

Substance Abuse Treatment: Addressing the Specific Needs of Women

A Treatment Improvement Protocol TIP 51



Substance Abuse and Mental Health Services Administration

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A Treatment Improvement Protocol

TIP 51

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Substance Abuse and Mental Health Services Administration

1 Choke Cherry Road
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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://store.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey “front-line” information quickly but responsibly. If research supports a particular approach, citations are provided.

Consensus Panel

Chair

Norma B. Finkelstein, Ph.D., M.S.W.
Executive Director
Institute for Health & Recovery
Cambridge, Massachusetts

Co-Chair

Juana Mora, Ph.D.
Professor
Northridge Chicano/a Studies Department
California State University, Northridge
Northridge, California

Workgroup Leaders

Karen Allen, Ph.D., R.N., FAAN
Professor/Chair
Department of Nursing
Andrews University
Berrien Springs, Michigan

Hortensia Amaro, Ph.D.
Distinguished Professor
Center on Health and Social Science Research
Director
Institute on Urban Health Research
Northeastern University
Boston, Massachusetts

Stephanie S. Covington, Ph.D., LCSW
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, California

Francine Feinberg, Psy.D., CISCW
Executive Director
Meta House
Whitefish Bay, Wisconsin

Beth Glover Reed, Ph.D.
Associate Professor
Social Work and Women's Studies
School of Social Work
University of Michigan
Ann Arbor, Michigan

Brenda L. Underhill, M.S., CAC
President
Underhill and Associates
El Cerrito, California

Panelists

Belinda Biscoe, Ph.D.
Assistant Vice President for Public and
Community Services
Director, Region VII Comprehensive Assistance
Center
Director, Education, Training, Evaluation,
Assessment and Measurement Department
(E-TEAM)
University of Oklahoma
Norman, Oklahoma

Vivian B. Brown, Ph.D.
Founder, Board Member Emeritus
PROTOTYPES
Culver City, California

Margaret A. Cramer, Ph.D.
Clinical Psychologist/Instructor
Massachusetts General Hospital
Boston, Massachusetts

Gloria Grijalva-Gonzales
Certified Sr. Substance Abuse Case Manager/
Counselor
Allies Project
San Joaquin County
Stockton, California

Tonda L. Hughes, Ph.D., R.N.
Professor
Department of Health Systems Science
University of Illinois at Chicago
Chicago, Illinois

Marty A. Jessup, Ph.D., R.N., M.S.
Associate Adjunct Professor
Department of Family Health Care Nursing
Institute for Health and Aging
University of California, San Francisco
San Francisco, California

Karol A. Kaltenbach, Ph.D.
Clinical Associate Professor of Pediatrics,
Psychiatry and Human Behavior
Director, Maternal Addiction Treatment
Education and Research
Department of Pediatrics
Jefferson Medical College
Thomas Jefferson University
Philadelphia, Pennsylvania

Robin A. LaDue, Ph.D.
Clinical Psychologist
Department of Psychiatry and
Behavioral Sciences
University of Washington
Renton, Washington

LaVerne R. Saunders, B.S.N., R.N., M.S.
Founder/Partner
Dorrington & Saunders and Associates
Framingham, Massachusetts

Starleen Scott-Robbins, M.S.W., LCSW
Women's Treatment Coordinator
Best Practice Consultant
Developmental Disabilities and Substance Abuse
Services
Division of Mental Health
North Carolina Department of Health and
Human Services
Raleigh, North Carolina

Sally J. Stevens, Ph.D.
Executive Director
Southwest Institute for Research on Women
University of Arizona
Tucson, Arizona

Sharon Wilsnack, Ph.D.
Professor
Department of Clinical Neuroscience
Medical School for the Public
School of Medicine & Health Sciences
University of North Dakota
Grand Forks, North Dakota

Rita Zimmer, M.P.H.
Founder
Women in Need, Inc.
New York, New York

Editorial Board

Gene Burkett, M.D., B.S., FRCOG, FACOG, Diplomate American Board, OB/GYN

Professor
Obstetrics and Gynecology
University of Miami School of Medicine

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS

Professor of Clinical Psychiatry (Social Work)
University of Cincinnati, College of Medicine
Executive Director
The Crossroads Center

Grace Chang, M.D., M.P.H.

Associate Professor of Psychiatry,
Harvard Medical School
Brigham and Women's Hospital

Elena Flores, Ph.D.

Associate Professor
Counseling Psychology Department
School of Education
University of San Francisco

Jacki McKinney

Executive Director
National People of Color Consumer Survivor Network

Lisa Najavits, Ph.D.

Associate Professor of Psychology
Harvard Medical School

Dace Svikis, Ph.D.

Associate Professor
Virginia Commonwealth University

William White, M.A.

Senior Research Consultant
Chestnut Health Systems/Lighthouse Institute

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

**Jacqueline Butler, M.S.W., LISW, LPCC,
CCDC III, CJS**
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, Ohio

Deion Cash
Executive Director
Community Treatment and Correction
Center, Inc.
Canton, Ohio

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, Colorado

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland Baltimore County
Baltimore, Maryland

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

Michael Galer, D.B.A.
Chairman of the Graduate School of Business
University of Phoenix - Greater Boston Campus
Braintree, Massachusetts

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse,
and Mental Health
Delaware Department of Health and Social
Services
New Castle, Delaware

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, California

Jack Hollis, Ph.D.
Associate Director
Center for Health Research
Kaiser Permanente
Portland, Oregon

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

Eduardo Lopez, B.S.
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse
and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, New Mexico

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
NJ Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Kensington, Maryland

Consulting Members:

Paul Purnell, M.A.
Social Solutions, L.L.C.
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.

Administrator

Substance Abuse and Mental Health Services Administration

Director

Center for Substance Abuse Treatment

Substance Abuse and Mental Health Services Administration

4 Screening and Assessment

In This Chapter

The Difference
Between Screening
and Assessment

Screening and
Assessment: Factors of
Influence

Screening
Assessment

Overview

Understanding the extent and nature of a woman's substance use disorder and its interaction with other life areas is essential for careful diagnosis, appropriate case management, and successful treatment. This understanding begins during the screening and assessment process, which helps match the client with appropriate treatment services. To ensure that important information is obtained, providers should use standardized screening and assessment instruments and interview protocols, some of which have been studied for their sensitivity, validity, and accuracy in identifying problems with women.

Hundreds of screening instruments and assessment tools exist. Specific instruments are available to help counselors determine whether further assessment is warranted, the nature and extent of a client's substance use disorder, whether a client has a mental disorder, what types of traumatic experiences a client has had and what the consequences are, and treatment-related factors that impact the client's response to interventions. This TIP makes no specific recommendations of screening and assessment tools for women and does not intend to present a comprehensive discussion of this complex topic. Rather, the TIP briefly describes several instruments that providers often use to examine areas of female clients' lives. Attention is given to instruments that have gender-specific normative data or are useful in attending to the biopsychosocial issues unique to women. Several of the screening and assessment instruments discussed in this chapter are provided in Appendix C.

This chapter introduces and provides an overview of current screening and assessment processes that may best serve women across the continuum of care. It covers several areas for which to screen, such as acute safety risk, mental disorders, sexual victimization, trauma, and eating disorders. The chapter also discusses factors that may influence the overall assessment, and reviews screening for substance abuse and dependence in settings other than substance abuse treatment facilities.

It provides information about instruments for use by drug and alcohol counselors, primary healthcare providers, social workers, and others. The assessment section includes general principles for assessing women, the scope and structure of assessment interviews, and selected instruments. Finally, other considerations that apply to screening and assessment are discussed, including women's strengths, coping styles, and spirituality.

The Difference Between Screening and Assessment

The purpose of screening is to determine whether a woman needs assessment. The purpose of assessment is to gather the detailed information needed for a treatment plan that meets the individual needs of the woman. Many standardized instruments and interview protocols are available to help counselors perform appropriate screening and assessment for women.

Screening involves asking questions carefully designed to determine whether a more thorough evaluation for a particular problem or disorder is warranted. Many screening instruments require little or no special training to administer. Screening differs from assessment in the following ways:

- *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.

Screening and Assessment: Factors of Influence

Ethnicity and Culture

The treatment field depends on tools or questionnaires that, for the most part, have been found valid and reliable with two

populations of women—Caucasians and African Americans. Although translations of some instruments for non-English-speaking populations have been made, the validity of the adapted instruments is not always documented.

Women need a thorough explanation of the screening and assessment process. Some women from diverse ethnic groups may find the process threatening, intrusive, and foreign. In some cultures, for example, questions about personal habits can be considered unnecessarily intrusive (Paniagua 1998). Many immigrant women have little experience with American medical care and do not understand the assessment process. Some women may have had negative experiences with human service agencies or other treatment programs and felt they were stereotyped or treated with disrespect.

Screening and assessment must be approached with a perspective that affirms cultural relevance and strengths. An understanding of the cultural basis of a client's health beliefs, illness behaviors, and attitude toward and acceptance of treatment provides a foundation for building a successful treatment program for the client. Whenever possible, instruments that have been normed, adapted, or tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population being evaluated can contain cultural biases and produce misleading results and perhaps inappropriate treatment plans and misunderstandings with clients.

Counselors and intake personnel may hold preconceived beliefs concerning the prevalence of substance abuse among women from particular ethnic groups. For example, counselors may overlook the need to screen and assess Asian women (Kitano and Louie 2002). All assessment staff members should receive training about the cultural and ethnic groups they serve; the appropriate interpersonal and communication styles for effective interviews; and cultural beliefs and practices about substance use and abuse, mental health, physical health, violence, and trauma. Through training, counselors can learn what cultural factors need to be considered to test accurately.

Advice to Clinicians and Administrators: **Culturally Responsive Screening and Assessment**

For Clinicians:

- Foremost, instruments should be used that have been adapted and tested on women in specific cultural groups and special populations.
- Even though a woman may speak English well, she may have trouble understanding the subtleties of questions on standard assessment tools.
- Acculturation levels can affect screening and assessment results. A single question may need to be replaced with an in-depth discussion with the client or family members in order to understand substance use from the client's point of view.
- Interviews should be conducted in a client's preferred language by trained staff members or an interpreter from the woman's culture.
- It is important to remember that many instruments have not been tested on women across cultural groups, and that caution should be taken in interpreting the results. Counselors need to discuss the limitations of instruments they use with clients (Gopaul-McNicol and Brice-Baker 1998).

For Administrators:

- Treatment programs can ask community members, professionals, and other treatment staff from culturally diverse communities to assist in tailoring assessment instruments and protocols for their clients. CSAT's planned TIP Improving Cultural Competence in Substance Abuse Treatment (CSAT in development a) discusses these issues in greater detail.

Acculturation and Language Issues

Acculturation level may affect screening and assessment results. The counselor may need to replace standard screening and assessment approaches with an in-depth discussion with the client and perhaps family members to understand substance use from the client's personal and cultural points of view. The migration experience needs to be assessed; some immigrants may have experienced trauma in their countries of origin and will need a sensitive trauma assessment.

Specifically, the counselor may begin by asking the client about her country of birth and, if she was not born in the United States, the length of time she has lived in this country. Several screening tools are available to determine general acculturation level. The Short Acculturation Scale for Latinos (Marin et al. 1987) is a

12-item acculturation scale available in English and Spanish. Acculturation, as measured by this scale, correlates highly with respondents' generation, length of residence, age at arrival, and ethnic self-identification. The scale can be adapted easily for other groups. Two other useful scales are the Acculturation Rating Scale for Mexican Americans II (ARSMA; Cuéllar et al. 1980) and the Oetting and Beauvais Questionnaire, available at www.casaa.unm.edu, which assesses cultural identification for Caucasian Americans, Hispanics, American Indians, and African Americans. Scales also have been developed for Asian-American groups (Chung et al. 2004).

Counselors should be aware that although a client speaks English relatively well, she still may have trouble understanding assessment tools in English. It is not adequate to simply translate items from English into another language. Some

words, idioms, and examples do not translate directly into other languages but need to be adapted. Ideally, interviews should be conducted in a woman's preferred language by trained staff who speak the language or by professional translators from the woman's culture. Differences in literacy level may require that some clients be screened and assessed by interview or that self-administered questions be adapted to appropriate reading levels. For women with low literacy levels, language comprehension problems, or visual impairments, screening personnel can read the questions to them; however, results may not be as accurate. Self-administered questionnaires should be available in a woman's preferred language if possible.

Socioeconomic Status

Counselors may have conscious or subconscious expectations based on socioeconomic status. Such perceptions have led to failures to diagnose drug or alcohol abuse in pregnant middle- and upper-class women, with tragic consequences for their infants. For example, primary care providers are much less apt to ask private middle-income patients about their use of drugs. Some healthcare providers may fear offending their patients by asking them about their substance use. Weir and colleagues (1998) found that clients with more than a high school education are less apt to disclose the use of drugs or alcohol during pregnancy.

Specific Populations: Other Noteworthy Considerations

Cognitive and learning disabilities

Prior to screening and assessment, the counselor should inquire about current or past difficulties in learning, past participation in special education, a diagnosis of a learning disability, prior involvement in testing for cognitive functioning or learning disability, and problems related to self-care and basic life management skills.

Depending on the type and severity of the disability or impairment, these women will likely need more assistance throughout the screening

and assessment process. Moreover, women with developmental disabilities or cognitive impairments are more likely to respond to items they do not understand by stating "yes" or by responding in a manner they think the assessment counselor will approve of instead of asking for clarification.

Sexual orientation

The Institute of Medicine's (IOM) report on lesbian health identifies substance abuse as one of the primary health concerns among lesbians (Solarz 1999). While research has concluded that the CAGE instrument has similar reliability and concurrent validity among lesbian and heterosexual women, very few studies have addressed the issue of validity and reliability in screening and assessment tools for lesbians (Johnson and Hughes 2005). Consequently, counselors need to cautiously interpret screening and assessment results.

Screening

Screening often is the initial contact between a woman and the treatment system, and the client forms her first impression of treatment during screening and intake. For women, the most frequent points of entry from other systems of care are obstetric and primary care; hospital emergency rooms; social service agencies in connection with housing, child care, disabilities, and domestic violence; community mental health services; and correctional facilities. How screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

Screening processes always should define a protocol or procedure for determining which clients need further assessment (i.e., screen positive) for a condition being screened and for ensuring that those clients receive a thorough assessment. That is, a professionally designed screening process establishes precisely how to score responses to the screening tools or questions and what constitutes a positive score for a particular possible problem (often called

a “cutoff” score). The screening protocol details the actions taken after a client scores in the positive range and provides the standard forms for documenting the results of the screening, the actions taken, the assessments performed, and that each staff member has carried out his or her responsibilities in the process. Although a screening can reveal an outline of a client’s involvement with alcohol, drugs, or both, it does not result in a diagnosis or provide details of how substances have affected the client’s life. The most important domains to screen for when working with women include:

- Substance abuse
- Pregnancy considerations
- Immediate risks related to serious intoxication or withdrawal
- Immediate risks for self-harm, suicide, and violence
- Past and present mental disorders, including posttraumatic stress disorder (PTSD) and other anxiety disorders, mood disorders, and eating disorders
- Past and present history of violence and trauma, including sexual victimization and interpersonal violence
- Health screenings, including HIV/AIDS, hepatitis, tuberculosis, and STDs

Substance Abuse Screening

The goal of substance abuse screening is to identify women who have or are developing alcohol- or drug-related problems. Routinely, women are less likely than men to be identified as having substance abuse problems (Buchsbaum et al. 1993); yet, they are more likely to exhibit significant health problems after consuming fewer substances in a shorter period of time.

