challenges and improving services

(https://www.unodc.org/documents/southasia/publications/sops/outreach-for-injecting-drug-users.pdf; /)

8.6

Principles of Outreach

- *Respect:* service providers should respect and trust women as individuals.
- *Team work:* delivering outreach is teamwork. Efficient team work helps in ensuring greater delivery of services.
- *Non-judgmental:* service providers should not have preconceived negative notions about the women. Such judgmental attitudes impede successful service delivery including outreach.
- *Empowerment:* providers of outreach services should empower the substance-using women to make decisions for their own health and welfare. A 'patient-generated' demand helps in greater acceptability of services provided.
- *Do no harm:* the service provider should ensure that women are not harmed in his/her attempt to provide services.

8.7

Characteristics of a Good Outreach Professional

- Non-judgmental attitude and passion to work with women
- Tolerance and respect for others
- Previous experience of working women
- Strong facilitation skills
- Good listening, communication and inter- personal skills
- Knowledge of local language and the local context
- Open to learning new things from the field
- Ability to document carefully and accurately
- Sensitive to the values of the community and maintains confidentiality
- Ability to lead small group discussions
- Self-care and healthy boundaries

8.8

Exercise: Defining Outreach Work for Women

Divide into groups of 4-5 participants

Plan outreach services, taking into consideration:

- Who are the women (or should be the women) whom you are looking to help?
- Do you know what the best ways are to reach and serve the women with substance use disorders?
- What are the strengths and gaps in your programs or services for women?
- What are your goals and objectives for outreach?

There are 12 minutes for small group discussion and then 3 minutes for each small group to present to the larger group

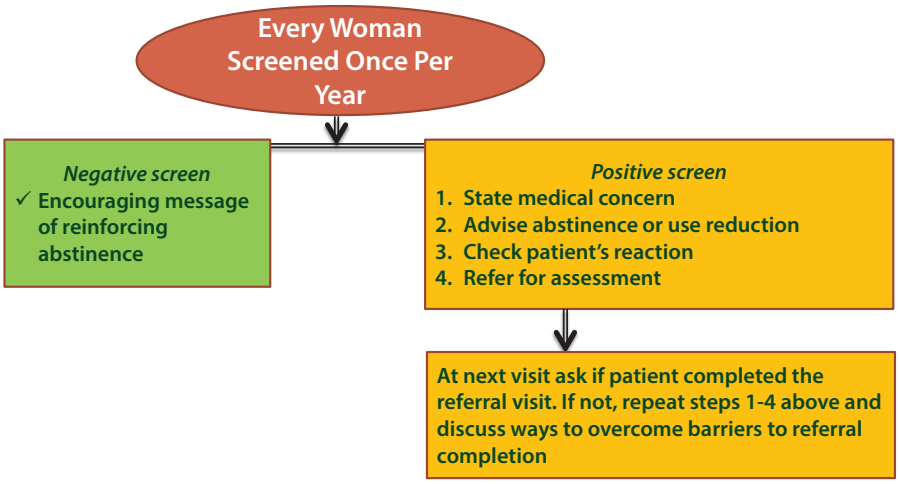
8.9

Lunch

60 minutes

8.10

Brief Intervention Model



8.11

Crisis Signs

A person's inability to cope with crisis may present itself with signs:

Feelings and Emotions

- hopelessness
- irritability
- anger
- grief
- apathy
- depression
- Anxiety
- suicidal ideation
- agitation

Behaviors

- poor concentration
- conflicts with others
- avoiding social situations
- difficulty eating or sleeping
- alcohol and/or other drug use
- self-harm/suicide
- poor hygiene
- compulsive behavior
- talking about hopelessness and not wanting to live
- Use and/or route of use of substances has gotten more risky

8.12

(https://online.grace.edu/news/human-services/crisis-intervention-models/)

Crisis Intervention

- A crisis can refer to trauma, a natural disaster, mental illness, medical illness, victimization, grief, or relationship changes.
- A crisis may cause a person to lose their ability to cope.
- An immediate and short-term emergency response is needed to alleviate mental, emotional, physical, and/or behavioral distress.
- Crisis interventions help to restore an individual's equilibrium in their biopsychosocial functioning, and to minimize the potential for long-term trauma or distress.
- Crisis intervention is a short-term intervention to help women receive assistance, resources, stabilization, and support.

)*Practice Guidelines: Core Elements for Responding to Mental Health Crises.* HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009)

8.13

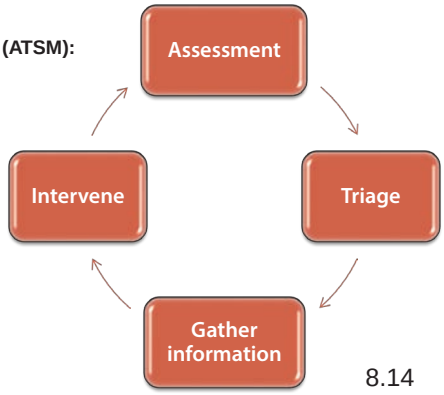
Crisis Intervention: Assessment and Response

The SAFER-R Model includes the following six stages:

- Stabilize
- Acknowledge
- Facilitate understanding
- Encourage adaptive coping
- Restore functioning or
- Refer

The 10 Stages of Acute Traumatic Stress Management (ATSM):

- Assess for danger/safety for self and others
- Consider the mechanism of injury
- Evaluate the level of responsiveness
- Address medical needs
- Observe and identify
- Connect with the individual
- Ground the individual
- Provide support
- Normalize the response
- Prepare for the future



(https://online.grace.edu/news/human-services/crisis-intervention-models/)

8.14

Women and Men Have Different Needs in Treatment

Problem severity	Women	Men
Employment/economic	⬆	
Drug	⬆	
Alcohol	More alcohol-related problems =relapsed more often than non alcohol using women	⬆
Family	⬆	
Medical	⬆	
Psychiatric	⬆	
Internalizing problems	⬆	
Legal		⬆
Conduct problems		⬆

Women, compared to men were:

- **Significantly younger**
- **More likely to identify as bisexual**
- **More likely to live with a sexual partner**
- **Have a shorter duration but similar age of onset of opioid use**

Luthar SS. Drug Alcohol Depend.1996 Dec 11;43(3):179-89. Back SE, et al., Am J Drug Alcohol Abuse. 2011 Sep;37(5):313-23; Senbacka M et al., Drug Alcohol Rev. 2007 Jan;26(1):55-63.

8.15

Treatment: Detoxification

- Can be a first step in a complete treatment process but is not sufficient as a treatment itself
- Detoxification when not paired with other services increases the risk of relapse and poor treatment engagement
- Treatment of chronic disease, including substance use disorder, should be directed toward optimal long-term outcome

8.16

Treatment: Pharmacotherapy

Substance	Medication Available
Alcohol	yes
Tobacco	yes
Cocaine or other stimulants	no
Marijuana	no
Hallucinogens Inhalants	no no
opioids	yes

Collective data suggest varenicline is best for women to help stop smoking

Some data suggest that buprenorphine is best for women to stop opioid use

World Health Organization. Guidelines for identification and management of substance use and substance use disorders in pregnancy. WHO Document Production Services, Geneva, Switzerland. 2014

Schottenfeld et al., The Journal of nervous and mental disease. 1998;186(1):35-43.

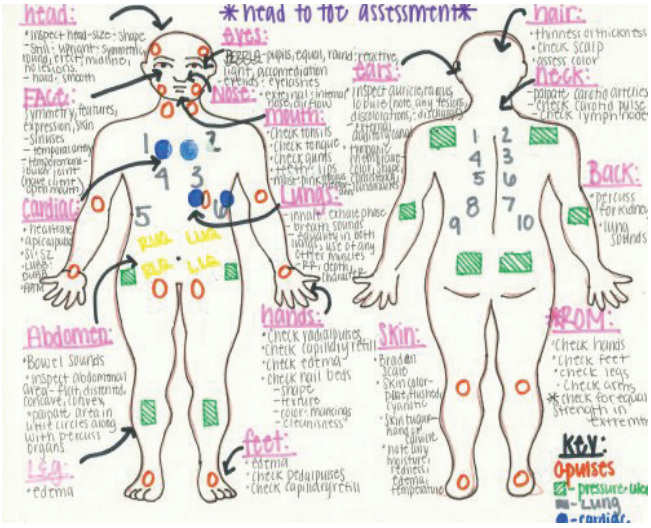
Jones et al., American Journal on Addictions. 2005;14(3):223-33.

Baraona et al., J Midwifery Womens Health.2017 May;62(3):253-269.

Smith et al., Nicotine Tob Res. 2017 Mar 1;19(3):273-281.

8.17

Treatment: Medical Services



8.18

Treatment: Group Therapy

- Women-only group treatment using a manualized approach has been found to improve
- Group-based Mindfulness-based relapse prevention may be more efficacious than group-based relapse prevention for reducing the number of days when drugs were used. This finding occurred when women compose at least one-third of the therapy group.

Roos et al., Mindfulness (N Y). 2019 Aug;10(8):1560-1567. Greenfield. The Women's Recovery Group Manual. Guilford Press, 2016.

8.19

Treatment: Other Interventions for Women

- Beyond Anger and Violence
- Beyond Trauma
- Circle of Security
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy (DBT)
- Helping Women Recover
- Nurturing Parenting Program
- A Woman's Way Through the 12 Steps
- Seeking Safety

8.20

Exercise: Identify the Strengths and Gaps in Clinical Services for Women

Clinical Treatment:

- Outreach and engagement
- Pre-treatment services
- Screening
- Brief Intervention
- Assessment
- Crisis intervention
- Treatment Planning
- Detoxification
- Pharmacotherapy
- Case management
- Counseling and education (individual)
- Group therapy for women
- Relapse prevention monitoring
- Medical services for whole health
- Monitoring of drug use
- Trauma services
- Mental health services
- Continuing care

1. Use the list to identify which services you have and which you want to provide
2. What are steps you can take to add or improve one of the services?

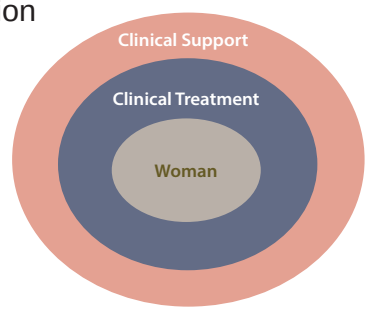
There are 10 minutes for individual work and 10 minutes for large group discussion

8.21

Components of Comprehensive Care for Women with Substance Use Disorders

Clinical Support:

- Primary healthcare services
- Life skills
- Parenting and child development education
- Family program
- Educational remediation and support
- Employment support
- Link with legal and child welfare systems
- Housing supports
- Recovery community support services
- Advocacy



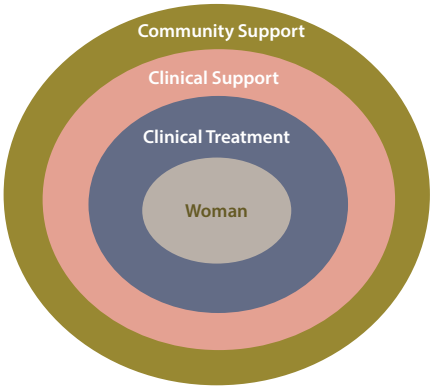
8.22

https://store.samhsa.gov/system/files/sma15-4426.pdf

Components of Comprehensive Care for Women with Substance Use Disorders

Community Supports

- Housing
- Family strengthening services
- Child care
- Transportation
- Social service linkages
- Recovery support
- Workplace prevention
- Vocation/educational services
- Faith based organizations



8.23

Guiding Principles of Women's Treatment Models

- Recognizing the role and significance of personal relationships in women's lives
- Addressing the unique health concerns of women
- Acknowledging the importance and role of socioeconomic issues and differences among women
- Promoting cultural competency that is specific to women
- Endorsing a developmental perspective
- Attending to the relevance and presence of various caregiver roles that women assume throughout their lives

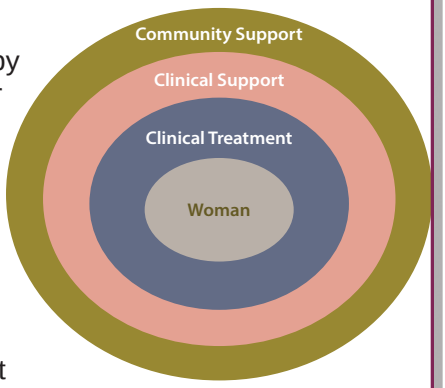
8.24

(https://www.elementsbehavioralhealth.com/addiction-recovery/women-have-special-needs-in-substance-abuse-treatment/)

Exercise: Identify the Strengths and Gaps in Components of Care for Women

- Divide into groups of 4-5 participants

1. List every service or element provided by your program or a local program in your area serving women for each of the 3 rings:
   - Clinical Treatment
   - Clinical Support
   - Community Support
2. Where are the strengths and where are the gaps?
3. What is one action step you can commit to do and take home to improve the care of women?



There are 10 minutes for small group work and 3 minutes for each group to present to the larger group

8.25

Summary
Learning Objectives: Module 8

- Identify the key components of a comprehensive care program for women
- Articulate strengths and gaps in the local services for women and develop initial steps to take action to fill a service gap

8.26

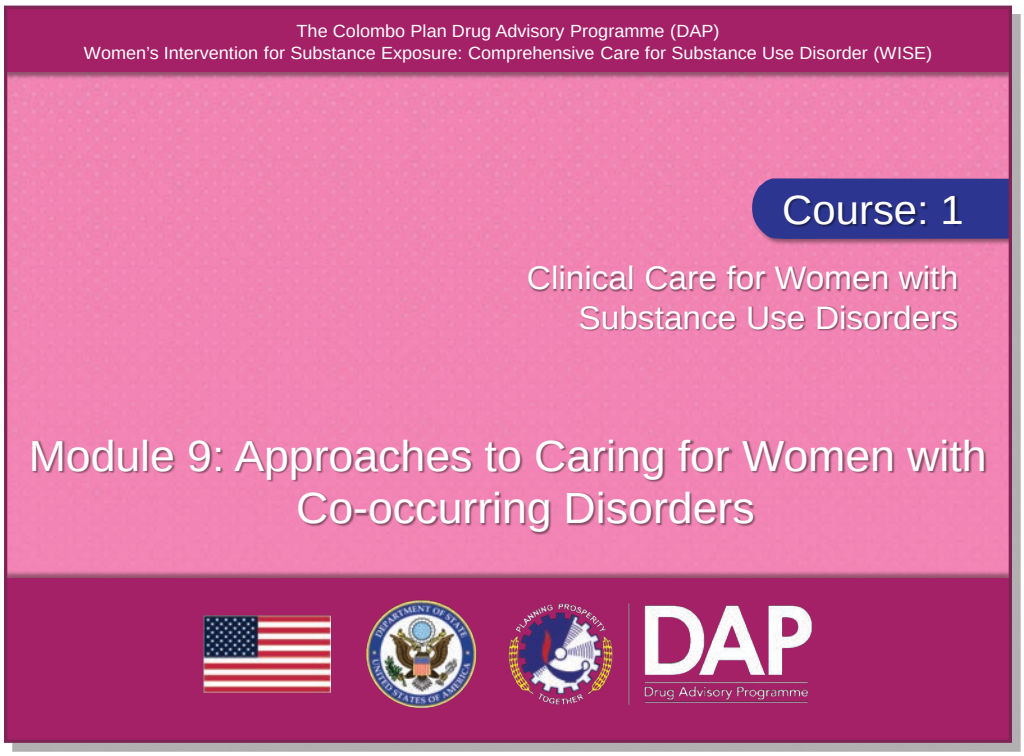
Break

15 minutes

8.27

MODULE 9

APPROACHES TO CARING FOR WOMEN WITH CO-OCCURRING DISORDERS


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 9: Approaches to Caring for Women with Co-occurring Disorders
DAP
Drug Advisory Programme

Learning Objectives: Module 9

- Identify the main co-occurring mental health issues that are present in women who have substance use disorders
- Articulate why integrated treatment for substance use disorders and other mental health issues is important for women

9.2

What is a Co-occurring Disorder?

