

# *Guidance to States: Treatment Standards for Women With Substance Use Disorders*

Prepared by:  
The National Association of State Alcohol and Drug Abuse Directors  
(NASADAD)

With assistance from:  
The Women's Services Network (WSN)

With support from:  
The Substance Abuse and Mental Health Services Administration's (SAMHSA's)  
Center for Substance Abuse Treatment (CSAT), under the SAMHSA/CSAT contract  
#270-03-1000, task order # 270-03-1002, to JBS International, Inc.

Washington, D.C.  
August 2008



**NASADAD BOARD OF DIRECTORS**

President ..... Flo Stein (North Carolina)  
First Vice President ..... Joe Hill (Arkansas)  
Vice President for Internal Affairs..... Kent Hunt (Alabama)  
Vice President for Treatment..... Emilio Vela, Jr. (Washington)  
Vice President for Prevention .....Debbie Synhorst (Iowa)  
Immediate Past President..... Barbara Cimaglio (Vermont)  
Secretary ..... Michael Botticelli (Massachusetts)  
Treasurer ..... Karen Carpenter-Palumbo (New York)

**Regional Directors**

Michael Botticelli (Massachusetts), Karen Carpenter-Palumbo (New York),  
Peter Luongo, Ph.D. (Maryland), Donna Hillman (Kentucky), Theodora Binion-Taylor (Illinois), Terri White  
(Oklahoma), David Dickinson (Kansas), JoAnne Hoesel (North Dakota),  
Renee Zito (California), Bethany Gadzinski (Idaho)

**Executive Director**

Lewis E. Gallant, Ph.D.

*Prepared by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) under the SAMHSA/CSAT contract #270-03-1000, task order #270-03-1002, to JBS International, Inc. NASADAD is solely responsible for the content and recommendations herein.*

**WOMEN'S SERVICES NETWORK BOARD OF DIRECTORS**

President ..... Susan Gadacz (Wisconsin)  
Vice President ..... Cassandra Price (Georgia)  
Secretary ..... Karen Mooney (Colorado)  
Treasurer ..... Sarah Harkless (Alabama)

**Regional Representatives**

Kristen Jiorle (Maine), Maria Morris-Groves (New York), Atrica Warr (Florida), Barbara Brooks (Illinois), Christine Reid (Arkansas), Stacy Chamberlain (Kansas), Peggy Bean (California), Sherry Johnson (Idaho)

**Women's Services Network Treatment Standards Sub-Committee Co-Chairs**

Maria Morris-Groves (NY) and Starleen Scott Robbins (NC)

**Women's Services Network Treatment Standards Sub-Committee Members**

Lynne Allar-Meine (MO), Becky Barnett (UT), Marjorie McKisson (CA),  
Barbara Caskey-Parisi (NE), Ruthie Dallas (MN), Sue Gadacz (WI), Sue Green (WA), Sarah Harkless (AL), Sherry Johnson (ID), Martha Kurgans (VA), Valerie Leal (CT), Peggy Bean (CA),  
Karen Mooney (CO), Karen Pressman (MA),  
Cassandra Price (GA), Atrica Warr (FL)

## Acknowledgments

Numerous people contributed to the development of this guidance document. This publication was produced by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) under a subcontract to the Center for Children and Family Futures (CCFF) and JBS International, Inc. (JBS), under a contract awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Kara Mandell (NASADAD) and Deborah Werner (CCFF) served as the principal authors with support from Lewis Gallant, Kathleen Nardini, Alan Moghul and Marcia Trick (NASADAD) and Nancy Young, Kim Dennis and Michelle Freeman (CCFF). Sharon Amatetti served as the Government Project Officer (SAMHSA/CSAT).

This publication is the result of the work of the Women's Services Network (WSN), a component of NASADAD's National Treatment Network (NTN). Maria Morris-Groves (NY) and Starleen Scott Robbins (NC) served as co-chairs for the WSN Treatment Standards Subcommittee. Members of the sub-committee included: Lynne Allar-Meine (MO); Becky Barnett (UT); Peggy Bean (CA); Barbara Caskey-Parisi (NE); Ruthie Dallas (MN); Susan Gadacz (WI); Sue Green (WA); Sarah Harkless (AL); Sherry Johnson (ID); Martha Kurgans (VA); Valerie Leal (CT); Marjorie McKisson (CA); Karen Mooney (CO); Karen Pressman (MA); Cassandra Price (GA); and Atrica Warr (FL). NASADAD would like to thank the NTN and other field reviewers for their support in reviewing this document.

Disclaimer:

The opinions expressed herein are the views of the WSN Women's Treatment Standards Subcommittee of NASADAD and do not necessarily reflect the official position of SAMHSA/CSAT or the NASADAD Board of Directors. NASADAD is solely responsible for the content and recommendations herein.

Recommended Citation:

Mandell, Kara, and Werner, Deborah, "Guidance to States: Treatment Standards for Women with Substance Use Disorders," National Association of State Alcohol and Drug Abuse Directors, 2008.

**Guidance to States: Treatment Standards for Women With Substance Use Disorders**  
**Table of Contents**

I. Introduction .....	6
II. Background .....	7
III. Approach for Developing This Guidance Document.....	8
IV. How To Use This Document .....	10
Element 1: Outreach and Engagement .....	11
Element 2: Screening .....	14
Element 3: Assessment .....	16
Element 4: Substance Abuse Counseling/Education .....	21
Element 5: Crisis Intervention .....	24
Element 6: Treatment Planning.....	26
Element 7: Coordinated Case Management.....	30
Element 8: Continuing Care .....	35
Element 9: Medication-Assisted Treatment .....	37
Element 10: Drug Monitoring.....	40
Element 11: Detoxification .....	42
Element 12: Medical Care/Primary Health Care.....	44
Element 13: Mental Health.....	47
Element 14: Trauma/Violence .....	49
Element 15: Life Skills.....	52
Element 16: Advocacy.....	55
Element 17: Family Strengthening .....	58
Element 18: Parenting Skills and Child Development Education .....	61
Element 19: Housing Supports and Assistance .....	63
Element 20: Education and Employment/Vocational Support .....	65
Element 21: Linkages With Social Services and the Child Welfare System .....	69
Element 22: Recovery and Community Support Services (including Faith-Based Organization Support).....	73
Element 23: Transportation.....	76
Element 24: Child Care and Child Development Services .....	77
Element 25: Recreational Services .....	81
VI. Administration/Operations and Policy Issues To Consider .....	83
VII. Possible Options for Administering Women’s Treatment Standards .....	88
VIII. Conclusion .....	92
IX. Bibliography.....	93
Appendix: Current State Standards By Element .....	<b>Error! Bookmark not defined.</b>

## **Guidance to States: Treatment Standards for Women With Substance Use Disorders**

### **I. INTRODUCTION**

The National Association of State Alcohol/Drug Abuse Directors (NASADAD) partnered with Federal and State stakeholders to craft this guidance document on developing standards to address the treatment needs of women with substance use disorders (SUDs). This document was created by experts in the States with the objective of helping States to create their own standards by providing guidance and implementation strategies that can assist them as they develop their own State treatment standards for women with SUDs.

The recommendations and sample standards that make up the bulk of this document are based on research, expert input and standards that have been adopted by various States and that can be used by States to draft or improve their own set of treatment standards for women. The information and guidance in this document are not mandatory requirements of NASADAD or Federal funding agencies; it is intended as a resource tool only. This document addresses the delivery of a continuum of services to meet the unique needs and barriers to treatment for women with SUDs that often prevent women from succeeding in recovery. These guidelines are meant to assist States in moving towards a vision that all women can receive individualized, high-quality, research-based treatment for SUDs that also cultivates the healthy development of children and families.

NASADAD envisions that this document will assist States in developing women's treatment standards that build on the capabilities and strengths of their own State systems and provider networks. The document provides guidance to States on appropriate policy options to implement standards and how to build on their State's strengths to improve women's services. In adopting standards, States will want to avoid any unintended consequences that could arise from unfunded State mandates. NASADAD recognizes that States may need to assess their own resources and the resources required to implement some of the practice standards described herein. States may generate a prioritization process and/or an incremental approach to treatment standards implementation. Women's treatment standard development and implementation may also tie to other State initiatives.

It is important for States to create treatment standards for women with SUDs to better communicate concrete expectations and best practices, as well as a general vision for women's services, to providers. NASADAD hopes that providing these concrete recommendations will make it less burdensome for States to create their own standards that reflect the uniqueness of each State and the needs of the women with SUDs in the State.

The standards included in this guidance document address the full continuum of treatment services, including clinical treatment, clinical support and community support services. The recommendations provided are based on experience and evidence and seek to address a continuum of treatment needs for women throughout the lifespan. This document does not

endorse any single approach, or modality. The guidance standards seek to address the multiple needs and pathways to recovery for women and recommend that the services provided be culturally fluent, woman specific and family centered. These standards recommend treatment methods that are individualized, nonjudgmental, trauma sensitive, respectful and based on an individual's unique strengths as well as her needs, preferences, experiences and age. Finally, these standards consider the special (internal and external) barriers that women face when seeking treatment for SUDs.

Research clearly demonstrates that women face unique barriers to treatment as compared with men (Bloom, Owen, & Covington, 2004; Brady & Ashley, 2005; Greenfield, 2006). Women face both personal and system barriers that keep them from treatment. Personal barriers that women face include, but are not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fear about confidentiality and the fear of making life changes. Women face systemic barriers such as lack of money or insurance, lack of linguistic/culturally accessible services, waiting lists, lack of treatment for pregnant women, absence of child care, lack of transportation, inability to find sustaining employment and need for time to address demands of other systems, such as child welfare and Temporary Aid for Needy Families (TANF) requirements.

This document includes specific recommendations for women in the criminal justice system, women's families and pregnant women, as applicable. Some administrative and policy issues that States should consider when crafting standards for providing treatment to women with SUDs are also detailed. The Appendix contains a collection of the current State standards for the treatment of women with SUDs organized by treatment element. These standards are meant to be used as further resources for the States.

## **II. BACKGROUND**

Despite evidence that gender-specific treatment provides better outcomes for women (Ashley et al., 2003; Greenfield et al., 2007; Najavits et al., 2007), most traditional treatment is designed for men. Recognizing that women "have unique treatment needs in contrast to males, and gender-specific approaches to [treating SUDs] have been developed to address these needs" (Brady & Ashley 2005, p. 14), many States are establishing women's treatment standards.

In 1994, CSAT published the first edition *Comprehensive Treatment Model for Women and Their Families* (CSAT, 1994). As practices and knowledge have changed, the *Comprehensive Model* has also evolved; the most recent model was developed in 2004 and was published as an appendix in *Family-Centered Treatment for Women With Substance Use Disorder—History, Key Elements and Challenges* (Werner, Young, Dennis, & Amatetti, 2007). The model's goal has not changed, and it still prescribes "treatment that addresses the full range of women's needs" (Werner, Young, Dennis, & Amatetti, 2007, p. 54). The model was conceived as a flexible guide that could be adapted to fit community needs to build comprehensive programs for women and their children. To do so, it identifies an interrelated array of clinical treatment services,

clinical support services and community support services. *Clinical treatment services* are defined as “services necessary to address the medical and bio-psycho-social issues of addiction;” *clinical support services* are defined as “services from treatment and services providers to assist clients in maintaining their recovery;” and *community support services* are defined as “services and community resources outside treatment but within a community that are an underpinning or support system for the recovering individual and family” (Werner, Young, Dennis, & Amatetti, 2007, p. 56). Each category of service is broken down into a framework of distinct service elements, with the understanding that not all services may be provided in a geographic area and that women and their children should be provided only with the services that they need. NASADAD used these elements to frame the standards that follow.

In 2005 and 2007, the Center for Children and Family Futures (CCFF), under a contract from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), collected information about State standards or protocols for women’s treatment. From those two inquiries, CCFF received standards for women from 28 States. After completing a qualitative analysis of these standards, CCFF presented the key themes from the standards at the 2007 Annual WSN/NASADAD meeting. The main finding of the analysis was that State standards for women with SUDs vary widely in terms of both content and level of detail. These findings are contained in the report *State Substance Abuse Standards for Women: A Review of the Current Landscape* (CCFF, 2007).

The WSN was established by a NASADAD board of director’s vote in December 2007 as a sub-body under the auspices of the National Treatment Network (NTN). The Single State Authority (SSA) of each State and the District of Columbia is encouraged to identify one member of its staff with expertise in women’s services who can serve on the WSN. At the WSN/NASADAD Annual Meeting in June 2007, the WSN created three sub-committees, including the Women’s Treatment Standards Sub-committee. This sub-committee was tasked with providing expert input to NASADAD to develop a document that addresses guidance to States on treatment for women with SUDs.

### **III. APPROACH FOR DEVELOPING THIS GUIDANCE DOCUMENT**

To create this document, NASADAD referred to *Substance Abuse Treatment Standards for Women* (CSAT, 2007), a corresponding summary, *State Substance Abuse Standards for Women: A Review of the Current Landscape* (CCFF, 2007) and *CSAT’s Comprehensive Substance Abuse Treatment Model for Women and Their Children* (Attachment 3 of Werner, Young, Dennis, & Amatetti, 2007). NASADAD also solicited input from the Women’s Services Network (WSN) Women’s Treatment Standards Sub-committee.

NASADAD first reviewed the current State standards that were collected by CCFF in *State Substance Abuse Standards for Women: A Review of the Current Landscape* (CCFF, 2007). Then, NASADAD organized these State standards by the elements in the *Comprehensive Model* (Attachment 3 of Werner, Young, Dennis & Amatetti, 2007). These data are included in



Appendix A of this document. Next, NASADAD briefly summarized the information in the existing State standards for each element in the *Comprehensive Model*. Finally, expert input from the WSN Women’s Treatment Standards Sub-committee was solicited. NASADAD synthesized input from these sources to develop a *description* of each treatment element, recommendations for the *key standards* for each element and *key considerations for special populations* including pregnant women, women with children and women involved in the criminal justice system. Some standards also include a list of *additional considerations*, which, although not necessarily thought to be essential, would contribute to better treatment outcomes for women.

The WSN Women’s Treatment Standards Sub-committee held several planning calls between November and February, during which it became evident that a face-to-face meeting was necessary. In February 2008, 16 WSNs met with NASADAD, CCFF and SAMHSA staff in Washington, D.C., for a 2-day meeting. During the meeting, the WSNs were divided into five three-member groups. Each group was given five treatment elements to consider and was given the current State standards relevant to its elements. The groups were asked to provide expertise on *the description* of each element, *key standards* for each element and *key considerations for special populations* including pregnant women, women with children and women involved in the criminal justice system. These recommendations make up the bulk of the standards.

NASADAD circulated an initial draft of this document among the members of the full WSN. The WSN members reviewed the document, discussed it with the Single State Authorities (SSAs), key providers and other experts and provided comments to NASADAD. NASADAD synthesized these comments and integrated them into the *Guidance to States: Treatment Standards for Women With Substance Use Disorders*.

#### **IV. ABOUT THIS DOCUMENT**

This guide is meant to assist States in creating their own, State-specific, treatment standards for women with SUDs. For each element, NASADAD has summarized the existing State standards and selected other resources pertaining to the service element. Next, this document briefly describes the element and offers key standards for women’s treatment and, when appropriate, specific concerns for special populations, including women with children, pregnant women and women involved in the criminal justice system. Some standards also include a list of “additional considerations,” which, although not necessarily thought to be essential, would contribute to better treatment outcomes for women. For more detailed information about State’s standards, refer to the appropriate element in Appendix A.

There are many other sub-populations of women who may require specialized services. While the standards described herein apply to these sub-populations of women, they may have additional specialized needs which are not specifically addressed in this document. These sub-populations include, but are not limited to:

- Older women.
- Adolescent women.
- Veterans.
- Lesbian, gay, bisexual, and transgender (LGBT) women.

In this document, NASADAD does not specifically define who is considered part of a woman's family but instead suggests that the woman's family be defined by the woman herself. This may include children, spouses and partners and may also include extended family members and other close members of the community.

Women with SUDs are often involved in multiple service systems including the child welfare system, the criminal justice system, the Medicare/Medicaid/primary health care system and the welfare system. The recommendations provided in this document address the role of the SSA and treatment providers for SUDs. The guidance standards in this document avoid addressing parallel systems/agencies that may not be under the control of the SSAs. Instead, this document suggests ways that the SSAs and treatment providers for SUDs can interact with other systems and the ways in which providers must be aware of the limitations and regulations of the other systems that women with SUDs may be involved with.

For example, the recommendations for women who are involved in the criminal justice system address women who are currently or have been incarcerated, are currently or have been on probation or parole and/or are currently or have been involved with the court system, including the drug courts. This document assumes that women who are currently incarcerated are receiving treatment from providers associated specifically with the criminal justice system that may not be under the authority of the SSAs; therefore it does not suggest standards on treatment for SUDs that should necessarily be implemented in detention centers, jails or prisons. This document does discuss ways that community-based treatment providers and SSAs can interact with the criminal justice system, including outreach, coordination of care and advocacy.

After careful consideration, NASADAD opted to use the verb "will" in the model standards provided in this document. This wording was chosen for the convenience of the States, to allow them to use the exact wording provided in this document for their own standards, not for prescriptive purposes. Not all of the standards may be desirable or immediately achievable in every State or geographic area, and States may choose to use different wording in their own Standards.

## **V. HOW TO USE THIS DOCUMENT**

Each State should review this guide and identify potential elements to address in its own standards. States may not be able to address all of the elements immediately but instead may need to prioritize specific elements or adopt an incremental approach to implementation. The State may choose to use the standards exactly as provided in this document or to use only

selected standards from an element; it may choose to modify the suggested standards to accomplish its goals and meet community needs. The State should consider its own existing standards, other pertinent State or Federal legislation, resources and the strengths and abilities of the providers in its State when selecting or crafting standards.

States may want to consult section VI “Administrative/Operations and Policy Issues To Consider” and section VII “Possible Options for Administering Women’s Treatment Standards” for additional policy, leveraging and implementation recommendations to help them most successfully operationalize the standards. States can also compare their existing standards, if any, with sample standards and recommendations and use the recommendations to enhance the existing standards in their States. States should consider what, if any, additional burden the new standards will have on providers and, based on this information, should work with providers to generate creative solutions to provide the best possible services given the resources available. It is important for States and providers to know that it is not only *what* is provided for women that makes treatment for women with SUDs effective, but *how* those services are provided. This document emphasizes the importance of trauma-informed, family-focused services that consider relational contexts and use empowerment philosophies.

## **VI. GUIDANCE ON DEVELOPMENT OF WOMEN’S TREATMENT STANDARDS**

For each of 25 service elements from CSAT’s Comprehensive Substance Abuse Treatment Model for Women and Their Children, an overview of State standards, a description and recommended content for standards addressing the element are described below. Some additional considerations for women’s family, pregnant women and women involved with the criminal justice system are also described.

### **Element 1: Outreach and Engagement**

Outreach and engagement are addressed or mentioned in 12 States’ treatment standards for women. The existing State standards that address outreach and engagement can be found in Table 1 in Appendix A. For the outreach element, States include *definitions* for “outreach,” the *purpose* of outreach and *services* that fall under outreach activities. Not all States that address outreach address all three areas. Seven States (AZ, CA, FL, GA, HI, TN and TX) define outreach activities as identifying eligible women in need of treatment services, educating women about treatment options and encouraging women with SUDs to take advantage of available services. Five States (CA, FL, GA, HI and TN) emphasize the importance of involving the client’s family and community in the outreach process. Three States (AZ, CA and TN) dictate that counties must publicize that pregnant women are given preference in admission to recovery and treatment programs as part of their outreach effort. As part of the Substance Abuse Prevention and Treatment (SAPT) Block Grant Women’s Set Aside funding requirements (Title 42 U.S.C. 300x-22 and 300x-24(b)), agencies must conduct outreach to publicize treatment admission preferences for pregnant women. Outreach can be conducted through Web sites, community events, brochures and other printed material, street-level outreach and the media. The *Comprehensive Model* notes that “outreach for women must address barriers that keep them from treatment” (CSAT 2004, p. 14) including systemic barriers and personal barriers.

### *Description*

**Outreach** is defined as a planned approach to reach all women in their environment for the purpose of preventing and/or addressing issues and problems as they relate to the use/abuse of alcohol or drugs and/or encouraging them to use substance abuse treatment services. Outreach and engagement services educate women about the risks associated with substance use, the treatment and support services that are available, how to access these services and why such services are important. Outreach and engagement offer an opportunity to make women more comfortable about seeking services. Outreach identifies women who may require services and provides information to women and their communities about what services are available. Outreach includes the attempt to contact and first point of contact with the woman. This contact can take place in a variety of ways, including via telephone and in person. **Engagement** allows the woman to embrace the services that are appropriate. Engagement services also help women identify substance use that may be problematic and enhance motivation to pursue care. Identification of and attention to women's immediate needs (e.g., legal, health, safety) are important aspects of engagement, even if those problems cannot be resolved instantly.

### *Key/Critical Content of Standards*

- Outreach and engagement will be targeted at the community, residents and collateral agencies to inform them about available services and how to access them:
  - Programs will use incentives with both women and collateral agencies to encourage participation.
- Outreach and engagement services will include education for individuals and collateral agencies about:
  - The risks of substance use.
  - Services available.
  - The ramifications that any relevant Federal and State legislation might have on pursuing or not pursuing services such as the Federal confidentiality regulations (including Federal Confidentiality Code 42 CFR Part 2) and State legislation developed in response to the Child Abuse Prevention and Treatment Act.
  - How to make a referral.
  - Relevant information about the program that relates to accessing services (e.g., waiting periods for intake and/or services, what to anticipate when requesting an appointment).
- Outreach to other service providers will be peer based (e.g., doctor-to-doctor, judge-to-judge).
- Outreach will acknowledge and address:
  - Personal barriers that keep women from treatment including, but not limited to, stigma, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers that reduce access to appropriate care such as cost of treatment, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care

(see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).

- Other common fears about making life changes.
- Outreach and engagement services will be available to women across the lifespan. Outreach and engagement will be culturally fluent, nonjudgmental, respectful and trauma sensitive. Outreach and engagement efforts must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted as appropriate to meet the needs of special populations.
- Outreach will be conducted in a variety of specific venues where eligible clients may be found (e.g., laundromats, salons/beauty parlors, malls and grocery stores), as well as in coordinating agencies (e.g., Department of Social Services, TANF, Women, Infants and Children [WIC], family courts and correctional facilities including prisons and jails).
- Both screening and assessment interviews should be recognized as critical opportunities to begin the engagement process (see Element 3: Assessment).
- Programs will conduct general public outreach that may include media campaigns. This will be an ongoing and continual process.