Screening for substance use disorders is conducted by an interview or by giving a short written questionnaire. While selection of the instrument may be based on various factors, including cost and administration time (Thornberry et al. 2002), the decision to use an interview versus a self-administered screening tool should also be based upon the comfort level of the counselor or healthcare professional (Arborelius and Thakker 1995; Duszynski et al.

Substance abuse screening and assessment tools, in general, are not as sensitive in identifying women as having substance abuse problems.

Advice to Clinicians:

Substance Abuse Screening and Assessment Among Women

- How screenings and assessments are conducted is as important as the information gathered. Screening and assessment are often the initial contact between a woman and the treatment system. They can either help build a trusting relationship or create a deterrent to engaging in further services.
- Self-administered tools may be more likely to elicit honest answers; this is especially true regarding questions related to drug and alcohol use.
- Face-to-face screening interviews have not always been successful in detecting alcohol and drug use in women, especially if the counselor is uncomfortable with the questions.
- Substance abuse screening and assessment tools, in general, are not as sensitive in identifying women as having substance abuse problems.
- Selection of screening and assessment instruments should be examined to determine if they were developed using female populations. If not, counselors need to explore whether or not there are other instruments that may be more suitable to address specific evaluation needs.

1995; Gale et al. 1998; Thornberry et al. 2002). If the healthcare staff communicates discomfort, women may become wary of disclosing their full use of substances (Aquilino 1994; see also Center for Substance Abuse Prevention [CSAP] 1993).

Many instruments have been developed to screen for alcohol consumption, and several measures have been adapted to screen for specific drugs. While numerous screening tools are available, information about the reliability and validity of these instruments with women is limited. The following listing, while not exhaustive, individually reviews tools with available gender-specific information.

General Alcohol and Drug Screening

AUDIT

The Alcohol Use Disorder Identification Test (AUDIT; Babor and Grant 1989) is a widely used screening tool that is reproduced with guidelines and scoring instructions in TIP 26 *Substance Abuse Among Older Adults* (CSAT 1998d). The AUDIT is effective in identifying heavy drinking among nonpregnant women (Bradley et al. 1998c). It consists of 10 questions that were highly correlated with hazardous or harmful alcohol consumption. This instrument can be given as a self-administered test, or the questions can be read aloud. The AUDIT takes about 2 minutes to administer. **Note:** Question 3, concerning binge drinking, should be revised for women to refer to having 4 (not 6) or more drinks on one occasion.

TCUDS II

The Texas Christian University Drug Screen II (TCUDS II) is a 15-item, self-administered substance abuse screening tool that requires 5–10 minutes to complete. It is based in part on Diagnostic Interview Schedule and refers to *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR; American Psychiatric Association [APA] 2000a) criteria for substance abuse and dependence. TCUDS II is used widely in criminal justice settings. It has good reliability among female populations (Knight 2002; Knight et al. 2002). This screen, along with related instruments, is available at www.ibr.tcu.edu.

CAGE

CAGE (Ewing 1984) asks about lifetime alcohol or drug consumption (see Figure 4-1). Each “yes” response receives 1 point, and the cutoff point (the score that makes the test results positive) is either 1 or 2. Two “yes” answers results in a very small false-positive rate and the clinician will be less likely to identify clients as potentially having a substance use disorder when they do not. However, the higher cutoff of 2 points decreases the sensitivity of CAGE for women—that is, increases the likelihood that some women who are at risk for a substance problem will receive a negative screening score (i.e., it increases the false-negative rate). **Note:** It is recommended that a cutoff score of 1 be employed in screening for women. This measure has also been translated and tested for Hispanic/Latina populations.

Figure 4-1
The CAGE Questionnaire

- Have you ever felt you ought to Cut down on your drinking [or drug use]?
- Have people Annoyed you by criticizing your drinking [or drug use]?
- Have you ever felt bad or Guilty about your drinking [or drug use]?
- Have you ever had a drink [or used drugs] first thing in the morning (Eye opener) to steady your nerves or get rid of a hangover [or get the day started]?

Source: Mayfield et al. 1974.

A common criticism of the CAGE is that it is not gender-sensitive—that is, women who have problems associated with alcohol use are less likely than male counterparts to screen positive when this instrument is used. One study of more than 1,000 women found that asking simple questions about frequency and quantity of drinking, coupled with a question about binge drinking, was better than the CAGE in detecting alcohol problems among women (Waterson and Murray-Lyon 1988).

The CAGE is “relatively insensitive” with Caucasian females, yet Bradley and colleagues report that it “has performed adequately in predominantly black populations of women” (1998c, p. 170). Johnson and Hughes (2005) conclude that CAGE has similar reliability and concurrent validity among women of different sexual orientations. The CAGE-AID (CAGE Adapted to Include Drugs) modifies the CAGE questions for use in screening for drugs other than alcohol. This version of the CAGE shows promise in identifying pregnant, low-income women at risk for heavier drug use (Midanik et al. 1998).

Screening for Tobacco Use

Similar to other substances, women pay an exceptional price for using tobacco. The second leading cause of death in women is cancer (CDC 2004), with tobacco accounting for 90 percent of all lung cancers, according to the Surgeon General’s Report on Women and Smoking (2001). Yet, women are less likely to be referred to smoking cessation programs or provided smoking cessation products (Steinberg et al. 2006). Therefore, screening for tobacco use and referral for nicotine cessation should be standard practice in substance abuse treatment. Counselors can simply screen for tobacco use beginning with current and past patterns of use, including type of tobacco, number of cigarettes smoked per day, frequency of use, circumstances surrounding use, and specific times and locations. For individuals who currently smoke, a more comprehensive assessment needs to be completed with recommendations incorporated into the woman’s treatment plan.

Screening Instruments for Pregnant Women

Considering the devastating impact of substances on the developing fetus, routine screening for drug, alcohol, and tobacco use among pregnant women is imperative. Face-to-face screening interviews are not always successful in detecting alcohol and drug use, especially in pregnant women. However, self-administered screening tools have been found to be more likely to elicit honest answers (Lessler and O’Reilly 1997; Russell et al. 1996; Tourangeau and Smith 1996). Three screening instruments for use with pregnant women are TWEAK, T-ACE, and 5Ps Plus (CSAP 1993; Morse et al. 1997).

TWEAK

TWEAK (Russell et al. 1991) identifies pregnant women who are at risk for alcohol use (Figure 4-2). It consists of five items and uses a 7-point scoring system. Two points are given for positive responses to either of the first two questions (tolerance and worry), and positive responses to the other three questions score 1 point. A cutoff score of 2 indicates the likelihood of risk drinking. In a study of more than 3,000 women at a prenatal clinic, the TWEAK was found to be more sensitive than the CAGE and Michigan Alcohol Screening Test (MAST), and more specific than the T-ACE (Russell et al. 1996). The tolerance question scores 2 points for an answer of three or more drinks. However, if the criterion for the tolerance question is reduced to two drinks for women, the sensitivity of TWEAK increases, and the specificity and predictive ability decrease somewhat (Chang et al. 1999). In comparison with T-ACE, TWEAK had higher sensitivity and slightly lower specificity (Russell

Women who smoked in the month before pregnancy are nine times more likely to be currently using either drugs or alcohol or both while pregnant (Chasnoff et al. 2001).

Figure 4-2 **The TWEAK Questionnaire: Women**

How many drinks does it take for you to feel high? [Tolerance] (2 or more drinks = 2 points)

Does your partner (or do your parents) ever **W**orry or complain about your drinking? (yes = 2 points)

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye opener) (yes = 1 point)

Have you ever **A**wakened the morning after some drinking the night before and found that you could not remember part of the evening? (yes = 1 point)

Have you ever felt that you ought to **K**cut down on your drinking? (yes = 1 point)

Source: Morse et al. 1997.

et al. 1994, 1996). It can also be used to screen for harmful drinking in the general population (Chan et al. 1993).

T-ACE

The T-ACE is a 4-item instrument appropriate for detecting heavy alcohol use in pregnant women (Sokol et al. 1989). T-ACE uses the A, C, and E questions from CAGE and adds one on tolerance for alcohol (see Figure 4-3). The first question assesses tolerance by asking if it takes more than it used to to get high. A response of two or more drinks is scored as 2 points, and the remaining questions are assigned 1 point for a “yes” response. Scores range from 0 to

5 points. A total of 2 or more points indicates risk drinking (Chang et al. 1999). T-ACE has sensitivity equal to the longer MAST and greater than CAGE (Bradley et al. 1998c). It has been validated only for screening pregnant women with risky drinking (Russell et al. 1994).

In a study with a culturally diverse population of pregnant women, Chang and colleagues (1998) compared T-ACE with the MAST (short version) and the AUDIT. The study found T-ACE to be the most sensitive of the three tools in identifying current alcohol consumption, risky drinking, or lifetime alcohol diagnoses (Chang et al. 1998). Although T-ACE had the lowest specificity of the three tests, it is argued

Figure 4-3 **The T-ACE Questionnaire**

How many drinks does it take you to feel high? [Tolerance] (2 or more drinks = 2 points)

Have people **A**nnoyed you by criticizing your drinking? (yes = 1 point)

Have you ever felt you ought to **C**ut down on you drinking? (yes = 1 point)

Have you had an **E**ye opener (a drink first thing in the morning) to steady your nerves? (yes = 1 point)

Source: Sokol et al. 1989

that false positives are of less concern than false negatives among pregnant women (Chang et al. 1998).

Prenatal substance abuse screen (5Ps)

This screening approach has been used to identify women who are at risk for substance abuse in prenatal health settings. A “yes” response to any item indicates that the woman should be referred for assessment (Morse et al. 1997). Originally, four questions regarding present and past use, partner with problem, and parent history of alcohol or drug problems were used (Ewing 1990). However, several adaptations have been made, and recently a question about tobacco use in the month before the client knew she was pregnant was added (Chasnoff 2001). Chasnoff and colleagues (2001) reported that women who smoked in the month before pregnancy were 11 times more likely to be currently using drugs and 9 times more likely to be currently using either drugs or alcohol or both while pregnant. This version, the 5Ps, is shown in Figure 4-4.

In a study evaluating prevalence of substance use among pregnant women utilizing this screening tool, the authors suggest that it not only identified pregnant women with high levels

of alcohol and drug use but also a larger group of women whose pregnancies were at risk from smaller amounts of substance use (Chasnoff et al. 2005). For a review on how to improve screening for pregnant women and motivate healthcare professions to screen for risk, refer to the Alcohol Use During Pregnancy Project (Kennedy et al. 2004).

Acute Safety Risk Related to Serious Intoxication or Withdrawal

Screening for safety related to intoxication and withdrawal at intake involves questioning the woman and her family or friends (with client’s permission) about current substance use or recent discontinuation of use, along with past and present experiences of withdrawal. If a woman is obviously severely intoxicated, she needs to be treated with empathy and firmness, and provision needs to be made for her physical safety. If a client has symptoms of withdrawal, formal withdrawal scales can be used by trained personnel to gather information to determine whether medical intervention is required. Such tools include the Clinical Institute Withdrawal Assessment for Alcohol Withdrawal (Sullivan et al. 1989; See Appendix C for specific

Figure 4-4
5Ps Screening

Peers: Do any of your friends have a problem with drug or alcohol use?

Partner: Does your partner have a problem with alcohol or drugs?

Parents: Did either of your parents ever have a problem with alcohol or drugs?

Past Use: Before you knew you were pregnant, how often did you drink beer, wine, wine coolers, or liquor? *Not at all, rarely, sometimes, or frequently?*

Present Use: In the past month, how often did you drink beer, wine, wine coolers, or liquor? *Not at all, rarely, sometimes, or frequently?*

Smoke: How many cigarettes did you smoke in the month prior to pregnancy?

Source: Morse et al. 1997; Chasnoff et al. 2001

Advice to Clinicians:

At-Risk Screening for Drug and Alcohol Use During Pregnancy

- In screening women who are pregnant, face-to-face screening interviews have not always been successful in detecting alcohol and drug use.
- Self-administered tools may be more likely to elicit honest answers; this is especially true regarding questions related to drug and alcohol use during pregnancy.
- While questions regarding past alcohol and drug use or problems associated with self, partner, and parents will help to identify pregnant women who need further assessment, counselors should not underestimate the importance of inquiring about previous nicotine use in order to identify women who are at risk for substance abuse during pregnancy.
- There are other factors that are associated with at-risk substance abuse among women who are pregnant, including moderate to severe depression, living alone or with young children, and living with someone who uses alcohol or drugs (for review, see Chasnoff et al. 2001).

information) and the Clinical Institute Narcotic Assessment for Opioid Withdrawal (Zilm and Sellers 1978). While specific normative data are unavailable, it is important to screen for withdrawal to assess risk and to implement appropriate medical and clinical interventions.

Not all drugs produce physiological withdrawal; counselors should not assume that withdrawal from any drug of abuse requires medical intervention. Only in the case of opioids, sedative-hypnotics, or benzodiazepines (and in some cases of alcohol), is medical intervention likely to be required. Nonetheless, specific populations may warrant further assessment and assistance in detoxification, including pregnant women, women of color, women with disabilities or co-occurring disorders, and older women. (Review TIP 45 *Detoxification and Substance Abuse Treatment*, [CSAT 2006a], pp. 105–113.) Specific to women who are pregnant and dependent on opioids, withdrawal during pregnancy poses specific medical risks including premature labor and mortality to the fetus.

Note: Women who are dependent on opioids may misinterpret early signs of pregnancy as opioid withdrawal symptoms (review TIP 43 *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* [CSAT

2005a], pp. 211–224).

Mental Illness Symptoms and Mental Disorders

Considering that women are twice as likely as men to experience mood disorders, excluding bipolar and anxiety disorders (Burt and Stein 2002), all women entering substance abuse treatment should be screened for co-occurring mental disorders. If the screening indicates the possible presence of a disorder, a woman should be referred for a comprehensive mental health assessment and receive treatment for the co-occurring disorder, as warranted. Depression, anxiety, eating disorders, and PTSD are common among women who abuse substances (McCrary and Raytek 1993).