- A diagnosis of distinct disorders if they are independent of the other
- Women who have at least one substance use disorder as well as one or more psychiatric or physical disorders
- It is possible and in some cases common to have women patients with three or more co-occurring disorders
- Effective treatments focus on both the substance use disorder and the other co-occurring mental health issues in an integrated approach

Treatment Improvement Protocol (TIP) Series, No. 42.
Substance Abuse Treatment for Persons With Co-Occurring Disorders.Center for Substance Abuse Treatment.Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005.
https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ebook.pdf

9.3

Co-occurring Mental Health Disorders Among Women with Substance Use Disorders: Comparisons to Men

- Women are more likely than men to have co-occurring drug use and mental disorders.
- Women are more likely to have multiple co-morbidity (3 or more psychiatric diagnoses), in addition to substance use disorder, than are men.
- Women who use substances may be using them to self-medicate distressing affect.

Part 6 Developing a women-specific dynamic treatment plan (Objective 5)

(Agrawal et al., 2005; Kessler et al., 1997; Zilberman et al. 2003)
(https://www.unodc.org/docs/treatment/UNODC-WHO_2016_treatment_standards_E.pdf)

9.4

Special Treatment Considerations

- Women with severe psychiatric disorders are at risk for reduced retention in treatment for substance use disorders.
- Women with psychiatric and personality disorders had rapid attrition (a 36 percent dropout rate), whereas women without such issues were more likely to complete treatment.
- The findings of a study examining the effects of trauma-integrated services suggest that women who receive these mental health services may engage in treatment longer.
- Depression, anxiety, post-traumatic stress disorder post-traumatic stress disorder, personality disorders and eating disorders are common among women with substance use disorders

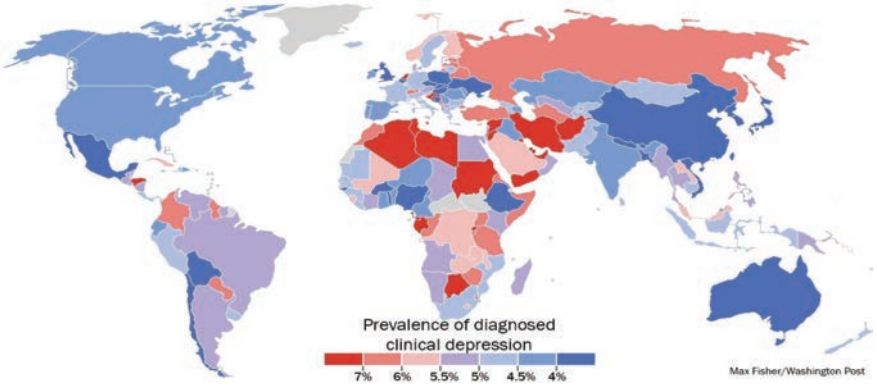
Part 6 Developing a women-specific dynamic treatment plan (Objective 5)

(https://www.unodc.org/docs/treatment/UNODC-WHO_2016_treatment_standards_E.pdf)
(Agrawal et al., 2005; Kessler et al., 1997; Zilberman et al. 2003 Haller et al. 2002; Haller and Miles et al., 2004; Amaro et al. 2008)

9.5

Women with Substance Use Disorders: Mood Disorders

- Mood disorders (uni and bi-polar) and their consequences



9.6

Women with Substance Use Disorders and Depression

- Depression is estimated to co-occur in adults with substance use disorder at somewhere between 15% and 30%
- Co-occurrence is higher in women than in men
- A higher rate of injection drug use is found in adults with co-occurring substance use disorder and depression
- Adults with co-occurring substance use disorder and depression are more likely to suffer more severe social and economic problems than individuals with substance use disorder without depression
- Lack of a treatment response is more likely for adults with co-occurring substance use disorder and depression

TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, 2015

9.7

Women with Substance Use Disorders and Anxiety Disorders

- Globally, more than 300 million people suffer from depression, and 260 million suffer from anxiety disorders—many of whom live with both conditions.
- The World Health Organization (WHO) estimates that such disorders cost the global economy $1 trillion in lost productivity each year.
- Trauma exposure is common throughout the world but unequally distributed.
- Women are much more likely than men to be exposed to intimate partner sexual violence (OR 2.3), roughly equal to men in odds of unexpected death of a loved one (OR 1.1), and significantly less likely than men to experience any of the other specific trauma types considered (OR 0.4–0.8)

Kessler RC et al., Trauma and PTSD in the WHO World Mental Health Surveys Eur J Psychotraumatol. 2017; 8(sup5): 1353383.
https://www.who.int/mental_health/in_the_workplace/en/

9.8

Women with Substance Use Disorders and Eating Disorders

- When examining eating disorders on a global basis, we have to include Western media's influence on perceptions of self.
- As countries grow in industrialization and globalization, eating disorders have risen with increasing dissatisfaction in body shape and size
- There are various factors related to the rise of eating disorders around the world. These factors include urbanization, industrialization, media influence, westernization, and socio-cultural and gender role shifts.
- Women who have substance use disorders are at high risk for eating disorders
- Drunkorexia is a new issue

(Lee, Lee, Pathy, and Chan 2003; Thompson-Memmer C et al., 2018)

9.9

Eating Disorders: Definitions

- Eating disorders are serious and often fatal illnesses that cause severe disturbances to a person's eating behaviors
- Obsessions with food, body weight, and shape may also signal an eating disorder
- Common eating disorders:
  - Anorexia nervosa- Self-imposed starvation
  - Bulimia nervosa- Eat more than self-imposed expectation and then consistently purge in order to limit weight
  - Binge-eating disorder- Uncontrolled eating, followed by uncontrolled purging

Source: https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml?utm_source=rss&utm_medium=rss#part_145410

9.10

Eating Disorders: Special Issues

Similarities Between Substance Use Disorder and Eating Disorders

- Disturbed eating patterns
- Dysfunctional attitudes toward food, eating and body shape
- Compulsive use or behavior
- Loss of control
- Continuing behavior despite negative consequences

Source: Clients with Substance Use and Eating Disorders: http://wvde.state.wv.us/counselors/documents/SMA10-4617.pdf

9.11

Eating Disorders: Special Issues (cont.)

- Some people have a false belief that substance use disorders are easier to manage when there is an eating disorder
- In recovery from an eating disorder, intense cravings for drugs may occur
- Those who give in to these cravings may find their recovery from eating disorders is much more complicated
- They might find it hard to:
  - Pay attention during therapy sessions
  - Do recovery-related homework
  - Eat properly
  - Attend support group meetings
- Some drugs can also erode a sense of control and willpower, too, so people might find that they slide back into disordered eating

Source: Clients with Substance Use and Eating Disorders: http://wvde.state.wv.us/counselors/documents/SMA10-4617.pdf

9.12

Eating Disorders: Treatment Response

- Ideally, a person would receive integrated treatment from one program, but such programs are rare
- Treatment of the substance use disorder should generally come first
- Many specialized eating disorder programs are not prepared to treat a patient who also has a substance use disorder
- Dialectical Behavioral Therapy (DBT) may be helpful with individuals with both eating and substance use disorder issues

Source: Clients with Substance Use and Eating Disorders: http://wvde.state.wv.us/counselors/documents/SMA10-4617.pdf

9.13

Post-Traumatic Stress Disorder: Definition

- An anxiety disorder that may develop subsequent to exposure to a traumatic event
- Traumatic events involve actual or threatened death, serious injury, or threat to the physical integrity of oneself or others and are responded to with intense fear, helplessness, or horror.
- Symptoms:
  - Re-experiencing symptoms from an event
  - Avoidance symptoms
  - Changing personal routine to escape reminders of event
  - Being hyper-aroused

Source: https://www.samhsa.gov/disorders/mental#PTSD

9.14

Post-Traumatic Stress Disorder: Diagnosis

- Risk for PTSD is separated into three categories:
  - pre-traumatic risk factors (e.g., childhood emotional problems, prior exposure to trauma, childhood adversity)
  - peri-traumatic (e.g., the severity of the trauma, perceived life threat)
  - post-traumatic factors (e.g., ineffective coping strategies)
- Diagnosis of PTSD must be preceded by exposure to actual or threatened death, serious injury, or violence.
- Women with PTSD and substance use disorder tend to have poorer treatment outcomes than those without the same co-morbidity
- The association between PTSD and alcohol use disorder is stronger for women than for men

(Berenz et al., 2016; Berenz and Coffey, 2012)

9.15

Post-Traumatic Stress Disorder: Treatment Issues

- PTSD and substance use disorders frequently co-occur.
- Several theories have been posited to explain the functional association between PTSD and SUDs.
- The *self-medication theory*, perhaps the most prominent theory, postulates that substance use serves as an attempt to alleviate PTSD symptoms.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3811127/
Chilcoat H, Menard C. Epidemiological investigations: Co-morbidity of posttraumatic stress disorder and substance use disorder. In: Ouimette P, Brown P, editors. Trauma and substance use. Washington, D.C: American Psychological Association; 2003. pp. 9–28.

9.16

Post-Traumatic Stress Disorder: Treatment Considerations

- Withdrawal from substances may closely mimic some symptoms of PTSD
- They contribute to a reinforcing cycle of self-medication that fosters the development of an SUD
- Detection of trauma exposure and problematic substance use behaviors can guide treatment

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3811127/

9.17

Post-Traumatic Stress Disorder: Treatment Response

- Integrated care for PTSD and SUD
- Plan should include:
  - Individual psychotherapy – respond to triggers for trauma and substances
  - Counseling sessions address both PTSD and SUD
  - Family counseling
  - Membership in a 12-step or other recovery support group
  - Medication therapy

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3811127/

9.18

Other Co-Occurring Motivated Behaviors

- Substance use is not the only motivated behavior (such actions are also known as "addictive behavior")
- Sex
- Gambling
- Shopping
- Eating
- Social media/video games

9.19

Exercise: Working with Women - Co-Occurring and Substance Use Disorders

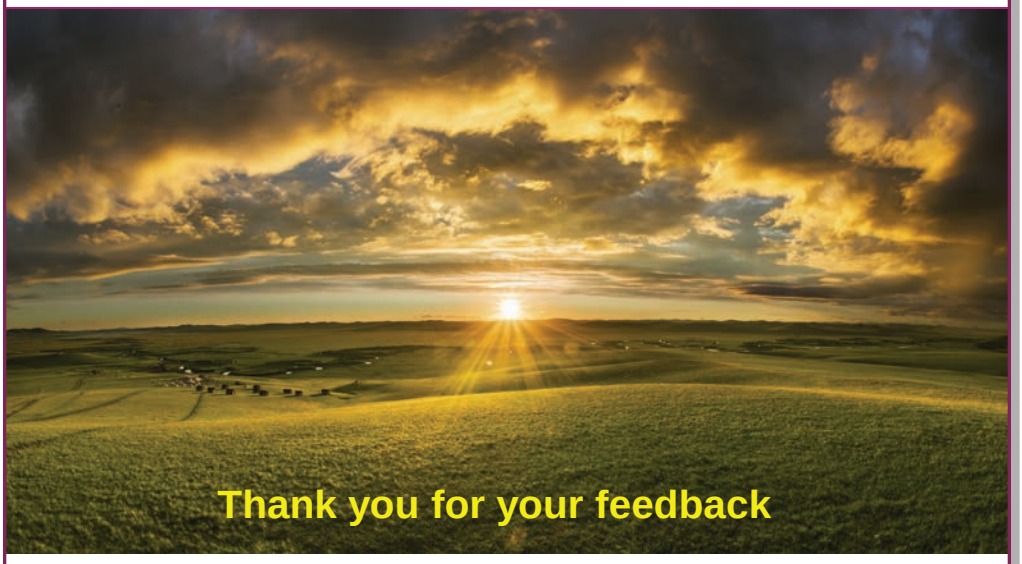
Please divide into 5 groups and complete the following activities:

- Group 1: Without using words, create a way to show the group the main ways you would address depression in women with SUD.
- Group 2: Without using words, create a way to show the group the main ways you would address anxiety in women with SUD.
- Group 3: Without using words, create a way to show the group the main ways you would address anorexia in women with SUD.
- Group 4: Without using words, create a way to show the group the main ways you would address bulimia in women with SUD.
- Group 5: Without using words, create a way to show the group the main ways you would address PTSD in women with SUD.

Take 15 minutes to complete the exercise and 3 mins to report to the large group

9.20

Day 4 Wrap-Up



9.21

Suicide and Interpersonal Violence

- More than 40% of individuals who enter treatment for substance use disorder have a history of a behavioral disorder
- The suicide rate is increasing in the world. The possibility of suicide needs to be directly addressed
- Many of the women who seek treatment for SUDs are in relationships with individuals who also use licit and illicit substances – and may subject the women to ongoing emotional, physical, and sexual abuse

Eggleston et al., 2009; http://www.who.int/mental_health/en/

9.22

Substance Use and Interpersonal Relationships

- Women with SUDs are more likely than men with SUDs to have partners who use drugs
- Some women continue using alcohol and illicit drugs to maintain the relationships. Interpersonal violence is a prevalent concern
- Although alcohol and marijuana use often begins with peer pressure during adolescence, women are likely to be introduced to cocaine and heroin by men

Jones et al. The Treatment of Opioid Dependence, Strain EC, Stitzer M (Eds). 2006, pp. 455-484

9.23

Effects of Interpersonal Violence

Psychological

- **Anxiety**
- **Depression/Suicide**
- **PTSD**
- **Poor self-esteem**
- **Blame and guilt**
- **Uncontrollable emotions**

Social

- **Isolation/Withdrawn**
- **Few social interactions**
- **Rigid sex-role expectations**

Physical/Stress Related

- **Injury**
- **Sleep problems**
- **Nutritional/ Low weight gain**
- **Substance use/ Smoking**
- **Chronic pain**
- **Hypertension**
- **Inadequate prenatal care**
- **Miscarriage**
- **Pre-term labor**
- **Fetal fracture/ Fetal death**
- **Placental abruption**
- **Uterine rupture**

9.24

Integrated Treatment Works

"While there are other models of care, such as sequential or parallel, the integrated model of care is the preferred model of care and the standard of care. In the integrated model, patients receive treatment and have higher rates of adherence to treatment and improved clinical outcomes compared to those patients receiving parallel or sequential treatment (Mueser et al., 2003)."