#### *Considerations for a Woman's Children and Family*

- Outreach and engagement will explain the potential impacts of treatment services on the woman's self-defined family.
- Education, outreach and engagement will be directed at individuals and family members who may be concerned about someone else's use and may want help directing them to services.
- Providers will identify and provide outreach services to agencies that may be involved with children (e.g., schools, child care, and welfare agencies).
- Providers will be alert to problems children may have, learn about children's systems of care and help women engage with these systems to obtain services for their children (see Element 21: Linkages With Social Services and Child Welfare).

#### *Pregnancy/Perinatal Considerations*

- Providers will identify collateral agencies that may be involved with pregnant women (i.e., Women, Infants, and Children (WIC) and Obstetrician/Gynecologist clinics) and will conduct outreach specific to pregnant women at these agencies.
- Priority will be placed on outreach to pregnant women in order to prevent prenatal substance exposure including fetal alcohol spectrum disorders (FASD).
- Providers will inform individuals, collateral agencies and the broader community that pregnant women have priority admissions to treatment for SUDs.

### *Considerations for Women Involved in the Criminal Justice System*

- Providers will educate staff in community corrections facilities and probation officers regarding their services and will develop outreach services in the corrections facilities as well as linkages with probation officers.
- When providing outreach services, providers will educate women who are involved in the criminal justice system regarding potential implications of their participation—or nonparticipation—in services and will address how services can be coordinated.
- When outreach is conducted with incarcerated women, providers will address the need to coordinate treatment with release and reintegration into the community.

### **Element 2: Screening**

Screening is addressed or mentioned in 14 States' treatment standards for women. The existing State standards that address screening can be found in Table 2 in Appendix A. For the screening element, States include the *purpose* of screening, *services* that fall under screening activities for women and their children and who should *administer* screenings. Not all States that address screening address all three areas. Four States (AZ, GA, ID and MA) recommended that women should be screened using a standardized brief alcohol- and drug-screening instrument that is gender specific. Three States (AZ, FL and HI) dictate that screening should be used to determine the most appropriate substance abuse treatment referral for the client. States also note that the screening should include reports from allied fields (AZ, GA and ID).

#### *Description*

**Screening** is a brief process in which information is gathered, reviewed and used to determine whether a woman potentially has, or is at high risk for development of, an SUD. Screening determines the need for a comprehensive assessment; it does not establish definitive information about diagnosis and possible treatment needs (Winters et al., 1999). Screening may also reveal the need for immediate assistance or services for a presenting problem identified during the interview process and thus require action by the interviewer to access care.

#### *Key/Critical Content of Standards*

- Women will be screened using a standardized, brief, gender-specific protocol that also addresses co-occurring disorders and domestic violence.
- The screening process will be sensitive to a woman's life circumstances and will be available during and beyond traditional work hours. Screening will be available via different formats (i.e., face-to-face, over the phone, Web based, computer assisted).
- Screening services will be available to women across the lifespan. Screening will be provided in a culturally fluent, nonjudgmental, trauma sensitive and respectful manner. Screening must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted as appropriate to meet the needs of special populations.

- Screening is a skill. Staff participating in the screening protocol will be trained on interview techniques, be oriented to the needs of women who have alcohol and drug use disorders and receive instruction on how to assist women based on the results of the screening.
- Ample time will be taken to discuss the screening results with each woman and to begin the process of engagement for transition to the next service level if so indicated.
- The screening process provides an opportunity to provide a brief intervention and educate the woman about the adverse effects of alcohol, tobacco and other substances and the benefits of stopping use at any time.
- A record of the screening process and its outcome will be maintained but will be kept confidential as required by the Health Insurance Portability and Accountability Act and confidentiality legislation, particularly Federal Confidentiality Code 42 CFR Part 2.
- Both screening and assessment interviews should be recognized as critical opportunities to begin the engagement process (see Element 1: Outreach and Engagement and Element 3: Assessment).
- Results of the screening will be governed by Federal, State and local regulations in regard to privacy and confidentiality.
- To enhance access to care, treatment providers will promote the availability of services for women with SUDs through the establishment of collaborative partnerships with community-based organizations and agencies that serve women, the provision of technical assistance and training for organizations that serve women and the publication and dissemination of information that identifies services available and criteria required for admission. These partners will be encouraged to screen women for substance use disorders.
- The SSA will maintain an up-to-date directory of women-responsive programs that includes addresses and phone numbers, specific services provided by these programs and guidelines on how to access care. This information will be shared with local treatment provider agencies, as well as other service systems including the healthcare, legal, educational and child welfare systems (see Element 21: Linkages With Social Services and the Child Welfare System).
- Community outreach efforts will be conducted to encourage universal screening of all women of childbearing age in their natural healthcare seeking environments.

#### *Considerations for a Woman's Children and Family*

- Providers will develop and implement protocols for screening family members and significant others for possible SUDs. Results of these screens will be entered into case files.
- Children in treatment with their mothers will be screened for potential developmental, emotional and health issues (see Element 24: Child Care).
- An evidence-based screening tool will be used to measure parenting attitudes and change (see Element 18: Parenting Skills and Child Development Education).

### *Pregnancy/Perinatal Considerations*

- Screening will be comprehensive to determine whether the woman is pregnant, stage of pregnancy and last use to link her with appropriate medical services.
- Providers will use the screening process to educate women regarding the adverse effects of substance use on the fetus, the importance of using family-planning protection if substance use is present and the need to stop all use if they wish or think they may become pregnant.

### *Considerations for Women Involved in the Criminal Justice System*

- Incarcerated women will be screened for potential treatment need and risk of resuming substance use following discharge.
- Screening will include women's pattern of substance use before incarceration, potential need for treatment and identification of a re-entry support system.

### *Additional Considerations*

- State agencies and service providers will provide training on screening to other agencies coming in contact with women who may have SUDs including public health agencies, social service agencies, child welfare agencies, TANF agencies, mental health providers, domestic violence programs, faith-based organizations, court (including drug court) personnel, corrections officers, medical providers (primary care physicians, emergency room personnel), colleges and universities, schools and providers of services for children.
- Training regarding screening for the above-mentioned providers will include information regarding the difference between screening and assessment, screening instruments suitable for the populations they serve, available treatment resources, how and where to make a referral for an assessment, tips for talking with women about their concerns and their use and confidentiality.

## **Element 3: Assessment**

Assessment is addressed or mentioned in 23 States' treatment standards for women. The existing State standards that address assessment can be found in Table 3 in Appendix A. For the assessment element, States included *services* defined as "assessment," the *purpose* of assessment, substance abuse counseling and education, *when the assessment should occur* and *assessment services for children*. Not all States that address assessment address each area. Four States indicate that women must be screened for trauma (AZ, CO, CT and WY). The *Comprehensive Model* distinguishes between assessments for women with SUDs and assessments for children. For women, the *Comprehensive Model* recommends that the assessment "should be the basis for a recommendation on the level of care and treatment placement" (Werner, Young, Dennis, & Amatetti, 2007, p. 14). For children, the *Comprehensive Model* (Werner, Young, Dennis, & Amatetti, 2007) recommends assessing the child's physical, developmental and psychological skills; trauma history; and support system with an emphasis on identifying issues that need to be addressed immediately.



### *Description*

An **assessment** is the process of becoming familiar with a woman's culture, beliefs, values and experiences as well as her individual and family needs, priorities and resources. The results of a comprehensive bio-psycho-social assessment should determine the level of care and focus of treatment. Effective assessments for women include the use of an established assessment tool in a supportive environment conducive to dialog. The assessment evaluates personal and family circumstances in primary life domains and the extent to which alcohol or drug use has interfered with the client's functioning in each area. A comprehensive bio-psycho-social assessment also addresses both current and past psychological, social, family and interpersonal functioning; health status; experiences of trauma; spiritual beliefs; and identifies both strengths and weaknesses. Assessment for children includes the child's support system; family relationships; physical, developmental and psychological skills; interests; and trauma history and issues.

### *Key/Critical Content of Standards*

- Initial treatment assessments will be scheduled as soon as possible while taking into account the woman's preferences. Assessments for pregnant women and women who inject drugs will be completed within 48 hours after first contact. Both screening and assessment interviews should be recognized as critical opportunities to begin the engagement process (see Element 1: Outreach and Engagement and Element 2: Screening).
- Assessments for pregnant women and women who inject drugs will be completed within 48 hours of presentation.
- The assessment will consider the multiple needs of women and will be gender specific and family centered. The assessment will use multidimensional means and will assess the severity of a woman's substance use, problems or illness as well as her level of functioning (assets and obstacles to improvement). Examples of such assessments include the seven assessment dimensions of the Addiction Severity Index or Psychosocial History and the six dimensions of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC). These tools are designed to assess the severity of a woman's substance use, problems or illness as well as her level of functioning (assets and obstacles to improvement).
- Assessment services will be available to women across the lifespan. Assessments will be culturally fluent, nonjudgmental, trauma sensitive and respectful. Assessment must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted as appropriate to meet the needs of special populations.
- Assessment will address:
  - Personal barriers that keep women from treatment including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.

- Systemic barriers that reduce access to appropriate care such as cost of treatment, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
- Other common fears about making life changes.
- Sufficient information must be obtained during the assessment to identify the focus of treatment and priority areas for intervention.
- The assessment will be a continuous process that evaluates the woman’s needs, strengths and treatment progress. Assessment may begin before intake to identify appropriate placement, continue as part of the intake process and then occur periodically during the course of treatment.
- Ongoing reassessment will be a routine process in the treatment episode. Reassessment may occur at specific milestones in the treatment process and in response to treatment progress or the lack thereof, newly identified symptoms, or the woman’s desires to address specific issues.
- Comprehensive reassessments will be conducted as required for mandates, certifications for services, utilization review of the treatment plan (see Element 6: Treatment Planning) and changes to level of care. These reassessments will be conducted at least on an annual basis.
- The assessment process should provide insight into and background on the woman including the significant events in her life and her culture, lifespan, family, relationships, talents, strengths, creative venues, sexuality, acculturation, spiritual perspective and beliefs, coping skills, priorities, resources and current and potential social supports such as faith-based organizations, mutual-help groups, family and cultural traditions.
- The assessment will use a family/relational context and consider substance use, barriers to treatment and related services, cultural and linguistic needs, nicotine and possible process addictions, current level of physical and emotional safety, trauma (see Element 14: Trauma/Violence), health (e.g., acute, chronic, dental, TB, HIV, pregnancy, family planning and eating habits) (see Element 12: Medical Care/Primary Health Care), mental health (see Element 13: Mental Health), relationships (see Element 17: Family Strengthening), sexuality, parenting (see Element 18: Parenting Skills and Child Development Education), child safety issues, legal issues, housing (see Element 19: Housing Support and Assistance), survival and self-sufficiency (see Element 15: Life Skills).
- The assessment will be conducted in a manner that is sensitive to a history of possible sexual abuse or domestic violence and should not lead to retraumatization. The use of an appropriate tool to explore these issues is recommended. Unless contraindicated, the assessment shall include trauma sequelae; if it is delayed for clinical reasons, the expected date of this assessment shall be documented (see Element 14: Trauma/Violence).

- The assessment should capture potential indicators of co-occurring health and mental health disorders. The tool will include questions on prescribed and nonprescribed medications and reasons for the use of these medications. Screening (see Element 2: Screening) and assessment for co-occurring disorders will continue throughout all stages of the treatment and recovery process.
- Drug and alcohol use monitoring (see Element 10: Drug Monitoring) can be used as an enhancement to the assessment but will not be used as a sole determinant of need.
- Based on modality of treatment and individually identified needs, but generally no longer than 30 days after admission, a comprehensive physical health assessment (see Element 12: Medical Care/Primary Health Care) will be completed for all women.
- The assessment shall result in a summary of the woman's needs, wants, skills, strengths and deficits and relate those attributes to an efficient service plan (see Element 6: Treatment Planning). This includes a determination of the client's eligibility and appropriateness for both SUD services and other services and for a specific level of care within those services. A case management (see Element 7: Coordinated Case Management) assessment will include a review of the functional areas needed for service procurement and vocational skills (see Element 20: Education and Employment/Vocational Support).
- During aftercare (see Element 8: Continuing Care), the potential for relapse is a significant challenge; reassessment may reveal new, recurring or unresolved problems that could interfere with recovery.
- A more extensive functional assessment may be necessary to match clients with work they can perform successfully. A functional assessment evaluates the individuals' performance of key functions in five areas: living, managing finances, learning, working and interacting socially. It aims to identify existing functional capabilities and capacities (i.e., job readiness, reading, writing, computer skills, ability to relate to supervisors and co-workers) and functional limitations (physical, psychological or social), along with the socio-cultural or environmental conditions that might impede or enhance the woman's success (see Element 20: Educational and Employment/Vocational Support and Element 15: Life Skills).
- Motivational interviewing techniques or approaches can be applied as a best practice for women.

#### *Considerations for a Woman's Children and Family*

- All children entering treatment with their mother shall be assessed for developmental, emotional and health needs. If assessments are performed by a third-party agency, copies of these assessments shall be contained in the child's record. All children involved with the mother (regardless of custodial arrangements) will be assessed when possible.
- Family functioning and strengths will be assessed.
- All family members participating in services will be oriented and assessed to ensure the safety of participants.
- Whenever possible, screening (minimum) or assessment will be conducted for all individuals the woman defines as her family (including individuals she lives with). Screening and assessment will be followed by linkages to services.

- When children are in custody of another or in the child welfare system, the woman's attitude toward parenting and interest in regaining custody will be explored and evaluated in a sensitive, nonjudgmental and nonpunitive environment.
- Children will be assessed to determine their need for treatment, and their treatment will be integrated with that of their mother's (see Element 24: Child Care and Child Development Services).

#### *Pregnancy/Perinatal Considerations*

- Assessment for pregnant women will include history of pregnancy (including abortions and miscarriages), prenatal care, feelings regarding pregnancy, detailed information on drug use, self-care, health risks while pregnant, preparation for the birth and the relationship with father.
- Providers will also assess the woman's past pregnancies and births, the status of each child at birth (including the infant's gestational age and birth weight) and each child's development.
- Providers will establish relationships with local methadone programs that have experience providing opioid replacement treatment to pregnant women. To ensure that pregnant women have ready access to such services, providers will develop necessary referral policies and procedures (see Element 9: Medication-Assisted Treatment).
- Medical stability for treatment must be assessed for pregnant women (see Element 12: Medical Care/Primary Health Care).
- Barriers to treatment participation and necessary accommodations for pregnant women will be assessed.
- Throughout the pregnancy and after delivery, women will be assessed and monitored for perinatal and postpartum depression.
- Assessments for all women will inquire about her pregnancy status to properly determine the need for detoxification services (see Element 11: Detoxification), immediate medical referrals (see Element 12: Medical Care/Primary Health Care) or appropriate type of treatment for the woman's SUDs.
- A pregnancy test will be conducted before initiation of methadone maintenance or other pharmacological intervention (see Element 10: Drug Monitoring).

#### *Considerations for Women Involved in the Criminal Justice System*

- In addition to the assessment elements described above, assessment for women involved in the criminal justice system will include a history of involvement in the criminal justice system, and plans for reintegration into the community.
- Assessment will address the woman's level of functioning both before and during incarceration/criminal justice involvement and the additional impact of this involvement on her psychological and interpersonal functioning; her relationship with her children, family and significant others; and issues and concerns regarding the consequences of her criminal justice involvement.

- Assessment will gather historical information about how the woman’s substance use is associated with her criminal behavior and will move to develop treatment in alignment with cause and effect, if appropriate.

#### **Element 4: Substance Abuse Counseling/Education**

Substance abuse counseling/education is addressed or mentioned in 20 States’ treatment standards for women. The existing State standards that address substance abuse counseling/education can be found in Table 4 in Appendix A. Standards that address substance abuse counseling and education state that this service must be based on an evidence-based curriculum (MA and TX) and must inform women about the negative effects of substance use. Two States (MA and WA) recommend that women receive both individual and group counseling. Three States (CA, ID and TX) require that women be informed of the effects of substance use during pregnancy, and four States (AZ, GA, HI and TX) specifically indicate that providers must inform women about the negative effects of substance use on fetuses. The *Comprehensive Model* notes that counseling and education should “address the dynamics associated with addiction in women, as well as current behavioral issues in her addiction and the interrelationship between addiction and other co-occurring disorders” (Werner, Young, Dennis, & Amatetti, 2007, p. 14). For children, the *Comprehensive Model* recommends beginning “education and prevention support at an early age, in part to correct their misconceptions of what is normal adult behavior” (Werner, Young, Dennis, & Amatetti, 2007, p. 18).

##### *Description*

**Substance abuse counseling/education** offers content and structure to assist women in the development of personal knowledge, skills and attitudes necessary for recovery from SUDs. Substance abuse counseling includes the use of specialized skills by a clinician to help women and their families achieve their individualized treatment objectives using individual, family or small group sessions. Substance abuse counseling and education use curricula to assist women in addressing the symptoms of SUDs and impaired functioning. Substance abuse counseling and education generally include issues of motivation, skills to resist use, understanding of alcohol/drug use and the recovery process, consequences, feelings, interpersonal relationships, self-efficacy, problem-solving abilities, alternatives to alcohol/drug use, self-esteem and identity. Substance abuse counseling and education use a relational framework that addresses women’s unique pathways to alcohol and drug use, consequences of use, motivations for change, treatment needs and relapse factors.

##### *Key/Critical Content of Standards*

- Programs will offer individual, family and group counseling and education. The purpose of education and counseling is to support the objectives of the individualized treatment plans.
- Group services will work to facilitate trust through a process of bonding with consistent role models and peer support.

- Substance abuse counseling and education services will be available to women across the lifespan. Counseling will be culturally fluent, nonjudgmental, trauma sensitive and respectful. Counseling must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Providers of substance abuse counseling and education will address:
  - Personal barriers that keep women from treatment and recovery including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of treatment, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
- All women and children should be screened for FASD. FASD should be considered not only when a woman has a child with an FASD, thus posing possible relapse factors, but also when a woman herself has an FASD. With the high prevalence rate of FASD, it is likely that many women in treatment are affected by FASD. Treatment strategies must take into account the specialized needs or interventions that are successful with these individuals.

### **Counseling**

- Counseling services will meet the objectives of the treatment plan and be accessible for women and their families. The purpose of counseling is to break the cycle of SUDs in a safe, nurturing environment that allows participants to explore their feelings and choices.
- Group size will be based on therapeutic standards, typically 10 or fewer individuals.
- All women will have access to gender-specific groups on a weekly basis unless contraindicated.
- Counseling will provide the opportunity for personal development. Groups shall integrate a strengths-based, empowerment approach that is responsive to the age and experience of group members. Groups will assist participants in exploring their strengths, skills, abilities and self-esteem.
- Programs will offer a coordinated trauma and substance use curriculum and will explain the relationship between trauma and substance use (see Element 14: Trauma/Violence).
- Counseling groups will be relational, trauma informed (see Element 14: Trauma/Violence) and delivered in a safe, accessible environment that emphasizes the possibility for individual transformation and encourages change. Group topics will include but not be limited to spirituality, relationships, sexuality, parenting and isolation.

- Counseling will provide the “utilization of special skills by a clinician to assist...individuals and/or their families/significant others in achieving treatment objectives...[This can be accomplished] through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision-making, and/or discussing didactic materials with regard to alcohol and other drug related problems” (HI).
- Counseling will include nicotine and Quitline referrals.

### **Education**

- The educational program will use curricula that are gender specific and address women’s unique pathways to use, relapse triggers, consequences for use, resilience, alternative activities and strategies to avoid problem use and relapse. The educational program will be based on current knowledge of addictions, health and wellness as it pertains to women. For example, the curricula will include education on the impact of alcohol and drugs specifically on the female body.
- Curricula will be flexible to facilitate different learning styles, such as the use of multimedia materials. Curricula will be strength based and will incorporate a participant’s talents and interests relative to the learning situation and will be relevant to women across the lifespan.
- The program will be provided in an environment that is safe, accessible and conducive to learning.
- Because 50 percent of pregnancies are unplanned, it is important for all women of childbearing age to be informed about the dangers of using alcohol, tobacco and drugs during pregnancy and the importance of safe-sex and family-planning practices.

### *Considerations for a Woman’s Children and Family*

- Child care will be provided during education and counseling sessions (see Element 24: Child Care and Child Development Services).
- Women and program staff will collaborate to identify appropriate family members the woman desires to include in the family group process as clinically appropriate.
- Family counseling will seek to improve family effectiveness through skill-building, address changes of family roles and responsibilities during the recovery process and emphasize family strengths (see Element 17: Family Strengthening).
- Family/couple counseling will provide “counseling for alcohol and/or drug treatment with a woman’s family members or significant others as needed. In some instances, the woman may not be present during these sessions” (HI).
- As part of substance abuse education, the program will include information about the impact of substance use on the family.

### *Pregnancy/Perinatal Considerations*

- Programs will provide pregnant women with education and counseling that address alcohol and drug use during pregnancy. The purpose of this education is to assist women with abstinence and prepare them for their parenting role. Education and counseling will include:

- The consequences of alcohol and drugs on fetal development as well as actions women can take to ensure their child's optimal development beyond delivery.
- Processing to address negative feelings related to substance use during pregnancy.
- Coping skills to overcome the stigma of prenatal alcohol and/or drug use.
- The impact of maternal substance use on parenting and the importance of remaining abstinent beyond delivery.
- Programs serving pregnant women will integrate bio-psycho-social aspects of pregnancy, family planning options and preparation for parenting into counseling and educational programs.

*Considerations for Women Involved in the Criminal Justice System*

- Programs serving women in the criminal justice system will address risk factors related to this system in counseling and education sessions.
- Education and counseling for women involved with the criminal justice system will include the consequences of criminal justice involvement, negative feelings related to substance use and criminal justice involvement and coping skills to overcome the stigma of criminal justice involvement.
- Programs serving women who have been incarcerated will provide counseling and education on issues related to reintegration including fear of reincarceration, appropriate behavior and language, development of self-reliance and decision-making.
- Family counseling and education for women who have been incarcerated will support reconnection and address specialized needs arising from separation and alienation.

**Element 5: Crisis Intervention**

Crisis intervention is addressed or mentioned in four States' treatment standards for women. The existing State standards that address crisis intervention can be found in Table 5 in Appendix A. States describe the training that treatment staff must possess in regard to crisis intervention (GA and MA) and dictate that providers must make crisis intervention services available to clients (GA, HI, MA, NC and WA). The *Comprehensive Model* (Werner, Young, Dennis, & Amatetti, 2007) recognizes that crises can occur both at intake and throughout the course of treatment.

*Description*

**Crisis intervention services** are short term. They are available in person, over the telephone or through other technologies, 24 hours a day, and will be aimed at addressing a specific problem and preventing its escalation and effects in various aspects of an individual's functioning. Crisis intervention may avert an emergency situation and may include addressing survival needs (e.g., food, shelter), health/mental health needs, family situations (e.g., safety concerns, school enrollment) and/or community situations. Emergency response is a separate and distinct service requiring immediate action. Preparedness to respond to individual or community emergencies is critical. Crisis intervention is usually an appropriate follow up after emergency services.