Because certain drugs as well as withdrawal symptoms can mimic symptoms of mental disorders, the continual reassessment of mental illness symptoms is essential to ensure accurate diagnosis and treatment planning. TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005e) contains information on screening and treatment of persons with co-occurring substance use and mental disorders.

General mental disorder screening instruments

Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. Circumstances surrounding the resolution of symptoms should be explored. For example, if the client is taking psychotropic medication and is no longer symptomatic, this may be an indication that the medication is effective and should be continued. Often, symptom checklists are used when the counselor needs information about how the client is feeling. They are not used to screen for specific disorders, and responses are expected to change from one administration to the next. Symptom screening should be performed routinely and facilitated by the use of formal screening tools.

Basic mental health screening tools are available to assist the substance abuse treatment team. The 18 questions in the Mental Health Screening Form-III (MHSF-III) screen for present or past symptoms of most mental disorders (Carroll and McGinley 2001). It is available at no charge from the Project Return Foundation, Inc., and is reproduced in TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005e), along with instructions and contact information (a Spanish-language form and instructions can be downloaded from www.asapnys.org/resources.html). MHSF-III was developed in a substance abuse treatment setting and is referred to as a “rough screening device” (Carroll and McGinley 2001, p. 35).

The Mini-International Neuropsychiatric Interview (M.I.N.I.) is a brief, structured interview for more than 20 major psychiatric and substance use disorders (Sheehan et al. 2002). Administration time is 15–30 minutes. Scoring is simple and immediate. M.I.N.I. can be administered by clinicians after brief training and by lay personnel with more extensive training. M.I.N.I. can be downloaded from www.medical-outcomes.com and used for no cost in nonprofit or publicly owned settings.

The Brief Symptom Inventory is a research tool that can be adapted for use as a screening checklist. This tool’s 53 items measure 9

primary symptom dimensions as well as 3 global indices of distress. Respondents rate the severity of symptoms on a 5-point scale ranging from “Not at all” (0 points) to “Extremely” (4 points) (Derogatis and Melisaratos 1983).

Depression and anxiety disorders

Many formal tools screen for depression, including the Beck Depression Inventory-II (Beck et al. 1996a, b; Smith and Erford 2001; Steer et al. 1989), the Center for Epidemiologic Study Depression Scale (Radloff 1977), and the General Health Questionnaire—a self-administered screening test to identify short-term changes in mental health (depression, anxiety, social dysfunction, and somatic symptoms)—are available.

Programs that screen for depression should ensure that “yes” answers to these questions are followed by a comprehensive assessment, accurate diagnosis, effective treatment, and careful followup. Asking these two questions may be as effective as using longer instruments (U.S. Preventive Services Task Force 2002). Little evidence exists to recommend one screening method over another, so clinicians can choose the method that best fits their preference, the specific population of women, and the setting. Refer to TIP 48 *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT 2008) for more guidance in working with clients who have depressive symptoms. **Note:** Women who are depressed are more likely to report bodily symptoms, including fatigue, appetite and sleep disturbance, and anxiety (Barsky et al. 2001; Kornstein et al. 2000; Silverstein 2002).

The U.S. Preventive Services Task Force (2002) recommends two simple questions that are effective in screening adults for depression:

1. Over the past 2 weeks have you felt down, depressed, or hopeless?
2. Over the past 2 weeks have you felt little interest or pleasure in doing things?

An example of an instrument that can detect symptoms of anxiety is the 21-item Beck Anxiety Inventory (BAI; Beck 1993; Hewitt and Norton 1993). Among a group of psychiatric patients with a variety of diagnoses, women's BAI scores indicated higher levels of anxiety than men's BAI scores. However, the nature of the anxiety reported appears similar for women and men (Hewitt and Norton 1993).

Assessing Risk of Harm to Self or Others

Suicidal attempts and parasuicidal behavior (nonfatal self-injurious behavior with clear intent to cause bodily harm or death; Welch 2001) are more prevalent among women. The greatest predictor of eventual suicide is prior suicidal attempts and deliberate self-harm inflicted with no intent to die (Joe et al. 2006). While substance dependence and PTSD are associated with self-harm and suicidal behavior (Harned et al. 2006), the most frequent diagnoses associated with suicide are mood disorders, specifically depressive episodes (Kessler et al. 1999). Considering the prevalence of suicidal attempts, self-injurious behavior, and depression among women, employing safety screenings should be a standard practice. From the outset, clinicians should specifically ask the client and anyone else who is providing information whether she is in immediate danger and whether she has any immediate intention to engage in violent or self-injurious behavior. If the answer is "yes," the clinician should obtain more information about the nature and severity of the thoughts, plan, and intent, and then arrange for an in-depth risk assessment by a trained mental health clinician. The client should not be left alone.

No tool is definitive for safety screening. Clinicians should use safety screening tools only as an initial guide and proceed to detailed questions to obtain relevant information. In addition, care is needed to avoid underestimating risk because a woman is using substances or has frequently engaged in self-injurious behavior. For example, a woman

who is intoxicated might seem to be making empty threats of self-harm, but all statements about harming herself or others must be taken seriously. Overall, individuals who have suicidal or aggressive impulses when intoxicated are more likely to act on those impulses; therefore, determination of the seriousness of threats requires a skilled mental health assessment, plus information from others who know the client very well. Screening tools and procedures in evaluating risk are discussed in depth in TIP 50 *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT 2009a).

Substance abuse treatment programs need clear mental health referral and follow-up procedures so that clients receive appropriate psychiatric evaluations and mental health care. The American Association of Community Psychiatrists (AACCP) developed the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) that evaluates clients along six dimensions and defines six levels of resource intensity. It includes an excellent tool for helping the counselor determine the risk of harm (AACCP 2000; See Appendix C for specific information on the LOCUS). The potential risk of harm most frequently takes the form of suicidal intentions, and less often the form of homicidal intentions. The scale has five categories, from minimal risk of harm to extreme risk of harm. It is available at www.comm.psych.pitt.edu/finds/LOCUS2000.pdf and can be easily adapted for use in treatment facilities.

Trauma and Posttraumatic Stress Disorder

PTSD can follow a traumatic episode that involves witnessing, being threatened, or experiencing an actual event involving death or serious physical harm, such as auto accidents, natural disasters, sexual or physical assault, war, and childhood sexual and physical abuse (APA 2000a). During the trauma, the individual experiences intense fear, helplessness, or horror. PTSD has symptoms that last longer than 1 month and result in a decline in

functioning in several life areas, such as work and relationships. A diagnosis of PTSD cannot be made without a clear history of a traumatic event (Figure 4-5 presents sample screening questions for identifying a woman's history of trauma). General symptoms of PTSD include persistently re-experiencing the traumatic event, numbness or avoidance of cues associated with the trauma, and a pattern of increased arousal (APA 2000a).

Historically, women have not been routinely screened for a history of trauma or assessed to determine a diagnosis of PTSD across treatment settings (Najavits 2004). Among women in substance abuse treatment, it has been estimated that 55–99 percent have experienced trauma—commonly childhood physical or sexual abuse, domestic violence, or

rape (Najavits et al. 1997; Triffleman 2003). Studies have reported that current PTSD rates among women who abuse substances range between 14 to 60 percent (Brady 2001; Najavits et al. 1998; Triffleman 2003). In comparison to men, women who use substances are still more than twice as likely to have PTSD (Najavits et al. 1997). Brief screening is paramount in not only establishing past or present traumatic events but in identifying PTSD symptoms. Upon identification of traumatic stress symptoms, counselors need to refer the women for a mental health evaluation in order to further assess the presenting symptoms, to determine the appropriateness of a PTSD diagnosis, and to assist in establishing an appropriate treatment plan and approach. Brief screenings are used to identify clients who are more likely to have

Figure 4-5 **Questions to Screen for Trauma History**

Responses include yes, no, or maybe. Maybe is used if the client is unsure (e.g., she was too young to remember but suspects it happened). If answering these questions is upsetting, the counselor may need to stop the interview or redirect the questions, provide support and reassurance to the client, and seek consultation from a clinical supervisor.

In your lifetime, have you suffered any of the following experiences or seen them happen to someone else? (Answers are yes, no, or maybe.)

- Child physical abuse (e.g., hitting that caused bruises or injury)
- Child sexual abuse (e.g., being molested, touched, or forced into any sexual activity)
- Child neglect (e.g., not enough to eat, inadequate shelter)
- Domestic violence (e.g., a partner who hurt you physically)
- Crime victimization (e.g., rape, holdup)
- Serious accident (e.g., car crash, chemical spill, or fire)
- Life-threatening illness (e.g., cancer)
- Natural disaster (e.g., hurricane, earthquake)
- War
- Captivity or kidnapping
- The *threat* of any of the events listed above, even if it wasn't completed (e.g., threat of being raped or murdered)
- Violence by you (e.g., you physically hurt someone, such as abusing a child, murdering someone, or attacking someone with a weapon)
- Other upsetting events (make a list)

Source: Najavits 2002a.

PTSD. A positive response to any PTSD screen does not necessarily indicate that a patient has PTSD, but it does warrant further investigation.

Numerous screening and assessment tools are available to assess lifetime traumatic events, traumatic stress symptoms, and diagnostic criteria for PTSD. Screening and assessment for trauma-related symptoms and disorders are discussed in depth in the planned TIP *Substance Abuse and Trauma* (CSAT in development *h*). One specific screening tool that coincides with the symptoms and criteria listed in the DSM-IV-TR is the PTSD Checklist – Civilian Version (PCL-C) and the PCL-Military Version (Weathers et al. 1993). The PTSD Checklist is a 17-item, self-report rating scale. It was initially developed and validated for male Vietnam veterans; further empirical data support the reliability, validity, and diagnostic utility among women and among mixed-gender civilian groups (Andrykowski et al. 1998; Blanchard et al. 1996; Dobie et al. 2004). This instrument requires no formal training to administer and can be downloaded from the National Center for PTSD (<http://www.ptsd.va.gov>).

Sexual Victimization, Childhood Abuse, and Interpersonal Violence

Sexual victimization and childhood abuse

Women entering treatment for substance use disorders have consistently reported high rates of sexual abuse. Approximately two-thirds of all women entering treatment have specifically reported a history of sexual violence (Gil-Rivas et al. 1996; Lincoln et al. 2006). In 1998, Bassuk reported higher rates of lifetime occurrence of physical and sexual violence among women who are poor and homeless (82 percent and 92 percent, respectively; Bassuk 1998). More recent research focuses on sociocultural factors supporting the belief that socioeconomic status contributes more to women's vulnerability to abuse and stress symptoms than does ethnicity (Vogel and Marshall 2001).

During the intake process, many women are reluctant to reveal their sexual abuse before trust is established with the counselor. Some women may not realize that their experiences

Note to Clinicians

So often, clients who have PTSD have a difficult time in distinguishing between the past feelings of danger associated with the trauma(s) and their current surroundings when discussing trauma-related material during interviews and counseling. Therefore, it is important for counselors to remember that discussing the occurrence or consequences of traumatic events and subsequent PTSD symptoms can feel as unsafe, dangerous, and helpless to the client as if the event were occurring now. While the counselor does not want to encourage avoidance or reinforce the belief that discussing trauma-related material is dangerous, it is important to be sensitive when gathering information about a woman's history of trauma in the initial screening.

Initial questions about trauma should be general and gradual. While ideally you want the client to control the level of disclosure, it is important as a counselor to mediate the level of disclosure. At times, clients with PTSD just want to gain relief; they disclose too much, too soon without having established trust, an adequate support system, or effective coping strategies. Preparing a woman to respond to trauma-related questions is important. By taking the time with the client to prepare and explain how the screening is done and the potential need to pace the material, the woman has more control over the situation. Overall, she should understand the screening process, why the specific questions are important, and that she can choose not to answer or to delay her response. From the outset, counselors need to provide initial trauma-informed education and guidance with the client.

were not normal and were abusive. Some women do not remember the abuse. Therefore, a negative finding on abuse at an intake screening should not be taken as a final answer. The Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Women, Co-Occurring Disorders and Violence Study includes questions about sexual abuse in its baseline interview protocol, presented in Figure 4-6. In addition, SAMHSA's CSAT has developed a brochure for women that defines childhood abuse and informs the reader of how to begin to address childhood abuse issues while in treatment (CSAT 2003a). TIP 36 *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b) includes detailed information on this topic.

Interpersonal violence

Studies estimate that between 50 to 99 percent

of women with substance use disorders have a history of interpersonal violence (Miller et al. 1993; Rice et al. 2001). In one study focused on sensitivity and specificity of screening questions for intimate partner violence, Paranjape and Liebschutz (2003) concluded that when three simple screening questions were used together, identification of lifetime interpersonal violence was effectively identified for women. This screening tool, referred as the STaT, is presented in Figure 4-7 (p. 72). Along with a sample personalized safety plan, additional screening tools, including the Abuse Assessment Screen (English and Spanish version), Danger Assessment, The Psychological Maltreatment of Women Inventory, and The Revised Conflict Tactics Scale (CTS2), are available in TIP 25 *Substance Abuse Treatment and Domestic Violence* (CSAT 1997b). **Note:** It is important to assess for interpersonal violence in heterosexual

Figure 4-6
Questions Regarding Sexual Abuse

Have you ever been bothered or harassed by sexual remarks, jokes, inappropriate touching, or demands for sexual favors by someone at work or school?

- How often has this happened?
- How old were you when this first happened?
- Has this happened in the past 6 months?

Were you ever touched or have you ever touched someone else in a sexual way because you felt forced or coerced or threatened by harm to yourself or someone else?

- How old were you when this first happened?
- How often did this happen before age 18?
- How often has this happened since you turned 18?
- Has this happened in the past 6 months?

Did you ever have sex because you felt forced or threatened by harm to yourself or someone else?

- How old were you when this first happened?
- How often did this happen before age 18?
- How often has this happened since you turned 18?
- Has this happened in the past 6 months?

Have you ever had sex when you did not want to in exchange for money, drugs, or other material goods such as shelter or clothing?

- How often has this happened?
- How old were you when this first happened?
- Has this happened in the past 6 months?

Source: SAMHSA n.d.

Figure 4-7 *STaT: Intimate Partner Violence Screening Tool*

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape and Liebschutz 2003.

and homosexual relationships.

Interpersonal violence and disabilities

Women with disabilities are at a significantly greater risk for severe interpersonal violence and neglect (Brownridge 2006). As a counselor, additional screening questions tailored to address unique vulnerabilities associated with the specific physical disability may be warranted. For example,

- Has anyone ever withheld food or medication from you that you asked for or needed?
- Has anyone ever refused to let you use your wheelchair or other assistive devices at home or in the community?
- Has anyone ever refused to assist you with self-care that you needed, such as getting out of bed, using the toilet, or other personal care tasks?
- Has anyone used restraints on you to keep you from getting out of bed or out of your wheelchair?

Initial questions about trauma should be general and gradual. While ideally you want the client to control the level of disclosure, it is important as a counselor to mediate the level of disclosure. At times, clients with PTSD just want to gain relief; they disclose too much, too soon without having established trust, an adequate support system, or effective coping strategies.