Part 6 Developing a women-specific dynamic treatment plan (Objective 5)

(c. Mueser, K.T., Torrey, W.C., Lynde, D., Singer, P., Drake, R.E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavioral Modifications, 27* (3), 387-411.)

9.25

Exercise: Identify Co-occurring Mental Health Issues and Respond

- Divide into groups of 4-5 participants
- Review the case and identify the type(s) of co-occurring mental health issues that the woman has and outline a response to help care for her
- There are 12 minutes for discussion in small groups and 3 minutes for each group to present their summary

HANDOUT: Identify type of co-occurring disorders and treatment responses

Part 6 Developing a women-specific dynamic treatment plan (Objective 5)

9.26

Summary
Learning Objectives: Module 9

- Identify the main co-occurring mental health issues that are present in women who have substance use disorders
- Articulate why integrated treatment for substance use disorders and other mental health issues is important for women

9.27

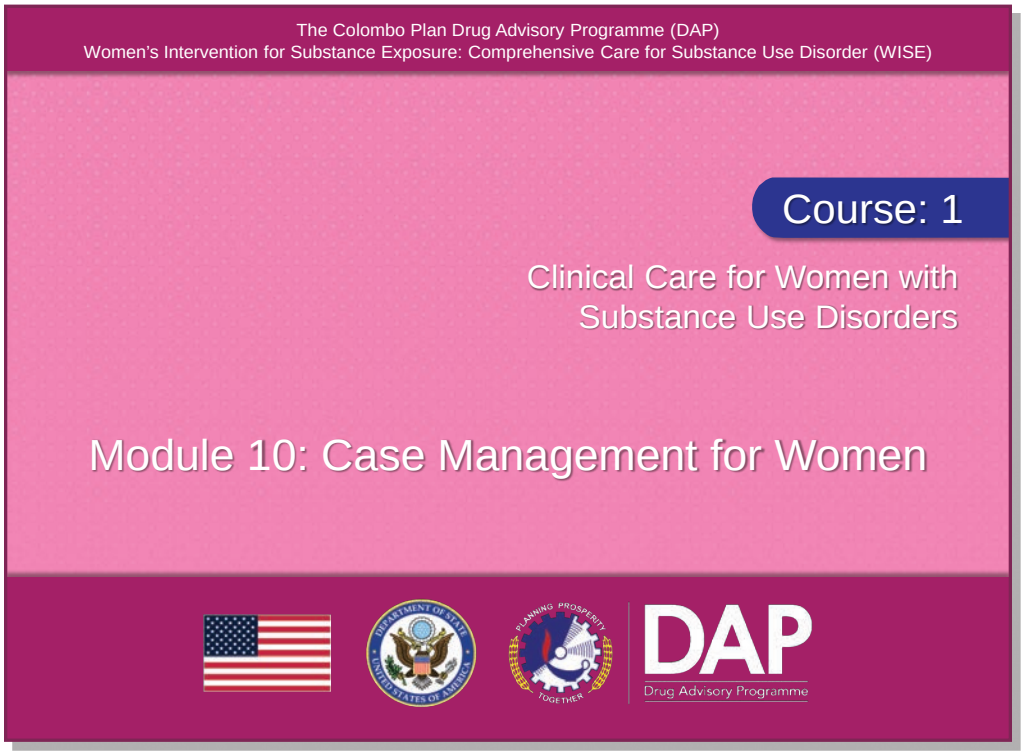
Break

15 minutes

9.28

MODULE 10

CASE MANAGEMENT FOR WOMEN


The Colombo Plan Drug Advisory Programme (DAP)
Women's Intervention for Substance Exposure: Comprehensive Care for Substance Use Disorder (WISE)
Course: 1
Clinical Care for Women with Substance Use Disorders
Module 10: Case Management for Women
DAP
Drug Advisory Programme

Learning Objectives: Module 10

- Name the specific ingredients that comprise comprehensive case management for women
- Identify key ways that case management differs at intake, during treatment and during after/continuing care

10.2

Case Management: Definition

- A patient-centered group of social service functions that help the patient with multiple needs to access the resources she needs to maintain her drug free status
- There appears to be an expanding demand for case management services as a result of the increasingly complex patient care systems and types of problems patients face in their lives

(CSAT, 1998; Mosley, 1989; Brindis & Theidon, 1997).

10.3

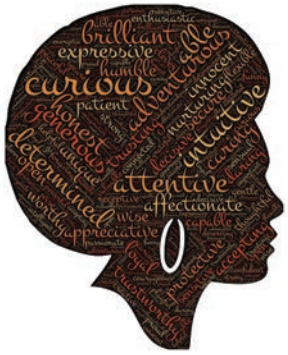
Case Management for Women

- A comprehensive continuum of services promotes recovery and enables the woman to fully integrate into society as a healthy, substance-free individual
- The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community
- Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse

10.4

Case Management for Women (cont.)

- Comprehensive
- Coordinated and Continuous
- Involves Active Participation by the Patient
- Advocacy
- Local Community Resources
- Supportive
- Practical
- Forward Thinking
- Adaptable
- Culturally Responsive



10.5

Ingredients of Comprehensive Case Management for Women

- Case management at intake
- Case management at outreach
- Needs Assessment
- Active linkage of patients to appropriate services
- Monitoring match between patient and agency
- Case management during continuing care

10.6

Ingredients of Case Management for Women: Intake

- Quickly establish rapport with the woman.
- Fear, mistrust, and reluctance to enter treatment can be overcome by using Motivational Interviewing techniques.
- It is often helpful to provide the patient with neutral, nonjudgmental information about the treatment program, what it provides, and what to expect from each stage of treatment.
- Get survival needs met quickly!
- Offering a message of hope and empowerment that the patient has the necessary psychological resources to make lasting, positive behavioral changes can help establish a positive rapport.

10.7

Ingredients of Case Management for Women: Outreach

- Determine what is most needed and get survival needs met quickly- often the focus is on issues like food and safety
- Types of contact
  - Telephone
  - Social media
  - Letters or texts (depends on literacy status)
  - In person
- Note that it is important to know the rules about confidentiality/privacy and use of social media to contact/communicate with patients

10.8

Ingredients of Case Management for Women: Needs Assessment

- Review the needs the patient has that are not being met and help her recognize that the provider and agency have resources and connections to empower her to meet those needs.
- A checklist of common problems can be helpful and she is asked to rate how much she needs help in each area.
- Her responses must not be merely collected and then ignored: for each question, there needs to be at least one service to which the patient can be referred.
- The case manager and the patient should review this list and then rank her needs. This tool can also be used later in treatment to show how much the patient has improved and what issues still need action.

10.9

Ingredients of Case Management for Women: Active Linkage

- Identifying resources can seem daunting.
- Developing and maintaining a diverse community network will help ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs.
- The staff member providing the referral must be knowledgeable about the agency to which the patient is being referred.
- Finally, staff must pay careful attention to patient confidentiality and must make sure that the appropriate releases are in place before exchanging any information.

10.10

Ingredients of Case Management for Women: Matching

- Just identifying resources for patients is not enough to achieve success in case management: the resources must be frequently evaluated to determine their adequacy and fit for the patient population.
- Information should be gathered from the referring staff, the agency itself, and the patients who used the service.

10.11

Ingredients of Case Management for Women: Continuing Care

- Review the needs the patient has regularly
- Use the treatment plan or a problem list to review
- Ask her what she needs most at this point in time
- Work on helping her to be self-sufficient and develop a community of support so she is less reliant on any one agency to meet her needs

10.12

Exercise: Identify Case Management Needs and How to Address Them

- Divide into groups of 4-5
- Identify what case management needs are present for the woman in the case
- Identify specific ways that each need can be addressed
- There is 20 minutes devoted to the small group work and each group has 5 minutes to report their summary to the larger group

HANDOUT: Identify case management needs and how to address them

10.13

Summary
Learning Objectives: Module 10

- Name the specific ingredients that comprise comprehensive case management for women
- Identify key ways that case management differs at intake, during treatment and during after/continuing care

10.14

Summary

Aim:

To increase providers' capacity to identify, assess and effectively treat women who have substance use disorders

Objectives:

1. Name at least three ways women differ from men in terms of substance use disorder treatment needs
2. Demonstrate ways to screen and assess women for substance use disorders
3. Identify key elements in a comprehensive women-specific substance use disorder treatment process

Course 1

10.15

Lunch

60 minutes

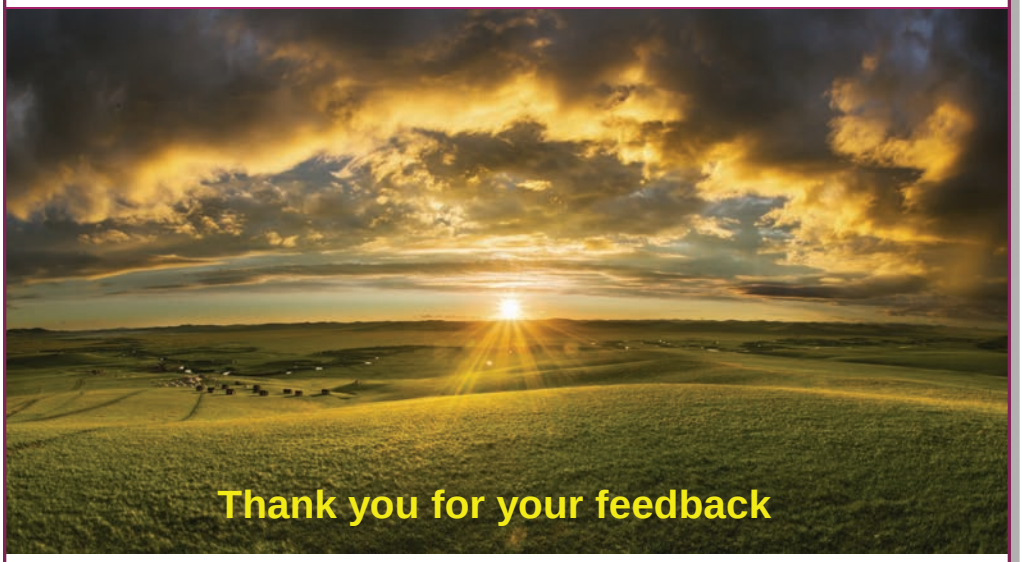
10.16

Post-Test

- 30 minutes is allocated to complete the test
- Remember to complete the training evaluation

10.17

Day 5 Wrap-Up and Overall Evaluation Form



10.18

Thought For Inspiration

The wisest women I know learn to create the light of strength and happiness from dark places

Hendree Jones

10.19

Resources for Course 1

Resource page 1.11 (Key Documents)

Key Documents for Background Reading

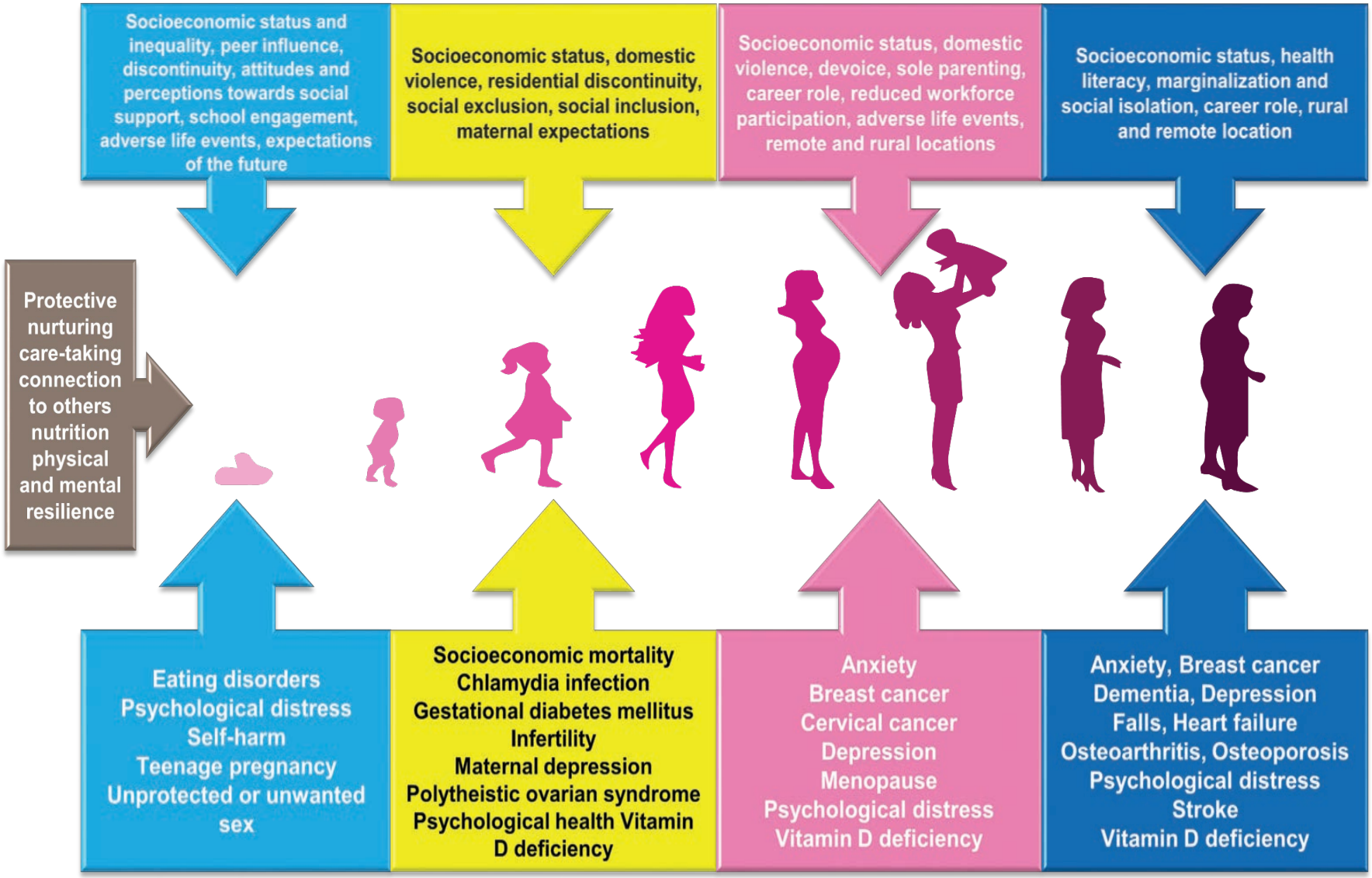
- International Narcotics Control Board (INCB). Annual Report for 2016. https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ThematicChapter-WomenAndDrugs.pdf
- United Nations Office on Drugs and Crime. April 2016. Guidelines on drug prevention and treatment for girls and women. https://www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf
- United Nations Office on Drugs and Crime and World Health Organization. Draft for Field Testing March 2016. International Standards for the Treatment of Drug Use Disorders https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP4_V1601463.pdf
- Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: https://store.samhsa.gov/system/files/sma16-4978.pdf
- Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication. https://store.samhsa.gov/system/files/sma18-5054.pdf
- World Health Organization 2014. Guidelines for identification and management of substance use and substance use disorders in pregnancy. https://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/