### *Key/Critical Content of Standards*

- Providers will have the capacity to respond to mental health (see Element 13: Mental Health), substance use, health (see Element 12: Medical Care/Primary Health Care), family safety, trauma (see Element 14: Trauma/Violence), veterans' and basic survival needs.
- Providers will have extensive knowledge of available community resources to address the immediate need of the individual and her family.
- Providers will maintain a readiness to "participate as members of an interdisciplinary crisis response team" (GA).
- Providers will have written affiliation agreements with agencies that will be able to meet the diverse crisis needs of individuals or families (see Element 21: Linkages With Social Services and the Child Welfare System).
- When a treatment plan is developed, crisis intervention strategies may be included as part of the treatment plan (see Element 6: Treatment Planning).
- Crisis intervention will both connect clients to needed assistance at intake and be proactive and employ crisis prevention techniques to avoid future problems.
- Crisis intervention services will be available to women across the lifespan. Crisis intervention services will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Crisis intervention services will address:
  - Personal barriers that keep women from treatment and recovery including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of services, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).

### *Considerations for a Woman's Children and Family*

- Programs will have linkages with other services in the community so they can offer an immediate and appropriate response to address the needs of a woman and her children (see Element 1: Outreach and Engagement and Element 21: Linkages With Social Services and the Child Welfare System).
- Providers will have the capacity to respond to intimate partner and family violence.
- During crisis intervention services, providers will help women secure child care (see Element 24: Child Care and Child Development Services).

- Providers will help each woman to create a plan for respite care for her children if she needs a break or “timeout.” The plan will include at least three sources that the mother could call upon when respite is needed (see Element 24: Child Care and Child Development Services).

#### *Pregnancy/Perinatal Considerations*

- Providers will have the capacity to respond to special health and safety needs of pregnant women including intimate partner violence, nutrition, pharmacological issues and prenatal care (see Element 14: Trauma/Violence).
- If a provider is not able to admit a pregnant woman for treatment within 48 hours, interim services will be provided. These include, but are not limited to, crisis intervention, counseling on the potential effects of alcohol, tobacco and drug use on the fetus; referral to prenatal care; and HIV/TB screening and counseling.
- Providers will establish relationships with physicians, local emergency rooms and hospitals that are knowledgeable in addiction treatment for medical care and evaluation of pregnant women (see Element 12: Medical Care/Primary Health Care).

#### *Considerations for Women Involved in the Criminal Justice System*

- The SSA will provide outreach to corrections staff and will provide training on appropriate crisis interventions for incarcerated women (see Element 1: Outreach and Engagement).
- Providers will have procedures in place to help women effectively deal with crises that involve the legal/criminal justice system.
- Providers may work with probation and parole officers to assist women to address emergency needs such as housing or economic issues, and remain in compliance with court requirements.

### **Element 6: Treatment Planning**

Treatment planning is addressed or mentioned in 23 States’ treatment standards for women. The existing State standards that address treatment planning can be found in Table 6 in Appendix A. For the treatment planning element, States include descriptions of the *services* that fall under treatment planning, as well as identify *when* treatment planning should occur. Not all States that address treatment planning address both areas. Three States (CO, CT and TX) require that the treatment plan be based on the assessment. Eight States (CO, CT, ID, MA, NJ, OK, OR and TX) dictate that treatment planning should also address parenting issues, whereas seven States (CT, HI, ID, MO, NJ, OK and SC) note that treatment planning should include setting attainable goals for the woman. Six states (CO, FL, MA, NV, OR and WI) include clauses that, when clinically appropriate, treatment planning should involve the woman’s family.

#### *Description*

**Treatment planning** focuses on the priorities, strengths, preferences and interests of a woman with an SUD. It is a collaborative process in which the woman and counselor to address substance use and problems identified in the assessment. Treatment planning is a proactive

and empowering experience that allows a woman to specify action steps that move her toward solutions to complex problems. Treatment plans are dynamic documents that should be updated regularly to meet the woman's changing needs. The treatment plan should be unique to the woman and her family and in some circumstances, family members participate in the treatment planning. It should encompass the development of strengths and supports to complete treatment and maintain lasting recovery. The treatment plan contains goals, objectives, action steps, resources and outcomes that serve as the foundation for services. Plans incorporate a comprehensive scope of services that addresses the life realities of the women and their families.

### *Key/Critical Content of Standards*

- An initial treatment/recovery plan will be developed during the intake process. This document, with further development by the end of the assessment period, can become the master treatment plan and will be updated thereafter as the woman's needs indicate. Program staff and the woman will participate in the development of a plan, which will reflect her goals and objectives. The staff member will act as the facilitator, and the woman will be the guide for the treatment planning process. This allows for proactive treatment planning and effective collaboration among the woman, treatment staff, family members and community agencies.
- Continuous assessment (see Element 3: Assessment) will explore the woman's needs, preferences, skills, strengths, deficits and preferences and relate them to an efficient service plan. This includes assessing the client's eligibility and appropriateness for both substance use and other services and for a specific level of care within those services. A case management (see Element 7: Coordinated Case Management) assessment will also include a review of the functional areas needed for service procurement and vocational skills (see Element 20: Educational and Employment/Vocational Support). These assessments predicate updates to the treatment plan.
- Treatment/recovery planning will be an ongoing process. The individual treatment/recovery plan will be reviewed and revised as clinically appropriate, in accordance with the identified needs and preferences of the woman and the level of care in which she is enrolled.
- The treatment/recovery plan will include concrete behaviorally oriented objectives that are practical and conducive to the recovery process. Objectives will focus on current issues and coping strategies (see Element 15: Life Skills). Objectives and interventions will promote self-reliance. The initial individual treatment/recovery plan will specify services, interventions, supports and staff necessary to meet identified measurable objectives.
- The treatment/recovery plan will incorporate comprehensive scope of services addressing the realities of the lives of women with SUDs and their families including, but not limited to, substance use recovery, mental health issues (see Element 13: Mental Health), trauma, grief/loss and/or posttraumatic stress disorder (PTSD), domestic violence (see Element 14: Trauma/Violence), safety, parenting (see Element 18: Parenting Skills and Child Development Education) and reunification plan if appropriate, relationships/sexuality (see Element 17: Family Strengthening), cultural issues, spirituality, life skills (see Element 15:

Life Skills), education and employment (see Element 20: Education and Employment/Vocational Support), legal issues, gambling, safe housing, medical and dental care and nutrition (see Element 12: Medical Care/Primary Health Care).

- Treatment will focus on individualized interventions and evidenced-based approaches. Individualized services will address multiple areas of functioning at individual, family and community levels that contribute to a woman's overall quality of life.
- Programs will ensure clinical supervision and will attempt to maintain continuity of staff over the course of a woman's treatment.
- The treatment/recovery plan will clearly delineate the roles and responsibilities of every person involved in execution of each action step and will promote and self-reliance.
- Individual treatment/recovery plans, goal setting and implementation will be based on the assessment (see Element 3: Assessment) and will list specific strengths and assets of the woman and how they will be used to address issues, challenges and methods of achieving recovery objectives.
- The treatment/recovery plan will clearly identify the objectives that are critical for discharge or transfer to a different (lower or higher) level of care. It will include objectives that are realistic, simple and obtainable.
- The treatment/recovery plan will identify community resources that are necessary for the woman's discharge from the treatment program and recovery process (see Element 22: Recovery and Community Support Services). If certain high priority areas of the recovery process are beyond the scope of the treatment program, these areas will be referenced in the treatment/recovery plan including how or when they will be addressed.
- Level and modality of care will remain flexible. A continuum of services will be available to women, including standard outpatient, intensive outpatient and group and individual therapy. Treatment hours will be flexible to facilitate treatment participation.
- Treatment planning will be available to women across the lifespan. Treatment planning will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Treatment planning will address specific retention issues:
  - Personal barriers that could prevent a woman from participating including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality, and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of services, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as time constraints and conflicting demands from other systems, such as child welfare and TANF

requirements (see Element 21: Linkages With Social Services and the Child Welfare System).

- Other common fears about making life changes.
- Drug and alcohol use monitoring (testing) can be used as a therapeutic tool to assist in assessment and evaluation of progress and to promote participant honesty and accountability. Results of drug testing will not be used as the only indicator of progress in treatment.
- Intimate violence will be treated as a critical element of treatment planning with safety of paramount importance (see Element 14: Trauma/Violence).
- Women will be provided a copy of their treatment plan and each update thereof.
- Education and employment/vocational supports that are appropriate to the woman's needs and abilities must be clearly integrated into the overall treatment plan, initiated early in the treatment process and evaluated and adjusted as needed (see Element 20: Education and Employment/Vocational Support).

#### *Considerations for a Woman's Children and Family*

- Treatment/recovery plans will be family centered, provide for family input when clinically indicated and address specific service needs and community supports for the family (see Element 22: Recovery and Community Support Services).
- A service plan for each child will be developed from findings of the child's assessment. The mother will be a full participant in the development of service plans for her children. If children access services through another service provider, they can use the plan developed by the other provider. Support to implement the plan will be provided as needed.
- When a family is involved with the child welfare system, specific objectives will be established to address child welfare needs and requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
- Treatment planning for pregnant and parenting women will include strategies to assist women in identifying and addressing the functional requirements of daily life with children.
- Treatment/recovery plans will integrate compliance with mandates and requirements of the Child Welfare System.

#### *Pregnancy/Perinatal Considerations*

- Pregnant women will be supported to develop a birthing plan and incorporate objectives that specifically address prenatal health and preparation for delivery.
- Integrated recovery/treatment planning that addresses the health (see Element 12: Medical Care/Primary Health Care), mental health (see Element 13: Mental Health), child welfare and community support (see Element 22: Recovery and Community Support Services) of the woman and child will be conducted and will involve other service agencies as applicable.

### *Considerations for Women Involved in the Criminal Justice System*

- Treatment/recovery planning will address reintegration into the community and development of social supports (see Element 22: Recovery and Community Support Services).
- Treatment/recovery plans will integrate compliance with mandates and requirements of probation, parole or drug courts.
- Treatment/recovery plans will support women in dealing effectively with the stigma associated with involvement with the criminal justice system as a means to prevent relapse.

### *Additional Considerations*

- The treatment/recovery planning described above applies to all women in treatment including women in an opioid replacement program (see Element 9: Medication-Assisted Treatment). Use of medication assistance will not be a basis for exclusion from other treatment services.

## **Element 7: Coordinated Case Management**

Coordinated case management is addressed or mentioned in 23 States' treatment standards for women. The existing State standards that address coordinated case management can be found in Table 7 in Appendix A. Many of the standards require that active coordination of care take place between providers and systems (AZ, AR, CA, CT, DC, FL, GA, HI, ID, MA, NJ, SC, WA, WI and WY). Most States dictate that women should be assigned to a single case manager or a care coordinator who, ideally, should remain the same person throughout the continuum of care (AZ, AR, FL, GA, NV and WI). In many States, the case manager is responsible for assessing what services women need (MA, NJ, OK, OR, TN and TX). The *Comprehensive Model* notes that coordinated case management can occur at any time during, before or after treatment. The *Comprehensive Model* also notes that "special attention should be paid to coordinating the children's services with those of their mothers" (CSAT 2004, p. 17).

### *Description*

Women with SUDs and their families often must interact with numerous systems including health, mental health, child welfare, housing, criminal justice, social services, employment/vocation and education. **Coordinated case management** is a participant-centered, goal-oriented approach to accessing and coordinating services across these multiple service systems. It facilitates a woman's recovery, self-sufficiency and overall well-being through five essential functions: 1) assessing needs, resources and priorities; 2) planning for how the needs can be met; 3) establishing linkages to enhance a woman's access to services to meet those identified needs; 4) coordinating and monitoring service provision through active cross-system communication and coordinated service plans; and 5) removing barriers to treatment and advocating for services (JCAHO, 1995).

Case management is interdisciplinary and seeks to delineate outcomes, roles and responsibilities. The participant should be the source of control and given the necessary

information and opportunities to make decisions that affect her and her family. Whether coordinated case management is an element of a recovery and treatment modality or a free-standing service, it occurs throughout the treatment continuum, as a pretreatment activity, during treatment and after treatment. It may be difficult to follow traditional approaches at times given the immediacy of participants' needs and the likelihood that they are still using alcohol or drugs. As women transition from treatment back to the community, ongoing coordinated case management often plays a critical role in helping them develop an effective recovery community support plan and secure resources needed to sustain their recovery. Disengagement is an important function as well. It gives the woman the opportunity to explore what she learned about interacting with service providers and about setting and accomplishing goals. It is also a time for the case manager to hear from the woman what she considers beneficial or not beneficial about the relationship. In addition, from an agency standpoint, coordinated case management may be a useful mechanism to maximize resources, meet documentation requirements and improve service quality by ensuring service plans and systems are consistent and compatible.

#### *Key/Critical Content of Standards*

- Providers will have staff that implements the following case management responsibilities:
  - Identify and engage women (see Element 1: Outreach and Engagement).
  - Assess each woman's needs (see Element 3: Assessment) and help develop her individualized comprehensive treatment and recovery plan (see Element 6: Treatment Planning). Arrange and facilitate direct service provision; advocate on the woman's behalf to ensure she and her family receive needed services (see Element 16: Advocacy).
  - Provide information, encouragement and support while facilitating services.
  - Understand how other service systems work and establish system linkages (see Element 21: Linkages With Social Services and the Child Welfare System) as needed.
  - Be proactive in identifying and addressing barriers that may affect a woman's treatment progress and long-term recovery, which may include, but are not limited to:
    - Personal barriers that keep women from treatment and recovery: fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
    - Systemic barriers to treatment and recovery such as cost of services, insurance requirements, stigma, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
    - Other common fears about making life changes.
  - Communicate regularly with the woman about her treatment plan (see Element 6: Treatment Planning) to monitor and reevaluate her plan as needed.

- Ensure that the woman is involved in all phases of case management.
- Coordinate the timing of various interventions to ensure that the woman can achieve her treatment goals (see Element 6: Treatment Planning).
- Intensify contact with the women to avoid crises during transitions such as when the woman is moving between different types of programming (from institutional programming to residential treatment, residential treatment to outpatient or to a less or more restrictive level of supervision), which is often stressful and frequently triggers relapse (see Element 5: Crisis Intervention). This ensures that service is not interrupted. Whenever possible, supervision and treatment activities will be coordinated to promote gradual movement to reduce the likelihood of relapse.
- Establish regular communication with the woman, program staff and others involved in the delivery of services to the woman to monitor and evaluate progress.
- Coordinate and/or integrate the mother's and child's case plans (where applicable).
- Enhance the woman's problem-solving, advocacy (see Element 16: Advocacy) and coping skills (see Element 15: Life Skills).
- Develop an aftercare plan with the woman before her discharge and conduct regular or periodic follow up with her to monitor and reevaluate the aftercare plan (see Element 8: Continuing Care).
- Advocate for longer length of stay, additional services or other considerations as needed.
- The treatment service areas that coordinated case management needs to address include:
  - Service plan development (see Element 6: Treatment Planning).
  - Assessment (see Element 3: Assessment). A case management assessment will include a review of the functional areas needed for service procurement and vocational skills.
  - Engagement and retention in treatment and participation in continuing care/recovery community support services (see Element 8: Continuing Care and Element 22: Recovery and Community Support Services).
  - Introduction to substance-free recreational and social connectedness activities (see Element 15: Life Skills and Element 22: Recovery and Community Support Services).
  - Mental health services (see Element 13: Mental Health).
  - Crisis intervention (see Element 5: Crisis Intervention).
  - Child care (including respite care) and therapeutic child care (see Element 24: Child Care and Child Development Services).
  - Dental care and medical/health care, including effective family planning (see Element 12: Medical Care/Primary Health Care).
  - Facilitation of positive parent-child relationships (see Element 17: Family Strengthening and Element 18: Parenting Skills and Child Development Education).
  - Employment, vocational and educational services to promote self-sufficiency and capability for independent living (see Element 20: Educational and Employment/Vocational Support).
  - Life skills education and training, for example, budgeting and nutrition, (see Element 15: Life Skills).



- Long-term, safe and drug-free housing (see Element 19: Housing Support and Assistance).
- Linking, monitoring and advocacy are important aspects of case management (see Element 21: Linkages With Social Services and the Child Welfare System, Element 3: Assessment and Element 16: Advocacy). After the linkage is made, service deliver will be monitored to ensure a good fit and relationship between the woman and the resource. Monitoring the woman's progress and adjusting the service plan are essential functions of case management. Individual advocacy for a woman will be geared toward achieving the goals established in the service plan (see Element 16: Advocacy).
- Coordinated case management will be carried out through a multidisciplinary team approach. The team composition will depend on the client's needs and input but will include representatives from the various systems with whom the woman has involvement. The goal will be to assist the woman in accessing and understanding services (see Element 21: Linkages With Social Services and the Child Welfare System).
- Coordinated case management will be available to women across the lifespan. Coordinated case management will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Whenever possible, as services come to a close, disengagement will be planned and deliberate. Disengagement will give the woman the opportunity to explore what she learned about interacting with service providers and about setting and accomplishing goals. It will also provide a time for the woman to tell the provider which elements the woman considered beneficial about the relationship.
- Programs will ensure clinical supervision and will attempt to maintain continuity of staff over the course of a woman's treatment. Case management techniques will be designed to reduce the participant's internal and external barriers that may impede progress.
- Case management will be flexible and will be driven by the unique needs of the woman.
- Services will be sequenced to be provided at the appropriate time and to maximize the amount of support that women receive.
- Case management should address reproductive health education.
- For adolescents who are in treatment for an SUD, providers will maintain linkages with schools and other youth-serving systems involved in the adolescent's care and encourage family involvement as much as is clinically appropriate. They will also have full knowledge of the legal issues in their State specific to serving adolescents (e.g., can adolescents sign themselves back into treatment).

#### *Considerations for a Woman's Children and Family*

- Case plans will be developed for children attending treatment with their mother, and other children as appropriate. In addressing the service needs of children of mothers with SUDs, programs will make sure that the treatment plans for the mother and child(ren) are coordinated or will develop a single coordinated care plan.

- When children are not in their birth mother’s custody, engagement of the caregiver including foster care or kin caregivers in care management is critical.
- Whenever clinically appropriate, a plan to regain custody of children should be developed.

#### *Pregnancy/Perinatal Considerations*

- Prenatal care coordination services will be provided for pregnant women. These services will include: ensuring the woman has the appropriate supplies for a newborn (e.g., crib, diapers, car seat); consulting with the woman’s physician to ensure as smooth a delivery as possible; continually monitoring participant’s scheduling and follow through on prenatal appointments; determining potential barriers facing the participant in getting to/from appointments; providing other support as needed (e.g., transportation to medical appointments, see Element 23: Transportation); coordinating with the appropriate agency to facilitate a smooth transition to the postnatal (pediatric) provider; and coordinating prenatal and postnatal care services (FL).
- Every pregnant woman will have a comprehensive discharge and aftercare plan (see Element 8: Continuing Care) developed that includes collaboration with other agencies to provide recovery support services for her and her children (see Element 22: Recovery and Community Support Services).
- Service planning for pregnant and parenting women will include strategies to assist women in identifying and addressing the functional requirements of daily life with children.

#### *Considerations for Women Involved in the Criminal Justice System*

- For a woman involved in the criminal justice system, case management services will arrange and connect her to the appropriate community supports upon her release from custody and reentry into the community and will provide regular communication with parole/probation.
- Providers will strive to create continuity of relationship as women are released from incarceration and begin to reintegrate into the community. This can also include conducting outreach with corrections facilities (see Element 1: Outreach and Engagement).
- Case management will help the woman address outstanding legal issues and legal/court mandates. This service will also connect clients to drug testing and drug courts and assist women with keeping appointments with probation/parole.
- Case management will provide appropriate linkages for the woman and her child/family while she is involved in the criminal justice system. This may include reporting progress in treatment to courts and the legal system.

#### *Additional Considerations*

- The office of the SSA will facilitate collaborative agreements to allow sharing of information across systems and agencies.
- Indicators of “success” will be defined by the treatment agency and its stakeholders (including funding and regulatory agencies). Data on outcomes will be collected to determine the effectiveness of case management.

- Structured feedback loops will be established to ensure that the gathered data are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development and future data requirements.
- One-stop service centers and co-location of staff are two examples of methods used to facilitate coordinated case management.

## **Element 8: Continuing Care**

Continuing care (sometimes called aftercare or recovery management) is addressed or mentioned in 20 States' women's treatment standards. The existing State standards that address continuing care/aftercare/recovery management can be found in Table 8 in Appendix A. Some States address each category separately, whereas other States amalgamate all services into one category. The standards emphasize the importance of retaining continuity of care through ongoing ties between the woman and the treatment staff following discharge (AR, GA, ID, MA, NJ, WA and WI). Current State standards also require that discharge planning actively involve community recovery supports (AZ, AR, CT, GA, MA, VT and WA).

### *Description*

**Continuing care** is the sustained provision of clinical and recovery support services after a woman has been discharged from a primary treatment episode. Participation in continuing care services is established by the needs of a woman and her family that are identified through a continuous process of clinical and self reassessment; there is no predetermined time, intensity or service approach. Continuing care services provide the foundation for a woman's life plan: a written document that charts and guides her movement from treatment to ongoing recovery and that includes her strengths, needs, goals, objectives and service preferences.

### *Key/Critical Content of Standards*

- Continuing care will be available to women across the lifespan. Continuing care services will reflect multiple pathways to recovery based on an individual's unique strengths, as well as her needs, preferences, experiences and age. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services will reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Continuing care services will emphasize the importance of continuity of relationship with the treatment provider for women.
- Discharge planning will include development of a life plan that incorporates continuing care services.
- Planning for discharge from the treatment program or transition to another level of care will begin following the initial assessment and continue throughout the treatment process.
- Transitions between levels of care and treatment providers will be as seamless as possible.