Preparing a woman to respond to trauma-related questions is important. By taking the

time with the client to prepare and explain how the screening is done and the potential need to pace the material, the woman has more control over the situation. Overall, she should understand the screening process, why the specific questions are important, and that she can choose not to answer or to delay her response. From the outset, counselors need to provide initial trauma-informed education and guidance with the client.

Eating Disorders

Eating disorders have one of the highest mortality rates of all psychological disorders (Neumarker 1997; Steinhausen 2002). Approximately 15 percent of women in substance abuse treatment have had an eating disorder diagnosis in their lifetimes (Hudson 1992). Three eating disorders are currently included in the DSM-IV-TR: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (APA 2000a). Compulsive eating, referred to as binge-eating disorder, is not included as a diagnosis in the DSM. Currently, it is theorized that substance use disorders and compulsive overeating are competing disorders, in that compulsive overeating (binge-eating) is not as likely to appear at the same time as substance use disorders. Consequently, disordered eating in

Be aware that weight gain during recovery can be a major concern and a relapse risk factor for women.

the form of compulsive overeating is more likely to appear after a period of abstinence, thus enhancing the risk of relapse to drugs and alcohol to manage weight gain.

Bulimia nervosa, characterized by recurrent episodes of binge and purge eating behaviors, has the highest incidence rates in the general population for eating disorders (Hoek and van Hoeken 2003), and it is the most common eating disorder among women in substance abuse treatment (Corcos et al. 2001; Specker et al. 2000; APA 2000a). For specific information regarding the co-occurring disorders of eating and substance use disorders, counselors should refer to TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005e).

Screening for eating disorders in substance abuse treatment is based on the assumption that identification of an eating disorder can lead to earlier intervention and treatment, thereby reducing serious physical and psychological complications and decreasing the potential risk for relapse to manage weight. Eating disorder screenings are not designed to establish an eating disorder diagnosis but instead to identify the need for additional psychological and medical assessments by a trained mental health

clinician and medical personnel. The EAT-26 (Garner et al. 1982), or Eating Attitudes Test, is a widely used screening tool that can help identify behaviors and symptoms associated with eating disorder risk (Garner et al. 1998). It is recommended that a two-stage process be employed using the EAT-26: screening followed by a clinical interview. Specifically, if the woman scores at or above a cutoff score of 20 on the EAT-26, she should be referred for a diagnostic interview. For a copy of the screening tool and scoring instructions, refer to Appendix C.

Figure 4-8 lists questions that probe for an eating disorder. A woman with an eating disorder often feels shame about her behavior, so the general questions help ease into the topic as the counselor explores the client's attitude toward her shape, weight, and dieting.

Screening by Healthcare Providers in Other Settings

Healthcare providers such as nurse practitioners, physicians, physicians' assistants, and social service professionals have opportunities to screen women to determine whether they use or abuse alcohol, drugs, or tobacco. The most frequent points of entry

Figure 4-8 **General and Specific Screening Questions for Persons With Possible Eating Disorders**

General Screening Questions

- How satisfied are you with your weight and shape?
- How often do you try to lose or gain weight?
- How often have you dieted?
- What other methods have you used to lose weight?

Specific Screening Questions

- Have you ever lost weight and weighed less than others thought you should weigh?
- Have you had eating binges in which you eat a large amount of food in a short period of time?
- Do you ever feel out of control when eating?
- Have you ever vomited to lose weight or to get rid of food that you have eaten?
- What other sorts of methods have you used to lose weight or to get rid of food?

Source: CSAT 2005e.

Our own preconceived images of women who are addicted, coupled with a myth that women are less likely to become addicted, can undermine clinical judgment to conduct routine screenings for substance use.

from other systems of care are obstetric and primary care; hospital emergency rooms; probation officer visits; and social service agencies in connection with housing, child care, and domestic violence.

Between 5 and 40 percent of people seeing physicians and/or reporting to hospital emergency rooms for care have an alcohol use disorder (Chang 1997), but physicians often do not identify, refer, or intervene with these patients (Kuehn 2008). Even clinicians who often use the CAGE or other screening tools for certain patients are less likely to ask women these questions because

women—particularly older women, women of Asian descent, and those from middle and upper socioeconomic levels—are not expected to abuse substances (Chang 1997). Volk and colleagues (1996) found that, among primary care patients who were identified as “at risk” for alcohol abuse or dependence by a screening questionnaire, men were 1.5 times as likely as women to be warned about alcohol use and three times as likely to be advised to stop or modify their consumption. Women may be less likely to have problems with alcohol or drugs than men (Kessler et al. 1994, 1995); however, when women have substance use disorders, they experience greater health and social consequences.

Screening must lead to appropriate referrals for further evaluation and treatment in order to be worthwhile. Missed opportunities can be especially unfortunate during prenatal care. In one study of ethnically diverse women

reporting to a university-based obstetrics clinic, 38 percent screened positive for psychiatric disorders and/or substance abuse. However, only 43 percent of those who screened positive had symptoms recorded in their chart, and only 23 percent of those screening positive were given treatment. This low rate of treatment is of great concern, given the untoward consequences of substance use for maternal and infant health (Kelly et al. 2001).

To address the disconnection that often happens (beginning with the lack of identification of substance-related problems of the patient and extending to the failure of appropriate referrals and brief interventions), SAMHSA has invested in the Screening, Brief Intervention, and Referral to Treatment Initiative (SBIRT)—research, resources development, training, and program implementation across healthcare settings. Although studies have not focused on gender comparisons, SBIRT programs have yielded short-term improvements in individual health (for review, see Babor et al. 2007). Specifically, some SBIRT programs on the State level have tailored SBIRT to provide assistance to pregnant women (Louisiana Department of Health and Hospitals 2007).

Assessment

The assessment examines a client’s life in far more detail so that accurate diagnosis, appropriate treatment placement, problem lists, and treatment goals can be made. Usually, a clinical assessment delves into a client’s current experiences and her physical, psychological, and sociocultural history to determine specific treatment needs. Using qualified and trained clinicians, a comprehensive assessment enables the treatment provider to determine with the client the most appropriate treatment placement and treatment plan (CSAT 2000c). Notably, assessments need to use multiple avenues to obtain the necessary clinical information, including self-assessment instruments, clinical records, structured clinical interviews, assessment measures, and collateral information. Rather than using one method for evaluation,

Advice to Clinicians: **Mental Health Screening and Women**

- Women need to be routinely screened for depressive, eating, and anxiety disorders including PTSD.
- Women tend to report higher levels of anxiety and somatic symptoms associated with depression.
- Explicit details, especially related to traumatic subject matter that may make a woman uncomfortable, are not necessary early in the process.
- For some women, drugs have had a secondary effect and purpose, i.e., weight management. Be aware that weight gain during recovery can be a concern and a relapse risk factor for women and that clinical and medical issues surrounding body image, weight management, nutrition, and healthy lifestyle habits are essential ingredients in treatment for women.
- Bulimia nervosa is the most common eating disorder among women in substance abuse treatment, and counselors should become knowledgeable about the specific behavioral patterns associated with this disorder, e.g., compensatory and excessive exercise for overeating, routine pattern of leaving after meals, persistent smell of vomit on the woman's breath or in a particular bathroom, taking extra food (from dining room), or hoarding food, etc.
- Be aware that women with bulimia nervosa are usually of normal weight.

assessments should include multiple sources of information to obtain a broad perspective of the client's history, level of functioning and impairment, and degree of distress.

Assessment should be a fluid process throughout treatment. It is not a once-and-done event. Considering the complexity of withdrawal and the potential influence of alcohol and drugs on physical and psychological functioning, it is very important to reevaluate as the client engages into recovery. Periodic reassessment is critical to determine the client's progress and her changing treatment needs. In addition, reassessment is an opportunity to solicit input from the client on what is and is not working for her in treatment and to alter treatment accordingly.

The following section reviews core assessment processes tailored for women, including gender-specific content for biopsychosocial histories and assessment tools that are either appropriate or possess normative data for women in evaluating substance use disorders and consequences. It is beyond the scope of this chapter to provide

specific assessment guidelines or tools for other disorders outside of substance-related disorders.

The Assessment Interview

To provide an accurate picture of the client's needs, a clinical assessment interview requires sensitivity on the part of the counselor and considerable time to complete thoroughly. While treatment program staff may have limited time or feel pressure to conduct initial psychosocial histories quickly, it is important to portray to clients that you have sufficient time to devote to the process. The assessment interview is the beginning of the therapeutic relationship and helps set the tone for treatment.

Initially, the interviewer should explain the reason for and role of a psychosocial history. It is equally important that the counselor or intake worker incorporate screening results into the interview, and make the appropriate referrals within and/or outside the agency to comprehensively address presenting issues. The notion that the women's substance use is not an isolated behavior but occurs in response to,

Advice to Administrators: **General Guidelines for Selecting and Using Screening and Assessment Tools**

- What are the goals of the screening and assessment?
- Is the screening and assessment process appropriate for the particular setting with women?
- What costs are associated with the screening process; e.g., training, buying the screening/assessment instruments or equipment (computer), wages associated with giving and scoring the instrument, and time spent providing feedback to the client and establishing appropriate referrals?
- What other staff resources are needed to administer and score the instrument, interpret the results, review the findings with the client, arrange referrals, or establish appropriate services to address concerns highlighted in the screening and assessment process?
- While screening measures can be completed in just a few minutes, positive screenings involve more work. Does staff see a need for and value of the additional work? Did you prepare and train staff? What strategies did you employ to obtain staff or administrative buy-in? What other obstacles have you identified if the screening is implemented? Have you developed strategies to target their specific obstacles?
- Do you have a system in place to manage the results of the screening and assessment process?

Note: While formal assessment tools are consistently used in research associated with substance use disorders, treatment providers and counselors are less likely to use formalized tools and more likely to only use clinical interviews (Allen 1991). The standardization of formal assessment measures offers consistency and uniformity in administration and scoring. If the implementation of these tools is not cost prohibitive and staff maintain adherence to administration guidelines, formal assessment tools can be easily adopted regardless of diverse experience, training, and treatment philosophy among clinicians. Using psychometrically sound instruments can offset clinical bias and provide more credibility with clients.

and affects, other behaviors and areas of her life is an important concept to introduce during the intake phase. This information can easily disarm a client's defensiveness regarding use and consequences of use.

The focus of the assessment may vary depending on the program and the specific issues of an individual client. A structured biopsychosocial history interview can be obtained by using The Psychosocial History (PSH) assessment tool (Comfort et al. 1996), a comprehensive multidisciplinary interview incorporating modifications of the Addiction Severity Index

(ASI) designed to assess the history and needs of women in substance abuse treatment.

Investigators have sought to retain the fundamental structure of ASI while expanding it to include family history and relationships, relationships with partners, responsibilities for children, pregnancy history, history of violence and victimization, legal issues, and housing arrangements (Comfort and Kaltenbach 1996). PSH has been found to have satisfactory test-retest reliability (i.e., the extent to which the scores are the same on two administrations of the instrument with the same people) and concurrent validity with the ASI (Comfort et al. 1999).

Psychosocial and Cultural History

Treatment programs have their own prescribed format for obtaining a psychosocial history that coincides with State regulations as well as other standards set by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Commission on Accreditation of Rehabilitation Facilities (CARF). While many States require screening and assessment for women, specific guidelines and specificity in incorporating women-specific areas vary in degree (CSAT 2007). **Note:** When using information across State standards, the following psychosocial and cultural subheadings should be included in the initial assessment for women, and these areas need to be addressed in more depth as treatment continues. **Keep in mind that the content within each subheading does not represent an entire psychosocial and cultural history. Only biopsychosocial and cultural issues that are pertinent to women were included in the list below.**

Medical History and Physical Health: Review HIV/AIDS status, history of hepatitis or other infectious diseases, and HIV/AIDS risk behavior; explore history of gynecological problems, use of birth control and hormone replacement therapy, and the relationship between gynecological problems and substance abuse; obtain history of pregnancies, miscarriages, abortions, and history of substance abuse during pregnancy; assess need for prenatal care.

Substance Abuse History: Identify people who initially introduced alcohol and drugs; explore reasons for initiation of use and continued use; discuss family of origin history of substance abuse, history of use in previous and present significant relationships, and history of use with family members or significant others.

Mental Health and Treatment History: Explore prior treatment history and relationships with prior treatment providers and consequences, if any, for engaging in prior treatment; review history of prior traumatic events, mood or anxiety disorders (including PTSD), as well as eating disorders; evaluate safety issues including parasuicidal behaviors, previous

or current threats, history of interpersonal violence or sexual abuse, and overall feeling of safety; review family history of mental illness; and discuss evidence and history of personal strengths and coping strategies and styles.

Interpersonal and Family History: Obtain history of substance abuse in current relationship, explore acceptance of client's substance abuse problem among family and significant relationships, discuss concerns regarding child care needs, and discuss the types of support that she has received from her family and/or significant other for entering treatment and abstaining from substances.

Family, Parenting, and Caregiver History: Discuss the various caregiver roles she may play, review parenting history and current living circumstances.

Children's Developmental and Educational History (applicable to women and children programs): Assess child safety issues; explore developmental, emotional, and medical needs of children.

Sociocultural History: Evaluate client's social support system, including the level of acceptance of her recovery; discuss level of social isolation prior to treatment; discuss the role of her cultural beliefs pertaining to her substance use and recovery process; explore the specific cultural attitudes toward women and substance abuse; review current spiritual practices (if any); discuss current acculturation conflicts and stressors; and explore need or preference for bilingual or monolingual non-English services.

Vocational, Educational, and Military History: If employed, discuss the level of support that the client is receiving from her employer; review military history, then expand questions to include history of traumatic events and violence during employment and history of substance abuse in the military; assess financial self-reliance.

Legal History: Discuss history of custody and current involvement with child protective services, if any; obtain a history of restraining orders, arrests, or periods of incarceration,

TIPs that provide assessment information relevant to women in specific settings:

TIP 43 *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, 2005

TIP 44 *Substance Abuse Treatment for Adults in the Criminal Justice System*, 2005

TIP 45 *Detoxification and Substance Abuse Treatment*, 2006

TIP 49 *Incorporating Alcohol Pharmacotherapies Into Medical Practice*, 2009b

Additional TIPs that address assessment strategies and tools for co-occurring disorders and interpersonal childhood and adult violence that are highly prevalent among women:

TIP 25 *Substance Abuse Treatment and Domestic Violence*, 1997

TIP 36 *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues*, 2000

TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, 2005

TIP 50 *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*, 2009a

Planned TIP, *Substance Abuse and Trauma*, in development h

if any; determine history of child placement with women who acknowledge past or current incarceration.

Barriers to Treatment and Related

Services: Explore financial, housing, health insurance, child care, case management, and transportation needs; discuss other potential obstacles the client foresees.