LANGUAGE MATTERS:

USING AFFIMATIVE LANGUAGE TO INSPIRE HOPE AND ADVANCE RECOVERY

Stigmatizing Language	Preferred Language
abuser	a person with or suffering from, a substance user disorder
addict	person with a substance user disorder
addicted infant	infant with neonatal abstinence syndrome (NAS) infant with substance withdrawal
addicted to [alcohol/drug]	has a [alcohol/drug] use disorder
alcohol	person with an alcohol use disorder
clean	abstinent
clean screen	substance-free
crack babies	substance-exposed infant
dirty	active using
dirty screen	testing positive for substance use
drug abuser	person who uses drugs
drug habit	regular substance use
experimental user	person who is new to drug use
lapse/ relapse/ slip	resumed/ experienced a recurrence
medication-assisted treatment (MAT)	medications for addiction treatment (MAT)
opioid replacement /substitution	medications for addiction treatment (MAT)
pregnant opiate addict	pregnant women with an opioid use disorder
prescription drug abuse	non-medical use of a psychoactive substance
recreational or casual user	person who uses drugs for nonmedical reasons
reformed addict or alcoholic	person in recovery
relapse	reoccurrence of substance use or symptoms
slip	resumed or experienced a reoccurrence
substance abuse	substance use disorder

Resource Page 1.39 Social Determinants of Health for Women Across the Lifespan



Resource page 1.72 (Exercise: Identify Ways to Improve Treatment Engagement for Women)

Identify ways to improve treatment engagement with women

Factor	Barriers	Solutions
Intrapersonal		
Interpersonal		
Sociocultural		
Structural		
Systemic		

Resource Page 2.4 (Multiple Theories Guide Treatment)

Multiple Theories Guide Treatment

There are several common theories that guide treatment for women with substance use disorders.

- Behaviorist learning theories. The theory of behaviorism is most often associated with B. F. Skinner. He put forth four tenets of learning that included learning being demonstrated by a change in behavior; the primary role of the environment in shaping behavior; the principle of contiguity (how close in time two events must be for a bond to be formed), and the principle of reinforcement (increasing the lik2.4elihood that an event will be repeated).
- For behaviorists, learning a new behavior occurs through conditioning. There are two types of conditioning, classical and operant.
- In classical conditioning, behavior becomes a reflex response to a stimulus. For example, if a person repeatedly eats hamburgers at a fast food restaurant and sees the sign of the fast food restaurant before and while she is eating the hamburger, eventually the sign of the fast-food restaurant itself will elicit her mouth-watering without eating the hamburger.
- With operant conditioning, behaviors are shaped by their consequences. This means that behaviors are shaped by the reinforcement (reward or a punishment) after the behavior occurs.
- A behavior may result either in reinforcement, which increases the likelihood of recurrence of the behavior, or punishment, which decreases the likelihood of recurrence of the behavior. It is important to note that a consequence is not considered to be punishment if it does not result in the reduction of the behavior.
- The terms punishment and reinforcement are determined only as a result of the actions of the person in response to the punishment or reinforcement. Within this framework, behaviorists are particularly interested in measurable changes in behavior. It is also important to note that not all behavioral disorders derive from misguided learning. In many ways much of substance use treatment, including treatment for women, commonly uses punishment and reinforcement. For example, patients in treatment programs may be "punished" for providing a drug-positive urine sample. The consequences that are aimed at stopping substance use behavior include increasing treatment intensity and/or duration of the treatment.
- Another consequence includes a report to a probation or parole officer or child protective services about her behavior. Reinforcement of drug abstinence behavior is also used in treatment settings. For example, opioid dependent women in treatment for substance dependence can earn take home methadone doses for providing consistent drug-negative urine samples.
- Cognitive learning theories are another important set of theories.

- A cognitive learning theory was first proposed by Edward Chace Tolman. He suggested that learning involves central constructs and new ways of perceiving events on the part of the person. This theory relates to cognitive therapy that will be discussed below in that it proposes that problems, like substance use disorders, are the result of maladaptive ways of thinking, distorted attitudes, and misperceptions of oneself and others.

- An example of when cognitive learning theory is applied in the treatment of women with substance use disorders is found in group treatments where the focus is on prompting patients to see the more positive side of situations, to help them have a more accurate appraisal of themselves and others, and to change their way of thinking to better cope with stressful situations.

- Social learning theory. Social learning theory has been considered a transition between behaviorist learning theories and cognitive learning theories. This theory focuses on learning that occurs within a social context. It was first proposed by N.E. Miller and J. Dollard in 1941.

- Miller and Dollard put forth the idea that if one were motivated to learn a behavior, then that behavior would be learned through observing others. By imitating these observed actions the person would learn the action and would be rewarded with positive reinforcement. Albert Bandura then expanded this theory by asserting that people learn from each other through observation, modeling, and imitation.

- Observation. People learn by observing the behavior of others and the outcomes of the behaviors that others emit. Unlike behaviorist learning theories, social learning theory states that learning can occur without a change in behavior when people learn through observation. Thus, learning may or may not result in behavioral change.

- Modeling. Many aspects of behaviors can be learned through modeling. Examples related to substance treatment include: patients can watch other patients remain substance-free on a daily basis, patients can watch the provider acting with respect and accurate empathy towards other patients as well as the patient herself.

- Modeling behavior can result in the teaching and learning of new behavior, as in the case of substance use treatment, when new ways of remaining drug abstinent can be taught and new patterns of substance-free living and recreating can be learned. Modeling can also influence how often previously-learned behaviors are performed. For example, in substance use treatment, modeling drug-abstinent behaviors can reduce the frequency with which substance use behavior is exhibited. Modeling can also increase the likelihood that other similar behaviors will be more frequently emitted.

- For example, within a substance use disorder treatment program, a patient might observe a peer attending Narcotics Anonymous (NA) meetings and the patient who is dependent on alcohol then begins to attend Alcoholic Anonymous meetings.

- Imitation. Both harmful and healthy behaviors can be learned by imitating the actions of others. For example, individuals can learn to smoke cigarettes by observing and

imitating the actions of their favorite movie stars whom they see smoke cigarettes in movies. Healthy behaviors such as abstinence-related behaviors that are shown in substance use treatment can also be learned through imitating the behaviors of others, including peers and providers.

- Other aspects of social learning theory include self-efficacy and self-regulation. Self-efficacy suggests that people will be more likely to engage in behaviors when they believe they are capable of emitting those behaviors successfully. Thus, in substance use treatment, there are often efforts made on the part of the provider to help the patient increase her belief and confidence in herself that she will be able to remain drug-abstinent and perform other behaviors (e.g., obtain employment) which will support that drug abstinence. Self-regulation is when a person has her individual thoughts about what is appropriate or inappropriate behavior and then chooses her actions accordingly. Within substance use treatment, a great deal of effort is devoted to teaching patients how to increase their self-regulatory behaviors.

- One way that self-regulation is taught in substance use treatment is through the use of providing rewards to oneself after completing a task. For example, a patient may complete three job applications and then reward herself by taking a warm bubble bath.

- Julian B. Rotter advanced social learning theory by integrating learning and personality theories in a novel way that has had an enduring but under-recognized impact on the field of clinical psychology. Rotter posited that individuals are motivated by stimulation. Specifically, individuals will emit behavior in an effort to experience pleasant stimulation and escape or avoid uncomfortable stimulation. The unique aspects of Rotter's Social Learning Theory included the proposition that the individual's dynamic interaction with her environment created and maintained a person's personality.

- Thus, to fully understand a person's behavior, one must consider both what the individual brings to the situation and what the person is noticing and responding to in her environment.

- Rotter viewed maladaptive behaviors, such as substance misuse, as learned behaviors that come to be relied on by the individual as her only means of positive stimulation because she had failed to learn a more diverse range of adaptive behaviors to provide her with positive stimulation.

- Viewing substance misuse as a maladaptive learned behavior suggests that the treatment would teach the patient with a substance use disorder new more adaptive behaviors to positively stimulate her.

- Another important aspect of Rotter's social learning theory that is central to understanding and modifying behavior is the concept of expectancies. If an individual's expectancy for reward following emission of a behavior is low, then it is her expectation that the behaviors she generates will not be successful in producing positive stimulation or avoiding negative experiences, and that expectation determines her behavioral response to a stimulus.

- Thus, it is this low expectation that results in the individual making minimal effort to seek the desired experience. Rotter suggested that making minimal effort increases the failure opportunities and that this failure experience in turn reinforces the lack of effort put forth to obtain a given reward.
- This low threshold for cessation of activity that might take effort in order to achieve a positive experience or avoid a negative one is often seen in patients with substance use disorders. Thus, using Rotter's theory, a patient exhibiting low expectancies for changing substance use behaviors would be treated by the provider through the use of methods focused on raising the patient's confidence that they can achieve a desired result with more effort.
- Having the patient make small steps toward the larger goal and experience the positive stimulation of the achievement of the small goals may help raise the person's expectancies for future behaviors to provide positive or avoid negative stimulation (Rotter, 1982). For example, a woman patient may be first asked to agree to 24 hours of drug abstinence. At the end of the 24 hours, if she is still drug abstinent she would be highly praised and then asked to agree to 48 hours of drug abstinence. This chain of small successes may serve to build up her expectations that she can sustain her drug abstinence for a longer and longer duration at each mark of time.
- A final aspect that was important to Rotter's social learning theory included the value individuals place on reinforcers. For Rotter, reinforcers are the goals an individual seeks to obtain or attain in her life. He argued that individuals with maladaptive behaviors have a mismatch between desired goals and realistic goals they can achieve without experiencing multiple failures, thereby leading to low expectancies. Thus, as described above, the setting of smaller more appropriately attainable goals is one of several keys to developing healthy adaptive behaviors.
- In summary, social learning theory posits that behavior is shaped by the understanding that the person has about the relationship between the behavior and the receipt of the reward or punishment, as well as the value that she places on that reward or punishment. Social learning theory emphasizes the choice that emitting a behavior represents where as operant conditioning theory sees behavior as a reaction based on past consequences of actions.
- The above theories, alone or in combination, have been used in the treatment of substance use disorders in women – oftentimes without the explicit recognition that these theories are being applied as part of the treatment process. The lack of recognition of the application of these learning theories in practice may stem from the fact that the theories are complex and necessarily broad. Thus, psychological theories often require translational approaches or practical bridging between theory and every-day clinical practice to allow for their effective use in treatment.

Resource page 3.11 (Exercise: Apply the UTC 8 Ethical Decision Framework to Cases with Women's Treatment)

Review the cases below and use the ethical framework to work through the ethical dilemma

Case 1

Jean is a counselor in a treatment program who works with women who have substance use disorders. The program prides itself for hiring completers of the program to work in the treatment program as peer coaches. Jean starts hearing from some of the women patients in the program that Renee (a peer coach in recovery for 5 years and working at the program for 3 years) is using cannabis with friends on the weekends. Jean also noticed the other day that she smells of cannabis smoke and her reaction time and ability to carry on a conversation was slow and impaired, respectively.

Case 2

Juanita is a new counselor in the mixed-gender substance use disorder treatment program. Her boss is a male who is known as a "touchy feely guy." He proclaims that hugging is the best medicine for patients and staff. Last week she came to you very upset that her boss hugged her without asking permission and then patted her on the head. She did not know how to react but she did tell him that his actions made her feel uncomfortable. He laughed and said she needs to get used to his style and that no one else seems to mind. She comes to you asking for advice about how to handle the situation.

Case 3

Selena works in a treatment center for women who have substance use disorders. She comes to you in tears saying that one of her female patients just told her that she was sexually assaulted by another patient in the bathroom.

Case 4

Nubia is an educator who works with women in a treatment program for women with substance use disorders. She is very religious and had been overheard talking to the patients trying to convert them to her form of religion. The treatment program prides itself for being welcoming of all faiths. Several patients have complained about Nubia's behavior.

Case 5

Sanita is a new staff member working in the women-only treatment facility. She is very kind and worries all the times about the women and always wants to do more to help them. One woman was asked to leave the facility because she was physically abusive to another patient. Sanita tried to help the woman find a place to live but she could not so she is letting the woman stay in her two bedroom apartment for the week while she tries to find her another place to live. She did not tell the program leadership she is doing this because she knows they will not like it. She told you about this issue and asked you not to say anything because she does not want to get in trouble.

Case 6

Calista is a 30-year-old woman who is social and liked. She sometimes looks "spacey" and jumps with anger if someone touches her from behind her back where she cannot see. Her husband calls the treatment center daily asking about her and when he can talk to her. He becomes angry and says he thinks the male staff are abusing his wife. She is overheard talking to him on telephone and he is telling her she is a bad and worthless woman.

UTC 8 Ethical Decision Framework

1. Whose interests are involved? Who can be harmed? (use the table below)

Stakeholders	Level of Impact		
	Significant	Moderate	Minimal or none
Clients			
Patients' Family Members			
Counselor			
Other Staff Members			
Program			
Board of Directors			
Funding Sources			
Professional Field			
Community Public Safety			

2. How may primary stakeholders be involved or harmed?

3. Whose interests, if any, are in conflict?

4. What universal values can be applied? (Use the table below.) Are any of these values in conflict?

Values	Level of Impact		
	Significant	Moderate	Minimal or none
Autonomy (freedom over one's destiny)			
Beneficence (do good; help others)			
Competence (be knowledgeable and skilled)			

Conscientious Refusal (disobey illegal or unethical directives)			
Diligence (work hard)			
Discretion (respect confidence and privacy)			
Fidelity (keep your promises)			
Gratitude ("giving back," or passing good along to others)			
Honesty and Candor (tell the truth)			
Justice (be fair; distribute by merit)			
Loyalty (don't abandon)			
Non-maleficence (don't hurt anyone)			
Obedience (obey legal and ethically permissible directives)			
Restitution (make amends to persons injured)			
Self-improvement (be the best that you can be)			
Self-interest (protect yourself)			
Stewardship (use resources wisely)			
Other Culture-Specific Values (list):			

5. What laws, standards, policies, historical practices, or cultural teachings could or should guide you in this situation?