- Before discharge from treatment, the woman will have had telephone and/or face-to-face contact with the providers who will be providing continuing care services for her and her family in the community.
- Providers from the discharging treatment programs will support and assist women in accessing and fully engaging in the following continuing care services:
  - A range of women-specific formal, family, natural and community supports (see Element 22: Recovery and Community Support Services) in the client's community will be arranged, with the client's input, before discharge (e.g., child care, see Element 24: Child Care and Child Development Services; transportation, see Element 23: Transportation; self-help groups, see Element 22: Recovery and Community Support Services; and health care, see Element 12: Medical Care/Primary Health Care) (CT).
  - A stable housing plan will be in place (see Element 19: Housing Support and Assistance) before discharge from residential programs.
  - Specific relapse prevention interventions will be developed with the woman and presented in a language she understands.
- Women will be supported in determining their own path of recovery. Life plans will be individualized and strength based and will support the woman's autonomy, self-determination and control over resources.
- The life plan will incorporate a strategy for ongoing clinical and self-reassessment (see Element 3: Assessment).
- The woman will be informed of the discharging treatment program's requirements for follow up, as well as procedures for readmittance should this be needed or desired in the future. The conditions for reentry to a program will be explained to the woman as part of the creation a life plan.
- The life plan will incorporate expectations and requirements of other programs or agencies that will provide continuing care services for the woman and her family (see Element 21: Linkages With Social Services and the Child Welfare System).
- There will be a staff member from the discharging program or another continuing care agency who will have primary responsibility for service coordination and serve as the principal point of contact for the woman and her family's continuing care efforts (see Element 7: Coordinated Case Management).
- For adolescents who are in treatment for an SUD, providers will maintain linkages with schools and other youth-serving systems involved in the adolescent's care and encourage family involvement as much as is clinically appropriate. They will also have full knowledge of the legal issues in their State specific to serving adolescents (e.g., can adolescents sign themselves back into treatment).

*Considerations for a Woman's Children and Family*

- Other family members will be involved in continuing care planning as much as clinically appropriate and possible.
- Women will be informed and assisted to understand the effects and implications of their treatment choices on their relationship with child welfare services (see Element 21: Linkages With Social Services and the Child Welfare System).

- Family needs will be integrated into the life plan as the woman chooses and as appropriate.
- Women will be helped to find a “medical home for their children.” There will be a plan for children’s medical care arrangement, preferably with providers who have experience with SUDs and early intervention (see Element 12: Medical Care/Primary Health Care).

#### *Pregnancy/Perinatal Considerations*

- There will be a clear plan to arrange medical support and appointments for pregnant women (see Element 12: Medical Care/Primary Health Care) during and after treatment.
- Providers will educate the woman and her family members regarding the need for early intervention services for children who have had prenatal or environmental exposure to parental alcohol and/or drug addiction.
- Providers will encourage pregnant women to continue to participate in treatment for their SUDs (particularly if they are receiving medication-assisted treatment, see Element 9: Medication-Assisted Treatment) through delivery and postpartum.
- Life plans will include parenting and family needs such as family strengthening (see Element 17: Family Strengthening).

#### *Considerations for Women Involved in the Criminal Justice System*

- Programs will have a clear understanding about the expectations of women getting treatment after being released from incarceration.
- Programs will seek all of a woman’s previous treatment records, particularly if she has been involved in the criminal justice systems, to create continuity of care and coordination with other services.
- The life plan of women with criminal justice involvement will include strategies to meet court requirements and prevent recidivism as well as substance use.

### **Element 9: Medication-Assisted Treatment**

Medication-assisted treatment is addressed or mentioned in 17 States’ women’s treatment standards. The existing State standards that address medication-assisted treatment can be found in Table 9 in Appendix A. The State standards reviewed for this document that address medication-assisted treatment focus on pregnant women. The SAPT Block Grant Women’s Set Aside funding requirements (Title 42 U.S.C. 300x-22 and 300x-24(b)) dictate that agencies must provide priority for admission to women who are pregnant. States also exempt women from other medication-assisted treatment admission policies if they are pregnant, are HIV positive or have been released from a corrections facility within 6 months (FL, MO, NJ, NH, OR, OK and RI). States require that women who are pregnant and are undergoing medication-assisted treatment must have access to prenatal care (FL and OR). Many States require regular pregnancy tests for women who receive medication-assisted treatment even when they are not pregnant at intake (AR, FL, NH, OK and RI). Some States also require licensed medical supervision for women who are undergoing medication-assisted treatment (CA, CO and NV).

### *Description*

**Medication-assisted treatment** services are indicated and effective interventions for some women with SUDs when combined with other gender-responsive counseling and services. The Food and Drug Administration has approved medications for treatment of alcohol dependence (naltrexone, disulfiram and acamprosate calcium) and opioid dependence (methadone, buprenorphine and naltrexone). For pregnant women who are opioid dependent, use of methadone is, at the time of this writing, the preferred standard of care. Medication-assisted treatment includes short-term adjunctive medication, as well as long-term maintenance protocols. Medications are usually provided by a healthcare provider or a free-standing outpatient program; however, access to a range of other counseling and supportive interventions may occur in a separate program. Collaboration among medical providers, mental health providers, stand-alone medication-based outpatient clinics and other treatment services for women with SUDs is needed to ensure coordinated treatment planning and comprehensive services for women.

### *Key/Critical Content of Standards*

- Medication is necessary for some women in treatment and will be considered and integrated into the overall plan of care.
- Pharmacotherapy intervention will be provided on an as-needed basis and will include provision of, or established referral linkages for, concurrent assessment and monitoring by qualified medical or psychiatric staff.
- The provider will have affiliation agreements with a physician with training in addictions, psychiatric disorders, psychotropic medications and women's health. Providers will obtain a signed release of information and coordinate care with the prescribing physician to ensure that the medication and the other services are working together effectively.
- Providers will ensure that women are informed of the risks and benefits of medication-assisted treatment.
- Providers will offer women a pregnancy test at intake and/or before implementation of medication-assisted treatment.
- Program staff will be educated about pharmacology, adverse drug interactions and side effects.
- Interventions will promote equal access to all levels of care for all women based on assessment of their treatment needs (see Element 3: Assessment) and their ability to participate in treatment (see Element 6: Treatment Planning). No woman who is taking prescribed medication including, but not limited to, methadone and buprenorphine as directed by her physician will be excluded from other treatment services, including residential treatment, for which the woman has otherwise been identified as appropriate.
- Medication-assisted treatment will be available to women across the lifespan as clinically indicated. Services will reflect multiple pathways to recovery based on an individual's unique strengths, as well as her needs, preferences, experiences and age. Medication-assisted treatment services will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs,

veterans, LGBT women, and women with disabilities. Services will be adapted for specific populations.

- Programs that provide medication-assisted therapy will address:
  - Personal barriers that keep women from treatment including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of services and medications, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
  - Other common fears about making life changes.

#### *Pregnancy/Perinatal Considerations*

- All women will be given timely access to prenatal care either by the program or by referral to appropriate healthcare providers (see Element 12: Medical Care/Primary Health Care).
- Treatment for pregnant women receiving methadone or other approved controlled substances from a treatment agency licensed to provide opioid replacement treatment will be based on up-to-date research. Women will not be detoxified during pregnancy without consideration by the doctor of the impact it would have on the mother and her fetus. In addition, all pregnant women on prescribed medications will be medically evaluated to determine the appropriateness of detoxification (see Element 11: Detoxification).
- Disulfiram, naltrexone and other medications that may be contraindicated for pregnant women will not be administered without an assessment by licensed medical professionals qualified in prenatal care.
- “If medication treatment will be indicated for the treatment of pregnant women with co-occurring disorders, non-addicting and non-teratogenic medications will be used” (AZ) (see Element 13: Mental Health).

#### *Considerations for Women Involved in the Criminal Justice System*

- The SSA will educate corrections professionals (probation officers) about the legitimacy of medication-assisted treatment for those involved in this system, particularly for pregnant women (see Element 1: Outreach and Engagement).
- The SSA will work with criminal justice officials to ensure opioid dependent incarcerated women have access to medication-assisted treatment (see Element 16: Advocacy).

### *Additional Considerations*

- Treatment providers will develop policies and procedures that acknowledge neuroscience of addiction and recognize that medication assisted treatment, in addition to counseling, is an effective course of treatment for many women.
- Treatment professionals should reduce the stigma associated with medication-assisted treatment by conveying the understanding of the neuroscience of addiction and the effectiveness of treatment. Treatment professionals may need to advocate that medication assisted treatment in combination with counseling is an evidence-based course and should be recognized as such. Treatment professionals can also reduce the stigma by educating the community and policy makers that individuals receiving medication assisted treatment should not be discriminated against.
- Treatment providers must act for the benefit of the woman and provide timely coordination of care when women are receiving medication assisted treatment (see Element 7: Coordinated Case Management).

### **Element 10: Drug Monitoring**

Drug monitoring (often called drug testing) is addressed or mentioned in five States' women's treatment standards. The existing State standards that address drug use monitoring can be found in Table 10 in Appendix A. The current State standards on drug monitoring primarily address drug testing or drug screening. The States detail when drug testing should occur, how many tests should be administered, and what kinds of tests should be used. States also describe what levels of care should provide drug testing. The "Comprehensive Model" (Werner, Young, Dennis, and Amatetti, 2007), *Principles of Drug Addiction Treatment: A Research-Based Guide* (NIDA, 2005) and TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT, 2005) all recommend conducting drug monitoring as it can help providers measure treatment progress and prevent relapse.

#### *Description*

**Drug monitoring** provides an objective assessment of alcohol and drug use. It assists with evaluations, provides clinical feedback on the woman's progress in treatment, provides opportunities for reinforcing the goals and objectives of treatment plans and celebrates treatment gains.

#### *Key/Critical Content of Standards*

- Drug and alcohol use monitoring (testing) will be used as a therapeutic tool to assist in assessment and evaluation of progress and promote participant honesty and accountability. Results of drug testing will not be used as the only indicator of progress in treatment (see Element 6: Treatment Planning).
- Drug and alcohol testing will be used where clinically appropriate and conducted on an initial and random basis.



- Programs will have clear written policies and procedures that address the collection methods, screening procedures, confirmation procedures and review of results. Programs will consider issues of respect and privacy and will work to minimize traumatic triggers in the development of collection methods, policies and procedures (see Element 14: Trauma/Violence).
- Clear communication and informed consent procedures will be included in the provision of testing. These policies will address the recognition that tests are not completely accurate, the woman's right to confidentiality, as well as her right to protest the results of the tests. The program will follow informed consent guidelines responsive to State reporting requirements.
- Drug use monitoring will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services will reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.

#### *Considerations for a Woman's Children and Family*

- Drug and alcohol testing may be an appropriate therapeutic screening or intervention tool for other family members. Before testing a minor in services with his/her mother, both the mother and youth will be consulted and will provide their consent to drug testing.

#### *Pregnancy/Perinatal Considerations*

- Additional drug and alcohol use monitoring for pregnant women (particularly pregnant women receiving methadone) will be conducted as clinically appropriate.
- A protocol will exist regarding the appropriate response to signs of neonatal exposure to alcohol or drugs.

#### *Considerations for Women Involved in the Criminal Justice System*

- When signed releases are in place, reports on progress in treatment (including drug and alcohol testing results) can be sent to parole, probation or other agencies identified in the release.
- Monitoring in these cases, like non-criminal justice cases, will follow recommendations for the woman (with her knowledge) based on progress in treatment. Results will not be used as a tool for sanctions.

#### *Additional Considerations*

- States may want to add an appendix or citation to their standards that lists State-approved toxicology screens as well as the benefits and drawbacks of each test.

## Element 11: Detoxification

Detoxification is addressed or mentioned in 12 States' women's treatment standards. The existing State standards that address detoxification can be found in Table 11 in Appendix A. In their Standards, many States describe specific detoxification procedures for pregnant women. *Principles of Drug Addiction Treatment: A Research-Based Guide* (NIDA, 2005) notes that detoxification by itself is generally ineffective at changing patterns of long-term use. Likewise, some States note that detoxification can often lead to engagement in long-term treatment (AZ, GA).

### *Description*

**Detoxification** is a set of interventions that assist women in overcoming physical dependence on alcohol or drugs by addressing acute intoxication and withdrawal symptoms. Since detoxification can be life threatening, medical supervision and emergency response may be needed. There are three components of detoxification services: (1) evaluation, (2) stabilization, and (3) fostering entry and engagement in treatment. During detoxification and early recovery, psychological dependency and physical needs such as nourishment and sleep must be considered.

### *Key/Critical Content of Standards and Source*

- All women will be screened and assessed for the need for detoxification services. If detoxification is warranted, an assessment will be made and services delivered (see Element 2: Screening and Element 3: Assessment).
- Providers will be aware that, concurrent to withdrawal, a woman may experience psychological symptoms including increased anxiety, guilt and fear associated with trauma or the consequences of her drug use. Providers will also be aware that the woman may have been dependent on alcohol and drugs to cope with her feelings, life circumstances and/or mental disorder (see Element 13: Mental Health and Element 15: Life Skills).
- Arrangements for transportation and entrance into detoxification service will be made (see Element 23: Transportation).
- Sufficient and appropriate detoxification services will be available.
- Access to services and support for the woman transitioning from detoxification to treatment for SUDs will begin on entry into detoxification programs. These services will include engagement services, access to treatment resources and case management (CSAT, 2006).
- Providers will educate the woman about the detoxification process including the physical and psychological symptoms they may experience during withdrawal (see Element 12: Medical Care/Primary Health Care and Element 13: Mental Health).
- Providers will monitor withdrawal symptom complaints and coordinate with medical staff (see Element 12: Medical Care/Primary Health Care) as indicated.
- Detoxification services will be provided in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly.

- Detoxification services will include monitoring for co-occurring disorders, need for stabilization and interventions to prevent escalation of anxiety.
- Detoxification services will be available to women across the lifespan as clinically indicated. Detoxification services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences and age. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities.

#### *Considerations for a Woman's Children and Family*

- "A facility or program that serves parents with children shall provide or arrange detoxification services for any parent who presents symptoms of intoxication, impairment or withdrawal" (DC).
- If a woman is in need of detoxification services, programs will ensure that her children have appropriate care and supervision. Age-appropriate activities, a welcoming environment and appropriate communication about the parent's well-being shall be provided to children (see Element 24: Child Care and Child Development Services).
- Communication with family members will be encouraged through program supervision and clinical recommendations (see Element 17: Family Strengthening).

#### *Pregnancy/Perinatal Considerations*

- Programs serving pregnant women with symptoms of intoxication, impairment or withdrawal will immediately provide or arrange for the woman to be "(a) Evaluated by a physician, hospital, or medical clinic; (b) Transported; (c) Admitted for detoxification services in a hospital, when clinically indicated; and/or, (d) Provided non-hospital detoxification services, if hospital services are not clinically indicated" (DC).
- Programs will have precautionary measures in place to protect the safety of the women and her fetus. The appropriate level of detoxification services must be provided when a pregnant woman presents for treatment. Symptoms of withdrawal will be relieved, and progression of withdrawal will be prevented using medications that are safe for use during pregnancy.
- Current research suggests that a pregnant woman should not undergo opioid detoxification because of the risk that detoxification poses to the fetus. Detoxification services for pregnant/perinatal women will take into account up-to-date medical research. Transition to methadone maintenance combined with gender-responsive therapeutic services is currently the preferred care for pregnant women. Buprenorphine may also become an approved standard of care in the near future.

#### *Considerations for Women Involved in the Criminal Justice System*

- The SSA will work with the criminal justice agency to screen women for substance use disorders and the potential need for detoxification services at the time of incarceration.

- The SSA will provide training to help corrections professionals to recognize the symptoms of withdrawal in incarcerated women.
- The SSA will advocate for incarcerated women experiencing withdrawal to receive appropriate detoxification services.

## **Element 12: Medical Care/Primary Health Care**

Medical care/primary health care is addressed or mentioned in 26 States' women's treatment standards. The existing State standards that address medical care/primary health care can be found in Table 12 in Appendix A. In many States, comprehensive assessments (see Element 3: Assessment) must include an evaluation of the woman's health care needs (AZ, CO, CT, DC, ID, NJ, OR, SC, WA). As part of the SAPT Block Grant Women's Set Aside funding requirements (Title 42 U.S.C. 300x-22 and 300x-24(b)), providers are required to provide "1) primary medical care for women, including referral for prenatal care and, while women are receiving such services, child care; [and] 2) primary pediatric care, including immunization, for their children." This requirement is included in the standards of many States (AR, CA, DC, FL, GA, NJ, NC, SC, TN, WI). In many States, this includes specific services for the population served, including pregnancy tests and gynecological exams (AZ, CO, ID, MA, MO, TN, WI).

### *Description*

Women with SUDs and their children often have co-occurring acute or chronic health problems that have been neglected or exacerbated during alcohol and drug use. **Medical care/primary health care** should be provided onsite or by referral to care providers who are sensitive to issues of gender, addiction, mental disorders and trauma. The types of services that may be needed include, but are not limited to, primary care; prenatal and postnatal care; emergency and hospital care; chronic diseases care (arthritis, diabetes, etc.); testing, treatment and counseling for HIV, viral hepatitis, tuberculosis and sexually transmitted diseases; and reproductive and sexual health care. Healthcare services also include, but are not be limited to, vision care, dental care, health and wellness programs, tobacco cessation, specialized education/support on addressing health needs, family planning services, pain management and nutrition and fitness programs. Health care, health education and preventive services are important recovery support needs for women and their children.

### *Key/Critical Content of Standards*

- Physical health is a priority when determining needs and services (see Element 6: Treatment Planning).
- Services will address the needs of racial and ethnic minority women and their children who may have experienced health care disparities during their lifetime, and are more at-risk for a variety of acute and chronic diseases.
- Program staff will refer and facilitate access to healthcare/primary healthcare providers and will follow up to ensure clients attend appointments (see Element 7: Coordinated Case Management).

- Client preventive education will be provided. This education will include, but will not be limited to, effective birth control and strategies to prevent infectious diseases, especially HIV/AIDS and other sexually transmitted diseases.
- Programs will ensure that their staff and the women that they serve understand that medical self-awareness, personal hygiene and self-advocacy for wellness are critical to primary health care.
- Programs will maintain policies and procedures that address use of tobacco products by staff and clients including access to tobacco cessation services.
- Health education/medical services/referrals to medical services will address:
  - Personal barriers that keep women from medical services including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers such as cost of services, insurance requirements, waiting lists, lack of treatment options, lack of culturally/linguistically appropriate treatment, discrimination, absence of child care (see Element 24: Child Care and Child Development Services) and lack of transportation (see Element 23: Transportation).
  - Other common fears about making life changes.
- Health education/medical services/referrals to medical services will be available to women across the lifespan and will address issues including, but not limited to, care before pregnancy, prenatal care, menopause and older adult health issues as appropriate.
- Agencies will have a mechanism for screening, diagnostic care, referral and treatment for FASD for both the woman seeking treatment and her children. Women will receive information about health education, FASD and the impact of prenatal alcohol exposure. This information will be provided in a manner that is free of shame and guilt. Supports will be available for women during and after the educational sessions for women to process the information. Staff training will include general information about FASD.

#### *Considerations for a Woman's Children and Family*

- Agencies will provide or arrange for primary pediatric care including immunizations for children.
- Agencies will provide or arrange for screening and the delivery of needed developmental services for children (see Element 2: Screening and Element 24: Child Care and Child Development Services).
- Appropriate referrals will be made to WIC, Healthy Start, Head Start, early intervention and/or Birth-to-Three programs (see Element 21: Linkages With Social Services and the Child Welfare System).

#### *Pregnancy/Perinatal Considerations*

- Agencies will provide or arrange for prenatal and perinatal care.
- Agencies will provide or arrange for screening for maternal and postpartum depression and arrange for appropriate services (see Element 2: Screening and Element and Element 13: Mental Health).

- For pregnant women being treated with psychotropic medications that are contraindicated during pregnancy, alternative medical or therapeutic interventions for the mental disorder will be considered. If medications are changed, potential risks and care needs related to withdrawal or detoxification will be addressed (see Element 11: Detoxification).

*Considerations for Women Involved in the Criminal Justice System*

- Women involved with the criminal justice system will receive assistance to access community-based preventative, acute and chronic health care whenever possible.

*Additional Considerations*

- The SSA will provide outreach to primary healthcare providers to educate them about the risks of substance use, services available, related Federal and State legislation including the Federal confidentiality regulations (Federal Confidentiality Code 42 CFR Part 2), how to make a referral and relevant information about accessing services (e.g., waiting periods for intake and/or services).

<b>Medical Elements to be Explored in the Medical Assessment of Women with SUDs (AZ)</b>	
<b>Medical Elements:</b> Addiction	Pattern of progression of symptoms of addiction, “telescoping” of symptoms Emergency room contacts, multiple physician contacts History of physical trauma, accidents
<b>Medical Elements:</b> Psychiatric, Behavioral Health	Previous psychiatric diagnoses, including postpartum syndromes Inappropriate or erratic behavior Depression or other mood disorders, difficulty concentrating Grief related to loss Suicide attempts Trauma history Anxiety disorders or symptoms Eating disorders or symptoms Dissociative disorders or symptoms
<b>Medical Elements:</b> Women’s Health	Gynecologic problems or disease: Amenorrhea Dysfunctional uterine bleeding Dysmenorrhea Infertility Pre-menstrual syndrome Obstetrical care and complications: Number of previous pregnancies History of multiple births Prenatal care history

	Spontaneous abortion Stillbirth Premature labor Low birth weight infants Fetal alcohol syndrome or effects
<b>Medical Elements:</b> Liver and gastrointestinal disease	Fatty live Hepatitis Cirrhosis Gastrointestinal bleeding
<b>Medical Elements:</b> Other Medical	Hypertension Nutritional status: Malnutrition, weight loss Infectious diseases: HIV, STDs, Hepatitis C Hematologic disorders: Anemia Pulmonary or lung disease: Smoking history, emphysema, allergies, asthma Skin/teeth

### Element 13: Mental Health

Mental health is addressed or mentioned in 19 States' women's treatment standards. The existing State standards that address mental health can be found in Table 13 in Appendix A.

#### *Description*

Psychiatric symptoms, syndromes and disorders may result from intoxication, toxicity, withdrawal and other states induced by alcohol and drugs. Substance use and substance-related disorders may coexist with anxiety disorders, mood disorders, personality disorders, psychotic disorders and other disorders and may mask, mimic, masquerade as or unmask them. Unrecognized, untreated and undertreated psychiatric conditions can interfere with successful recovery from SUDs. Mental disorders include, but are not limited to, a range of disorders, from serious and persistent mental illness including depression, anxiety disorders, eating disorders and PTSD. **Mental health** services include screening, assessment, evaluation, treatment, pharmacological interventions, therapeutic counseling, cognitive behavioral therapies and other modalities. Addressing the needs of women with co-occurring mental and substance use disorders best occurs in a coordinated manner or when collaborating with a mental health provider who is familiar with SUDs and women's specific needs including trauma-informed mental health services. After initial assessment and stabilization, ongoing monitoring and reassessment are required as the woman progresses in her recovery.

#### *Key/Critical Content of Standards*

- Providers will demonstrate the ability to identify concurrent mental disorders, including eating disorders, and develop a process to have treatment for these disorders take place in a coordinated manner with treatment for SUDs and other health care.