Strengths and Coping Strategies: Discuss the challenges that the client has faced throughout her life and how she has managed them, review prior attempts to quit substance use and identify strategies that did work at the time, identify other successes in making changes in other areas of her life.

Assessment Tools for Substance Use Disorders

Addiction Severity Index (ASI): The ASI (McLellan et al. 1980) is the most widely used substance abuse assessment instrument in both research and clinical settings. It is administered as a semi-structured interview and gathers

information in seven domains (i.e., drug use, alcohol use, family/social, employment/finances, medical, psychiatric, and legal). The ASI has demonstrated high levels of reliability and validity across genders, races/ethnicities, types of substance addiction, and treatment settings (McCusker et al. 1994; McLellan et al. 1985; Zanis et al. 1994; See Appendix C for specific information on the ASI).

ASI-F (CSAT 1997c): The ASI-F is an expanded version of ASI; several items were added relevant to the family, social relationships, and psychiatric sections. Additional items refer to homelessness; sexual harassment; emotional, physical, and sexual abuse; and eating disorders. The supplemental questions are asked after the administration of ASI. Psychometric data for ASI-F are limited.

Texas Christian University Brief Intake, the Comprehensive Intake, and Intake for Women and Children: These instruments are available electronically and are administered by a counselor. The seven problem areas in the Brief Intake Interview were derived from

Since women are more likely to experience greater consequences earlier than men, using an instrument that highlights specific consequences of use is crucial.

the ASI: drug, alcohol, medical, psychological, employment, legal, and family/social. Scoring is immediate, and the program generates a one-page summary of the client's functioning in 14 domains (Joe et al. 2000). The Comprehensive Intake has an online version for women (Simpson and Knight 1997).

Drinker Inventory of Consequences (DrinC): This measurement is a self-administered 50-item, true-false questionnaire that elicits information

about negative consequences of drinking in five domains: physical, interpersonal, intrapersonal, impulse control, and social responsibility (Miller et al. 1995). This instrument has normative data for women, men, inpatient and outpatient, and has good psychometric properties. Since women are more likely to experience greater consequences earlier than men, using an instrument that highlights specific consequences of use is crucial. A version that assesses drug use consequences is also available (Tonigan and Miller 2002). For a copy of the assessment tool, scoring, and gender profile in interpreting severity of lifetime consequences, see Appendix C.

Available screening and assessment tools: Language availability

Figure 4-9 (p. 80) provides available information on screening and assessment versions in languages other than English. This is not an exhaustive list, and counselors and administrators should not assume language availability is a sign that the instrument is appropriate for a particular culture, ethnic, or racial group.

Other Considerations in Assessment: Strengths, Coping Styles, and Spirituality

Looking at women's strengths

Focusing on a woman's strengths instead of her deficits improves self-esteem and self-efficacy. Familiarity with a woman's strengths enables the counselor to know what assets the woman can use to help her during recovery. In the *Woman's Addiction Workbook* (Najavits 2002a), the author provides a self-assessment worksheet that focuses on individual strengths. In addition to assessing strengths, coping styles and strategies should be evaluated (see Rotgers 2002).

Measurements of spirituality and religiousness

Spirituality and religion play an important role in culture, identity, and health practices (Musgrave et al. 2002). In addition, women are more likely to embrace different coping strategies (including emotional outlets and religion) to assist in managing life stressors (Dennerstein 2001). Practices such as consulting religious leaders or spiritual healers (*curanderas*, medicine men) and attending to spiritual activities (including sweats and prayer ceremonies, praying to specific saints or ancestors) are common. The consensus panel believes it is important that programs assess the spiritual and religious beliefs and practices of women and incorporate this component into their treatment with sensitivity and respect.

A challenge in determining the effect of spirituality on treatment outcomes is how to assess the extent and nature of a person's spirituality or religiousness. Several assessment tools are available; however, they are more often used for research. They include, but are not limited to, the Religious Practice and Beliefs measurement (CASAA 2004), a 19-item self-assessment tool that reviews specific activities associated with religious practices; the Multidimensional Measure of Religiousness/Spirituality, an assessment device that examines domains of religious or spiritual activity such as

Figure 4-9
Available Screening and Assessment Tools
in Multiple Languages

<i>Instrument</i>	<i>Language</i>
Addiction Severity Index	Spanish
Alcohol Use Disorders Identification Test (AUDIT)	Numerous language versions including Spanish, French, German, Russian, Chinese, etc.
Beck Depression Inventory (BDI)	Numerous language versions including Spanish, French, German, Swedish, Chinese, Korean, etc.
Brief Symptom Inventory (BSI)	Spanish and French
CAGE	Numerous language versions including Spanish, Flemish, French, Hebrew, Japanese, etc.
Eating Attitudes Test (EAT-26)	Numerous language versions including Spanish and Japanese
General Health Questionnaire (GHQ)	Numerous language versions including Spanish, Japanese, Chinese, Farsi, etc.
Mini International Neuropsychiatric Interview (MINI)	Available in 43 languages including Spanish
Spiritual Well-Being Scale	Spanish
Texas Christian University Drug Screen II (TCUII)	Spanish
TWEAK	Spanish

daily spiritual experiences, values and beliefs, and religious and spiritual means of coping (Fetzer Institute 1999); and the Spiritual Well-Being Scale, a 20-item scale that examines the benefits of spirituality for African-American women in recovery from substance abuse (Brome et al. 2000; See Appendix C for specific information on the Spiritual Well-Being Scale).

Health Assessment and Medical Examination

Because women develop serious medical problems earlier in the course of alcohol use disorders than men, they should be encouraged to seek medical treatment early to enhance their chances of recovery and to prevent serious medical complications. Health screenings and

medical examinations are essential in women's treatment. In particular, women entering substance abuse treatment programs should be referred for mental health, medical, and dental examinations. In many cases, they may not have had adequate health care because of lack of insurance coverage or transportation, absence of child care, lack of time for self-care, chaotic lifestyle related to a substance abuse, or fear of legal repercussions or losing custody of children. The acute and chronic effects of alcohol and drug abuse, the potential for violence, and other physical hardships (e.g., homelessness) greatly increase the risk for illness and injury.

Women may practice behaviors that put them at high risk for contracting sexually transmitted diseases (STDs) and other infectious diseases

Advice to Clinicians:

General Guidelines of Assessment for Women

- Similar to the screening process, women should know the purpose of the assessment.
- To conduct a good quality assessment, counselors need to value and invest in the therapeutic alliance with the client. Challenging, disagreeing, being overly invested in the outcome, or vocalizing and assuming a specific diagnosis without an appropriate evaluation can quickly erode any potential for a good working relationship with the client.
- The assessment process should include various methods of gathering information: clinical interview; assessment tools including rating scales; behavioral samples through examples of previous behavior or direct observation; collateral information from previous treatment providers, family members, or other agencies (with client permission); and retrospective data including previous evaluations, discharge summaries, etc.
- Assessment is only as good as the ability to follow through with the recommendations.
- Assessments need to incorporate sociocultural factors that may influence behavior in the assessment process, interpretation of the results, and compliance with recommendations.
- The assessment process should extend beyond the initial assessment. As the woman becomes more comfortable, additional information can be gathered and incorporated into the revised assessment. Subsequently, this new information will guide the reevaluation of presenting problems, treatment priorities, and treatment planning with input and guidance from the client.
- Reassessments help monitor progress across the continuum of care and can be used as a barometer of effective treatment. Moreover, the presenting problems and symptoms may change as recovery proceeds.

(Greenfield 1996). Testing for HIV/AIDS, hepatitis, and tuberculosis is important; however, it is as essential to have adequate support services to help women process test results in early recovery. Anticipation of the test results is stressful and may place the client at risk for relapse. Residential centers may offer medical exams onsite, but outpatient service providers may need to refer patients to their primary care provider or other

affordable health care to ensure that each client has a thorough medical exam. Healthcare professionals may benefit in using the Women-Specific Health Assessment (Stevens and Murphy 1998), which assesses health and wellness and addresses gynecological exams, HIV/AIDS, drug use, STDs, pregnancy/child delivery history, family planning, mammography, menstruation, disease prevention, and protection behaviors.

5 Treatment Engagement, Placement, and Planning

In This Chapter

Barriers to Treatment Engagement

Treatment Engagement Strategies

Considerations in Treatment Placement and Planning

Levels of Care

Overview

Women often encounter numerous obstacles and barriers prior to and during the treatment process. While these hurdles may not be entirely unique to women, they are often more common for women due to the myriad pressures associated with assuming various caregiver roles, intrinsic socioeconomic and health conditions (particularly for women with substance use disorders), and societal bias and stigma associated with substance abuse. These challenges often interfere with treatment initiation and engagement.

This chapter is devoted to the exploration of treatment barriers as well as to the engagement strategies conducive to supporting treatment initiation for women. Considerations in treatment placement and the importance of client involvement are reviewed. The chapter ends with an overview of American Society of Addiction Medicine (ASAM) placement criteria for each treatment level with emphasis on issues specific to women, pregnant women, and women and children.

Barriers to Treatment Engagement

Making a decision to change is an essential step toward fulfilling any goal, but is only one ingredient of a successful outcome. Many times, the idea of making a change is shortsighted: How often has a decision been made without looking beyond the initial necessity or enthusiasm for the change? To support change across time, obstacles need to be anticipated and strategies need to be developed either to decrease the occurrence of the barriers or to find alternative routes around the potential obstacles.

Barriers to treatment are not exclusive to women (for review, see Appel et al. 2004), yet identifying potential challenges and obstacles can help enable successful treatment engagement and outcome. Historically, women have identified multiple factors as barriers to entering treatment, to engaging and continuing the utilization of treatment services across the continuum of care, and in maintaining connections with community services and self-help groups that support long-term recovery (see Figure 5-1 for an overview of barriers identified in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health [NSDUH]).

While the identification of barriers is essential to effective case management and treatment planning, it is equally important to develop specific strategies to address each barrier as early as possible. As highlighted in the Center for Substance Abuse Treatment's (CSAT's) *Comprehensive Substance Abuse Treatment Model for Women and Their Children* (for review, see Appendix B; HHS 2004), strategies to overcome these barriers need to focus on three core areas: clinical treatment services, clinical support services, and community support systems. Without a proactive plan to address barriers, women will not be as able to engage in or benefit from substance abuse treatment.

At the outset, barriers may exist on several levels:

- **Intrapersonal:** Individual factors including health problems, psychological issues, cognitive functioning, motivational status, treatment readiness, etc.
- **Interpersonal:** Relational issues including significant relationships, family dynamics, support systems, etc.
- **Sociocultural:** Social factors including cultural differences; the role of stigma, bias, and racism; societal attitudes; disparity in health services; attitudes of healthcare providers toward women; and others.
- **Structural:** Program characteristics including treatment policies and procedures, program design, and treatment restrictions.
- **Systemic:** Larger systems including Federal, State, and local agencies that generate public policies and laws; businesses including health insurance companies; and environmental factors such as the economy, drug trafficking patterns, etc.

Intrapersonal Obstacles

Various individual factors impede interest in and commitment to entering treatment. The anticipation of not being able to use substances to cope with stress, to manage weight, or to deal with symptoms associated with other mental disorders creates considerable apprehension in making a commitment to treatment. While the level of motivation and the degree of treatment readiness may also obstruct a woman's commitment to treatment (Miller and Rollnick 2002), there are other individual characteristics that may serve as a barrier to treatment, including feelings related to previous treatment failures, feelings of guilt and shame regarding use and behavior associated with use, fear of losing custody of children if the drug or alcohol problem is admitted and treatment is sought, feelings of helplessness, and a belief that change is not possible (Allen 1995; Greenfield 1996).

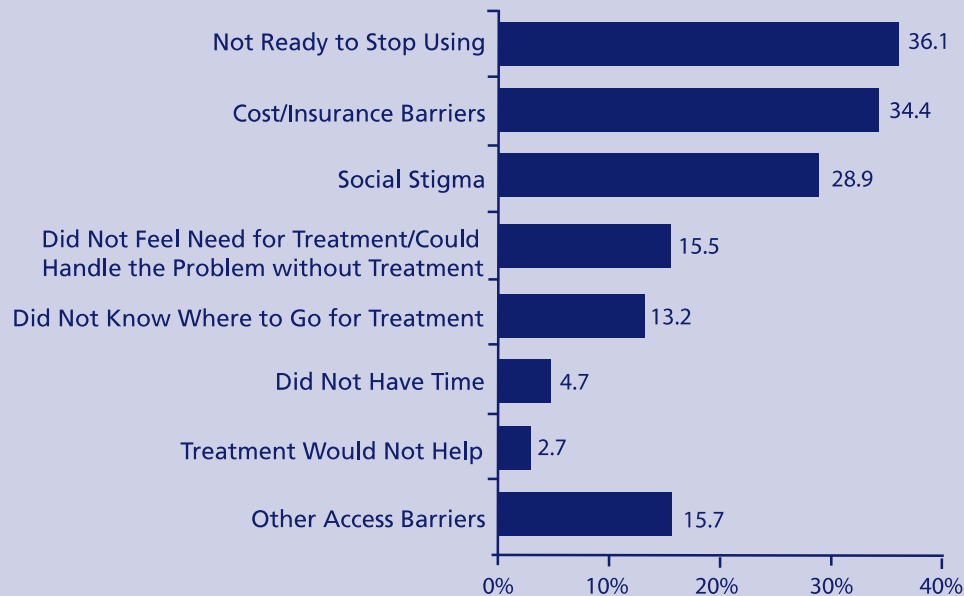
Moreover, health issues can serve as a powerful roadblock for women. Depending on the medical diagnosis and severity of the disorder, women may encounter difficulties in accessing treatment, securing appropriate services, and coordinating medical and substance abuse treatment needs. Many women neglect their health while they are actively using substances, hence treatment entry may be delayed or difficult to coordinate due to the additional burden imposed by health issues (including HIV/AIDS, viral hepatitis and other infectious diseases, mental disorders, and gynecological and obstetric needs). Thus, poor physical health may hinder entry into treatment (Jessup et al. 2003).

Interpersonal Obstacles

Because women are usually the primary caregivers of children as well as of other family members, they are often unable or not

Figure 5-1

Percentages of Reasons for Not Receiving Substance Use Treatment in the Past Year Among Women Aged 18 to 49 Who Needed Treatment and Who Perceived a Need for It: 2004–2006



Sources: SAMHSA 2004, 2005, 2006.

encouraged to enter and remain in treatment. Also, sometimes their families and friends are involved with substance use and abuse. Further, women may share a social network in which drug or alcohol use is a central activity. This group of family and friends may see no benefit in and offer no encouragement for becoming alcohol and drug free (Amaro and Hardy-Fanta 1995; Finkelstein 1993; Salmon et al. 2000). While women report fear of losing their partner during treatment, they are particularly vulnerable to losing their partner upon entering treatment (Lex 1991). In addition, women generally fear family or partner reactions or resistance to asking for help outside the family.