A. Laws:

B. Standards:

C. Policies:

D. Historical Practices:

E. Cultural Teachings:

Resource Page 3.6 (Exercise: Thinking About What We Know and Need to Know)

Issue	What we know	What we need to know
How does citizenship play a role in treatment access and delivery?		
How does religion play a role in treatment access and delivery?		
How does the law play a role in treatment access and delivery?		
How does race and/or ethnicity play a role in treatment access and delivery?		
What are the other factors that play roles in treatment access and delivery for women?		

Exercise: Practice Screening Role Play

For your pair, select one of the cases that you will be. Remember that you are not conducting the screening. You are only introducing the screening to the woman.

1. *Monique is a 48-year-old woman who has complained to the doctor about depression, inability to sleep and pain in her legs. She says she sometimes uses alcohol to help these issues.*
2. *Fatima is a 20-year-old woman who says her mother in law is abusive to her. Her husband is also unkind. She works long hours in the home and has pain. She uses many over the counter medications to feel better. There is opium smoking in the home too.*
3. *Alice is a 30-year-old woman with five children. She has anxiety and worries about her weight and her ability to get everything done. She has tried different diet pills for weight loss but nothing works. Her doctor thinks she may be using amphetamines.*
4. *Arianna is a 22-year-old woman who can't sleep. She says "I can't eat," and says "memories come into my head" often. She has been in treatment for different psychiatric illnesses and she says uses benzodiazepines and alcohol "often."*

Resource Page 6.7: Assessment: Validated Tools

Addiction Severity Index (Blank)

Addiction Severity Index 5th Ed.
Women's Version Adaptation from UNODC Treatnet ASI Version 3.0

The ASI was developed by Tom McLellan & Deni Carise, Treatment Research Institute, www.tresearch.org

INTRODUCING THE ASI:

1. All clients receive this same interview. The information from this interview helps plan your treatment. This interview is not a test.

2. **Seven Potential problem areas** or Domains: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Mental Health (known as Psychiatric in other cultures).

3. Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:
0 - Not at all
1 – Slightly
2 – Moderately
3 – Considerably
4 – Extremely

This Response Card [show the client ASI Response Card #1] gives you the scale with pictures to help you answer the question.

4. All information gathered is confidential. However, There are limits to confidentiality. For example, if you tell us you are thinking or planning to harm yourself or others or that you are harming a child, we will need to let the authorities know.

5. Accuracy - If a question feels too personal or painful to an answer, just tell me, "I want to skip that question."

6. **Two time periods** will be discussed:
♦ The past 30 days ♦ Lifetime

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.

2. Mark an X = Question not answered. Client cannot or will not answer.

3. Mark an N = Question not applicable. The item instructions note when to use "N"

4. Rounding up. If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

5. Hints and clarification notes in the ASI are bulleted "•".

International Standard Classification of Occupations:

1. Legislators/officials: Main tasks are forming government policies, laws, regulations and overseeing implementation.
2. Professionals: Requires high level of professional knowledge in physical and life sciences, or social sciences/ humanities.
3. Technicians /assoc. professionals: Requires technical knowledge, experience in fields of physical, life or social sciences, humanities.
4. Clerks: Performs secretarial duties, word processing and other customer-oriented clerical duties.
5. Service & Sales: Includes services related to travel, catering, shop sales, housekeeping, and maintaining law and order.
6. Skilled agricultural and fishery workers: Consists of growing crops, breeding or hunting animals, catching or cultivating fish, etc.
7. Craft & Trades: Main tasks consist of constructing buildings and other structures, making various products, includes handicrafts.
8. Plant and machine operators: Main tasks consist of driving vehicles, operating machinery, or assembling products.
9. Elementary Occupations: Includes simple and routine tasks, like selling goods in streets, doormen, cleaning, and working laborers.
10. Armed forces: Includes army, navy, air force workers, etc. Excludes non-military police, customs, and inactive military reserves.

LIST OF COMMONLY USED DRUGS:

Heroin:	Smack, H, Horse, Brown Sugar
Methadone:	Dolophine, LAAM
Opiates:	Opium, Fentanyl, Buprenorphine, pain killers - Morphine, Dilaudid, Demerol, Percocet, Darvon, etc.
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal, Doriden, etc.
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine, Crack, Rock, etc.
Amphetamines/: Stimulants	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal, Khat
Cannabis:	Marijuana, Hashish, Pot, Bango Igbo, Indian Hemp, Bhang, Charas, Ganja, Mota, Anasha
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, PCP, MDMA, Ecstasy, Angel Dust
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.
Alcohol:	Beer, wine, liquor, grain (methyl alcohol)

DRUG USE/ALCOHOL INSTRUCTIONS:
The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.
⇒ 30 day questions **only** require the number of days used.
⇒ Lifetime use is asked to determine **extended periods of regular use**.
⇒ Regular use =
1. Three or more times per week; 2. Binges (meaning uses in excess); 3. Problematic irregular use
⇒ Ask these questions with the following sentence stems -
→ **"**How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"
Alcohol to intoxication does not necessarily mean "drunk", use the words "to where you felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule, 3 or more drinks in one sitting, 4 or more drinks in one day for women (5 or more for men) is coded under "intoxication" to designate heavy drinking

GENERAL INFORMATION

G1. Client ID_____

G2. Center_____

G3. Date of Admission to program: ☐☐ ☐☐ ☐☐☐☐

G4. Date of Interview: MM / day / Year ☐☐ ☐☐ ☐☐☐☐

G5. Type of Interview (check one): ☐ Intake ☐ Follow-up

G6. Gender (check one): ☐ Male ☐ Female

_____
Interviewer Name

_____

_____

_____

G7. Date of birth: Day ☐☐ Month ☐☐ Year ☐☐☐☐

7a. Age ☐☐ Years old

G8. What race/ethnicity/nationality do you consider yourself?
Specify_____

G9. Have you been in a controlled environment in the past 30 days? ☐

1. No
2. Correctional Facility
3. Alcohol/Drug Treat.
4. Medical Treatment
5. Psychiatric Treatment
6. Other: _____

•A controlled environment means a place, *theoretically*, without access to drugs/alcohol.

G10. How many days? ☐☐

• If G9=1 ("No"), G10= *"NN"*
Refers to total number of days detained in the past 30 days.

MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? ☐☐

• Include overdoses. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** hospitalizations for medical problems. EXCLUDE depression or other mental health issues- those issues are asked about later.

M2. Do you have any chronic medical problems which continue to interfere with your life? 0=No ☐ 1=Yes ☐

• If ***"Yes",*** specify in comments.

• A chronic medical condition is a serious physical condition that requires regular care, (i.e., diabetes, hypertension, cancer) preventing full advantage of their abilities.

M3. Has a health care provider recommended you take any medications on a regular basis for a physical problem? 0=No ☐ 1=Yes ☐

• Health care provider means doctor or someone who is trusted to prescribed medication

• **Do not include various remedies given by a non-healthcare Provider.** Must be for a medical condition; **don't** include mental health **(psychiatric) medicines**. Include medicines prescribed whether or not the patient is currently taking them.

• The intent of this section is to verify chronic physical medical problems.

M4. Do you have any dental problems problems (meaning issues with teeth or gums)? 0=No ☐ 1=Yes ☐

M5. How many days have you experienced medical problems in the past 30 days? ☐☐

• Include flu, colds, injuries, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, HIV, HCV, HBV abscesses from needles, etc.).

0=No, 1=Yes, 2=Unsure

M6. Are you currently pregnant? ☐

M14a. If pregnant: have you seen a doctor? ☐

M14b. If unsure: would you like help obtaining a pregnancy test? ☐

• If M14= 0 or 2 (No or Unsure), M14a = N

M7. How long ago was your last gynecological/obstetrical exam (in months)? ☐☐☐

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M8. How troubled or bothered have you been by these medical problems in the past 30 days? ☐

M9. How important to you now is treatment for these medical problems? ☐

• If client is currently receiving medical treatment, refer to the need for ***additional*** medical treatment by the patient.

Note: The patient is rating their need for additional medical services or referrals from your agency, above any services they may already be getting.

EMPLOYMENT/SUPPORT STATUS

E1. Education completed:

Yrs. Mos.

• Include formal education only where a certificate or degree could be earned or in education in a school that is recognized by the government.

E1a. Highest degree earned, specify type and name of school from which it was obtained _____

E2.* Training or Technical education completed: Months

• Formal/organized training only.

E3. How long was your longest full-time job? Years Months

• Full time = 30+ hours weekly; does not necessarily mean most recent job.

E4.* Usual (or last) occupation?
Specify: _____
(Use International Classification references page 1)

E5. Does someone contribute the majority of your support?

0 - No 1 - Yes

• Is patient primarily financially supported on a regular basis from family/friends. Include spouse's contribution; exclude support by an institution. "Housing" is considered the majority of someone's support.

E6. Which of these represents how you spent the majority of the past three years?

1. Full-time (35+ hours)
2. Part-time (regular hours)
3. Part-time (irregular hours)
4. Student
5. Military
6. Retired/Disability
7. Unemployed
8. In controlled environment (a place where you cannot leave like prison, an inpatient hospital)
9. Homemaker
10. begging
11. Other: _____

• Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times, select category which best represents the current situation.

E7. How many days in the past 30 did you work for payment of some form (money, goods or services)?

• Include days actually worked, paid sick days and paid vacation.

For questions E8 and E9: How much money did you receive from the following sources in the past 30 days? Use your local currency. Specify: _____

E8. Employment?

• Net or "take home" pay, include any money earned except illegal income

E9. Spouse, family, or friends?

• Money for personal expenses. Also code unreliable sources of income, windfalls (unexpected money) money from loans, inheritance. (Record ***cash*** payments only, etc.).

E10. How many people depend on you for the majority of their food, shelter, etc.?

• Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E11. How many days have you experienced employment problems in the past 30 days?

• Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.
• If the patient has been in a controlled environment all of the past 30 days, code "NN", they can't have had problems

For Questions E20 & E21, ask the patient to use the Patient Rating scale.

E12. How troubled or bothered have you been by these employment problems in the past 30 days?

• If E19=N, code N

E13. How important to you now is help for these employment problems?

• Stress help in finding or preparing for a job, getting training for a job, not giving them a job.

Note: The patient is rating their need for employment/support Services, referrals, etc. from your agency.

ALCOHOL/DRUGS

Note: Route of Administration (ROA) Types:
1. Oral (anything swallowed)
2. Nasal (snorting, or any other subcutaneous membrane administration)
3. Smoking (includes inhaling fumes)
4. Non-IV injection (such as intramuscular IM; subcutaneous/ "skin popping")
5. IV (shooting directly into a vein).
6. Sublingual (held under tongue or rubbed on gums)
7. Topical

• . In cases where two or more routes are used, the most serious route should be coded. The routes listed are from least severe to most severe.

	Past 30 Days	Lifetime (years)	ROA	Age of First Use
D1 Heroin				
D2 Methadone				
D3 Other Opiates/Analgesics				
D4 Barbiturates				
D5 Sedatives/Hypnotics/ Tranquilizers				
D6 Cocaine				
D7 Amphetamines/Stimulants				
D8 Cannabis				
D9 Hallucinogens				
D10 Inhalants				
D11 More than 1 substance (including alcohol)				
D12 Alcohol (any use at all, 30 days)				
D12 Alcohol - to intoxication				

Note that the order of substances should be adapted for the culture

D13a. Identify the primary substance of abuse: ☐☐

D13b. Identify the secondary substance of abuse: ☐☐

• Interviewer should determine the primary and secondary drugs of abuse. Code the number next to the drug in questions D1-D12

D13c. Since you started using these major substances, has there ever been a time when you stopped using them? 0=No 1=Yes ☐ ☐

D 13d. If you stopped using these major substance[illegible]was it bec[illegible]e you were in a controlled environment like a hospital or a jail where you could not leave if you wanted to leave? 0=No 1=Yes ☐ ☐

D14. How long was your most recent period of voluntary abstinence from these major substance(s)? ☐☐ Months

• Most recent sobriety lasting at least one month. Periods of hospitalization/ incarceration *do not count*. Periods of antabuse, methadone, or naltrexone use *do count*. Code 00 = if D14c is no.

D15. How many days in the past 30 have you experienced Drug problems? ☐☐

• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28 and D30, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

D16. How troubled or bothered have you been in the past 30 days by these drug problems? ☐

D17. How important to you now is treatment for these drug problems? ☐

D18. How many days in the past 30 have you experienced: ☐☐
. Alcohol problems?

• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D19 and D20, ask the patient to use the Patient Rating scale. The patient is rating the need for substance abuse treatment.

D19. How troubled or bothered have you been in the past 30 days by these alcohol problems? ☐

D20. How important to you now is treatment for these alcohol problems? ☐

D21. Who introduced you to substances (for each person, respond yes or no): 0 - No 1 - Yes

D21a. Mother	☐
D21b. Father	☐
D21c. Brothers/Sisters	☐
D21d. Partner/Spouse	☐
D21e. Children	☐
D21f. Other Significant Family (specify)_____	☐

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes ☐

L2. Are you on parole or probation? 0 - No 1 - Yes ☐

- Note duration and level in comments.

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal	☐☐	L10* Assault	☐☐
L4 * Parole/Probation Violations	☐☐	L11* Arson	☐☐
L5 * Drug Charges	☐☐	L12* Rape	☐☐
L6 * Forgery	☐☐	L13* Homicide/ Manslaughter	☐☐
L7* Weapons Offense	☐☐	L14* Prostitution/Sex Work, women/child trafficking?	☐☐
L8* Burglary/Larceny Breaking and Entering	☐☐	L15* Contempt of Court	☐☐
L9 * Robbery, Corruption people smuggler?	☐☐	L16* Other: _____	☐☐

- Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
- Include formal charges only.

L17* How many of these charges resulted in convictions? ☐☐

- If L3-16 = 00, then question L17 = "NN".
- Convictions include fines, probation, incarcerations, suspended sentences, guilty pleas, and plea bargaining.

L18. How many months were you incarcerated in your life? ☐☐

- If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated. Months

L19. Are you presently awaiting charges, trial, or sentencing? 0 - No 1 - Yes ☐

L20. What for? ☐☐

- Use the number of the type of crime committed 03-16 in previous questions, above. If awaiting on more than one charge, choose most severe.

L21. How many days in the past 30, were you detained or incarcerated? ☐☐

- Include being arrested and released on the same day.

L22. How many days in the past 30 have you engaged in illegal activities for profit? ☐☐

- Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc.

For Questions L21-22, ask the patient to use the Patient Rating scale.

L21. How serious do you feel your present legal problems are? ☐

- Exclude civil problems, such as divorce, etc.

L22. How important to you now is counseling or referral for these legal problems? ☐

- **NOTE:** Patient is rating need for referral (or services) from your agency to legal counsel for defense against criminal charges.

FAMILY/SOCIAL STATUS

F1. Marital Status (check one only):

☐ 1-Married ☐ 3-Widowed ☐ 5-Divorced

☐ 2-Remarried ☐ 4-Separated ☐ 6-Never Married

☐ 7- married to 2 or more wives

• Common-law marriage = 1. Specify in comments.