- Collaboration with mental health providers is necessary for treatment planning, staffing and coordinated care that addresses both disorders (see Element 6: Treatment Planning).
- Providers will provide or provide referrals to trauma-specific mental health services for women who are seeking services for SUDs (see Element 14: Trauma/Violence).
- During treatment planning (see Element 6: Treatment Planning), providers will consider and will include as appropriate other effective strategies, such as nutrition, exercise, meditation and other nonpharmacological interventions (see Element 15: Life Skills).
- Women with recurrent addiction relapses, exacerbations and/or failure to improve in treatment will be reevaluated for the presence of a co-occurring mental disorder (see Element 3: Assessment).
- Women with serious and persistent mental illness will be treated using evidence-based practice models such as Integrated Dual Diagnosis Treatment (IDDT) or Comprehensive Continuous Integrated Systems of Care.
- Providers (see Element 7: Coordinated Case Management) will advocate for mental health services as indicated in the treatment plan (see Element 6: Treatment Planning) and encourage clients to use these services and follow through with recommended treatment, including taking medications as prescribed.
- Mental health services will be available to women across the lifespan. These services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences and age. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. Mental health services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Mental health services and referrals will address:
  - Personal barriers that keep women from treatment and recovery including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of treatment, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, discrimination, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
  - Other common fears about making life changes.

#### *Considerations for a Woman's Children and Family*

- Children who grow up in the care of adults with substance use or mental disorders may also experience mental disorders or psychological distress. This distress may be the result of emotional, physical or sexual abuse and/or neglect. Children of mothers with co-occurring



disorders may need to address their own psychological symptoms and/or disorders through psychological counseling and therapy in individual and/or group modalities.

- Providers will identify strategies to prevent or reduce intergenerational perpetuation of violence, substance use and mental disorders by reducing risk factors, increasing resiliency and improving emotional and behavioral health.

#### *Pregnancy/Perinatal Considerations*

- “All women will be evaluated for intrapartum exacerbations of psychiatric conditions and for postpartum depression and psychosis. The safety and well-being of infants and other children of women with active psychiatric symptoms or disorders must be assured” (AZ).
- “If medication treatment will be indicated for the treatment of pregnant women with co-occurring disorders, non-addicting and non-teratogenic medications are used” (AZ) (see Element 9: Medication-Assisted Treatment).
- For pregnant women being treated with psychotropic medications and for whom it is determined that detoxification is necessary, alternative medical or therapeutic interventions will be considered to address the mental disorder.

#### *Considerations for Women Involved in the Criminal Justice System*

- Providers will assist women who received treatment for mental health disorders while incarcerated to continue to receive mental health care after being released from incarceration.
- Providers will make an effort to obtain all treatment records for women who have been incarcerated.
- As women transition from incarceration, they will be screened for potential mental health disorders and exacerbation of symptoms as they address their SUDs and reenter the community.

### **Element 14: Trauma/Violence**

Trauma/violence is addressed or mentioned in 21 States’ women’s treatment standards. The existing State standards that address trauma/violence can be found in Table 14 in Appendix A.

#### *Description*

**Trauma/violence** services can be divided into two, overlapping categories: those that are *trauma informed* and those that are *trauma specific*. Given the high prevalence of histories of violence among women with SUDs, providing treatment in a trauma-informed environment is especially important. Trauma-informed services and organizations create safe, supportive environments that improve women’s treatment retention and proactively assist them in developing healthy coping strategies. Trauma-informed services require staff members who are trained to understand the multiple and complex links among violence, trauma and addiction; understand trauma-related symptoms as attempts to cope; understand that violence

and victimization play large and complex roles in the lives of most consumers in substance abuse and mental health services; and behave in ways that are not retraumatizing to women.

Trauma-specific services include individual and group services that directly address the effect of trauma and facilitate recovery and healing. All women should receive trauma-informed as well as trauma-specific services; women should not have to disclose their trauma history to receive trauma-specific services. Best practices for women's treatment include entering into every treatment relationship as if the woman has experienced trauma, regardless of whether trauma is disclosed (Clark et al., 2003; Covington, 2003; Finkelstein, 2004; Harris & Falot, 2001; Morrissey et al., 2005).

#### *Key/Critical Content of Standards*

- Safety planning for the woman and her children and related advocacy will be integrated into all aspects of service delivery (see Element 16: Advocacy).
- When providing trauma-informed services, programs will recognize that intimate partner violence is a critical element of treatment planning and safety is of paramount importance (see Element 6: Treatment Planning).
- Providers will help women develop healthy coping strategies to deal with past, present and future trauma. The direct recall of the woman's past traumatic experiences is not required to develop healthy coping strategies (see Element 13: Mental Health).
- All services will be delivered in a trauma-informed setting and provide safety from abuse and stalking by partners, family, other participants, visitors and staff (WI).
- Recent immigrants and returning combat veterans may have specialized needs that will be incorporated into the treatment plan. If appropriate, linkages will be made with local veterans' or refugees' services for coordination of care (see Element 21: Linkages With Social Services and the Child Welfare System and Element 7: Coordinated Case Management).
- Programs will conduct screening and assessment of trauma-related effects (see Element 2: Screening and Element 3: Assessment) and integrate trauma-specific content and approaches in SUD counseling sessions and mental health services, including medication, when necessary (see Element 13: Mental Health and Element 9: Medication-Assisted Treatment).
- Programs will demonstrate an understanding of the effects of traumatic experiences and the unique vulnerabilities of trauma survivors so that revictimization and misdiagnosis do not occur.
- A comprehensive staff training program will include the following elements: creating a trauma-informed and trauma-responsive environment, the role of trauma in treatment and recovery and issues of retraumatizing, sexuality, sexual abuse, family violence and parenting.
- Agencies will have written affiliations with rape crisis, sexual assault, veterans' health and domestic violence agencies for needed referrals and services.

- Trauma-informed and trauma-specific services will be available to women across the lifespan. These services will reflect multiple pathways to recovery based on an individual's unique strengths and her needs, preferences, experiences and age. They will be culturally fluent, nonjudgmental and respectful. Trauma-informed and trauma-specific services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations. Trauma services will address historical trauma and trauma resulting from racism, persecution or immigration.
- Trauma-informed and trauma-specific services will address:
  - Personal barriers that keep women from treatment and recovery including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of treatment, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
  - Other common fears about making life changes.

*Considerations for a Woman's Children and Family*

- Providers that treat children, youth, young adults and older adults will include the following services:
  - Identifying and treating children (including children who have parents in treatment but who are not themselves in treatment for an SUD) who have witnessed violence or suffered direct abuse or neglect and lack of nurturing (this may be accomplished through appropriate referrals).
  - Reporting suspected child or older adult abuse as mandated by the State.
  - Providing trauma-sensitive services that do not retraumatize children or older adults.
- Providers will ensure that family services are trauma informed and that trauma recovery linkages/services are integrated into the treatment model. The effects of trauma can have a significant impact on a woman's ability to parent, and specialized programs may be needed.
- Programs will provide onsite therapeutic child care/developmental activities and/or a written affiliation agreement with an outside agency to address children's needs (see Element 24: Child Care and Child Development Services and Element 17: Family Strengthening).

### *Pregnancy/Perinatal Considerations*

- All pregnant women will be screened for intimate violence.
- Pregnant women with histories of trauma will be supported to avoid retraumatization and develop healthy coping skills.

### *Considerations for Women Involved in the Criminal Justice System*

- Trauma services will be sensitive to and will address traumatic experiences that occurred before or during incarceration.
- Programs will acknowledge the retraumatization that often occurs via the standard operating practices (shackling, pat and body searches, cuffing and isolation).

## **Element 15: Life Skills**

Life skills are addressed or mentioned in 15 States' women's treatment standards. The existing State standards that address life skills can be found in Table 15 in Appendix A. The current State standards recognize that it is important to help women with SUDs to develop the life skills necessary for independent living and community integration. The standards describe *what* services should be provided as well as *when* they should be provided.

### *Description*

Alcohol and drug use disorders adversely affect every aspect of a woman's life. As part of the treatment and recovery process, service strategies should be established to address each area of impairment, including deficits in basic skills that support routine activities of daily living.

**Life skills** development is a process through which women are provided and encouraged to participate in services designed to nurture a range of skills needed for performance of everyday tasks, to attain self-sufficiency and to sustain independent living in the community. Strategies for skill development are structured to teach, train and motivate women to take more deliberate approaches in making decisions that affect their lives, their bodies, their families and their communities. Opportunities for development of life skills better equip women to identify and resolve problems that create risks for return to alcohol or drug use.

A woman's need for life skills development may fall within three broad categories: interpersonal skills, daily living skills and societal skills. Interpersonal skills are those abilities needed to support healthy interactions in relationships with others. Daily living skills consist of the abilities needed to access and use resources required to function efficiently and effectively within the immediate environment, such as at home or at work. Societal skills reflect those abilities needed to access, navigate and use systems of services and/or other resources in the community that support independent living and community integration. Strategies for life skills development are not ancillary services but are fundamental elements of treatment and recovery support service plans that guide care for alcohol and drug use disorders.

### *Key/Critical Content of Standards*

- Life skills training will address personal and systemic barriers that prevent participation or impede the development of skills necessary for independent functioning in the community. These may include:
  - Personal barriers that keep women from recovery including, but not limited to, fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, fears about confidentiality and linguistic or cultural barriers.
  - Systemic barriers to treatment and recovery such as cost of services, insurance requirements, waiting lists, lack of appropriate treatment (e.g., pregnant women, cultural/linguistic appropriate), discrimination,, shortages of quality child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), employment (see Element 20: Education and Employment/Vocational Support), and safe, affordable housing as well as conflicting demands from other systems, such as child welfare and TANF requirements (see Element 21: Linkages With Social Services and the Child Welfare System).
- At a minimum, the life skills assessment (see Element 3: Assessment) will address the following areas of skill development:
  - Interpersonal skills including, but not limited to, communication, assertiveness/self-advocacy, anger management, social skills and impulse control.
  - Daily living skills including, but not limited to, stress management, organizational skills, time management/structure, self-care, nutrition and healthy food preparation, housekeeping, household management, employment, driving, child care arrangement, grooming and clothing, recreation and leisure, budgeting/financial planning and banking, literacy and linguistic skills.
  - Societal skills including, but not limited to, systems access and navigation (transportation, healthcare, housing, legal services, etc.), financial support (access to TANF, Medicaid/health insurance, food stamps, child support, etc.), civic participation, compliance with laws and organizational policies, problem-solving and conflict resolution.
- Women will be full participants in the assessment process (see Element 3: Assessment) and in the development of strategies established to address needs for and barriers to life skills development (see Element 6: Treatment Planning).
- Age-appropriate and responsive life skills development will be available to women across the lifespan. Strategies to support life skills development will reflect multiple pathways to recovery based on an individual's unique strengths, as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations including women with learning difficulties.

- Both individual and group interventions will be used to support development of life skills, with ample opportunity provided for participation in experiential activities provided in the treatment environment.
- Opportunities to practice skill development in the treatment environment will be used to formalize linkages with other programs (nutrition, vocational, educational, financial institutions, transit system, etc.) to augment each woman's transition back into community life (see Element 22: Recovery and Community Support Services).
- Formal collaborative agreements with community-based, governmental and faith-based agencies and organizations, along with written program policies and procedures, will be established to enhance the availability of services necessary for life skills development (see Element 21: Linkages With Social Services and the Child Welfare System and Element 22: Recovery and Community Support Services).
- Services will be offered during times and in settings that take into account a woman's responsibilities to others under her care.

#### *Considerations for a Woman's Children and Family*

- Service planning for pregnant and parenting women will include strategies to assist women in identifying and addressing the functional requirements of daily life with children.
- Family sessions will address development of family life skills and establishment of clear roles and responsibilities.
- Providers should assist women in navigating the primary education system. Frequently, their children (based on past traumatization and physical and learning difficulties that may result from prenatal substance abuse exposure) will require special services in the school. Women should know the educational rights of their children or at least know how to obtain advocates and assistance in navigating this system.

#### *Pregnancy/Perinatal Considerations*

- Providers will accommodate the physical limitations and needs unique to pregnant women in regard to service planning for life skills development.

#### *Considerations for Women Involved in the Criminal Justice System*

- Assessment of life skills development needs will take into account the length of a woman's incarceration and the functional deficits that could be a direct result of her isolation from community living. When women cannot earn a living legally outside prison they are at risk of returning to illegal means of support.
- Mentoring and other recovery support services will be available to assist women in the actual performance of basic life skills during the period of transition from incarceration to community living (see Element 22: Recovery and Community Support Services).

#### *Additional Considerations*

- Life skills development may be directly provided by the woman's primary treatment or recovery support service provider; by a contract, volunteer or other service provider

formally affiliated with the primary service provider; or through referral to another community-based organization or agency (see Element 7: Coordinated Case Management).

## **Element 16: Advocacy**

Advocacy is addressed or mentioned in six States' women's treatment standards. The existing State standards that address advocacy can be found in Table 16 in Appendix A. States prescribe family advocacy in addition to advocacy for the woman (HI and MA). The current State standards and Treatment Improvement Protocol 27: *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998) recommend that advocacy be based on the client's individual needs. Advocacy is often defined as part of case management (CSAT, 2005; MA; TN; WI; Ashery, 1992). The *Comprehensive Model* (Werner, Young, Dennis, & Amatetti, 2007) discusses advocacy services for women and advocacy services for children. Advocacy services for women will assist them in negotiating the pathways, with a goal of empowerment and self-sufficiency. Advocacy services may include direct advocacy services, and providers will assist women in developing appropriate advocacy skills to ensure that they can negotiate for the needs of their children. Children will also be introduced to advocacy skills when it is developmentally appropriate.

### *Description*

**Advocacy** is the process of working in partnership with an individual or group of individuals and speaking out on their behalf in a way that represents their best interests. It can be used as a way to engage individuals and establish a trusting, positive relationship between the woman and service provider. Advocacy for women with SUDs and their children and families can occur at the individual, community and systems levels. At the individual participant level, advocacy is considered a key component of case management and encompasses negotiating and obtaining needed services for women throughout the treatment continuum, as well as empowering women to effectively advocate for services for themselves and their children and families.

### *Key/Critical Content of Standards*

- Advocacy will occur throughout the treatment continuum, be an explicit part of the treatment or life plan (see Element 6: Treatment Planning and Element 8: Continuing Care) and be carried out with an underlying goal of participant empowerment in which a woman is taught how to access services and effectively advocate for herself and her family. The role of the advocate for the individual participant will be clearly defined within the treatment agency, with one person assuming responsibility for identifying and working with the other agencies and service providers with whom a woman may be involved.
- Advocacy will be available to women across the lifespan. Advocacy services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs,

veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.

- Advocacy on behalf of the women will always be direct and professional and will always be geared toward achieving the goals established in the service or case plan (see Element 6: Treatment Planning).
- In most instances at the individual level, advocacy will be part of more specific coordinated case management activities (see Element 7: Coordinated Case Management). Advocacy will address the following areas:
  - Timely access to treatment for all women and priority access, in particular, for pregnant and parenting women.
  - Adequate resources for specialty programs and/or services that address the unique needs of special populations of women (i.e., teenagers, mature women, pregnant women, women with dependent children, women involved in the criminal justice system, women with co-occurring disorders, women living with HIV/AIDS, LGBT women).
  - Provision of an array of treatment-related support services that are essential to promoting treatment engagement and retention. These services may include, but are not limited to, child care (see Element 24: Child Care and Child Development Services), transportation (see Element 23: Transportation), parenting (see Element 18: Parenting Skills and Child Development Education), training and education (see Element 20: Education and Employment/Vocational Support), trauma and domestic violence services (see Element 14: Trauma/Violence), mental health services (see Element 13: Mental Health) and health services (see Element 12: Medical Care/Primary Health Care).
  - Access to appropriate services including length of stay and types and frequency of services. At the community and systems levels, the SSA (or appropriate body) may take the lead to advocate for needed policy and systems change in this area and will work with other agencies and entities (e.g., insurance companies) that can affect decisions about treatment availability. At the individual level, the provider should advocate for all necessary services (see: Element 7: Coordinated Case Management).
  - Legal issues and related court matters that include, but are not limited to, connecting individuals with court-ordered services; communicating with judges, attorneys and probation/parole officers about treatment progress; and/or assisting a woman with court-related requirements to address intimate partner violence.
  - Helping a woman develop the skills she needs to successfully transition back to the community, return to her parenting roles and responsibilities (if applicable) and secure needed community recovery support services (e.g., housing, employment) to sustain her recovery and self-sufficiency (see Element 15: Life Skills and Element 22: Recovery and Community Support Services).
  - The cost effectiveness and/or cost savings to the community and other service systems (e.g., criminal justice, child welfare) of providing comprehensive family-centered treatment services.



### *Considerations for a Woman's Children and Family*

- Advocacy for women with children will address family preservation and reunification issues including advocating for the child to be reunited with the mother while she is in treatment (where appropriate), communicating with child welfare about treatment progress and obtaining intensive home-based family services (see Element 21: Linkages With Social Services and the Child Welfare System).
- Advocacy for all pregnant and parenting women (including those involved in the criminal justice system) will recognize and acknowledge the family as a unit and, where appropriate, support family preservation and reunification. At times, this may mean supporting a woman's decision to relinquish parental rights. In addition to empowering a pregnant or parenting woman to advocate on her own behalf, providers will assist a mother in developing skills to advocate and negotiate for the needs of her children.
- The positive outcomes associated with the provision of comprehensive family-centered treatment and support services can be used as a leverage point for advocating that infants and young children accompany their mothers in treatment or be returned more quickly (provided the mother is doing well in treatment).

### *Pregnancy/Perinatal Considerations*

- Advocacy on behalf of pregnant women will center on priority access, provision of primary medical care (including prenatal care) and, on the system level, adequate funding for early intervention and support services to give pregnant women time (up to 3 months) to enter treatment.

### *Considerations for Women Involved in the Criminal Justice System*

- The State Agency will work with criminal justice officials to advocate for incarcerated women to have access to a full range of treatment options including medication-assisted treatment (see Element 9: Medication-Assisted Treatment).
- Providers may seek to reduce the stigma faced by women with SUDs and criminal justice involvement. Providers may advocate for access to a range of services (i.e., employment, housing) for recovering women with felony convictions.

### *Additional Considerations*

- Even when advocating for participants, the provider must respect system boundaries. While advocating for certain participants, providers must remember that the concern for clients will not override goals of public health and safety.
- States and providers may choose to create a recovery specialist position to perform the following services:
  - Facilitate immediate access to assessment, treatment and support services by assisting the participant in navigating the resources available and removing barriers.

- Maintain a supportive monitoring relationship with the woman by focusing on engagement and retention in treatment and serving as a liaison to the courts, child protection, SUD treatment providers and other key service providers.
- Serve in the role as a mentor and monitor to keep the participant focused on entering recovery.
- Advocates for women with SUDs must be aware of the differences between advocacy and lobbying at the community and systems levels. Lobbying may be prohibited for some treatment providers.
- If State agencies fund treatment providers to advocate, potential conflicts or tensions may arise as providers push to change policies, procedures, rules or regulations (e.g., advocating to keep a woman in treatment longer than the “rules” allow). The State agency or substance abuse treatment system may have to adjust or modify the rules as needed, based on data, evaluations and the experiences of providers, consumers and the SSA.
- Advocacy will address access to medication-assisted treatment for women for whom this is the best indicated treatment.

### **Element 17: Family Strengthening**

Family strengthening is addressed or mentioned in 24 States’ women’s treatment standards. The existing State standards that address family strengthening can be found in Table 17 in Appendix A. In their standards, States express their commitment to family-based therapy. States describe the ways that a woman’s family can be integrated into her treatment program (AZ, AR, CA, CO, CT, HI, ID, MA, MO, NJ, TN, TX, VT), and specifically prescribe whether a woman can bring her children into treatment with, and under what circumstances this should be allowable (AZ, DC, NC, TX). The standards also dictate what services should be available for the family of a woman in SUD treatment (AZ, AR, CA, FL, GA, ID, MA, MO, NJ, OK, OR, TX).

#### *Description*

**Family strengthening** is a strategic approach to building a family support network for women, improving their parenting and resources and improving family dynamics. Family dynamics and support play an important role in recovery for most women with SUDs. For most family-based services, “family” is defined by the woman. Assisting a woman in establishing communication and safety strategies for interacting with unsupportive family members (e.g., estranged spouse, formerly abusive parent) can be part of family strengthening. Family-strengthening services may include specific treatment plan objectives, counseling, communication workshops, family groups, family case plans and structured family engagement activities.

#### *Key/Critical Content of Standards*

- Services will be family centered and family focused. “A family-centered/focused approach means that families are a family of choice defined by the woman themselves. Families are responsible for their children and are respected and listened to as we support them in meeting their needs, reducing system barriers, and promoting changes that can be sustained overtime. The goal of a family-centered team and system is to move away from

the focus of a single woman represented in systems, to a focus on the functioning, safety, and well being of the family as a whole” (WI).

- Services will involve the woman and her family. The family’s involvement in the process is “empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives including decisions made about their service plans” (WI).
- Services will build on formal, natural and community supports. Services will recognize and use “all resources in the woman’s community creatively and flexibly, including formal and informal supports and service systems. Every attempt will be made to include the families’ relatives, neighbors, friends, faith community, co-workers or anyone the woman would like to include in the team process. Ultimately, families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all” (WI).
- Family-strengthening services will be strength based and will build “on the family’s unique qualities and identified strengths which can then be used to support strategies to meet the family’s needs. Strengths can also be found in the family’s environment through their informal support networks as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family’s initial needs are met and new needs emerge with strategies discussed and implemented” (WI).
- Programs will provide unconditional care. The service team will be responsible for adapting to the needs of the family, not vice versa. If difficulties arise, the individualized services and supports will change to meet the family’s needs.
- “Sometimes re-connecting with the woman’s traditional family may not be supportive of the recovery process, especially if family members have addiction problems or a history of domestic violence or abuse. Helping women to assess dangers, as well as support systems, is part of the recovery process. Sometimes when the newly sober individual resumes the role of partner, parent, or child without the necessary support, the stress can trigger a relapse. This is especially true for parents who have to balance their own recovery while parenting their children who have been affected by their parent’s addiction. In some cases, parents may lose and not regain custody of their children and have to deal with the pain of family loss and bereavement. These family issues are part of the woman’s recovery and must be addressed in order to avoid the high risk of relapse” (MA).
- Family-strengthening services will be available to women across the lifespan. They will reflect multiple pathways to recovery based on an individual’s unique strengths as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. These services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Family-strengthening services will address personal, familial and systemic barriers that prevent participation including fear of change or retribution, cost or transportation.

- In the event no family members are available, participants will be encouraged to develop a peer network that provides the supportive relationships common among family members.

#### *Considerations for a Woman's Children and Family*

- See above standards for women's families.