Sociocultural Obstacles

Women are more stigmatized by alcohol and illicit drug use than men, being characterized sometimes as morally lax, sexually promiscuous, and neglectful as mothers. In addition, women who have children often fear that admitting

a substance use problem will cause them to lose custody of their children. They worry that they will be perceived as irresponsible or neglectful—as “bad mothers” if they admit to substance abuse or dependence. These fears and stereotypes compound a woman’s shame and guilt about substance use (Finkelstein 1994) and subsequently interfere with help-seeking behavior.

To compound the issue, women in some cultural groups experience more negative attitudes toward their substance use in general and may express more difficulty in engaging in help-seeking behavior and treatment services based on gender roles and expectations. For example, Asian women, in conjunction with cultural practices and level of acculturation, may have considerable difficulty in engaging in mix-gender groups due to the value placed upon male offspring, gender role expectations, and patriarchal family hierarchy (Chang 2000). African-American and Native-American women

The barriers that exist before treatment are often the same obstacles that interfere with successfully completing treatment or maintaining abstinence.

are likely to mistrust treatment services. Specifically, Jumper Thurman and Plested (1998) reported that Native-American women list mistrust as one of the primary barriers to engaging in treatment services. A more recent study evaluating barriers among African-American women identified staff attitudes as a significant obstacle in maintaining treatment engagement and retention (Roberts and Nishimoto 2006).

Similar to men, women may face language and cultural barriers that

impede involvement or retention in substance abuse treatment. Women whose first language is not English may have language difficulties (Mora 2002). Women with specific needs or from specific groups can face social indifference, lack of culturally appropriate programming, and limited cultural competence among staff. For example, lesbians who are seeking treatment may not trust the service provider or treatment staff to appropriately handle their personal information in a group setting—fearing their sexual orientation will be prematurely disclosed.

Structural Obstacles

According to SAMHSA's 2005 National Survey of Substance Abuse Treatment Services, 87 percent of these programs accepted women as clients, but only 41 percent provided special programs or groups for women. Overall, only 17 percent of treatment facilities offered groups or programs for pregnant or postpartum women (SAMHSA 2006). Being responsible for the care of dependent children is one of the biggest barriers to women entering treatment (Wilsnack 1991). Women who do not have access to a treatment program that provides child care or who cannot arrange alternative child care may

have to choose between caring for their children or entering treatment.

Unfortunately, few residential programs have provisions that allow mothers to have their children with them, and outpatient programs often do not provide services for children or child care (Drabble 1996; Finkelstein 1994; Finkelstein et al. 1997). Only 8 percent of substance abuse treatment facilities provided child care in 2003, and only 4 percent provided residential beds for clients' children (SAMHSA 2004). Even when children are accepted into residential treatment, programs often impose age restrictions and limit the number of children a mother is permitted to bring to treatment.

Treatment resources for pregnant women who abuse substances are also scarce. Few programs can simultaneously combine the necessary prenatal care with substance abuse treatment and services for older children (Amaro and Hardy-Fanta 1995; Finkelstein 1993). Finkelstein (1993) stresses that the major barriers to providing resources for pregnant women are based on administrative concerns about medical issues for mothers, infants, and children; fear of program liability; inability to care for infants and lack of services for other children while mothers are in treatment; lack of financial resources; and limited staff training and knowledge about pregnancy and substance use.

Substance abuse treatment providers may not fully understand the needs and the types of interventions most conducive to assisting women in recovery. Vannicelli (1984) found that treatment staff attitudes and unsubstantiated myths about women actually may act as barriers to successful treatment completion among women. In addition, programs may lack cultural competence in addressing treatment issues for women from different cultural or language backgrounds; thus ethnic women may be reluctant to seek treatment if treatment staff or the programs feel foreign, judgmental, hostile, or indifferent.

Even women who are highly motivated for treatment face additional program barriers

that may produce significant challenges. These barriers include waiting lists, delayed admission, limited service availability, and preadmission requirements (e.g., paperwork requirements, detoxification). Other barriers are related to program structure, policies, and procedures and include program location, lack of case management services, limited funding sources, and lack of transportation (Wechsberg et al. 2007). Because women are more likely to be poor, their ability to obtain transportation may make it difficult to receive treatment (Lewis et al. 1996). Also, women may have to travel with their children and use public transportation to reach treatment agencies; this can be a hindrance for women in rural areas and for those who have limited income.

Treatment services continue to struggle to effectively broaden the scope of clinical services, secure adequate resources, and adopt gender-responsive policies to address co-occurring disorders. While more programs have endorsed trauma-informed services in conjunction with programming for women, the coordination and integration of these specific services remains limited. In addition to the barriers mentioned above, others may exist regarding compliance with the Americans with Disabilities Act, such as no translators for women who are deaf, lack of materials for individuals who are visually impaired, and lack of treatment program policies and procedures and acceptance of women who are using methadone maintenance.

Systems Obstacles

Many women in need of treatment are involved in multiple social service systems that have different expectations and purpose. According to Young and Gardner (1997), the co-occurrence of a substance use disorder and involvement in the child welfare system ranges from 50 to 80 percent. Moreover, collaboration among substance abuse treatment, child welfare, and welfare reform systems is challenging and often not integrated because of differences in timetables, definition of clients, complexity of client needs, staff education and training, and funding streams (Goldberg 2000; Young et al. 1998).

Services may be fragmented, requiring a woman to negotiate a maze of service agencies to obtain assistance for housing, transportation, child care, substance abuse treatment, vocational training, education, and medical care. In addition, many agencies have requirements that conflict with each other or endorse repetitive intake processes, including different forms that gather the same information. Overall, these simultaneous demands can discourage a woman, particularly when seeking treatment or during early recovery.

Women who have substance use disorders often fear legal consequences. In entering treatment, they sometimes risk losing custody of their children as well as public assistance support (Blume 1997). Likewise, women who have substance use disorders often fear prosecution and incarceration if they seek treatment during pregnancy. The public debate over privacy and the fetus's right to be born free from harm fuels a legal focus on pregnant women who smoke, drink alcohol, or use illicit drugs. "These conflicts have impeded the diagnosis of women with substance abuse problems, the availability of services, and access to appropriate care" (Chavkin and Breitbart 1997, p. 1201).

Treatment Engagement Strategies

Treatment engagement approaches are important regardless of gender, yet women are likely to benefit from services that support the initiation of treatment and address the diverse challenges that often hamper treatment involvement. Engagement services include an array of strategies that begin in the initial intake and can extend across the continuum of care. Ultimately, they are designed to promote appropriate access to treatment, to increase treatment utilization, to promote treatment retention, and to enhance treatment outcome. Promising engagement practices have evolved by integrating and centralizing services to meet the wide range of treatment needs and social services for women and children (Niccols and Sword 2005). Today, some programs and

Challenges in Maintaining a Therapeutic Alliance: Child Welfare and Issues of Confidentiality

State law can require substance abuse treatment providers to report individuals for child abuse and neglect and to supersede Federal confidentiality laws that cover substance abuse treatment. It is critical, therefore, that admissions staff, program materials, and counselors clearly present and discuss the limits of confidentiality as regulations require. Without this explicit discussion, women in treatment may have questions and feel uneasy with regard to mandated reporting. For instance, when counselors intervene to protect a client's children, this may seem contradictory to the client and raise questions about confidentiality.

A great barrier to treatment for women is fear of losing their children, a fear that engenders intense mistrust on the part of clients who are mothers. Therapeutic alliance and trust are vital to the treatment process, yet treatment providers must protect children. To resolve this, women must understand that although providers will report their concerns for the safety of children, providers are advocates for the women and their families (CSAT 1996; Lopez 1994; U.S. Department of Health and Human Services, Office for Civil Rights 2002).

communities provide very formal strategies such as comprehensive case management and incentive programs to promote engagement (Jones et al. 2001). Other engagement strategies include more specific services such as transportation and escorts to appointments, phone calls to initiate services and to remind clients of appointments, and child care during scheduled appointments or sessions (for review, see Comfort et al. 2000).

Women who are offered services during the intake period are more likely to engage in similar services throughout the treatment process than women from a comparison group (Comfort et al. 2000). Three core engagement strategies that are particularly beneficial for women are outreach services, pre-treatment intervention groups, and comprehensive case management.

Outreach Services

Women are more likely to gain awareness of substance abuse treatment if outreach services are implemented. Outreach and engagement services can be clinically effective in increasing the likelihood of entering substance abuse treatment, particularly for those individuals who are less likely to access treatment services (Gottheil et al. 1997). Effective outreach programs, such as the one described in Figure

5-2 (p. 91), are designed to connect women to substance abuse treatment regardless of point of service entry. For example, programs that address domestic violence, HIV/AIDS, or crisis intervention can be a vital conduit for helping women take the first step in connecting to substance abuse services.

Gross and Brown (1993) outlined three major components of outreach: (1) identifying a woman's most urgent concerns and addressing those first, until she is ready to take on other issues; (2) empathizing with the woman's fears and resistances, while assisting her in following through on commitments; and (3) assisting the woman in negotiating the human service system, particularly when the decision to seek drug or alcohol treatment is stymied by the lack of adequate, appropriate, or accessible programs or when relapse alienates the woman from institutional connections. Although outreach appears to benefit women—in that they are more likely to initiate contact with treatment providers—women's response to outreach services appears related to level of readiness, history of trauma, and degree of support. For instance, Melchior et al. (1999) reported that women who have a history of trauma are more reluctant to follow through with referrals than men.

Clinical Tools and Activities

Helping Women Overcome Barriers to Treatment

Strategy: Success Stories

To counter stigma, counselors might provide clients with stories or information about women who have achieved and maintained recovery, such as Marty Mann (www.ncadd.org) or Betty Ford. These stories can be used to stimulate group discussions or could be a part of regular client readings.

Strategy: Barriers to Treatment Assessment Tool

Counselors can gain significant information pertaining to current, potential, or perceived barriers through evaluation. Beyond a comprehensive psychosocial history, counselors and administrators can gain insight into the current obstacles to treatment (for review, see *Allen's Barriers to Treatment*, Appendix D).

Strategy: Decisional Balancing Exercise

The decisional balancing exercise was designed to identify cognitive appraisals associated with benefits and costs of substance use (Cunningham et al. 1997). Both cognitive-behavioral therapy and motivational interviewing endorse this strategy. By easily adapting this activity to analyze pros and cons associated with entering treatment or not entering treatment, counselors are more likely to discover barriers that were not identified in the initial assessment. Counselors may want to demonstrate the activity by using examples, such as the pros and cons of going on a diet or not smoking. This exercise is not a simple pros-and-cons list for one side of the argument, but rather it involves looking at the benefits and costs for both sides of the argument; e.g., pros and cons for going on a diet as well as pros and cons for not going on a diet. This is an important aspect of this exercise. While many issues can be identified with one side of the argument, there are often other subtle issues that are acknowledged by discussing both sides of the argument. Following is the format for the decisional balancing exercise involving the pros and cons of entering or not entering substance abuse treatment.

	Pros (Benefits)	Cons (Costs)
Entering Treatment	Better role model for my children Knowing that I can quit Maybe I can do some things that I haven't been able to do while I have been using, e.g., working toward a GED	Boyfriend may leave Don't like other people watching my children
Not Entering Treatment	Don't have to think about my use Don't have to worry about leaving my family Can continue to use	May end up having more legal problems May lose my children Not HIV positive now, but it may happen if I continue to use

Strategy: Finishing the Story Exercise

Counselors can “reframe” a woman’s misgivings about treatment so she may see that the feared outcome of seeking or staying in treatment is, in reality, the likely outcome of ending or not starting treatment. For example, a woman who fears she will lose her children if she enters or

Clinical Tools and Activities

Helping Women Overcome Barriers to Treatment (continued)

stays in treatment should be asked to look into the future. This exercise might clarify for her that continued addiction virtually guarantees that she will lose her children in the long run, whereas treatment and recovery will most likely ensure a long-term and stable relationship with her children. By asking the woman to imagine how her story will end if she continues to use substances, she is less likely to glorify her current use and more likely to withstand the common hassles associated with initiating and engaging in treatment.

Strategy: Caregiver Portrait

Women typically assume caregiver roles that may prevent, complicate, or interfere with treatment. They may feel they should not leave their spouse or significant other and fear the consequences of doing so. In entering treatment, they may express worry because they carry the burden of primary caretaker for their parents, children, or other relatives. They may feel that they are being disloyal to friends and family members for leaving them—believing the message that their substance abuse problem is “not that bad.” Women may also maintain primary financial responsibilities for housing and food for others and fear they will not be able to provide support during treatment. In addition, they may worry about child care during treatment regardless of treatment level. Hence, beyond identifying these concerns and potential barriers, it is important to provide a way to discuss these as well as to determine their level of importance based on their perception.

In a group setting, first introduce the idea that everyone has specific and perceived obstacles that can interfere with treatment and it is important to give a voice to these challenges. Next, state that at least one or two people will have an opportunity to create a visual picture of these obstacles—similar to taking a family picture. Next, ask a woman to identify each current or potential obstacle to treatment and assign each obstacle to a particular group member. Emphasize to group members that if they are selected to participate, they don’t need to say anything in this assigned role. This decreases anxiety and hesitancy in participating.

After the obstacles are assigned, ask the client to arrange the obstacles (group members) as if she were a photographer setting up a family portrait. Remind her to arrange (only verbally directing other group members) the portrait in one area of the room according to how important she perceives the obstacles, e.g., placing the most challenging or fearful barriers in front of others. Next, have the client discuss each obstacle and the rationale for her placement. As the exercise unfolds, obstacles may end up being rearranged in the picture. In addition, counselors may want to help the client identify feelings related to specific obstacles in the picture by walking around the portrait. Other strategies may be used in conjunction with this activity including problemsolving, cognitive restructuring, or motivational interviewing strategies. However, it is often best to keep it simple and to encourage other group members to do the same exercise. You can involve the entire group through discussion or by using a paper-pencil drawing that demonstrates their barriers. While this exercise is ideal for group, you can modify it by using a paper-pencil drawing for individual sessions.

Note: To reinforce appropriate boundaries, remind participants not to touch others during the exercise.

Pretreatment Intervention Groups

Early identification and intervention may prevent more significant alcohol- and drug-related consequences. Pretreatment intervention groups are typically designed to initially provide personalized or structured feedback to clients about their alcohol and drug use, to provide information regarding available treatment services and treatment processes, and to utilize strategies to enhance motivation and to decrease alcohol and drug use. Specific to women, pretreatment groups are designed to address certain psychosocial barriers, including the stigma that is associated with women's substance use. Similar to frequent misconceptions held by clients that detoxification is treatment, pretreatment can be perceived as treatment rather than an initial step. This is particularly the case with women who are either reluctant or suspicious to use treatment services or who are unable to use treatment services at the time (Wechsberg et al. 2007). While research reports

that brief interventions are not consistently helpful for women (Chang 2002), more specific research is needed to examine differences in factors that influence early intervention outcomes, including client-matching studies targeting gender.