	Living with you	Living outside your home
F1a. How many children do you have?	☐☐	☐☐
F1b. How many of these are under age 18	☐☐	☐☐

F2. Living arrangements past 30 days? Please mark everyone who lives with you.

	0 – No	1 - Yes
F2a. Mother	☐	☐
F2b. Father	☐	☐
F2c. Brother/Sister	☐	☐
F2d. Partner/Spouse	☐	☐
F2e. Children (specify how many_____)	☐	☐
F2f. Other Significant Family Member(s) (specify)_____	☐	☐
F2g. Friends (specify how many_____)	☐	☐
F2h. Mother-in-Law	☐	☐
F2i. Father-in-Law	☐	☐

F3. Do you worry about having enough food for you or your family? 0-No ☐ 1-Yes ☐

F4. Do you have access to transportation? 0-No ☐ 1-Yes ☐

F5. Do you have access to clean water? 0-No ☐ 1-Yes ☐

Do you live with anyone who:

F6. Has a current alcohol problem? 0-No ☐ 1-Yes ☐

F7 Uses non-prescribed drugs? 0-No ☐ 1-Yes ☐

(or abuses prescribed drugs)

F8. With whom do you spend most of your free time (please make only one answer)?

1-Family ☐ 2-Friends ☐ 3-Alone ☐

F9. How many of your close friends use drugs? ☐

Note: If patient has no close friends, code "N"

F10. How many of your close friends abuse alcohol? ☐

Note: If patient has no close friends, code "N"

Have you had significant periods in which you have experienced serious problems getting along with: **0 – No, 1 - Yes**

	Past 30 days	In Your Life
F11. Mother	☐	☐
F12. Father	☐	☐
F13. Brother/Sister	☐	☐
F14. Partner/Spouse	☐	☐
F15. Children	☐	☐
F16. Other Significant Family (specify)_____	☐	☐
F17. Close Friends	☐	☐
F18. Neighbors	☐	☐
F19. Co-workers	☐	☐
F20. Mother-in-law	☐	☐
F21. Father-in-law	☐	☐

• "Serious problems" mean those that endangered the relationship.

• A "problem" requires contact of some sort, either by telephone or in person. If no contact, code "N" If no relative (ex: no children) Code "N". in all boxes that are relevant

Has anyone ever abused you?

	Past 30 days 0- No	Past 30 days 1-Yes	In Your Life 0- No	In Your Life 1-Yes
F22. Physically? • Caused you physical harm.	☐	☐	☐	☐
F23. Sexually? • Forced any sexual advances/acts.	☐	☐	☐	☐

How many days in the past 30 have you had serious conflicts:

F24. With your family? ☐☐

Ask the patient to use the Patient Rating scale:

How troubled or bothered have you been in the past 30 days by:

F25. Family problems? ☐

How important to you now is treatment or counseling for these:

F26. Family problems ☐

• Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend

Note: The patient is rating their need for you/your program to provide or refer them to family services, above and beyond any services they may already be getting.

How many days in the past 30 have you had serious conflicts:

F27. With other people (excluding family)? ☐☐

Ask the patient to use the Patient Rating scale:

How troubled or bothered have you been in the past 30 days by:

F28. Social problems? ☐

How important to you now is treatment or counseling for these:

F29. Social problems ☐

• Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.

Note: The patient is rating their need for you/your program to provide or refer them to these types of services, above and beyond treatment they may already be getting somewhere else.

MENTAL HEALTH (PSYCHIATRIC) STATUS

How many times have you been treated for any mental health, psychological or emotional problems:

P1* In a hospital or inpatient setting? ☐☐

P2* Outpatient/private patient? ☐☐
- Do not include substance abuse, employment, or family counseling.
- Treatment episode = a series of continuous visits or treatment days, not the number of visits.

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

		Past 30 Days		Lifetime	
		0-No	1-Yes	0-No	1-Yes
P3.	Experienced serious depression-sadness, hopelessness, loss of interest?	☐	☐	☐	☐
P4.	Experienced serious anxiety/tension uptight, unreasonably worried, inability to feel relaxed?	☐	☐	☐	☐
P5.	Experienced hallucinations-saw things/heard voices that others didn't see/hear? Code other psychotic symptoms here also.	☐	☐	☐	☐
P6.	Experienced trouble understanding, concentrating, or remembering?	☐	☐	☐	☐

P7. Do you make yourself Sick because you feel uncomfortably full? **Past 30 Days** **0-No** ☐ **1-Yes** ☐ **Lifetime** **0-No** ☐ **1-Yes** ☐

P8. Do you worry you have lost Control over how much you eat? **Past 30 Days** **0-No** ☐ **1-Yes** ☐ **Lifetime** **0-No** ☐ **1-Yes** ☐

P9. Have you recently lost more than 14 pounds in a 3-month period? **Past 30 Days** **0-No** ☐ **1-Yes** ☐ **Lifetime** **0-No** ☐ **1-Yes** ☐

P10. Do you believe yourself to be fat when others say you are too thin? **0-No** ☐ **1-Yes** ☐

P11. Would you say that Food dominates your life? **0-No** ☐ **1-Yes** ☐

		0-No	1-Yes
P12.	Has a health care provider recommended you take any medications for psychological or emotional problems?	☐	☐

- Recommended for the patient by a physician or other health care provider as appropriate. Record "Yes" if a medication was recommended even if the patient is not taking it.

P13. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

For Questions P14-P15, ask the patient to use the Patient Rating scale

P14. How troubled or bothered have you been by these psychological or emotional problems in the past 30 days? ☐

P15. How important to you now is treatment for these psychological or emotional problems? ☐

Note: The patient is rating their need for you/your program to provide or refer them to psychological/psychiatric services, above and beyond treatment they may already be getting somewhere else.

ASI Response Card

1 Not at all

2 Slightly

3 Moderately

4 Considerably

5 Extremely

Addiction Severity Index (Completed)

Addiction Severity Index 5th Ed.
Women's Version Adaptation from UNODC Treatnet ASI Version 3.0

The ASI was developed by Tom McLellan & Deni Carise, Treatment Research Institute, www.tresearch.org

INTRODUCING THE ASI:

1. All clients receive this same interview. The information from this interview helps plan your treatment. This interview is not a test.

2. **Seven Potential problem areas** or Domains: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Mental Health (known as Psychiatric in other cultures).

3. Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:
0 - Not at all
1 – Slightly
2 – Moderately
3 – Considerably
4 – Extremely

This Response Card [show the client ASI Response Card #1] gives you the scale with pictures to help you answer the question.

4. All information gathered is confidential. However, There are limits to confidentiality. For example, if you tell us you are thinking or planning to harm yourself or others or that you are harming a child, we will need to let the authorities know.

5. Accuracy - If a question feels too personal or painful to an answer, just tell me, "I want to skip that question."

6. **Two time periods** will be discussed:
♦ The past 30 days ♦ Lifetime

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.

2. Mark an X = Question not answered. Client cannot or will not answer.

3. Mark an N = Question not applicable. The item instructions note when to use "N"

4. Rounding up. If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

5. Hints and clarification notes in the ASI are bulleted "•".

International Standard Classification of Occupations:

1. Legislators/officials: Main tasks are forming government policies, laws, regulations and overseeing implementation.
2. Professionals: Requires high level of professional knowledge in physical and life sciences, or social sciences/ humanities.
3. Technicians /assoc. professionals: Requires technical knowledge, experience in fields of physical, life or social sciences, humanities.
4. Clerks: Performs secretarial duties, word processing and other customer-oriented clerical duties.
5. Service & Sales: Includes services related to travel, catering, shop sales, housekeeping, and maintaining law and order.
6. Skilled agricultural and fishery workers: Consists of growing crops, breeding or hunting animals, catching or cultivating fish, etc.
7. Craft & Trades: Main tasks consist of constructing buildings and other structures, making various products, includes handicrafts.
8. Plant and machine operators: Main tasks consist of driving vehicles, operating machinery, or assembling products.
9. Elementary Occupations: Includes simple and routine tasks, like selling goods in streets, doormen, cleaning, and working laborers.
10. Armed forces: Includes army, navy, air force workers, etc. Excludes non-military police, customs, and inactive military reserves.

LIST OF COMMONLY USED DRUGS:

Heroin:	Smack, H, Horse, Brown Sugar
Methadone:	Dolophine, LAAM
Opiates:	Opium, Fentanyl, Buprenorphine, pain killers - Morphine, Dilaudid, Demerol, Percocet, Darvon, etc.
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal, Doriden, etc.
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine, Crack, Rock, etc.
Amphetamines/: Stimulants	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal, Khat
Cannabis:	Marijuana, Hashish, Pot, Bango Igbo, Indian Hemp, Bhang, Charas, Ganja, Mota, Anasha
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, PCP, MDMA, Ecstasy, Angel Dust
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.
Alcohol:	Beer, wine, liquor, grain (methyl alcohol)

DRUG USE/ALCOHOL INSTRUCTIONS:

The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.
⇒ 30 day questions **only** require the number of days used.
⇒ Lifetime use is asked to determine **extended periods of regular use**.
⇒ Regular use =
1. Three or more times per week; 2. Binges (meaning uses in excess); 3. Problematic irregular use
⇒ Ask these questions with the following sentence stems -
→ **"**How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"
Alcohol to intoxication does not necessarily mean "drunk", use the words "to where you felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule, 3 or more drinks in one sitting, 4 or more drinks in one day for women (5 or more for men) is coded under "intoxication" to designate heavy drinking

GENERAL INFORMATION

G1. Client ID_____**100**_____
G2. Center____**Horizons**_____

G3. Date of Admission to program: 09/10/2018

MM / day / Year

G4. Date of Interview: 09/13/2018

G5. Type of Interview (check one): X Intake ☐ Follow-up

G6. Gender (check one): ☐ Male ☐ Female

_____
Interviewer Name

_____

_____

_____

	Day	Month	Year
G7. Date of birth	09	09	2000

7a. Age 19 Years old

G8. What race/ethnicity/nationality do you consider yourself?
Specify_**I do not want to specify**_____

G9. Have you been in a controlled environment in the past 30 days? **1**

1. No
2. Correctional Facility
3. Alcohol/Drug Treat.
4. Medical Treatment
5. Psychiatric Treatment
6. Other: _____

•A controlled environment means a place, *theoretically*, without access to drugs/alcohol.

G10. How many days? **NN**

• If G9=1 ("No"), G10= *"NN"*
Refers to total number of days detained in the past 30 days.

MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? **04**

• Include overdoses. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** hospitalizations for medical problems. EXCLUDE depression or other mental health issues- those issues are asked about later.

M2. Do you have any chronic medical problems which continue to interfere with your life? 0=No 1=Yes

• If ***"Yes",*** specify in comments.
• A chronic medical condition is a serious physical condition that requires regular care, (i.e., diabetes, hypertension, cancer) preventing full advantage of their abilities.

0=No 1=Yes

M3. Has a health care provider recommended you take any medications on a regular basis for a physical problem?

• Health care provider means doctor or someone who is trusted to prescribed medication
• **Do not include various remedies given by a non-healthcare Provider.** Must be for a medical condition; **don't** include mental health (**psychiatric) medicines**. Include medicines prescribed whether or not the patient is currently taking them.
• The intent of this section is to verify chronic physical medical problems.

M4. Do you have any dental problems problems (meaning issues with teeth or gums)? 0=No 1=Yes

M5. How many days have you experienced medical problems in the past 30 days? **05**

• Include flu, colds, injuries, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, HIV, HCV, HBV abscesses from needles, etc.).

0=No, 1=Yes, 2=Unsure

M6. Are you currently pregnant? **0**

M14a. If pregnant: have you seen a doctor? **N**

M14b. If unsure: would you like help obtaining a pregnancy test? **N**

• If M14= 0 or 2 (No or Unsure), M14a = N

M7. How long ago was your last gynecological/obstetrical exam (in months)? **15**

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M8. How troubled or bothered have you been by these medical problems in the past 30 days? **2**

M9. How important to you now is treatment for these medical problems? **2**

• If client is currently receiving medical treatment, refer to the need for ***additional*** medical treatment by the patient.

Note: The patient is rating their need for additional medical services or referrals from your agency, above any services they may already be getting.

EMPLOYMENT/SUPPORT STATUS

E1. Education completed:

Yrs.	Mos.
10	**5**

• Include formal education only where a certificate or degree could be earned or in education in a school that is recognized by the government.

E1a. Highest degree earned, specify type and name of school from which it was obtained? **none**

E2.* Training or Technical education completed: **00** Months
• Formal/organized training only.

E3. How long was your longest full-time job?
• Full time = 30+ hours weekly; does not necessarily mean most recent job.
02 Years **03** Months

E4.* Usual (or last) occupation?
Specify: **house cleaner** **5**
(Use International Classification references page 1)

E5. Does someone contribute the majority of your support?
0 - No (1 - Yes)
• Is patient primarily financially supported on a regular basis from family/friends. Include spouse's contribution; exclude support by an institution. "Housing" is considered the majority of someone's support.

E6. Which of these represents how you spent the majority of the past three years? **9**

1. Full-time (35+ hours)
2. Part-time (regular hours)
3. Part-time (irregular hours)
4. Student
5. Military
6. Retired/Disability
7. Unemployed
8. In controlled environment (a place where you cannot leave like prison, an inpatient hospital)
9. Homemaker
10. begging
11. Other: _____

• Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times, select category which best represents the current situation.

E7. How many days in the past 30 did you work for payment of some form (money, goods or services)? **00**

• Include days actually worked, paid sick days and paid vacation.

For questions E8 and E9: How much money did you receive from the following sources in the past 30 days? Use your local currency. Specify: **$10**____

E8. Employment? **0**
• Net or "take home" pay, include any money earned except illegal income

E9. Spouse, family, or friends? **$10**
• Money for personal expenses. Also code unreliable sources of income, windfalls (unexpected money) money from loans, inheritance. (Record ***cash*** payments only, etc.).

E10. How many people depend on you for the majority of their food, shelter, etc.? **0**
• Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E11. How many days have you experienced employment problems in the past 30 days? **15**
• Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.
• If the patient has been in a controlled environment all of the past 30 days, code "NN", they can't have had problems

For Questions E20 & E21, ask the patient to use the Patient Rating scale.

E12. How troubled or bothered have you been by these employment problems in the past 30 days? **3**
• If E19=N, code N

E13. How important to you now is help for these employment problems? **3**
• Stress help in finding or preparing for a job, getting training for a job, not giving them a job.

Note: The patient is rating their need for employment/support Services, referrals, etc. from your agency.

ALCOHOL/DRUGS

Note: Route of Administration (ROA) Types:
1. Oral (anything swallowed)
2. Nasal (snorting, or any other subcutaneous membrane administration)
3. Smoking (includes inhaling fumes)
4. Non-IV injection (such as intramuscular IM; subcutaneous/ "skin popping")
5. IV (shooting directly into a vein).
6. Sublingual (held under tongue or rubbed on gums)
7. Topical

• . In cases where two or more routes are used, the most serious route should be coded. The routes listed are from least severe to most severe.