#### *Pregnancy/Perinatal Considerations*

- Providers will assist pregnant women who are in treatment and recovery in developing a birth plan with an appropriate medical provider who knows of the woman's substance use history and can integrate that knowledge into the birth plan.
- "Infants [will] accompany their mothers when services are provided in a supervised residential setting, unless contraindicated by medical, legal or other reasons, which are documented in the woman's record" (DC).
- In the event an infant remains in a medical facility while the mother participates in services, the program will ensure, whenever clinically appropriate and possible within the confines of the program, that there will be daily visit/contact between the mother and infant. "Any medical or therapeutic reasons that prevent such daily contact [will] be documented in the woman's record and shall be accompanied with plans to improve parent-child bonds during the separation and to restart contact" (DC).
- Clinicians who prevent parents from regular contact with their children shall provide written justification to the Department as to why contact is detrimental for the parent or child. A plan will be made to:
  - Ensure that the woman will have regular contact with her infant, if they are separated.
  - Ensure that the woman has the knowledge needed to make an informed choice about breast-feeding when clinically indicated.

#### *Women Involved in the Criminal Justice System*

- Providers will identify family issues and create linkages between these and involvement in the criminal justice system, if appropriate.
- Services to a woman involved in the criminal justice system will include the woman and her family whenever possible. The family's involvement in the process will be "empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision making process affecting their lives including decisions made about their service plans" (WI). This component will strengthen the family bond and make for a smoother transition on reintegration into the community.
- Providers will deliver outreach and engagement services to encourage participation from appropriate family members as identified by the woman (see Element 1: Outreach and Engagement).

## Element 18: Parenting Skills and Child Development Education

Parenting skills and child development education are addressed or mentioned in 24 States' women's treatment standards. The existing State standards that address parenting skills and child development education can be found in Table 18 in Appendix A.

### *Description*

Treatment for women with children is optimized when the women's roles as mothers are acknowledged and incorporated throughout treatment. **Parenting skills** including identification of feelings, empathy, active listening, boundary setting and appropriate discipline are skills that women can employ with themselves as well as their children. Parenting skills are improved through education about child development and care and skill-building training. Counseling, modeling and problem-solving in specific instances of parent-child interactions as well as grief and loss counseling regarding past parenting experiences also help improve parenting. Women with SUDs with histories of child abuse and neglect often have specialized parenting skill and support needs.

### *Key/Critical Content of Standards*

- Educational services that address parenting skills and/or child development will be aimed at enhancing the parent's sense of competence, whether the woman is a custodial or noncustodial parent, and will support the parent-child relationship. These services can encourage parents to stay in treatment, increase their ability to avoid relapse and reduce the risk that their children will use or abuse substances.
- The program will provide directly or by referral evidence-based or best practice parenting curricula for women.
- An evidence-based tool will be used to measure parenting attitudes and change (see Element 3: Assessment).
- "Issues identified in the screening tool will help to develop treatment planning around parent issues" (NJ) (see Element 2: Screening and Element 6: Treatment Planning).
- "Facilities providing services to women and children will develop and implement policies and procedures to insure that mothers engage in meaningful age-appropriate activities with their children" (NJ).
- Providers will help women augment their parenting skills by including parenting skills and child development education activities as components of the treatment plan (see Element 6: Treatment Planning). These activities will be clinically appropriate and may include child care laboratory, formal instruction in a classroom setting, group discussion and formalized staff interaction.
- Providers will "[educate] the mother or caregiver about ways to promote the child(ren)'s health, safety, and development" (FL).
- Parenting skills and child development education will be available to women across the lifespan. These services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma

sensitive and respectful. Parenting skills and child development education must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.

- Parenting skills and child development education will address personal and systemic barriers that prevent participation including, but not limited to, fear of the loss of custody, lack of transportation, conflicting responsibilities and cost of services. Providers will document that treatment professionals shall have training in the following:
  - Child development and age-appropriate behaviors.
  - Parenting skills appropriate to infants, toddlers, and preschool and school-age children.
  - Strategies for working with children who have prenatal and/or environmental exposure to alcohol or drug use by parents or other caregivers.
- Child development staff will provide the mothers with supportive role modeling.
- Services will be provided in a trauma-informed and trauma-sensitive manner. Talking about parenting or child welfare may trigger trauma responses for women who have experienced child neglect or abuse and with child welfare history themselves (see Element 14: Trauma/Violence).
- Opportunities will be provided during the treatment process for providers to observe parent-child, staff-child and peer interactions to document this process in the clinical record and to discuss observations with the parent. Feedback and discussion with the parent will note both positive and challenging interactions and may be used for developmental goal setting for the child and the parent.
- When parental rights are terminated and the relationship with children can continue, opportunities will be made available for the woman to address her relationship with her children, as this may be an important step in the treatment and recovery process.
- Grief counseling will be made available to all women who have lost a child regardless of how or when that loss occurred.
- Even if the mother is not the primary caregiver, the programs will provide or advocate for the following services for the mother: parenting education; anticipatory guidance about possible child reactions; information about normal growth and development and information about the effects of substance exposure; education about child-soothing techniques; and feedback about mother/caregiver-child interactions.
- During noncustodial visitations with the woman's children, providers will create supportive environments for women to interact appropriately with their children in a supervised arena.
- Providers should account for the possibility of a woman having FASD herself, making it difficult to adhere to/achieve requirements for reunification (or recovery success in general). Without the right supports in place for these women, the traditional system is a set up for failure. However, if adaptations are made and supports provided, these women may be good mothers and may be able to care for and be involved with their children.

#### *Considerations for a Woman's Children and Family*

- See above standards for women's families.

### *Pregnancy/Perinatal Considerations*

- “When possible, prior to discharge of the newborn, a home assessment will be conducted. It will include:
  - An environmental and family assessment focused on the safety and quality of care that is or will be provided for the child including the following:
    - The mother’s or caregiver’s ability to care for the child’s unique needs in the home environment;
    - Strengths and needs relating to family composition;
    - Parenting capabilities of those persons in the home with primary child care responsibilities; [and]
    - Education needs of the mother and caregiver for any special health related care the child may require” (FL).

### *Women Involved in the Criminal Justice System*

- Providers will understand the legal issues regarding visitation and the Adoption and Safe Families Act of 1997 (ASFA) and will help women to understand them.
- Providers will offer parenting education programs for women involved with the criminal justice system even if they do not have custody of their child(ren).
- Family strengthening services will assist families to recover from the effects of separation and trauma resulting from incarceration.
- Incarcerated parents will be supported to maintain a relationship with their child as appropriate. Materials for innovative approaches such as letters and drawings or making audio-tapes of favorite stories will be offered.

## **Element 19: Housing Supports and Assistance**

Housing supports and assistance are addressed or mentioned in 16 States’ women’s treatment standards. The existing State standards that address housing supports and assistance can be found in Table 19 in Appendix A. In their standards, the states describe the different kinds of housing that providers may offer including transitional housing, housing for residential treatment and aftercare housing. States also define the services that must be provided by each type of housing.

### *Description*

Access to safe, affordable and substance-free housing is a critical component of treatment and ongoing recovery support. In developing treatment, life and other care plans for the woman, the provider will review environmental circumstances to determine the condition of housing and whether it is safe, affordable and drug free. Safe housing is an essential component of recovery that must be addressed by women in any level of treatment including both residential and out-patient treatment. Creating a viable plan for obtaining affordable, safe, drug-free housing needs to be part of early treatment planning and housing and must be in place before

discharge from residential programs. **Housing support and assistance** will include, but will not be limited to, helping a woman access transitional and/or permanent housing, develop adequate independent living skills and maintain her housing and a substance-free lifestyle.

#### *Key/Critical Content of Standards*

- Housing support includes assistance not only in obtaining safe, affordable, permanent housing, but also in developing adequate life skills such as budgeting; housekeeping and maintenance skills; ensuring timely payment of rent and utilities; and child-proofing the house (see Element 15: Life Skills). Housing support services provide the necessary support and encouragement so that the woman can adjust to a substance-free lifestyle and manage activities of daily living to move toward independent housing and life management.
- Housing assistance includes help with accessing housing subsidy programs, completing housing applications, working with property owners or assistance programs (see Element 16: Advocacy), transportation (see Element 23: Transportation), addressing credit and eviction challenges, understanding and complying with the housing program's regulations. Periodic follow up with the woman will be conducted to ensure she is in compliance with the housing rules and regulations and the facility is in appropriate and satisfactory condition.
- If transitional housing is provided, it will include coordinated case management (see Element 7: Coordinated Case Management) and other needed supports (e.g., obtaining permanent housing, independent living skills).
- Housing supports and assistance will be available to women across the lifespan. These services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. Housing supports and assistance must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Housing support services will address personal and systemic barriers to accessing safe, affordable, substance-free housing.
- Providers seeking to provide comprehensive care must address the issue of where a woman resides during and after treatment, including during residential treatment, and must make provisions for the adequate housing part of the program's continuum of care (see Element 6: Treatment Planning and Element 22: Recovery and Community Support Services).

#### *Considerations for a Woman's Children and Family*

- Transitional and/or permanent housing will be family oriented and sensitive to family needs and able to accommodate women with more than one child and women with minor children of all ages.
- Priority for housing will be given to pregnant women, women with dependent children and women who are homeless and are coming out of treatment.



- Providers will refer pregnant and parenting women, women who are homeless and women who are currently living in a domestic violence situation to interim safe housing while awaiting available residential treatment beds.
- Within housing associated with treatment programs, there will be an expectation of an alcohol and drugfree environment and ongoing or continuing care associated with substance use, mental health or co-occurring disorders to address relapse prevention.

#### *Considerations for Women Involved in the Criminal Justice System*

- Providers will be aware of Federal, State and local regulations on public housing and will be prepared to find alternative sources of housing for women in the criminal justice system as Federal public housing prohibits women from admission if they have a drug-related felony charge.
- Providers will maintain a list of transitional housing or safe, sober housing that can be accessed by women who have recently been released from incarceration.
- Within housing associated with treatment programs, there will be an expectation of ongoing or continuing care associated with substance use, mental health or co-occurring disorders to address relapse prevention and to ease the transition from institution to community.
- When women are released from incarceration, providers will help them find housing in a community where they are likely to be able to use varying modes of transportation in the community. Providers will also help women learn how to access transportation (see Element 23: Transportation).

#### *Additional Considerations*

- Providers will develop agreements with housing providers to increase access for women.
- Increasing available affordable, safe housing in the community may be part of a larger systems advocacy agenda (see Element 16: Advocacy).
- The Oxford House model (reasonable rent, living with other people in recovery) for alcohol- and drug-free housing and the Corporation for Supportive Housing approach may offer viable supportive housing options appropriate for many women and families in treatment.

### **Element 20: Education and Employment/Vocational Support**

Education and employment/vocational support are addressed or mentioned in 19 States' women's treatment standards. The existing State standards that address education and employment/vocational support can be found in Table 20 in Appendix A.

#### *Description*

**Education and employment/vocational support** services are important elements of recovery for the majority of women with SUDs. Quality employment can provide women with greater economic security and self-esteem that contribute to recovery and enhanced capacity to provide for their family's well-being. Yet women with SUDs often have significant barriers to

employment that require specialized employment counseling, job development services or advocacy with employers. Education and employment/vocational support consist of strategies to assist women in entering and remaining in the workforce and in achieving resilience, self-sufficiency and improved quality of life for themselves, their families and their communities. Such support may include educational and vocational screening and assessment, prevocational counseling, basic work skills training, employment/vocational counseling, training and educational programs and employment and vocational services.

This broad array of supports serves five essential functions:

- 1) Provide the woman with information about the job market, the skills and experience necessary to obtain and maintain work and the types of stressors and rewards associated with different jobs.
- 2) Help the woman develop a realistic view of her skills, abilities and limitations.
- 3) Teach the woman basic problem-solving and coping skills.
- 4) Help the woman develop or maintain motivation for vocational services and employment.
- 5) Assist the woman in obtaining educational services, skills training or the necessary entitlements to obtain education and training (CSAT, 2000).

#### *Key/Critical Content of Standards*

- Education and employment/vocational supports that are appropriate to the woman's needs and abilities must be clearly integrated into the overall treatment plan, initiated early in the treatment process and evaluated and adjusted as needed (see Element 6: Treatment Planning).
- Economic issues continue beyond treatment; recovery support and discharge planning will address economic hardship, barriers to meeting multiple responsibilities, employment retention and career advancement strategies (see Element 22: Recovery and Community Support Services).
- To effectively provide education and employment/vocational services, detailed formal linkage agreements with community-based vocational, educational and employment services will be established. Planning needs will include collaborations with workforce development partners and community colleges for onsite training and assistance. In addition, treatment agencies and providers will identify and establish relationships with potential community employers that will actively recruit, hire and support women in recovery (see Element 1: Outreach and Engagement and Element 22: Recovery and Community Support Services). This is especially true for women who are involved in the criminal justice system. Furthermore, effective linkages with child welfare and TANF agencies are needed (as appropriate) to coordinate case planning and leverage all available resources (see Element 21: Linkages With Social Services and the Child Welfare System).
- Assessment will be conducted to determine the kinds of vocational services the woman needs and to develop an appropriate vocational component to the treatment plan. Assessment will explore the woman's vocational and educational history and employment-related education and experience; identify the woman's associated capacities and special skills, as well as limitations (e.g., visual and hearing impairments, mental health problems,

literacy and learning abilities); assess her psychological willingness and readiness to enter the workforce; determine what services and referrals are needed to help her attain appropriate vocational and educational outcomes; identify the necessary resources to make employment feasible for the individual (e.g., child care, transportation, mental health services); and determine whether further assessment is needed by a trained vocational rehabilitation/employment counselor to develop this component of the treatment plan (see Element 3: Assessment).

- A more extensive functional assessment may be necessary to match clients with work they can perform successfully. A functional assessment evaluates the individuals' performance of key functions in five areas: living, managing finances, learning, working and interacting socially. It aims to identify existing functional capabilities and capacities (e.g., job readiness, reading, writing, computer skills, ability to relate to supervisors and co-workers) and functional limitations (physical, psychological or social), along with the socio-cultural or environmental conditions that might impede or enhance the woman's success (see Element 3: Assessment).
- Educational services may include literacy, subject-based learning, mental/cognitive and skill development, General Education Diploma (GED) classes, English as a Second Language (ESL) classes, college readiness courses and computer and vocational skills.
- Prevocational counseling activities will be available directly or by referral. They will be provided before an individual begins the job-seeking process and may include psycho-social-spiritual development (e.g., role playing, values clarification), career exploration (e.g., visit community resources, read about employment trends) and structured activity (e.g., volunteer work, vocational tests). This may also include phone skills and transportation (see Element 23: Transportation).
- Basic life skills training may include life skills training programs (see Element 15: Life Skills), job readiness, work adjustment and mentoring.
- Employment readiness services will be available directly or by referral. They help individuals gain the specific skills, attitudes and motivation needed to obtain and maintain employment and may include interpersonal training on topics such as appropriate work place behaviors (including clothing), problem-solving, managing multiple responsibilities, resume and interview skills and job-seeking strategies.
- Educational and training programs will be available directly or by referral. They will include, but will not be limited to, school-to-work transition programs, on-the-job training, apprenticeship programs, technical schools and colleges, community-sponsored adult education and colleges and universities.
- Employment and vocational services will be available directly or by referral. They will include, but will not be limited to, the development of an employment plan with realistic goals and objectives, removal of employment barriers, job-seeking skills, job training, job referrals, job development and placement approaches, supported work programs (e.g., job coaching, mentoring), job retention (e.g., peer alumni support groups) and advancement and community resource utilization. Emphasis will be placed on job retention and providing support for both the women and employers.

- Education and employment/vocational support services will be available to women across the lifespan. These services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. Education and employment/vocational support must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Education and employment/vocational support services will remove personal and systemic barriers to participation including linguistic or cultural barriers, discrimination, absence of child care (see Element 24: Child Care and Child Development Services) and lack of transportation (see Element 23: Transportation).

#### *Considerations for a Woman's Children and Family*

- Providers will recognize that reliable child care (see Element 24: Child Care and Child Development Services) is particularly essential for women entering the workforce and will assist the woman in finding this service.
- Women will be assisted in developing healthy coping skills and balancing the demands of recovery and self-care, parenting and employment.

#### *Pregnancy/Perinatal Considerations*

- Providers will directly or by referral help working pregnant women to ensure job security to maximize the potential for them to have a job on returning from maternity leave.
- Providers will be aware of any Federal or State rules or regulations regarding work requirements and the effect that pregnancy has on these requirements, with specific emphasis on knowledge of TANF.

#### *Considerations for Women Involved in the Criminal Justice System*

- Other legal or regulatory factors may affect participation in employment plans and treatment plans. Some clients may be required or mandated to perform certain activities by the courts or probation and parole. Welfare-to-work regulations may impose other conditions the client must fulfill. Depending on legal or regulatory factors providers may need to adopt specific strategies to support, guide and encourage women as they seek to comply with and meet the demands of the employment plan and external forces. In addition, providers may need to consult with or refer clients to a trained vocational rehabilitation/employment counselor and job developers because of the difficulty of finding gainful employment after being involved with the criminal justice system, particularly if the woman has been convicted of committing a felony.
- After women have been released from incarceration, providers will support women who want to continue their education and/or identify potential learning difficulties that may have contributed to their involvement with the criminal justice system.

### *Additional Considerations*

- While providers are not expected to achieve complete mastery of vocational counseling, they will acquire at least rudimentary skills in providing vocational services and be able to communicate with women on employment/educational objectives and should be able to recognize when their clients should be referred to a vocational rehabilitation counselor.

## **Element 21: Linkages With Social Services and the Child Welfare System**

Linkages with social services and the child welfare system are addressed or mentioned in 19 States' women's treatment standards. The existing State standards that address linkages with social services and the child welfare system can be found in Table 21 in Appendix A. Standards that mention linkages recommend co-located or interdisciplinary staff (FL, GA). Linkages with social services and the child welfare system allow for shared continuity of purpose and consistent treatment plans for the woman. *Screening and Assessment for Family Engagement, Retention, and Recovery* (Young, Nakashian, Yeh, & Amatetti, 2007), developed by the National Center for Substance Abuse and Child Welfare, emphasizes the importance of cross-system collaboration and provides concrete suggestions on how to do so.

### *Description*

**Linkages with social services and the child welfare system** play critical roles in the lives of many women entering treatment. Treatment agencies will coordinate services with collateral agencies as they can play a critical role in providing support during a woman's recovery process.

Many parenting women entering treatment are involved with the child welfare agency and family/dependency court to determine whether their children may safely remain in their care. Many women in treatment have requirements ordered by the court and monitored by the child welfare agency to maintain their parenting role or to reunite with children who may have been removed from their custody. Treatment providers have a responsibility to help women meet their requirements within the timelines set by Federal and State laws for a mother to resume parenting responsibilities. This effort includes assisting mothers in maintaining their visitation schedules if a child has been removed from the mother's custody. Child welfare case plan requirements often include reports on progress that is being made toward treatment goals, completion of parenting and anger management programs, supervised child visits, obtaining or maintaining safe housing, drug testing and court appearances. Communication among the woman, treatment providers, child welfare workers, the mother's legal advocates and the dependency court helps the woman meet these goals.

### *Key/Critical Content of Standards*

- Substance abuse treatment professionals will be cross-trained in allied systems including child welfare, mental health, court and TANF agencies. Training components will include operations, philosophies, techniques, mandates and limitations of the other agencies' systems.

- Staff working in the alcohol and drug service system will receive specialized training that addresses at least the following:
  - State definitions of child maltreatment.
  - The role of the treatment provider in reporting suspected abuse or neglect. Alcohol and drug services staff will understand and comply with State laws regarding the reporting of child abuse and neglect.
  - Benefits from addressing family dynamics and potential child maltreatment when working with a parent who has an SUD.
  - Consequences for children whose parents have SUDs (see Element 24: Child Care and Child Development Services).
  - Family issues that arise when parents are involved with the child welfare system (see Element 17: Family Strengthening).
  - The continuum of child welfare activities, processes and timetables. Staff will understand that a parent can have an open child welfare case and still have custody of children (these are often referred to as “in home” services).
  - The continuum of State or district family court systems, processes and timetable, including the roles of judges or magistrates, mediators, court appointed special advocates and attorneys.
  - Ways treatment staff can help parents prepare for child welfare and court reviews.
  - How the ASFA requirements influence decisions regarding treatment.
- State agencies and substance abuse treatment providers will offer cross-training in SUDs and treatment to child welfare, mental health, court and TANF agencies/providers. Training components will include operations, philosophies, techniques, mandates and limitations of the other agencies’ systems (see Element 1: Outreach and Engagement).
- Staff development will also include training and support in learning how to work with colleagues from allied systems, including how to share confidential information, develop coordinated or uniform case and treatment plans, share decision-making and work as members of multidisciplinary teams.
- Providers will assist women in establishing eligibility for Federal, State and local programs that provide health services (see Element 12: Medical Care/Primary Health Care), mental health services (see Element 13: Mental Health), housing services (see Element 19: Housing Supports and Assistance), employment services, educational services (see Element 20: Education and Employment/Vocational Support) or other children’s and social services.
- The SSA will collaborate with providers to conduct outreach (see Element 1: Outreach and Engagement) to help child welfare staff in their decision-making roles involving families that have been affected by SUDs. Providers will help child welfare staff to understand the following:
  - The fundamentals of SUDs, the implications of those disorders on child safety and well-being and the potential for effective treatment.
  - The SUD treatment process and its relationship to ASFA requirements and timeframes.
  - How their local alcohol and drug service system works and the nature of local assessment and treatment services.

- The ways that SUDs put children at risk and the ways that the child welfare system must respond to those risks, including ASFA requirements.
- Development and implementation of protocols for screening family members for possible SUDs and documenting results in case files.
- Treatment providers will formalize community relationships with social services, law enforcement, TANF agencies and child welfare agencies. When possible, these linkages will allow for shared continuity of purpose and design and consistent treatment plans across agencies. Formal linkage agreements or Memoranda of Understanding (MOUs) will be developed to allow for information sharing and further frontline collaboration between systems and programs.
- Treatment providers will share responsibility with child welfare, court, mental health and other identified social service systems to:
  - Facilitate the engagement of families by establishing joint policies and procedures for sharing information regarding screening (see Element 2: Screening), assessment (see Element 3: Assessment) and treatment and case planning (see Element 6: Treatment Planning and Element 7: Coordinated Case Management).
  - Ensure that case plans and court orders (when relevant) for children and families are developed collaboratively with child welfare, court, mental health, substance abuse and other identified social service systems. Providers will collaborate with allied providers to create a context in which staff from each system can actively help families engage and succeed in services.
  - Develop indicators of progress that meet the needs, requirements and missions of each system and that focus on the entire family.
  - Co-locate services and programs when possible. Co-location provides opportunities for professionals to learn about other systems and to develop more complete understanding about family strengths and problems.
- Outpatient and other appropriate services will be available to ensure that families, women leaving residential services, will have access to the complete continuum of care necessary for their preservation and for the parents' treatment and recovery (see Element 22: Recovery and Community Support Services).
- Linkages to onsite or offsite mental health services (see Element 13: Mental Health), necessary health (see Element 12: Medical Care/Primary Health Care) and social services (outpatient primary/pediatric care, Head Start, afterschool programs, early intervention, domestic violence programs, etc.) and opioid treatment services (see Element 9: Medication-Assisted Treatment) will be provided.
- The SSA and providers will maintain an updated list of community resources, including legal aid, educational resources and other supportive services.
- Providers will develop agreements with the parent and their child welfare workers for parents whose children are involved with the child welfare system for the following:
  - For women whose children accompany them to a residential program, providers will :
    - Conduct an onsite visit (if geographically possible) or conference call with the child welfare worker within 2 weeks of admission.