Case Management

Comprehensive case management helps bridge the gap between services and agencies. It is based on the premise that services need to match the client's needs rather than force the client to fit into the specific services offered by the agency. With the wide range of services often warranted for most women (especially for women who are pregnant or who have children), comprehensive case management that involves medical and social case management is an essential ingredient (Sorensen et al. 2005). According to Brindis and Theidon (1997), case management serves several functions and provides numerous services for the client,

Figure 5-2 **PROTOTYPES**

The PROTOTYPES Outreach Program in Culver City, California, is a pretreatment program that helps women form therapeutic alliances by providing outreach services that help women enter treatment.

PROTOTYPES began in 1987 in Los Angeles County with outreach to women who used substances and were at risk for HIV/AIDS. The pretreatment program staff grew to include more than two dozen outreach workers. PROTOTYPES staff see outreach as a strategy of sustained contact and support that helps women move from contemplation to action.

Outreach workers learned that even though PROTOTYPES provided a healing and nurturing environment, a large treatment program of this type could be frightening to women contemplating treatment, especially women coming from the streets or other difficult environments. To allay their fears, women were brought in for visits before they entered or committed to enter the residential treatment program. In these visits, the women had an opportunity to talk to counselors and other clients, return home, and revisit at will. Every effort was made to make them feel comfortable. The workers learned that it was best that women enter treatment on their own schedules and terms.

Once in treatment, a woman maintained a relationship with her outreach worker, who usually conducted group sessions in the residential setting. The client decided when to move her primary therapeutic relationship from the outreach worker to the in-house counselor, and the outreach worker could withdraw gradually. If a woman did not wish to return to her home community following residential treatment, the outreach worker helped her settle into a new community (Melchior et al. 1999).

including outreach, needs assessment, planning and resource identification, service linkages, monitoring and ongoing reassessment, and client advocacy. In recent years, communities and agencies have shown considerable progress in developing formal linkages, protocols, and integrated care systems. To date, case management services are key to overseeing the appropriate referral and utilization of services. According to OAS (SAMHSA 2004), approximately 55 percent of facilities provide assistance with obtaining social services, 43 percent provide assistance in locating housing, and 69 percent provide case management services. For an in-depth review, see TIP 27 *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998a).

Research sheds light on the potential value of case management, in that it may be particularly useful for individuals with complex problems (Havens et al. 2007; Morgenstern et al. 2003). Morgenstern and colleagues (2006) completed a study on intensive case management with women receiving Temporary Assistance for Needy Families (TANF). The results show that women assigned to intensive case management had significantly higher levels of substance abuse treatment initiation, engagement, and retention in comparison to women who received only screening and referral. In addition, alcohol and drug abstinence rates were higher and length of abstinence was longer among women involved in case management. An earlier study showed similar results, emphasizing that women assigned to intensive case management accessed a greater variety of services (Jansson et al. 2005). Improvement in abstinence rates and family and social functioning are also noted when case management services are employed (McLellan et al. 2003).

Considerations in Treatment Placement and Planning

Based on the assessment process, appropriate treatment placement for a client depends on

many factors, including the nature and severity of a woman's substance use disorder, the presence of co-occurring mental or physical illnesses or disabilities, and the identification of other needs related to her current situation. Placement decisions are also affected by other psychosocial factors. Once the comprehensive assessment is completed, the placement can be determined.

Women need to be able, whenever possible, to contribute to the planning and placement discussion for their treatment. For example, when residential care is recommended, barriers such as being unable to bring her children may cause a woman to reject the placement option. In this situation, it is critical to work with the woman to make appropriate arrangements to help her enter treatment. Treatment planning must also include assistance in helping her to express needs, make decisions and choices, and recognize that she is the expert on her life. Overall, active client involvement in all aspects of treatment planning significantly contributes to recovery, validates and builds on a woman's strengths, and models collaborative and mutual relationships, including, most importantly, the client-counselor relationship.

To date, limited literature has examined placement criteria specific to women. However, some States have developed criteria for placing women in appropriate treatment options (CSAT 2007). The available State substance abuse treatment standards listed in Figure 5-3, *Services Needed in Women's Substance Abuse Treatment*, should be considered in placing female clients in specific services.

Levels of Care

The need for appropriate level of care and treatment is not gender specific; both men and women require a range of treatment services at various levels of care. In 1991, ASAM developed patient placement criteria based on matching severity of symptoms and treatment needs with five levels of care. ASAM's Patient Placement Criteria (ASAM's PPC; ASAM 2001) identifies six clinical dimensions: alcohol intoxication and/

Figure 5-3

Services Needed in Women's Substance Abuse Treatment

The following services are recommended by the consensus panel and reinforced by some State standards (CSAT 2007), and these services may be warranted across the continuum of care beginning with early intervention and extending to continuing care services. More than ever, services need to be tailored to women's needs and to address the specific hardships they often encounter in engaging treatment services. Promising practices designed to treat women with substance use disorders include comprehensive and integrated clinical and community services that are ideally delivered at a one-stop location. Note: This list does not incorporate the customary services that are provided in standard substance abuse treatment, but rather services that are more reflective of women's needs.

Medical Services

- Gynecological care
- Family planning
- Prenatal care
- Pediatric care
- HIV/AIDS services
- Treatment for infectious diseases, including viral hepatitis
- Nicotine cessation treatment services

Health Promotion

- Nutritional counseling
- Educational services about reproductive health
- Wellness programs
- Education on sleep and dental hygiene
- Education about STDs and other infectious diseases; e.g., viral hepatitis and HIV/AIDS
- Preventive healthcare education

Psychoeducation

- Sexuality education
- Assertiveness skills training
- Education on the effects of alcohol and other drugs on prenatal and child development
- Prenatal education

Gender-Specific Needs

- Women-only programming; e.g., is the client likely to benefit more from a same-sex versus mix-gender program due to trauma history, pattern of withdrawal among men, and other issues?
- Lesbian services

Cultural and Language Needs

- Culturally appropriate programming
- Availability of interpreter services or treatment services in native language

Life Skills

- Money management and budgeting
- Stress reduction and coping skills training

Figure 5-3

Services Needed in Women's Substance Abuse Treatment (continued)

Family and Child-Related Services

Childcare services, including homework assistance in conjunction with outpatient services

Children's programming, including nurseries and preschool programs

Family treatment services including psychoeducation surrounding addiction and its impact on family functioning

Couples counseling and relationship enrichment recovery groups

Parent/child services, including developmentally age-appropriate programs for children and education for mothers about child safety; parenting education; nutrition; children's substance abuse prevention curriculum; and children's mental health needs, including recreational activities, school, and other related activities

Comprehensive Case Management

Linkages to welfare system, employment opportunities, and housing

Integration of stipulations from child welfare, TANF, probation and parole, and other systems

Intensive case management, including case management for children

Transportation services

Domestic violence services, including referral to safe houses

Legal services

Assistance in establishing financial arrangements or accessing funding for treatment services

Assistance in obtaining a GED or further education, career counseling, and vocational training, including job readiness training to prepare women to leave the program and support themselves and their families

Assistance in locating appropriate housing in preparation for discharge, including referral to transitional living or supervised housing

Mental Health Services

Trauma-informed and trauma-specific services

Eating disorder and nutrition services

Services for other co-occurring disorders, including access to psychological and pharmacological treatments for mood and anxiety disorders

Children's mental health services

Disability Services

Resources for learning disability assessments

Accommodations for specific disabilities

Services to accommodate illiteracy

Services to accommodate women receiving methadone treatment

Figure 5-3 ***Services Needed in Women's Substance Abuse Treatment (continued)***

Staff and Program Development

- Strong female role models in terms of both leadership and personal recovery
- Peer support
- Adequate staffing to meet added program demands
- Staff training and gender-competence in working with women
- Staff training and program development centered upon incorporating cultural and ethnic influences on parenting styles, attitudes toward discipline, children's diet, level of parenting supervision, and adherence to medical treatment
- Flexible scheduling and staff coordination (Brown 2000)
- Adequate time for parent-child bonding and interactions
- Administrative commitment to addressing the unique needs of women in treatment
- Staff training and administrative policies to support the integration of treatment services with clients on methadone maintenance
- Culturally appropriate programming that matches specific socialization and cultural practices for women

Source: Consensus Panel.

or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment. The levels of care are determined by the presence and severity of issues within each dimension. The current version (PPC-2R) lists five broad levels of care:

- Level 0.5: Early intervention
- Level I: Outpatient treatment/partial hospitalization
- Level II: Intensive outpatient treatment
- Level III: Residential/inpatient treatment
- Level IV: Medically managed intensive inpatient treatment (ASAM 2001)

ASAM's PPC-2R (2001) is used widely and standardizes treatment placement. It is focused on identifying individual treatment needs, but does not focus specifically on the placement of women or treatment needs that extend to children or family. Counselors needing detailed criteria for each level of care should consult ASAM's PPC-2R Manual. The following review

of ASAM's levels of care contains information that is unique and important to women; it is not meant to be a comprehensive overview of ASAM's placement criteria. When there are relevant issues, the specific needs of pregnant women and children are discussed at the end of each level of care.

Early Intervention (ASAM Level 0.5)

Early intervention, or ASAM Level 0.5, can be considered a pretreatment service that provides an opportunity for treatment providers to intervene across a wide variety of settings. It is designed for individuals with risk factors or problems associated with substance abuse but with whom an immediate substance-related disorder cannot be confirmed. Services that represent this level of care include assessment, psychoeducational services, and counseling. In essence, the goals for this level of care are prevention and intervention. For example, educational experiences allow clients to gain further awareness of their current substance

use and the expected consequences of this use, along with the future consequences of use if they continue on their present course. This level of care also provides a forum to assist individuals in developing skills associated with behavioral change, in creating strategies to avoid future problems related to substance use, and in establishing a supportive pretreatment environment and therapeutic alliance.

Early intervention approaches can be provided through many channels—a drop-in model, in-home or mobile treatment services, or a pretreatment group in a treatment setting. It

can also be provided through involuntary venues such as drug courts, or voluntary settings such as outpatient or primary medical care clinics. Faith-based initiatives can also provide opportunities for early interventions.

For women, early intervention services appear quite valuable in enhancing motivation, decreasing anxiety and reluctance in initiating current and future treatment services, gaining support, and establishing strategies to address obstacles associated with treatment access and engagement (Wechsberg et al. 2007). Programs that provide flexibility in attendance, easy access to care, and at-home or mobile

services are particularly conducive for women, especially those who have the primary role of parenting. TIP 34 *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999a), discusses how to implement brief interventions in substance abuse treatment and other settings.

Early intervention during pregnancy

Pregnancy creates an increased sense of urgency for both clients and counselors because of the temporary upswing in motivation to change and the need for problem resolution. For some women who abuse substances, pregnancy creates a window of opportunity to enter treatment, become abstinent, quit smoking, eliminate risk-taking behaviors, and lead generally healthier lives (Hankin et al. 2000; Nardi 1998). Brief interventions are sometimes effective in helping pregnant women stop using substances (Hankin et al. 2000). Abstinence for pregnant women should be construed to include alcohol, tobacco, caffeine, and many over-the-counter medications, in addition to illicit substances.

Some studies have found that brief interventions using motivational interviewing (MI) in prenatal care can reduce problem drinking by pregnant women (Handmaker and Wilbourne 2001; Miller 2000). Therapists using MI employ a gentle, empathic style to avoid client defensiveness and constructively and compassionately explore ambivalence about change and motivation for recovery (refer to TIP 35 *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999b]). MI may be more effective for those women who are primarily dependent on alcohol; studies targeting pregnant women identified as primarily abusing drugs have shown no differences between MI and other standard practices in reducing substance use (Winhusen et al. 2007).

Detoxification (ASAM Levels I–IV)

Detoxification is a set of procedures employed to manage acute intoxication and withdrawal symptoms from drug and alcohol dependence. During this process, the body’s physiology adjusts to the absence of alcohol or drugs. Detoxification alone is not substance abuse treatment; it is only the beginning of the treatment process. Issues such as retaining clients in detoxification, stabilization, and fostering treatment entry are discussed in TIP 45 *Detoxification and Substance Abuse Treatment* (CSAT 2006a).

Healthcare providers

have a window of opportunity in working with women who abuse substances. Brief interventions can provide an opening to engage women in a process that may lead toward treatment and wellness.

Not all communities have detoxification services. Furthermore, women's programs do not often have adequate medical supervision to perform detoxification, hence women must be detoxified at another facility. Typically detoxification from alcohol or addictive drugs has been a 3- to 5-day inpatient procedure, but as more and more health insurers have declined to reimburse inpatient detoxification, it increasingly is done on an outpatient basis. Yet, if severe withdrawal is expected (as from severe alcohol or sedative-hypnotic dependence), detoxification should be done in a medical facility. Withdrawal from severe alcohol use, sedatives, and benzodiazepines can have severe medical complications.

Some women who are dependent on sedative-hypnotics (tranquilizers) may need a 30-day withdrawal regimen with pharmacological medical intervention to prevent seizures. Concerning alcohol, more recent studies have begun to focus on the effects of sex-specific hormones in response to alcohol dependence and withdrawal. Although research on sex-specific hormonal differences in alcohol withdrawal is in its infancy, currently there appears to be a robust sex difference in seizure susceptibility, in that women appear to have less risk for alcohol withdrawal-induced seizures (Devaud et al. 2006). Women also tend to display fewer and less severe alcohol withdrawal symptoms than men. However, even though research reflects less risk associated with withdrawal from alcohol among women, clinicians and health professionals need to maintain vigilance in evaluating withdrawal symptoms and other health concerns. Detoxification can be a vulnerable period for women who have a history of trauma and violence. They may have significant distress associated with not feeling physically or psychologically safe, and anxiety associated with the anticipation of trying to manage their emotions and trauma-related symptoms without being able to self-medicate. From the outset of treatment, women need interventions and education surrounding traumatic stress reactions. Along with supportive and frequent contact with staff, trauma-informed services can help create or increase a sense of safety and a feeling of control.

For all intents and purposes, if a woman's contact with a substance abuse treatment agency stops at detoxification, the treatment system has failed. Women without treatment subsequent to detoxification are likely to relapse and be lost to followup. Thus, detoxification programs should have adequate funding to include case management, brief interventions, and discharge planning. Immediately after detoxification, a woman may be more likely to be ready for treatment, and this opportunity for engaging the woman in treatment should be maximized. Aggressive case management, referral networks, and treatment linkages are needed to prevent women from disengaging from treatment. From initial contact with the client, the ability to follow up, to coordinate care, and to provide comprehensive services (such as transportation and child care), is essential to effective treatment.