		Past 30 Days	Lifetime (years)	ROA	Age of First Use
D1	Heroin	0	0	0 0	0	0 0
D2	Methadone	0 0	0 0	0	0 0
D3	Other Opiates/Analgesics	30	12	3	07
D4	Barbiturates	0 0	0 0	0	0 0
D5	Sedatives/Hypnotics/ Tranquilizers	0 0	0 0	0	0 0
D6	Cocaine	0 0	0 0	0	0 0
D7	Amphetamines/Stimulants	0 0	0 0	0	0 0
D8	Cannabis	0 0	0 0	0	0 0
D9	Hallucinogens	0 0	0 0	0	0 0
D10	Inhalants	0 0	0 0	0	0 0
D11	More than 1 substance (including alcohol)	0 0	0 0	0	0 0
D12	Alcohol (any use at all, 30 days)	0 0	0 0	0	0 0
D12	Alcohol - to intoxication	0 0	0 0	0	0 0

Note that the order of substances should be adapted for the culture

D13a. Identify the primary substance of abuse: **D3**

D13b. Identify the secondary substance of abuse: **00**

• Interviewer should determine the primary and secondary drugs of abuse. Code the number next to the drug in questions D1-D12

D13c. Since you started using these major substances, has there ever been a time when you stopped using them? 0=No 1=Yes

D 13d. If you stopped using these major substances, was it because you were in a controlled environment like a hospital or a jail where you could not leave if you wanted to leave? 0=No 1=Yes

D14. How long was your most recent period of voluntary abstinence from these major substance(s)? **00** Months

• Most recent sobriety lasting at least one month. Periods of hospitalization/ incarceration *do not count*. Periods of antabuse, methadone, or naltrexone use *do count*. Code 00 = if D14c is no.

D15. How many days in the past 30 have you experienced Drug problems? **30**
• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28 and D30, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

D16. How troubled or bothered have you been in the past 30 days by these drug problems? **3**

D17. How important to you now is treatment for these drug problems? **3**

D18. How many days in the past 30 have you experienced: Alcohol problems? **00**
• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D19 and D20, ask the patient to use the Patient Rating scale. The patient is rating the need for substance abuse treatment.

D19. How troubled or bothered have you been in the past 30 days by these alcohol problems? **3**

D20. How important to you now is treatment for these alcohol problems? **3**

D21. Who introduced you to substances (for each person, respond yes or no): 0 - No 1 - Yes

D21a. Mother	1
D21b. Father	1
D21c. Brothers/Sisters	0
D21d. Partner/Spouse	0
D21e. Children	0
D21f. Other Significant Family (specify)_____	0

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes 0

L2. Are you on parole or probation? 0 - No 1 - Yes 0

• Note duration and level in comments.

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal	0 0	L10* Assault	0 0
0L4 * Parole/Probation Violations	0 0	L11* Arson	0 0
L5 * Drug Charges	0 0	L12* Rape	0 0
0L6 * Forgery	0 0	L13* Homicide/ Manslaughter	0 0
L7* Weapons Offense	0 0	L14* Prostitution/Sex Work, women/child trafficking?	0 0
L8* Burglary/Larceny Breaking and Entering	0 0	L15* Contempt of Court	0 0
L9 * Robbery, Corruption people smuggler?	0 0	L16* Other: _____	0 0

• Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
• Include formal charges only.

L17* How many of these charges resulted in convictions? **NN**

• If L3-16 = 00, then question L17 = "NN".
• Convictions include fines, probation, incarcerations, suspended sentences, guilty pleas, and plea bargaining.

L18. How many months were you incarcerated in your life? 00

• If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated. Months

L19. Are you presently awaiting charges, trial, or sentencing?
0 - No 1 - Yes

L20. What for? **NN**

• Use the number of the type of crime committed 03-16 in previous questions, above.
If awaiting on more than one charge, choose most severe.

L21. How many days in the past 30, were you detained or incarcerated? 00

• Include being arrested and released on the same day.

L22. How many days in the past 30 have you engaged in illegal activities for profit? 00

• Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc.

For Questions L21-22, ask the patient to use the Patient Rating scale.

L21. How serious do you feel your present legal problems are?
• Exclude civil problems, such as divorce, etc. 1

L22. How important to you now is counseling or referral for these legal problems? 1

• **NOTE:** Patient is rating need for referral (or services) from your agency to legal counsel for defense against criminal charges.

FAMILY/SOCIAL STATUS

F1. Marital Status (check one only):

x 1-Married ☐ 3-Widowed ☐ 5-Divorced

☐ 2-Remarried ☐ 4-Separated ☐ 6-Never Married

☐ 7- married to 2 or more wives

• Common-law marriage = 1. Specify in comments.

	Living with you	Living outside your home
F1a. How many children do you have? =	0	0
F1b. How many of these are under age 18	0	0

F2. Living arrangements past 30 days? Please mark everyone who lives with you.

	0 – No	1 - Yes
F2a. Mother		x
F2b. Father		x
F2c. Brother/Sister		x
F2d. Partner/Spouse		x
F2e. Children (specify how many_____)	x	
F2f. Other Significant Family Member(s) (specify)_____	x	
F2g. Friends (specify how many_____)	x	
F2h. Mother-in-Law		x
F2i. Father-in-Law	x	

F3. Do you worry about having enough food for you or your family? 0-No 1-Yes **1**

F4. Do you have access to transportation? 0-No 1-Yes 1

F5. Do you have access to clean water? 0-No 1-Yes 1

Do you live with anyone who:

F6. Has a current alcohol problem? 0-No 1-Yes 1

F7 Uses non-prescribed drugs? 0-No 1-Yes 1
(or abuses prescribed drugs)

F8. With whom do you spend most of your free time (please make only one answer)?

1-Family ☐ 2-Friends ☐ 3-Alone x

F9. How many of your close friends use drugs?
Note: If patient has no close friends, code "N" N

F10. How many of your close friends abuse alcohol?
Note: If patient has no close friends, code "N" N

Have you had significant periods in which you have experienced serious problems getting along with: **0 – No, 1 - Yes**

	Past 30 days	In Your Life
F11. Mother	1	1
F12. Father	1	1
F13. Brother/Sister	1	1
F14. Partner/Spouse	1	1
F15. Children	N	N
F16. Other Significant Family (specify)_____	0	0
F17. Close Friends	0	0
F18. Neighbors	0	0
F19. Co-workers	N	N
F20. Mother-in-law	1	0
F21. Father-in-law	N	N

• "Serious problems" mean those that endangered the relationship.

• A "problem" requires contact of some sort, either by telephone or in person. If no contact, code "N" If no relative (ex: no children) Code "N". in all boxes that are relevant

Has anyone ever abused you?

	Past 30 days		In Your Life	
	0- No	**1-Yes**	**0- No**	**1-Yes**
F22. Physically?	1			1
• Caused you physical harm.				
F23. Sexually?	1			1
• Forced any sexual advances/acts.				

How many days in the past 30 have you had serious conflicts:

F24. With your family? 12

Ask the patient to use the Patient Rating scale:

How troubled or bothered have you been in the past 30 days by:

F25. Family problems? 4

How important to you now is treatment or counseling for these:

F26. Family problems

• Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend 4

Note: The patient is rating their need for you/your program to provide or refer them to family services, above and beyond any services they may already be getting.

How many days in the past 30 have you had serious conflicts:

F27. With other people (excluding family)? 06

Ask the patient to use the Patient Rating scale:

How troubled or bothered have you been in the past 30 days by:

F28. Social problems? 4

How important to you now is treatment or counseling for these:

F29. Social problems 4

• Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.

Note: The patient is rating their need for you/your program to provide or refer them to these types of services, above and beyond treatment they may already be getting somewhere else.

MENTAL HEALTH (PSYCHIATRIC) STATUS

How many times have you been treated for any mental health, psychological or emotional problems:

P1* In a hospital or inpatient setting? 00

P2* Outpatient/private patient?
- Do not include substance abuse, employment, or family counseling. 00
- Treatment episode = a series of continuous visits or treatment days, not the number of visits.

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

		Past 30 Days		Lifetime	
		0-No	1-Yes	0-No	1-Yes
P3.	Experienced serious depression-sadness, hopelessness, loss of interest?		1		1
P4.	Experienced serious anxiety/tension uptight, unreasonably worried, inability to feel relaxed?		0		1
P5.	Experienced hallucinations-saw things/heard voices that others didn't see/hear? Code other psychotic symptoms here also.		0		0
P6.	Experienced trouble understanding, concentrating, or remembering?		0		0

P7. Do you make yourself Sick because you feel uncomfortably full? **Past 30 Days** **0-No** ☐ **1-Yes** 1 **Lifetime** **0-No** ☐ **1-Yes** ☐

P8. Do you worry you have lost Control over how much you eat?
Past 30 Days **0-No** ☐ **1-Yes** 1 **Lifetime** **0-No** ☐ **1-Yes** ☐

P9. Have you recently lost more than 14 pounds in a 3-month period? **Past 30 Days** **0-No** 0 **1-Yes** ☐ **Lifetime** **0-No** ☐ **1-Yes** ☐

P10. Do you believe yourself to be fat when others say you are too thin? **0-No** ☐ **1-Yes** 1

P11. Would you say that Food dominates your life? **0-No** 0 **1-Yes** ☐

		0-No	1-Yes
P12.	Has a health care provider recommended you take any medications for psychological or emotional problems?	☐	1

- Recommended for the patient by a physician or other health care provider as appropriate. Record "Yes" if a medication was recommended even if the patient is not taking it.

P13. How many days in the past 30 have you experienced these psychological or emotional problems? 1 ☐

For Questions P14-P15, ask the patient to use the Patient Rating scale

P14. How troubled or bothered have you been by these psychological or emotional problems in the past 30 days? 4

P15. How important to you now is treatment for these psychological or emotional problems? 4

Note: The patient is rating their need for you/your program to provide or refer them to psychological/psychiatric services, above and beyond treatment they may already be getting somewhere else.

ASI Response Card

1 Not at all

2 Slightly

3 Moderately

4 Considerably

5 Extremely

Resource page 7.23 Treating Women for Substance Use Disorders: A Comprehensive and Trauma Responsive Approach

HANDOUT: Initial Treatment Plan

Patient Name: _____ Date:_____

Problem Statement: Patient has been regularly using opium for the past 12 ye

Goal	Objectives What will the woman do? Under what circumstances? How often will she do this?	Target Date	Interventions What will the counselor/staff do to assist her? Under what circumstances?	Date Achieved	Notes

Participation by Others in the Treatment Planning Process- describe roles and specific actions

Patient:_____ Date:_____

Counselor:_____ Date:_____

HANDOUT: Initial Treatment Plan

Patient Name: _____ Date:_____

Problem Statement: Patient has been regularly using opium for the past 12 years without interruption

Goal	Objectives What will the woman do? Under what circumstances? How often will she do this?	Target Date	Interventions What will the counselor/staff do to assist her? Under what circumstances?	Date Achieved	Notes
To live a substance free life	To complete a 24 hour vacation from opium	9/14/18	The counselor will help patient plan her day hour by hour	9/13/18	Patient completed 24 hour clock plan with details about how she would spend her day without use of opium
	To complete a 72 hour vacation from opium	9/17/18	The counselor will help patient plan her day hour by hour	9/17/18	Patient completed contract and also received withdrawal medications
	Complete 12 sessions of relapse prevention group	9/20/18	The counselor will lead the group and help patient plan to overcome barriers for attendance	9/24/18	Patient completed 12 groups and identified key relapse triggers, engaged in practicing drug avoidance skills etc.

Participation by Others in the Treatment Planning Process- describe roles and specific actions

Patient:_____ Date:_____

Counselor:_____ Date:_____

Resource page 9.26 (Identify type(s) of Co-occurring Disorders and Treatment Responses)

Review the case and identify the type(s) of co-occurring mental health issues that the woman has and outline a response to help care for her

Case 1

Katia is a 38-year-old woman who had a history of childhood abuse- she was refused food and beaten often by her caregivers. She has been noticed having a flat affect and crying sometimes without warning. She reports dreaming about being a small child and being locked in small dark places. She reports that she cannot concentrate. She wants to use alcohol to numb the thoughts in her head.

Case 2

Rihanna is a 48-year-old woman who is in treatment for the 10th time. She is irritable, walking, pacing and has a short temper. She gets very upset when a woman wearing noisy jewelry sits next to her. She hates the noise the jewelry makes and she is refusing to come to group treatment. She is jumpy, cries or shows no emotion. She says given her past, she has no hope and feels like trash on the street.

Case 3

Beatrice is a 26-year-old woman who was taken from her parents by soldiers and has lived in armed conflicts since she was a child of 10. She is quite thin, refuses to eat anything except oatmeal and chicken. She talks often about her appearance. She is also impulsive, has anger outbursts and has been sick with several chronic infections. Her attention span is short and he is easily jumpy and distractible.

Case 4

Molly Anne is a 58-year-old woman who is shy, quiet and withdrawn. She eat often and says she only wants to eat sweets are carbohydrate food. She sleeps all the time but reports not sleeping and being tired. She feels lost in life and has no faith in anything. She says she has been a failure in life and no one cares about her. She will not even try to make friends with peers. Today she reported she wants to kill herself.

Case 5

Sunatai is a 22-year-old female who sees herself as not having a problem. She says she is the life of the party and gets angry at any perceived insult. She is quick to blame others and engages in dangerous competitions with others in treatment like snorting cinnamon or drinking dilutions of bleach.

Case 6

Calista is a 30-year-old woman who is social and liked. She sometimes looks "spacey" and jumps with anger if someone touches her from behind her back where she cannot see. Her husband calls the treatment center daily asking about her and when he can talk to her. He becomes angry and says he thinks the male staff are abusing his wife. She is overheard talking to him on telephone and he is telling her she is a bad and worthless woman.

Resource page 10.13 (Identify case management needs and how to address them)

Case 1

Vickie is a 24-year-old woman who has not seen a doctor in 6 years. She has had two miscarriages, and says she is tired all the time and her gums are very pale. She has an abusive husband and cannot leave him because she does not have a job or other way to support herself. She has been using alcohol, opioids and cannabis for 5 years.

Case 2

Winona is a 38-year-old woman who has been selling sex to support herself for the past few years. She has a large network of people she knows in the community. She has no permanent place to live but always finds a room or living room to sleep in at night. She complains of tooth pain and says she missed her period for the past three months. She has been using cocaine, cannabis and other substances she does not even know their names.

Case 3

Gabriella is a 41-year-old woman who has been living under a bridge with her five children for a month. She has been going to soup kitchens and places of worship to beg for food. Her children attended school until the school uniform had to be paid for. She complains of headaches, stomach aches and that she cannot sleep. She uses benzodiazepines, over the counter medications and prescribed pain medications.