- Provide the child welfare worker with a copy of the woman’s Individual Service Plan (ISP) on admission and an updated ISP 1 week before the court date.
- Monitor the schedule of court dates.
- Request information from child’s previous caregiver regarding the child’s current eating, sleeping and behavior patterns as well as medical status.
- Maintain information regarding transportation arrangements and funding availability for court dates, relocation and visitation.
- Maintain adequate supplies, clothing and medications for the child.
- Have contingency plans and the ability to get a court order for child abandonment, kidnapping should the need arise.
- For women whose children do not accompany them to a residential program:
  - Conduct an onsite visit (if geographically possible) or conference call in 2 weeks of admission with the child welfare worker to discuss proposed placement of child with mother.
  - Establish phone contact between the woman and her children and visitation for children to the treatment center if geographically feasible.
  - Provide the child welfare worker with a copy of the ISP on admission and an updated ISP 1 week before the court date.
  - Monitor the schedule of court dates.
  - Request information from the child’s previous caregiver regarding the child’s current eating, sleeping and behavior patterns as well as medical status.
  - Maintain information regarding transportation arrangements and funding availability for court dates, relocation and visitation.
  - Provide information regarding reimbursement for onsite/overnight visits by children.
- Referrals for children and family members of women in treatment may include, but will not be limited to, food banks, child well-being screening (see Element 2: Screening), budgeting assistance (see Element 15: Life Skills) and parent-child attachment activities (see Element 17: Family Strengthening).
- Parenting women entering treatment who are not involved in the child welfare system may also require service linkages (e.g., WIC, TANF).
- For adolescents who are in treatment for an SUD, providers will maintain linkages with schools and other youth-serving systems involved in the adolescent’s care and encourage family involvement as much as is clinically appropriate. They will also have full knowledge of the legal issues in their State specific to serving adolescents (e.g., can adolescents sign themselves back into treatment).

*Pregnancy/Perinatal Considerations*

- The SSA will work with its partners to ensure that pregnant women receive prenatal care and treatment for SUDs without fear of prosecution or loss of custody of their children.



### *Considerations for Women Involved in the Criminal Justice System*

- Providers will have policies and procedures to address the needs of women entering treatment who are experiencing legal problems, including custody issues, civil actions, criminal charges and probation and parole.

### *Additional Considerations*

- TANF provides assistance and work opportunities to needy families by granting States the Federal funds and wide flexibility to develop and implement their own welfare programs. SSAs will work with social service agencies to address the needs of TANF eligible families with SUDs.

## **Element 22: Recovery and Community Support Services (including Faith-Based Organization Support)**

Recovery and community support services (including faith-based organization support) are addressed or mentioned in 19 States' women's treatment standards. The existing State standards that address recovery and community support services (including faith-based organization support) can be found in Table 22 in Appendix A. Some State standards simply require programs to encourage participants to become involved in Recovery Support Services (AR, MA), others require programs to provide those services, or to provide referrals to those services (CA, CO, DC, FL, GA, HI, NJ, SC, TX, VT, WA). States also define what services are considered part of Recovery Supports (CT, GA, NV). Types of Recovery supports mentioned in the standards include self-help/support groups (AZ, AR, CA, CT, GA, ID, NV, NJ, OR, SC) and faith-based supports (CT, ID).

### *Description*

**Recovery and community support services** are specific services used to extend care for alcohol and drug use disorders, beyond the goal of abstinence, to that of full reengagement with family, friends and community, based on resilience, health and hope. Recovery and community support services can encompass a wide range of activities that may be provided at any level of care, as well as across levels of care. These are not clinical treatment services but may be provided by professionals, in addition to peers, volunteers and/or other community partners.

Recovery and community support services help women and their family's access formal as well as natural and informal supports and service systems. Based on the woman's individualized needs, these services may encompass all aspects of her life, including housing, social networks, employment, education, mental health and healthcare treatment and family supports. Recovery and community support may include crisis intervention, case management, home visiting, linkages to community-based programs, and child care and advocacy as well as exposure and access to self-help programs, peer- and faith-based support and other supportive networks that the woman identifies. Transportation, monitoring and outreach, parent education and child development, employment services and job training are also examples of community and recovery support services.

*Key/Critical Content of Standards:*

- A woman-centered assessment process and service plan will guide the provision of recovery and community support services.
- To the extent possible, service provision will be based on the choices and preferences of the woman and her family that are identified as necessary to bridge the gap between treatment and life in the community.
- Recovery and community support services may be provided before treatment as an adjunct to current treatment or at discharge from treatment.
- Recovery and community support services will reflect the principles of a recovery-oriented system of care, and the recovery oriented system of care elements (CSAT, 2007) including:
  - Person centered;
  - Family, peer and other ally involvement;
  - Individualized and comprehensive treatment;
  - Community based;
  - Continuum of care;
  - Partnership-consultant relationships;
  - Strength based;
  - Culturally fluent;
  - Responsive to personal belief systems;
  - Involvement of recovering individuals and their families;
  - Coordinated services across systems;
  - Research based and outcomes driven;
  - Ongoing monitoring and outreach; and
  - Adequate and flexible financing.
- Recovery and community support will include individual, group and family activities that are relevant to each woman's individualized life circumstances.
- Recovery and community support services will be available to women across the lifespan. These services will reflect multiple pathways to recovery based on an individual's unique strengths as well as her needs, preferences, experiences, age, sexual and spiritual orientation and family circumstances. They will be culturally fluent, nonjudgmental, trauma sensitive and respectful. Recovery and community support services must reflect a commitment to serving women of color, women who are homeless, linguistic minorities, women with HIV/AIDS, women who inject drugs, veterans, LGBT women and women with disabilities. Services will be adapted for specific populations.
- Recovery and community support activities will encourage personal recognition for change, self-determination, self-acceptance and regaining self-belief.
- Women will have the authority to participate in all decision-making processes that affect their lives and will be educated and supported in this regard.
- Recovery and community support services will include opportunities for positive experiences for women.

- Programs will encourage self-esteem and self-efficacy through identification and acknowledgment of positive experiences and accomplishments through client recognition and contingency management.
- Programs will provide creative, experiential opportunities for women to take as much responsibility for their own lives as possible.
- Programs will provide opportunities for women to be supported in developing relationships with other women and persons in recovery who can offer support, friendship and companionship in pursuing safe and sober leisure activities and who can serve as positive role models.
- Programs will have formal MOUs or agreements with community-based organizations that provide recovery support services.
- Programs will have linkages with positive role models and community mentors. Providers will invite women in recovery to talk to program participants, provide recovery coaches, provide access to peer-driven recovery mutual-support services (e.g., Alcoholics Anonymous, Narcotics Anonymous, Women for Sobriety) and employ staff in recovery.
- Providers will help women find women-only meetings (where available) and temporary sponsors.
- Programs will have linkages with appropriate resources, including faith-based organizations and 12-Step programs that address the spiritual issues related to addiction and recovery.
- Services will be provided in comfortable environments, with consideration that the living environment is important to enhancing positive self-images and human dignity.
- Recovery and community support services will be structured and coordinated throughout the continuing care process. Programmatic responsibilities for service coordination, including transition from one service level to another, will be clearly delineated.
- Program services will accommodate flexibility, taking into account a woman's life circumstances and responsibilities to her family in regard to attendance requirements, the need for scheduling during nontraditional hours and weekends, the provision of child care and transportation availability.
- Economic issues continue beyond treatment; recovery support and discharge planning will address economic hardship, barriers to meeting multiple responsibilities, employment retention and career advancement strategies (see Element 20: Education and Employment/Vocational Support).

#### *Considerations for a Woman's Children and Family*

- Participation of a woman's significant others, including her children, in recovery support services will be welcome, based on the woman's preference and her family's assessed needs.
- Providers will assist parenting women in accessing systems of care for their children.
- Programs will continue to provide services for a woman's children after their mother's formal treatment has concluded or will help them transition to other services.
- Programs will provide referrals for support and advocacy for a woman's family and children throughout the recovery process.

### *Pregnancy/Perinatal Considerations*

- Providers will assist pregnant women in seeking ongoing pregnancy-specific services.

### *Considerations for Women Involved in the Criminal Justice System*

- Women with criminal justice involvement will be supported to overcome the stigma associated with involvement and other challenges and develop a recovery support system that assists them in preventing recidivism and sustaining their health, wellness and recovery.

## **Element 23: Transportation**

Transportation is addressed or mentioned in 19 States' women's treatment standards. The existing State standards that address transportation can be found in Table 23 in Appendix A. States acknowledge that lack of transportation can be a major barrier for treatment (AZ, CO, CT, FL, GA, HI, OR, WI, WY). The current state standards addressing transportation dictate when transportation must be provided and for which services. Several States (CA, CO, CT, VT) require an evaluation of transportation limitations and abilities as part of the formal assessment.

### *Description*

Provision of **transportation** assistance eliminates a significant barrier to engagement and retention in substance abuse treatment programs, obtaining other treatment-related services and achieving treatment and recovery plan goals. Throughout the treatment continuum, many women need assistance in resolving ongoing transportation difficulties so they can access community resources, carry out their treatment plan as indicated and participate in recovery support networks. Transportation assistance may be accomplished in a variety of ways, including use of the provider's vehicle, provision of public transportation passes and identification of and access to other community transportation resources.

### *Key/Critical Content of Standards*

- Transportation will be provided or arranged to and from the recovery and treatment site and to and from ancillary services for women who do not have their own transportation. Ancillary services include, but are not limited to, offsite child care, primary medical care and prenatal care, primary pediatric care, dental care, social services, community services, educational and vocational training, employment and probation/parole.
- Providers will have access to transportation that is able to accommodate women with young children or those who need special assistance.
- Transportation provided directly by the treatment provider will involve properly licensed and insured vehicles. When program transportation is provided, the motor vehicle will be maintained in a safe operating condition and will adhere to all State transportation rules, regulations and codes. Smoking will be prohibited in the vehicle.

- Unless exempt because of State legislation, the motor vehicle will be equipped with appropriate safety devices and individual seat belts or age-appropriate safety seats for each child to use when the vehicle is in motion. The number of passengers will not exceed the seating capacity of the motor vehicle.
- The driver will have a valid State driver's license. The use of cell phones and other distracters will be prohibited while driving.
- The provider will assess the woman on her transportation skills and address transportation issues as part of the treatment and life plan. If appropriate, the provider may assist a woman in obtaining a driver's license and/or her own vehicle for transportation.

#### *Considerations for a Woman's Children and Family*

- Transportation to children's services will also be provided if no other transportation is available.
- Transportation will have car seats appropriate to the age and size of the child.
- School-age children will have access and transportation to school.
- The driver or staff supervising a child without parental supervision in the motor vehicle will have current first aid and cardiopulmonary resuscitation training.
- The provider will ensure a minimum of one staff person, other than the driver, is present in the motor vehicle when:
  - Seven or more preschool-age and younger children are present without parental supervision.
  - Staff-to-child ratio guidelines require a second person (see Element 24: Child Care and Child Development Services).
- Children will never be left unattended in a vehicle.

#### *Pregnancy/Perinatal Considerations*

- Programs will provide transportation to prenatal care and other appointments. Women in residential and non-residential programs will be supported to include transportation and transportation contingencies in their birthing plan.

#### *Considerations for Women Involved in the Criminal Justice System*

- When women are released from incarceration, providers will help women access transportation and/or will assist them in finding housing (see Element 19: Housing Supports and Assistance) in a community where they are likely to be able to use varying modes of transportation in the community or help them learn how to access transportation.

### **Element 24: Child Care and Child Development Services**

Child care services are addressed or mentioned in 21 States' women's treatment standards. The existing State standards that address child care can be found in Table 24 in Appendix A. Because 70 percent of women entering treatment have children (Werner, Young, Dennis & Amatetti, 2007), existing State standards about child care are extensive. The standards describe

where child care can be provided (either on- or off-site) and when child care must be provided (during which treatment activities). States also dictate facilities, physical environment and equipment required to provide child care (AR, MA, TX, WA) as well as the required educational or experiential qualifications for child care providers (MA, MO, OK, WA).

### *Description*

**Child care** is the delivery of organized care and supervision for children by someone other than the parent. Child development services provide for organized supervision as well as bio-psycho-socially appropriate activities that support the healthy growth and development of children. Children of women with SUDs are at risk of physical, mental or developmental problems and benefit from screening, assessment and specialized interventions. Therapeutic child care and child development services provide an enriching environment for children while offering the specialized interventions children may need. Older children may also need a range of assessments, educational supports, interventions and afterschool activities.

### *Key/Critical Content of Standards*

- Providers will recognize that many women, including adolescents are responsible for child care for their children, siblings or other relatives and these responsibilities may be a barrier to participation in treatment activities. Providers will ensure that child care is not a barrier to participation in treatment services.
- Programs serving women with or without children present will consider the parenting and family needs of the woman in treatment and life planning (see Element 6: Treatment Planning and Element 8: Continuing Care).
- Programs will maintain formal linkages with community-based child service organizations to support establishment of a continuum of care for the children of mothers in treatment.

### *Considerations for a Woman's Children and Family*

- All children accompanying their parent will be in visual or auditory distance of the parent or staff at all times.
- Children will be appropriately supervised by a competent adult when they are not in the care of a parent during short-term, intermittent treatment-related activities.
- To ensure a safe, healthy and welcoming environment, providers will:
  - Provide a safe and sanitary environment that is appropriate for children and meet State law.
  - Maintain the indoor and outdoor premises in sanitary condition, free of hazards and in good repair.
  - Maintain one or more accessible telephones in working order.
  - Ensure that no firearms are brought onto the premises.
  - Supply bathrooms and other rooms subject to moisture with washable, moisture impervious flooring.
  - Locate hand-washing facilities in or adjacent to rooms used for toileting.

- Provide toileting privacy for opposite sex children age 6 or older and for any children demonstrating a need for privacy.
- Provide toilets, urinals and hand-washing sinks of appropriate height and size for the child in care or furnish safe, easily cleanable platforms impervious to moisture.
- Provide developmentally appropriate equipment for the toilet training and toileting of the young child. Providers or the parent will also sanitize the equipment after each use.
- Provide children with soap and individual towels or other appropriate hand-drying devices.
- Provide a cheerful, well-lighted, environment at a comfortable temperature.
- Accommodate the needs of children with disabilities.
- To ensure the general health, safety and nutrition of children, providers will:
  - “[C]ontinuously [assess] the safety, health and developmental status of the child(ren) in the facility” (FL). This will include observing each child daily for signs of illness.
  - Ensure that the child’s immunization status is current.
  - Separate ill children from the other children and contact the parent when the child has an illness, is injured or is overly anxious or upset.
  - Collect a health history on admission including date of last physical exam, allergies and reactions, special health problems and immunization record.
  - Require periodic reviews by a physician or registered nurse of health policies specific to infants and children to include the following: preventive, illness and injury care; immunization follow up; and procedures that adhere to State law in regard to medication administration.
  - Provide staff certified in infant and child cardiac pulmonary resuscitation at all times.
  - Have accessible first aid supplies and policies and procedures readily available.
  - Have a written transfer policy to a hospital providing pediatric services.
  - Post emergency phone numbers next to all phones.
  - Establish and implement policies and procedures in regard to communicable diseases.
  - Store all medications as required by State law.
  - Prepare, store and provide food in a sanitary manner. Meet the nutritional needs of each child in care, taking into consideration the ages, developmental level, individual differences, cultural background, preferences and any disabling condition.
  - Plan and practice emergency evacuation procedures.
  - Provide a clean, separate and firm mat, cot, bed, mattress, play pen or crib for a child requiring a nap or rest period.
- Programs will have policies and procedures that state that staff will not allow anyone except the legal guardian or a person authorized by the legal guardian to take a child away from the facility. If an individual shows documentation of legal custody, staff shall record the person’s identification before releasing the child.
- Programs will evaluate the appropriateness of admitting a child to the treatment program with a parent based on the needs of the family and established admissions criteria.
- Policies and procedures will be established that include processes for introducing and integrating each new resident and child into the program.

- Programs for women with SUDs can unintentionally create additional upheaval in the lives of children if the programs do not plan carefully. Creating a stable environment for the children should be a strong consideration driving all decisions including but not limited to, whether to admit children to the program, where to place them in child care, creation of an aftercare plan.
- Providers will comply with all State and local child care standards.
- Offsite child care facilities in which children are not under the care and supervision of their mothers will be either licensed or licensure exempt.
- The following staff-child ratio will exist when parents are unavailable to supervise their children unless the State licensing agency has developed an alternative staff-child ratio

<u>Age of Children</u>	<u>Staff Ratio</u>
1 mo.–11 mos.	1:4
12 mos.–29 mos.	1:7
39 mos.–5 yrs.	1:10
Any age during clinical care	1:10

- Providers will assist families in identifying appropriate child care services and providers.
- Child care programs will:
  - Be designed to meet the developmental needs of the various age groups served and address cultural and other identified needs of individuals, as well as groups of children.
  - Prohibit corporal punishment by any person on the premises. Behavior management shall be fair, reasonable and consistent.
  - Guide behavior based on an understanding of each child’s needs and stage of development.
  - Facilitate the development of positive interaction between the child and adults and of positive interaction with peers through the emphasis on building coping skills.
  - Contain a range of age appropriate learning experiences for the child to gain self-esteem, self-awareness, self-control and decision-making abilities; develop socially, emotionally and intellectually; learn about nutrition, health and personal safety; and experiment, create and explore.
  - Provide the child with a variety of easily accessible, developmentally appropriate learning and play materials. The material shall be culturally relevant and promote social development, intellectual ability, language development and communication, self-help skills, sensory stimulation, large and small muscle development and creative expression.
  - Provide for a balance between free play and organized activities and between individual play and sharing experiences among children and promote individual contact between staff and child.
  - Provide reasonable regularity of age-appropriate activities with allowance for a variety of special events and time for children to be outdoors daily, weather permitting.
  - Be culturally fluent, nonjudgmental, trauma sensitive and respectful.
- Providers will employ a staff person dedicated exclusively to meeting the needs of children of the mothers in treatment. This person shall be qualified by meeting all State and/or local criteria (i.e., having a minimum of a bachelor’s degree in early childhood education or a



closely related field).

- Program staff members who work with children will have a basic knowledge of normal child growth, development and milestones. Staff will be able to recognize deficits in development and to implement activities that can overcome such deficits.
- All staff and volunteers will have the understanding, ability, personality, emotional stability and physical health suited to meet the emotional, mental, physical and social needs of the child in care and will receive ongoing training to support knowledge development and maintenance of skills.
- All children ages 3 and older will have opportunities to participate in SUD prevention services.
- Programs will include designated child care staff in clinical staffing meetings to discuss the progress of the child and child-parent relationship. Significant findings/discussions will be noted in the child's and parent's records.
- Therapeutic child care services will be provided for the health and welfare of the children accompanying parents who participate in residential treatment programs. The provider of child care services will deliver services for the care, protection and treatment programs. Services will include the following elements:
  - Developmental assessment using recognized standardized instruments (such as the ASQ, DENVER, NCAST).
  - Play therapy.
  - Behavioral modification.
  - Individual counseling.
  - Self-esteem building.
  - Family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

#### *Pregnancy/Perinatal Considerations*

- Providers will assist women to plan for child care after the birth of her baby. Educational materials regarding early childhood daycare available to women in treatment.
- Providers will be able to make referrals for infant care.
- Mothers will be encouraged to identify friends, family members or other individuals as respite care providers.

#### *Considerations for Women Involved in the Criminal Justice System*

- For women who have been recently released from incarceration or for women on probation, care should be taken to provide assistance for child care to make it more likely that the women will follow through on their obligations/mandates with this system.

### **Element 25: Recreational Services**

Recreational services are addressed or mentioned in 11 States' women's treatment standards. The existing State standards that address recreational services can be found in Table 25 in Appendix A. The standards on recreational services address these services for both women and

their children. The State standards recognize recreation as an important part of the recovery process, because it is important for women to develop interests and hobbies that do not involve substance use. The *Comprehensive Model* notes that recreational services provide children with an important learning opportunity and the chance to improve their self-esteem. Recreational services also allow children “to socialize, express themselves, relax, experience new activities, and become knowledgeable about healthful, alcohol- and drug-free leisure activities” (Werner, Young, Dennis & Amatetti, 2007 p. 56).

### *Description*

**Recreation** and leisure is a major domain of life activity. Development of, or reengagement in, safe and healthy recreational activities is critical for ongoing recovery support. Women and families whose lives have been focused on substance use for survival, particularly those who have experienced trauma, may not be familiar with ways to relax and enjoy friendships and experiences without alcohol and drugs.

Recreation and leisure services increase participation in prosocial activities that may serve as alternatives to substance use. They may include helping clients develop interests and participate in recreational and social activities that do not involve stimulant or other substance use. Development of and reengagement in hobbies, family activities, sports, creative ventures and other recreational and leisure activities, both structured and unstructured, are important components of treatment.

### *Key/Critical Content of Standards*

- Leisure and recreational skills will include, but will not be limited to, selecting and self-initiating activities for enjoyment, self-expression, relaxation and socialization.
- Comprehensive recreational services will include, but will not be limited to, assessment, integration of recreation/leisure into individual and family plans, structured exploratory activities and identification of community resources.
- “Potential activities [will] be evaluated by the counselor and the woman according to how interesting they are to the woman, how costly, to what degree they involve others, how much time they require, how likely the woman is to engage in them, and how much physical exertion they require” (Rawson et al., 1999).
- Potential co-participants will be identified by the counselor and woman (Rawson et al., 1999).
- The development of an action plan will identify the specific steps necessary to engage in the activities and will be incorporated into the treatment plan (Rawson et al., 1999).
- Counselors or other program professionals will work with clients to develop new relationships, creative outlets, hobbies or other recreational activities that promote healthful behaviors and that do not involve drugs or alcohol. These may include participation in Narcotics Anonymous or Alcoholics Anonymous meetings, joining groups that explore emotions and relationships or getting involved in local sports or religious events.