Considerations for women who are parents with dependent children

The safety of children often is a chief concern and one of the principal barriers to treatment engagement and retention for parents—especially women—entering detoxification programs. Even if women do not have custody of their children, they often are the ones who continue to care for them. Thus, ensuring that children have a safe place to stay while their mothers are in detoxification is of vital importance. Working with parents to identify supportive family or friends may help identify available temporary child care resources. A consult or referral to the treatment facility's social services while the patient is being detoxified is indicated when the care of children is uncertain (CSAT 2006).

Detoxification and methadone treatment during pregnancy

Some detoxification programs will not treat a pregnant woman because they lack the necessary obstetrical support and are concerned about liability. Detoxification presents critical risks to a fetus, and withdrawal of a pregnant woman from addictive drugs or alcohol should always

be accompanied by close medical supervision and monitoring. Risks of detoxification depend on the drug being abused, but the primary drugs of concern are typically opioids and, potentially, sedative-hypnotics. Sudden withdrawal of these drugs results in withdrawal by a fetus and sometimes leads to fetal distress or death. Withdrawal should be done under supervised conditions and with proper substitutes, such as methadone for opioids. TIP 45 *Detoxification and Substance Abuse Treatment* (CSAT 2006a), TIP 43 *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005b), and TIP 40 *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* (CSAT 2004a), have more comprehensive information on this subject.

In general, it is neither recommended nor necessary for pregnant women to cease methadone treatment. In situations where withdrawal is being contemplated, a thorough assessment should be conducted to determine whether the woman is an appropriate candidate for medical withdrawal. It is important to note that relapse rates among women who use heroin are high, thus placing their fetuses at risk for adverse consequences (Jones et al. 2001). Situations in which medically supervised methadone withdrawal during pregnancy may be considered include the following:

- The client moves to an area where methadone maintenance is not available.
- The client has been stable during treatment and requests withdrawal before delivery.
- The client refuses to be maintained on methadone.
- The client plans to detoxify through a structured treatment program (Archie 1998; Kaltenbach et al. 1998).

If withdrawal is elected, it should be conducted under the supervision of physicians experienced in perinatal addiction and under the guidance of a protocol using fetal monitoring. Medical withdrawal usually is conducted in the second trimester because of the danger of miscarriage in the first trimester and because withdrawal-induced stress may cause premature delivery or fetal death in the third trimester (Donaldson

2000; Kaltenbach et al. 1998). While pharmaceutical agents other than methadone have been introduced to treat symptoms of opioid withdrawal, the research is still preliminary (Anderson et al. 1997; Dashe et al. 1998; Jones and Johnson 2001; McElhatton 2001).

Outpatient Treatment (ASAM Level I)

Outpatient, or ASAM Level I, treatment usually consists of one or two weekly sessions of group or individual therapy. Outpatient treatment settings are the most common, are widely available, and are the setting in which most women receive treatment. In general, outpatient treatment is most appropriate for women with less severe substance use problems and with greater social support and resources. While outpatient services are used for less severe symptoms of substance use disorders, this level of treatment can be employed at various points across the continuum of care. Specifically, continuing care services use outpatient treatment to provide support for ongoing recovery and treatment in a less restrictive environment as recovery evolves. (Refer to chapter 8 for review of continuing care services.)

Women who benefit most from outpatient therapy frequently have some stability in their lives, such as housing and employment. Effective outpatient treatment programs for women should be more comprehensive than traditional programs and should provide a constellation of services (refer to Figure 5-3). For example, outpatient services should evaluate the need for and provide child care and children's treatment services.

Although few women-only outpatient programs exist, mix-gender programs can be made more responsive to women's needs by providing comprehensive case management, services, and programs that support more client-provider contact, more opportunities for individual therapy, and referral to other community services. The development of interagency relationships is essential, yet referral alone will not guarantee utilization of these services. Beyond staff support, it is often necessary to

initiate the first contact with the agency referral, to assist the client in developing or making the necessary arrangements to access the community service or referral, and to provide followup to obtain the outcome of the referral. Throughout the last two decades, substance abuse programs have acknowledged the necessity of establishing formalized relationships among community agencies to streamline services and to effectively address and manage the diverse needs of women seeking treatment for substance use disorders. *TIP 46 Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006b), provides more information on this level of care.

Intensive Outpatient Treatment (ASAM Level II)

Intensive outpatient treatment (IOP), or ASAM Level II, provides a higher treatment level than traditional outpatient programs but does not require structured residential living. Generally, IOP provides many of the same services as residential treatment; however, the intensity of treatment, the time of engaging services, and level of counselor involvement are less. IOP appears to have higher completion rates than traditional outpatient services among postpartum women (Strantz and Welch 1995). The flexibility of IOP may help women overcome barriers to treatment, provided the program attends to the unique needs identified during intake (refer to Figure 5-3). Although IOP historically provides more accommodating schedules and offers treatment during the evening, weekends, and other times of the day, it will not be as useful for some women unless child care and transportation are available. *TIP 47 Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006c), provides more information on this level of care.

Residential and Inpatient Treatment (ASAM Level III)

Residential treatment, or ASAM Level III, is for women who have multiple and complex needs and require a safe environment for stabilization, intensive treatment, and an intensive recovery

support structure. Professional staff are available 24 hours a day, and the facility is clinically managed. The type of residential or inpatient placement depends in part on the severity and complexity of the woman's conditions, including but not limited to co-occurring medical and psychiatric disorders, history of trauma (including sexual and domestic violence), and pregnancy. Clinical experience has shown that women in residential care frequently require some or all of the services listed in Figure 5-3 in addition to specific substance abuse treatment services.

Residential treatment can take place in various settings, including halfway houses and other extended care facilities, primary residential or inpatient programs, and recovery homes. As an example, SHIELDS for Families (a Los Angeles agency) uses a combination of day treatment and housing to provide comprehensive residential treatment for families. Overall, the effectiveness of residential treatment appears to rely on at least one key element—length of treatment. Greenfield and colleagues (2004) reviewed data about the effectiveness of residential substance abuse treatment for women from CSAT's Residential Women and Children/Pregnant and Postpartum Women (RWC/PPW) Cross-Site Study and two other national studies. Despite differences in treatment programs, client profiles, followup intervals, data collection methods, and other factors, all three studies found high treatment success rates—ranging from 68 to 71 percent abstinence—among women who spent 6 months or more in treatment. Success rates were lower for clients with shorter stays in treatment.

While length of stay seems paramount, residential treatment has several other components that must be in place to meet the various roles, needs, and other presenting issues of women with substance use disorders. Whether short or long term, residential treatment must maintain a healing, nurturing, and safe environment. This may require special accommodations for women, particularly in mix-gender treatment centers. These accommodations include adequate facilities for visits with children, safety precautions,

and treatment programming and policies that decrease the likelihood of potential assaults and sexual involvement in mix-gender residential settings and women-only space. Women who are trauma survivors benefit from secure sleeping accommodations where they can maintain their sense of security and control over bedroom access (except staff rounds; Harris 1994).

Children in residential treatment programs

For many women, having their children with them in treatment is essential to their recovery and removes a barrier to treatment entry. Research suggests that allowing children to accompany their mothers to a residential program has a positive effect on engagement, retention, and recovery (Lungren et al. 2003; Szuster et al. 1996). For example, studies have found that length of stay in residential treatment is associated with women being able to bring their children with them (Hughes et al. 1995; Wobie et al. 1997). One study suggested that the earlier a mother's infant resides with her in the treatment setting, the longer the mother's stay in treatment will be (Wobie et al. 1997). Overall, women in residential treatment accompanied by their children showed better outcomes (abstinence, employment, child custody, and involvement with continuing care or support groups) than women not accompanied by their children at 6 months after discharge (Stevens and Patton 1998). Review Appendix B to obtain an overview of CSAT's *Comprehensive Substance Abuse Treatment Model for Women and Their Children*.

Since 2004, CSAT has funded over 50 grants to treatment facilities under its Residential Women and Children/ Pregnant and Postpartum Women (RWC/PPW) programs. This cross-site evaluation found that the 6- to 12-month treatment programs had several positive outcomes. First, alcohol and drug use was much lower 6 months after discharge compared with pretreatment. The percentage of women reporting alcohol use decreased from 65 percent at pretreatment to 27 percent 6 months after discharge, and the percentage of women

reporting crack/cocaine use decreased from 51 to 20 percent. Second, 60 percent of the women reported being completely abstinent throughout the 6 months following discharge. Third, criminal involvement dropped markedly, and economic well-being improved. Next, pregnancy outcomes improved (fewer premature deliveries, fewer low-birth-weight babies, and lower infant mortality) compared with expected rates for this population. In addition, 75 percent of the women had custody of one or more children 6 months after discharge, up from 54 percent before initiating treatment, and fewer clients had children in foster care (CSAT 2001a).

Women who completed treatment that allowed children in residence had less psychological distress and improved skills for independent living, parenting, employment, and relationships (Saunders 1993). In fact, one study found that outcomes from a treatment environment that welcomed children were more positive for women both with and without children. Researchers suggest that “living with and helping with other women's children may provide a sense of shared responsibility and community” in a therapeutic community (Wexler et al. 1998, p. 232). Chapter 7 addresses parenting and the need for children services; it also emphasizes the importance of providing assessment and treatment for both mothers and their children.

The amount of responsibility the mother has for her children during her stay needs to be determined on an individual basis; some mothers can keep their children with them almost continually, whereas others may need to attend treatment apart from their children. Specifically, some women may not want the responsibility of parenting at such a stressful time in their lives but may feel social pressure to keep their children with them during treatment. These mothers should be supported in their decision to place their children in the care of others (such as reliable family members) during their treatment. The following questions can be used by agencies to determine some key decisions regarding children:

- How will child care be handled if the mother is hospitalized?

- Are there limits on the severity of illness of mothers or children beyond which they will not be accepted by the program?
- What rule infractions will result in expulsion from the program?
- How will suspected child abuse or neglect be identified and reported?
- Does the program allow overnight home visits? What guidelines and rules need to be in place to permit mothers and their children to leave residential treatment overnight (Metsch et al. 1995)?
- How will children be disciplined?
- How will visitation by the mother's partner be handled when court-ordered visitation privileges have been issued but the partner continues to abuse alcohol and/or drugs?

Maintenance of relationships with noncustodial children is important. Reunification with children in the care of child protective service agencies is a sensitive issue. Staff of residential programs should be knowledgeable about child welfare issues and develop collaborations with child protective services to facilitate an effective and supportive reunification process for mothers and children.

Residential services for pregnant women

Acknowledging the urgency of treating women who are pregnant, Federal law requires that pregnant women receive priority admission into substance abuse treatment programs, allowing them to bypass waiting lists and gain immediate admission when a bed in a residential program is available (42 U.S.C. § 300x-27[a]). The primary treatment provider must secure prenatal care if a pregnant woman is not already receiving such care.

Notably, collaboration among providers of substance abuse treatment, obstetric care, and pediatric care is a necessity. A comprehensive care program for pregnant women that includes prenatal care and substance abuse treatment has been shown to improve birth outcomes and increase the chances of being drug free at delivery for women who used cocaine (Burkett et al. 1998). Corse and colleagues (1995) looked

at innovative possibilities such as bringing primary obstetric care providers (usually a nurse practitioner or certified nurse midwife) onsite. They found that educating nurse midwives about substance use disorders and pregnancy enhanced their effectiveness and level of comfort in working with this population. Foremost, residential staff should learn the danger signs of pregnancy complications and when to triage a woman to an emergency department or to the doctor of the woman's choice. An internal or external medical or nursing resource is helpful to evaluate need for emergency care.

Upon delivery, some infants have withdrawal symptoms that require supportive care. In individual cases, depending on symptom severity, babies may need to be managed pharmacologically, and most experts agree that newborns should remain hospitalized while on medication related to drug withdrawal. In a residential center, public health nursing visits are critical to the evaluation of infant and maternal status. If a program does not have a nursing staff, public health nurses can provide some service.

The consensus panel recommends that residential programs provide a number of specialized services for pregnant women, including:

- Nutrition services
- Prenatal care
- Transportation to obstetric appointments
- Childbirth education and preparation and a coach, if possible

Telling Their Stories: Reflections of the 11 Original Grantees That Piloted Residential Treatment for Women and Children for CSAT (CSAT 2001c), provides profiles of residential programs for women and children, along with issues that arose in treatment and management, evaluation information, and lessons learned.

- Mental health evaluation at least twice during the pregnancy and postpartum periods, and treatment as needed to rule out (or treat) postpartum depression or other disorders
- Education about alcohol and drug use specifically related to pregnancy, including education about neonatal abstinence syndrome and, if possible, a tour of the delivery site's nursery for the woman in anticipation of the need for infant monitoring in the hospital
- Education about HIV/AIDS risk and management during pregnancy, especially because HIV/AIDS transmission to the fetus and infants can be prevented
- Education about breastfeeding and strong support for mothers who nurse their babies unless they are HIV positive

Comprehensive programs for women who are parents or pregnant typically include outreach, family support services, medical care, case management, and continuing care for women and their children (Finkelstein 1993, 1994). Some researchers recommend individual and group counseling services, independent living skills training, and parenting classes (Haskett et al. 1992). Childbirth education and family planning also are recommended for women in treatment at childbirth and postpartum, along with activities that address bonding and attachment. Home visits help in assessing a woman's needs and in identifying family members who can support her in recovery (Grella 1996). Children who accompany their mothers to treatment can benefit from

separate, developmental- and age-appropriate programming, health care, and education programs including substance abuse prevention. For an overview of CSAT's *Comprehensive Substance Abuse Treatment Model for Women and Their Children*, refer to Appendix B.

Medically Managed Intensive Inpatient Treatment (ASAM Level IV)

Treatment in a medically managed intensive inpatient setting, or ASAM Level IV, commonly is used for a person who is medically compromised and meets ASAM Level IV criteria. This patient is at high risk for complications associated with withdrawal and requires the full resources provided by a hospital. Typically, this type of acute inpatient treatment lasts between 3 and 5 days; stays of 10 to 14 days are more likely in an acute care psychiatric unit. It most often includes medical detoxification, client education, group therapy, individual therapy, family therapy, and medical treatment.

As discussed in the detoxification section, appropriate referral from inpatient care to subsequent long-term treatment is needed. Repeat assessments are performed to indicate when a client is ready for a less intrusive or less intense setting for treatment. This referral should include case management and linkage to other treatment services, community services, and support groups.

Advice to Clinicians and Medical Staff: **The Impact of Trauma and Prenatal Care**

Women who have been sexually traumatized may experience considerable emotional discomfort with prenatal care, labor, and delivery in part because of the necessity of frequent vaginal exams and the physical contact necessary to support women during labor and delivery. The optimal situation for many pregnant women with a history of sexual trauma is to have a female prenatal care provider or a female obstetrician. These clients should have a labor coach or a support person to accompany them on all medical visits and during the labor process and delivery.

Appendix A: Bibliography

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