Case 4

Nataja is a 60-year-old woman in treatment for the 15th time. She has no family- they all died in a war or an earthquake. She has no place to live; she has no money other than the money she received from the government for her husband's death. She has multiple health needs for her physical and psychological health. She uses cannabis and alcohol for the past 50 years.

Case 5

Fadawa is a 21-year-old who dropped out of school at age 15. She learned to repair bicycles from her father. She wants to go to college for engineering. She has been using stimulants at night to do work and then benzodiazepines to sleep. She has been doing this for 3 years.

APPENDIX A— GLOSSARY

Abstinence: Refraining from further substance use

Addiction Treatment: Aims to reduce addiction

Addiction: A repeated activity that continuously causes harm to oneself or others

Age at Onset: The age at which one's addictive behavior began; an important factor in addiction assessment

Agonist: A chemical substance that binds to and activates certain receptors on cells, causing a biological response. Oxycodone, morphine, heroin, fentanyl, methadone, and endorphins are all examples of opioid receptor agonists

Alcoholics Anonymous (AA): A voluntary program concerned with helping individuals with alcohol use disorder initiate or maintain recovery and continued sobriety

Alkaloids: Plant-produced organic compounds that are the active ingredients in many drugs

Amphetamine: A stimulant drug that acts on the central nervous system (CNS). Amphetamines are medications prescribed to treat attention deficit hyperactivity disorder and narcolepsy

Analgesics: A group of medications that reduce pain.

Anesthetic: A drug that causes insensitivity to pain and is used for surgeries and other medical procedures.

Antagonist: A substance that can nullify another's effects (a drug that does not elicit a response)

Barbiturate: A type of CNS depressant sometimes prescribed to promote relaxation and sleep, but more commonly used in surgical procedures and to treat seizure disorders.

Benzodiazepine: A group of depressants used to induce sleep, prevent seizures, produce sedation, relieve anxiety and muscle spasms, etc.

Bioavailability: A drug's ability to enter the body

Biofeedback: Signal use to control physiological processes that are normally involuntary

Buprenorphine: A semi-synthetic partial agonist opioid derived from thebaine; medication prescribed for the treatment of used for treating opioid use disorder that relieves drug cravings without producing the high or dangerous side effects of other opioids.

Cannabinoids: Chemicals that bind to cannabinoid receptors in the brain. They are found naturally in the brain (anandamide, 2-arachidonoylglycerol) and also in cannabis (THC and CBD). They are involved in a variety of mental and physical processes, including memory, thinking, concentration, movement, pain regulation, food intake, and reward.

Cannabis: Another name for the marijuana plant, Cannabis sativa.

Cardiovascular system: The system consisting of the heart and blood vessels. It delivers nutrients and oxygen to all cells in the body.

Ceiling Effect: Occurs when the dosage of buprenorphine is increased beyond maximum levels and no differences result

Central Nervous System (CNS): The brain and spinal cord

Cirrhosis: Chronic liver disease

Clinical Opiate Withdrawal Scale (COWS): Used to determine the severity of opioid withdrawal

CNS depressants: A class of drugs that include sedatives, tranquilizers, and hypnotics. These drugs slow brain activity, making them useful for treating anxiety, panic, acute stress reactions, and sleep disorders.

Cold Turkey: Abruptly quitting a drug by choice in order to try to quit long-term

Cognitive-behavioral therapy (CBT): A form of psychotherapy that teaches people strategies to identify and correct problematic associations among thoughts, emotions, and behaviors in order to enhance self-control, stop drug use, and address a range of other problems that often co-occur with them.

Comorbidity: When two disorders or illnesses occur in the same person. Drug addiction and other mental illnesses or viral infections (HIV, hepatitis) are often comorbid. Also referred to as co-occurring disorders.

Compulsion: A physical behavior one repeats involuntarily that can be harmful (e.g., addiction)

Conditioning: A behavioral change that results from an association between events

Craving: A powerful and strong desire/urge for a substance; a symptom of the abnormal brain adaptions that result from addiction

Crisis Intervention: The action taken when one's usual coping resources pose a threat to individual or family functioning

Cross-Dependence: The ability of one drug to prevent the withdrawal symptoms of one's physical dependence on another

Cross-Tolerance: Occurs when one's tolerance for one drug results in their lessened response to another

Depressants: Sedatives that act on the CNS (e.g. to treat anxiety, high blood pressure, tension, etc.)

Depression: One of the most frequent types of distress resulting from addiction; an ongoing state of sadness involving the inability to concentrate, inactivity, etc.

Detoxification (Detox): The process of removing a toxic substance (e.g. a drug) from the body

Disease Model: A theory that considers addiction a disease rather than only a social or psychological issue.

Disease: A condition featuring medically significant symptoms that often have a known cause

Drug Misuse: One's use of a drug not specifically recommended or prescribed when there are more practical alternatives; when drug use puts a user or others in danger

Drug Tolerance: A progressive state of decreased responsiveness to a drug

DSM-5: The handbook most often used for diagnosing mental disorders

DUI: Stands for (driving under influence) (of alcohol or another illicit substance that impairs one's ability to drive)

DWI: Stands for (driving while intoxicated)

Endogenous Opioid: The opioids that the body naturally produces in order to help us tolerate pain

Endorphins: Opium-like substances produced by the brain; natural painkillers

Euphoria: A pleasurable state of altered consciousness; one reason for the preference of one addictive behavior or substance over another

Evidence-based Treatment: Scientifically validated treatment approaches

Fetal Alcohol Syndrome (FAS): Birth defects/abnormalities in babies of alcoholic and alcohol abusing mothers

Flashback: A sudden but temporary recurrence of aspects of a drug experience (including sights, sounds, and feelings) that may occur days, weeks, or even more than a year after using drugs that cause hallucinations. Follicular Phase is the phase of the estrous cycle, during which follicles in the ovary mature. It ends with ovulation.

Hallucinations: Sensations, sounds and/or images that seem real though they are not.

Hydrocodone: An effective narcotic analgesic first developed as a cough medication

Induction: Beginning phase of buprenorphine or methadone treatment

Intoxication: A state of being drugged or poisoned; results from abuse of alcohol, barbiturates, toxic drugs, etc.

Intrinsic Activity: The extent to which a drug activates a receptor

Legal Drugs: Everyday drugs not for medical use (e.g. alcohol, caffeine, carbohydrates, nicotine, etc.)

Luteal Phase: The latter phase of the menstrual cycle or the earlier phase of the estrous cycle. It begins with the formation of the corpus luteum and ends either in pregnancy or luteolysis.

Maintenance: Receipt of a medication that is a stable and effective dose

Medical Model: An addiction theory that considers addiction a medical illness to be treated rather than just a social issue

Metabolism (of drugs): The chemical and physical reactions carried out by the body to prepare for a drug's execution

Methadone: A long-acting opiate (synthetically produced)

Monotherapy: Therapy using one drug

Morphine: A major sedative/pain reliever found in opium

Mu Agonist: A drug that stimulates physiologic activity on mu opioid cell receptors

Mu Opioid Receptor: Nerve cell receptor that mediates opioid addiction and tolerance through drug-induced activity

Naloxone: An opioid antagonist that blocks the effects of opioid agonists

Naltrexone: A narcotic antagonist that blocks the effects of opioids

Narcotic: A drug that produces sleep/drowsiness and that also relieves pain while being potentially dependence producing

Neonatal abstinence syndrome (NAS): A condition of withdrawal that occurs when certain drugs pass from the mother through the placenta into the fetus' bloodstream during pregnancy causing the baby to become drug dependent and experience withdrawal after birth. The type and severity of a baby's withdrawal symptoms depend on the drug(s) used, how long and how often the mother used, how her body broke down the drug, and if the baby was born full term or prematurely. NAS can require hospitalization and treatment with medication to relieve symptoms.

Neurotransmitter: The natural chemical a neuron releases to communicate with or influence another

Opioid receptors: Proteins on the surface of neurons, or other cells, that are activated by endogenous opioids, such as endorphins, and opioid drugs, such as heroin. Opioid receptor subtypes include mu, kappa, and delta.

Overdose: An overdose occurs when a person uses enough of a drug to produce a life-threatening reaction or death.

Partial Agonists: Bind to and activate receptors to a lesser degree than full agonists

Pharmacology: Scientific branch dealing with the study of drugs and their actions

Physical Dependence: The body's physiologic adaptation to a substance

Placebo: A substance with no pharmacological elements that may elicit a reaction because of a patient's mindset

Polysubstance Abuse: Concurrent abuse of more than one substance

Post-Acute Withdrawal Syndrome (PAWS): Withdrawal symptoms after initial acute withdrawal

Precipitated Withdrawal Syndrome: Can occur when a patient on full-agonist opioids takes an antagonist

Prescription Drugs: Only available by a physician's order

Psychopharmacology: The study of how drugs affect consciousness, mood, sensation, etc.

Psychotropic Drug: Any drug that acts on one's psychic experience or mood behavior

Receptor: Protein on a target cell's membrane or cytoplasm with which a drug interacts

Recovery Rates: The percentage of addicted persons undergoing treatment who partake in abstinence in their first year

Recovery: Reducing or ceasing substance abuse; often followed by one's personal life being turned around by way of a supportive environment

Relapse Prevention: A therapeutic process that interrupts believes and behaviors that lead to substance use

Relapse: Symptom recurrence after a period of sobriety or drug use cessation

Remission: A symptom-free period

Self-medication: The use of a substance to lessen the negative effects of stress, anxiety, or other mental disorders (or side effects of their pharmacotherapy) without the guidance of a health care provider. Self-medication may lead to addiction and other drug- or alcohol-related problems.

Serotonin: A neurotransmitter involved in a broad range of effects on perception, movement, and emotions. Serotonin and its receptors are the targets of most hallucinogens.

Stigma: A set of negative attitudes and beliefs that motivate people to fear and discriminate against other people. Many people do not understand that addiction is a disorder just like other chronic disorders. For these reasons, they frequently attach more stigma to it. Stigma, whether perceived or real, often fuels myths and misconceptions, and can influence choices. It can impact attitudes about seeking treatment, reactions from family and friends, behavioral health education and awareness, and the likelihood that someone will not seek or remain in treatment.

Sublingual: Drugs that enter the blood through the membranes under the tongue

Substance use disorder (SUD): A medical illness caused by disordered use of a substance or substances. According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed

through assessing cognitive, behavioral, and psychological symptoms. An SUD can range from mild to severe.

Telescoping: The quicker duration from substance use onset to problem development. Appears in women more often than men

Therapeutic Community: A setting where people with similar issues can meet to support each other's recovery

Tolerance: Condition in which one must increase their use of a drug for it to have the same effect

Trigger: Anything that results in psychological and then physical relapse

Withdrawal Symptoms: Severe and excruciating physical and emotional symptoms that generally occur between 4 to 72 hours after opiate withdrawal (e.g., watery eyes, yawning, loss of appetite, panic, insomnia, vomiting, shaking, irritability, jitters, etc.)

Withdrawal Syndrome: Combined reactions or behaviors that result from the abrupt cessation of a drug one is dependent on

Withdrawal: The abrupt decrease in or removal of one's regular dosage of a psychoactive substance

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ThematicChapter-WomenAndDrugsINCB.pdf

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APPENDIX C— SPECIAL ACKNOWLEDGMENT

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Aditi Anil Ghanekar
Master Trainer/ Colombo Plan
India

Aisha Siddique
National/ Global Master Trainer of DAP,
Pakistan

Andia Meksi
Specialist in Mental Health and SUD
Albania

Anna Puklo Dzadey
Consultant Psychiatrist to Panatang Hospital
Ghana

Asia Almas Ashraf,
Head of the Psychology Department & Director of Rehabilitation / Sunny Trust International
Pakistan

Beatrice Muthoni Maingi
Director/ Nobility House Treatment and Rehabilitation Center
Kenya

Caroline Kathira Rukunga
Ass. Dean of Students/University of Nairobi
Kenya

Catherine Wanjiru Muthiani
Head of Training/SAPTA
Kenya

Christine Mutinda Munyao
Addiction Counsellor/Support For Addiction Prevention And Treatment In Africa Trust
Kenya

Dirceu Henrique Paulo Mabunda
Psychiatrist/ Mavalane General Hospital
Mozambique

Esther Nana Awuku
Clinical Psychologist/Ministry of Health & Social Services
Namibia

Eunicek. Ndulu
Head of counseling services/ Government of Makueni County
Kenya

Farida Bazger
National master Trainer-Addiction (Afghanistan)
Afghanistan

Hawwa Zimna
Counselor / National Drug Agency
Maldives

Kallista Yuliastuti
Counselor, Social Worker /Treatment Center of National Narcotics Board Bogor
Indonesia

Kimani Caroline J.Kabura
Lecturer/ Prisons Staff Training College (PSTC)
Kenya

Lorato Oaitse Koosaletse
Clinical Program Manager/ Botswana Substance Abuse Support Network
Botswana

Lorato Oaitse Koosaletse
Clinical Program Manager/ Botswana Substance Abuse Support Network
Botswana

Mercy Musisi Wambua
Clinical Service Coordinator/Retreat Treatment Centre both Limuru and Ngong facilities
Kenya

Mercy Wanjiru Karuru
Trainer/SAPTA
Kenya

Nooreen Begum
Clinical Psychologist /Anti Narcotics Force
Pakistan

Nuraan Osman
Director/ Ihata Shelter for Abused Women and Children
South Africa

Nyein Zaw Htet Doe
Project Manager – Curriculum Development (Treatment)
Drug Advisory Programme
Colombo Plan

Paul Kirungu Ndungu
Treatment coordination /Asumbi Treatment Center
Kenya

Sana Ullah Rathore
Project Director/Mian Afzal Trust Hospital
Pakistan

Sikander Azam Khan
Pakistan

Siripan Pothong
Plan and Policy Analyst, Drug Demand Reduction Bureau, Office of the Narcotics Control Board, Bangkok
Thailand

Summaira Iqbal
Pakistan

Sun Min Kim
Lecturer/ Graduate school of Social Work at Ewha Womans University
Korea

Sylvia Mbabazi
Social worker /Uganda Youth Development Link
Uganda

Tanittha Poonsin Lee
Plan and Policy Analyst
Office of the Narcotics Control Board, Bangkok
Thailand

Therese Cambe Castillo
Assistant Vice Presidnet for Bheavioural Health and Project Head at Seagulls Flight Foundation, Inc , Global Master Trainer-DAP
Philippines

Tram Tran Hoang
Vietnam

Veronica Felipe
Senior Advisor
Drug Advisory Programme
Colombo Plan

Vu Thi Tuong Vi
Coordinator, Master Trainer of Counselling/Vietnam HIV - Addiction Technology Transfer Center (UMP-VHATTC)/University of Medicine and Pharmacy (UMP) at Ho Chi Minh City
Vietnam

Wilfred Njogu Mbogo
Addiction counselor/ SAPTA
Kenya