- Leisure and recreational activities may trigger trauma, eating disorders, process addictions and anxiety disorders. Women will be encouraged to identify healthy, safe leisure activities. Screening and support will be provided before, during and after leisure and recreational activities.
- Providers will encourage engagement in recovery support or mutual aid groups.
- Programs will provide pro-recovery activities and will have an emphasis on activities that involve a recovery community.

#### *Considerations for a Woman's Children and Family*

- Activities with children and their mothers will, when appropriate to the action plan, encourage healthy interaction between mothers and their children. Mothers will learn how to interact with their children through safe activities.
- In facilities serving women and children, the program will provide age-appropriate, accessible recreational activities for the children while the mothers are participating in treatment services and provide recreational activities for mothers and their children.

#### *Pregnancy/Perinatal Considerations*

- There might be a limit to recreational activities depending on pregnancy conditions.

#### *Considerations for Women Involved in the Criminal Justice System*

- Activities for women may be limited by physical location or potential associations that violate court requirements
- When laws permit, children and their mothers will be encouraged to engage in safe and age-appropriate activities together.

## **VI. ADMINISTRATION/OPERATIONS AND POLICY ISSUES TO CONSIDER**

### **Introduction**

This section discusses some of the administrative and operational elements that are often included in women's treatment standards. These elements offer the context or framework necessary for implementation of service standards. States may want to consider the best ways to make standards operational and the essential features necessary to implement the service standards. Six administrative elements are discussed in this section: advisory systems, gender-responsive services philosophy, staffing, facilities, evaluation and funding.

### **Advisory Systems**

Advisory bodies provide a mechanism for feedback, oversight and evaluation by stakeholder groups. Standards may specify the purpose, composition or meetings of the advisory body. Some States have developed formal advisory bodies that provide oversight and

recommendations on the delivery of services for women or groups of women. The type, composition, scope and specific responsibilities of an advisory body will be determined by the needs and structure of the State. For example, the Illinois Alcoholism and Other Drug Dependency Act established a Committee on Women’s Alcohol and Substance Abuse Treatment to provide the State with input and recommendations on how to best address the intervention, prevention and treatment needs of women and ensure effective service delivery to women (among other duties).

When States contract with providers or counties, they may require them to have an advisory body to guide services. In some instances, the composition of the advisory body is also specified. South Carolina requires residential programs to have and use an Advisory Committee, the composition of which “should be consistent with the population to be served and include consumers.” The District of Columbia requires a program’s governing board to include “members with special interest and expertise related to programs and services for parent(s) and children.”

### **Gender-Responsive Service Philosophy**

Women’s treatment service, and therefore the standards that guide these services, should be grounded in a philosophical base that considers women’s psychology, development and sociological context as well as scientific knowledge on SUDs. An extensive body of research has been developed that identifies the epidemiological rationale for women-specific treatment of SUDs. The service elements described in the previous section and the methods by which they are delivered are best understood when the philosophical basis for their delivery is also provided. Although many States specify that gender-responsive or gender-specific services be provided, only a few States define them. Some States specify a definition of gender-responsive treatment, guiding principles or a philosophical framework within their standards. Arizona, Colorado, Connecticut, Georgia, Idaho and Wisconsin are examples of States that elaborate on the concept and practice of gender-specific treatment in their standards.

- Arizona emphasizes the importance of a “relational/cultural approach that focuses on the centrality of relationships in women’s lives.”
- Colorado explicitly states, “Program policies and procedures will reflect that women’s substance abuse differs from that of men both in its etiology and the treatment or service required for remediation.”
- Georgia defines gender-specific treatment as having gender-specific staff; gender-specific services, including prenatal services and child care; and gender-specific therapies including all-female groups, trauma counseling, sexual abuse counseling, nonaggressive/nonconfrontational therapy styles, therapeutic parenting skills classes and other recommended services.
- Wisconsin lays out an overall philosophy—consisting of six core fundamental principles—of working with women with SUDs. These core principles address concepts such as the importance of women’s relationships in recovery, the provision of wraparound services

through intersystem collaboration and involvement of informal supports and work as a vital therapeutic tool in recovery.

- Connecticut cites six guiding principles for gender-responsive treatment (gender, environment, relationships, services, socioeconomic status and community) developed by Bloom, Owen and Covington (2003). It also has nine Guiding Principles for Behavioral Health Recovery Management citing Boyle, White, Corrigan and Loveland (2005). These principles address: recovery focus, client empowerment, destigmatization of experience, evidence-based intervention, service coordination, recovery partnership, ecology of recovery, sustained monitoring and support and continual evaluation.

### **Program Staffing, Qualifications and Staff Development**

Effective staffing is essential to the delivery of effective women's treatment. There is general consensus that women's treatment programs should have:

- Female staff that meet minimum qualifications (i.e., a multidisciplinary mix of staff including clinicians and peer support professionals who are responsive and representative of the cultural makeup of the target population).
- Staff that are knowledgeable about women's SUDs, treatment issues, gender responsiveness and family interventions.
- Ongoing staff training and development.
- Clinical supervision for all staff.
- Sufficient staff to meet program requirements.
- Trained child development specialists (when children are present).

Standards for staff qualifications and training can help ensure that treatment agencies can implement the women's treatment standards. Standards may identify specific licensing or certifications for staff and general staff requirements as well as identify core competencies in which staff will be knowledgeable. In their women's treatment standards, some States are very specific about the staffing pattern, minimum staffing requirements, job descriptions and staff qualifications whereas others are not. In addition, some States specify detailed staff qualifications to perform particular services, such as assessment.

There is general agreement that women's treatment in most instances is best provided by female staff members. Some States have addressed this in their Standards. Arizona, for example, states that staff must include female role models, including women in management positions, and counseling staff should be predominantly female, including women in recovery. Connecticut notes that the majority of staff members should be women.

When standards address programs that serve women with children, staff qualifications for working with children may also be addressed within the standards. Several States provide criteria for working with children. Georgia and Washington provide specific requirements for therapeutic child care staff (e.g., program director, program supervisor, teachers/lead

caregivers and caregivers/aides), and Idaho's Targeted Intensive Case Management staff includes an intensive case manager, early child development/parenting specialist and children's behavioral health specialist.

Staff supervision, development and training build the expertise and skills of the workforce. Establishing minimum standards for staff training acknowledges the need for specially trained staff and provides a mechanism for creating this expertise. Sixteen States include language about staff training and development in their women's treatment standards. Some States have general language calling for staff training on gender-responsive treatment skills or therapeutic issues relevant to women. Other States specify the staff training topics and issues. For example, North Carolina requires staff training on domestic violence, trauma, child abuse and neglect, grief and loss, impact of substance use on parenting and family units and traditional and nontraditional community supports within 60 days of employment. Connecticut requires a comprehensive staff training program that provides staff with the necessary competencies including sessions on women's development, co-occurring disorders, cultural issues, trauma, sexuality, grief and loss, parenting and spirituality. States may also require that staff members have specialized training on prenatal alcohol or drug exposure, child development or other children's issues. States may also establish requirements for clinical supervision.

Recently, there has been considerable progress in the research, education, certification and licensing of professionals who can address the needs of women with SUDs. All States have certification requirements for alcohol and drug treatment program staff. Few certification programs have established specialized educational program that specifically address women with SUDs. States may want to consider working with educators and licensing/certification bodies to establish a women's specialty counselor certification or core competencies. However, the alcohol and drug treatment field is challenged by workforce shortages (SAMHSA, 2008). Workforce shortages particularly of staff members from similar racial/ethnic backgrounds as the population served, coupled with low salaries, high staff turnover and insufficient professional development present numerous challenges to maintaining a highly qualified workforce. These shortages often make agencies reticent to establish additional staff qualifications. Staff training and development programs may be relied on to build the necessary competencies. In considering staffing protocols, States must consider the types of programs, availability of staff and other workforce development requirements and efforts.

The specific staffing-related information a State opts to include in standards will depend on the modality, other State standards, counselor licensing and certification options, financial resources and the availability of a qualified workforce.

### **Program Environment/Facilities**

Some States may include standards on specific criteria for facilities in their women's treatment standards, whereas others rely on other regulations or standards for facility requirements. Some considerations include size, square footage per resident, layout, safety for children,

accessibility, maximum number of participants, and the ambiance of the facility. For example, Arkansas mandates “a safe and sanitary environment appropriate for children” and details a list of 15 minimum standards. In many States, the SSA is not the licensing agency for treatment facilities. In these instances, it is important that the agency responsible for licensing understand the intent of regulations and how to monitor facilities.

In addition to the physical surroundings, standards may address the need for a safe, respectful environment. For example, Idaho provides a detailed description of the use of supportive inquiry and a nonstigmatizing environment. In its standards, Arizona acknowledges: “Women recover best in a healing environment that provides safety and facilitates connection and empowerment. Gender-specific addiction treatment should be provided in a supportive, nurturing and non-judgmental environment.” Connecticut integrates the importance of a safe and secure setting with the need for a warm, inviting and comfortable setting that is culturally diverse.

Regardless of the State agency responsible, there is a generally recognized shortage of optimal facilities for serving women or families. Thus, while standards must comply with a State’s licensing requirements, they cannot be so ambitious that they result in a lack of facilities.

### **Evaluation, Quality Assurance and Outcomes**

Demonstrating outcomes continues to be a high priority for States and the Federal Government. Standards often include desired outcomes and measurement tools. Some States proscribe specific outcome measurement tools and reporting requirements. Other States list general areas for both performance and outcome measures or require service providers to identify criteria for evaluation, documentation and quality assurance protocols. Data requirements should fit with the other reporting requirements of funding and regulatory agencies. Some examples of State standards related to evaluation are described below.

- South Carolina, in addition to semiannual narrative reports that include outcome evaluations, requires residential programs to conduct 6- and 12-month follow up of clients to determine program effectiveness.
- Arizona’s standards include an extensive section on desired outcomes that outlines signs, symptoms and behaviors and corresponding targets and measurement tools for addiction treatment generally, as well as gender-specific treatment. Arizona requires outcome categories to be measured at baseline, regular intervals (e.g., 30, 60, 90 days of treatment, then every 1-2 months throughout treatment) and discharge as well as during changes in treatment level of service.
- Maine requires the use of six standardized instruments—Alcohol and Drug Refusal Self-Efficacy Questionnaire (ADRSEQ), Drug Avoidance Self-Efficacy Scales (DASES), Coping Behaviors Inventory (CBI), Commitment Scales (CS), Problem Solving Questionnaire (PSQ) and Perceived Modes of Processing Inventory (PMPI)—as well as a Client Satisfaction Questionnaire. This battery of assessments is used for ongoing assessment, as well as treatment planning and outcome evaluation measures.

- Connecticut includes evaluation of the appropriate utilization of gender-responsive treatment services and short- and long-term impact of interventions on program participants in 10 domains.
- New Jersey’s programs must measure child welfare outcomes in the areas of safety, permanency and well-being of children. Improved parenting is an expected outcome of residential programs in North Carolina.
- Georgia defines successful completion of treatment within the standards.

States may consider integrating specific outcome measures, benchmarks and documentation requirements as part of women’s treatment standards. This will provide for aggregating data, comparative analysis, quality assurance and a documentation of the effectiveness of treatment services.

### **Funding Flexibility**

Standards often address fiscal accountability, funding availability and restrictions. States may want to examine whether mechanisms enable treatment providers to braid additional revenue sources and funding streams for specific services or whether there are disincentives or barriers to accessing multiple funding sources. When standards are tied to funding, through contracts or requests for proposals, other provisions of these documents can be evaluated to ensure that barriers or disincentives to adding additional revenue are minimized and accessing additional revenue is encouraged. For example, in New Jersey, contracting requirements state that programs must develop a system for allocating, tracking and differentiating revenue, expenses, services and capacity by payer to provide a comprehensive view of their service programs. In Massachusetts, the Bureau of Substance Abuse Services is working with its partners to identify payer mechanisms to support programs that want to offer parenting as part of the services and explore coordinated systems for clients’ children to receive treatment, as needed. Georgia’s standards identify the funding sources and “acknowledge that funds are intended to allow treatment providers maximum flexibility in meeting the needs of program participants.” Agencies will need to have access to flexible funding to implement many of the standards described above. Not all needs can be met with existing community resources.

## **VII. POSSIBLE OPTIONS FOR ADMINISTERING WOMEN’S TREATMENT STANDARDS**

This section explores the ways in which States can administer women’s treatment standards. States use a variety of approaches to establish and implement treatment standards, thus women’s treatment standards can be found in a variety of documents and departments and with different implementation mechanisms.



## Target Populations

Treatment standards have been developed for different target populations. Many States include some women's standards within other standards that apply to all individuals in treatment or a particular treatment modality and maintain specialty standards for pregnant/postpartum women or women with their children.

There are generally five primary target populations for which States develop standards for women with SUDs:

- All women in treatment or a specific modality of treatment.
- Pregnant/postpartum women in treatment or a specific modality of treatment.
- Women and their children in treatment or a specific modality of treatment.
- Subgroups of women served by specialty programs.
- Subgroups of women served by a collaborating State agency (e.g., social services, criminal justice).

Most States have a mix of programs that includes some that serve women but provide no specific women-responsive services and others with more established women-responsive approaches. Standards that apply to the different populations, resources available and the service element priorities may vary depending on the population served and the type of program.

## Implementation of Standards

States have a variety of leverage points that can be used to implement women's treatment standards. When deciding which leverage points to use, States may consider the breadth, depth, scope and emphasis of the standards they are seeking to establish and the most effective way to make the standards operational. Although there is some variation by State, most SSAs can either directly or through interagency collaboration use most of the following channels to implement women's treatment standards:

- Legislation.
- Administrative codes and regulations.
- Guidelines, protocols and administrative priorities.
- RFPs, funding and contracts.
- Licensing and certification.
- Interdepartmental MOUs.

Most States use an array of mechanisms to establish and enforce women's treatment standards. States may have several types of women's treatment standards: legislation mandating specific provisions and resulting regulations; criteria established in facility licensing or certification; documentation within MOUs, RFPs and contracts with other departments, local entities or providers; and/or voluntary consensus guidelines. In some States, these documents

come together in an organized manner; in others, women’s services may be inconsistent or fragmented.

### **Opportunities To Consider**

States may choose to conduct an inventory of their current implementing policies and procedures and collate their standards across the various methods they use. When this inventory is evaluated, a clearer picture of the existing standards, strengths, gaps and opportunities for improvement will emerge.

Having documented standards is an important step; however, documentation often must also be accompanied by tools and protocols, together with accountability measures, for the standards to be implemented. During the inventory, standards may be identified that lack appropriate accountability and are not being implemented. These could be evaluated to determine whether the standard needs to change or what provisions are needed to enforce the standard. Monitoring tools, technical assistance or clarification of the purpose or funding may be needed for some standards to become practice.

States may want to bring together stakeholders to assess their standards, develop an approach to address gaps and improve women’s treatment standards. This stakeholder group may consider the different types of standards tools that are available, as well as the different target populations. Consulting with other agencies and providers may also be necessary. It may be helpful to explore how this effort complements other State initiatives and identify ways to coordinate efforts.

States may want to think of the programs in their States in a continuum of women-responsive services and use this framework as a tool for considering the standards and priority service elements. States could consider the range of options for applying the service elements to the array of women in their entire treatment service delivery system including women served in co-educational programs and specialty gender-responsive programs and all service modalities. States can use the service element standards described in the previous sections to consider and prioritize how to define core standards (applicable to all programs) and/or more

#### **Possible Steps to Women’s Treatment Standards**

- a) Review this document
- b) Inventory existing standards
  - i. Target population
  - ii. Type of standard
  - iii. Implementation
  - iv. Is it working?
- c) Bring together stakeholders to identify strengths, weaknesses and opportunities for enhanced standards; consider other initiatives and leverage points
- d) Consider the efficacy of the women’s service continuum recognizing some programs have limited women-responsive services, some are capable of such services and others have enhanced levels of services and then plan accordingly for improvements
- e) Identify and prioritize service elements to address
- f) Establish key outcomes, evaluation and monitoring tools
- g) Work to adopt standards as needed
- h) Bring together affected providers for training, technical assistance and mutual support
- i) Establish an approach for ongoing quality improvement and celebration of accomplishments
- j) Continue to seek new opportunities and to capitalize on opportunities as they emerge

comprehensive standards applicable to specialty or more established programs. Thinking in terms of a continuum of women-responsive services may help identify how to enhance services among those who cannot currently provide all service elements. States may consider which service elements are currently in place and prioritize other service elements to focus on and move toward becoming more women responsive.

States may consider the structure of the SSA, service delivery framework, collaboration with other departments and policy options and identify relevant channels for establishing and implementing women's treatment standards. There may be opportunities to integrate women's treatment standards into the existing policy, program and programmatic efforts.

It may be helpful to look at ways to establish women's treatment standards, not in isolation, but along with the States' other current initiatives. Efforts to adopt women's treatment standards are compatible with, and can improve, other State initiatives in the SSA or in other State agencies such as corrections and child welfare. States may have the opportunity to address women's treatment standards while responding to new mandates, opportunities or trends. For example, women's standards may be included in a State's response to:

- Implementation of new funds, State improvement plans, outcome measurement systems or other developments such as adoption of a recovery support/chronic care model or evidence-based practices.
- Federal changes such as changes to TANF and ASFA.
- Workforce development initiatives.
- Initiation of requests for proposals or renegotiation of contracts.

Funding challenges are real and are not intended to be minimized; however, often standards can be adopted and transitions made that save money, capitalize on funds from other sources or include long-run cost-saving measures. Improving women's treatment retention and outcomes and reducing recidivism save funds in the short and long term. By recognizing a continuum of women-responsive programs, States can recognize that not all providers can meet the same level of standards and work toward improvements at all service levels. States may benefit from conducting a concurrent inventory of funds available, including funds that are not under the jurisdiction of the SSA, and identifying possible ways to expand services or improve outcomes through collaborations with other departments.

### **Standards Are Not Just Documents**

Adopting women's treatment standards alone may not be sufficient for establishing quality women's programs. In addition to the adoption of standards, there are three additional venues for implementing women's standards that States may want to consider: monitoring, training and technical assistance and establishing a women's services network or consortium or advisory body to plan for change

### *Monitoring and Assessment Tools*

States can use a variety of methods to monitor progress in implementing women's treatment standards. Developing assessments, self-assessments and monitoring tools that are linked to the standards is an important step for maintaining accountability to the standards. Whether monitoring and assessment are conducted by one primary office or through a coordinated effort of multiple offices will depend on the structure, staffing and other standards the State has established. If monitoring is conducted by multiple agencies, key questions and background training may produce improved results. For example, if a different department monitors compliance for licensing and certification, it may be able to examine specific women's treatment standards concurrent to other licensing and certification issues if it is provided a tool and background education on how to do so.

### *Training and Technical Assistance*

Improving women's treatment by establishing and implementing women's treatment standards may require training and technical assistance for treatment agencies and local entities on how to implement these standards. One approach to the delivery of technical assistance and training would be to develop an assessment tool that concurrently enables providers to learn about key elements of women-responsive programs while assessing what changes would be necessary to meet identified standards. Training serves to improve staff ability to deliver gender-responsive programs while reinforcing the treatment standards.

### *Establishing a State Women's Services Network*

States may use provider meetings or advisory groups to evaluate current women's treatment standards and to develop opportunities for enhancing the standards and strategies to roll out improvements. Establishing networking and discussion opportunities provides a mechanism for individuals involved in implementing women's treatment standards to work together, share resources, discuss barriers and leverage one another's expertise. Involving stakeholders in identifying and implementing standards may help identify opportunities for establishing and implementing standards and leverage opportunities for implementing women's treatment standards.

## **VIII. CONCLUSION**

Research has long shown that, compared with men, women have different treatment and recovery needs. This document presents concrete suggestions that are based on evidence and experience to help providers address these differences. NASADAD hopes that the suggested standards and information on leverage points will be helpful to States as they create State standards for women's treatment. NASADAD believes that flexibility of these guidelines will allow States to create standards that use the strengths of each State's system and that address the specific and unique needs of women.

NASADAD recognizes that a great deal of work still needs to be done to help States provide care to women with SUDs. Areas for future work include a review of gender-specific evidence-based practices; a review of promising practices for specific sub-populations including veterans, LGBT women, adolescents and older women; the creation of a self-assessment tool for States; and providing technical assistance to help States implement their standards.

## IX. BIBLIOGRAPHY

American Society of Addiction Medicine. (2008). *Patient placement criteria, Second edition—Revised*. Chevy Chase, MD: American Society of Addiction Medicine.

Ashery, R.S. (1992). Case management community advocacy for substance abuse clients. In: Ashery, R.S. (ed.), *Progress and issues in case management*. National Institute on Drug Abuse Research Monograph, Number 127. DHHS Pub. No. ADM 92-1946. Rockville, MD: National Institute on Drug Abuse. pp. 383-394.

Ashley, O.S., Marsden, M.E., & Brady, T.M. (2003). Effectiveness of substance abuse treatment programming for women: A review. *American Journal of Drug and Alcohol Abuse*, 29(1), 19-53.

Bloom, B., Owen, B. & Covington, S. (2003). *Gender-responsive strategies: Research, practice and guiding principles for women offenders*. Washington, DC: National Institute on Corrections.

Boyle, M., White, W., Corrigan, P., & Loveland, D. (2008) *Behavioral health recovery management: A statement of principles*. Peoria, IL: Behavioral Health Recovery Management Project. Available at: <http://www.bhrm.org/papers/principles/BHRMprinciples.htm>

Brady, T.M., & Ashley, O.S. (eds.). (2005). *Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS)*. Analytic Series A-26. DHHS Publication No. SMA 04-3968. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Center for Children and Family Futures. (2007, June 6). *State substance abuse standards for women: A review of the current landscape*. Presented at the NASADAD-WTC Annual Meeting, Burlington, VT. Prepared under contract for the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2007. Available at: <http://womenandchildren.treatment.org/policy.htm#standards>

Center for Substance Abuse Treatment (CSAT). Substance Abuse and Mental Health Services Administration. (2007, May) "Substance Abuse Treatment Standards for Women" summary binder presented at the Center for Substance Abuse Treatment's 2007 State Women's Treatment Coordinators' Meeting June 6, 2007 in Burlington, Vermont.

Center for Substance Abuse Treatment. (2007). National Summit on Recovery: Conference Report. DHHS Publication No. (SMA) 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2006). *Detoxification and substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (2005). *Substance Abuse Treatment and Family Therapy*. Treatment Improvement Protocol (TIP) Series 39. DHHS Publication No. (SMA) 04-3957. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment, (2001). *Telling Their Stories: Reflections of the 11 Original Grantees That Piloted Residential Treatment for Women and Children for CSAT*. DHHS Publication No. (SMA) 01-3529. Rockville MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (2000). *Substance Abuse Treatment and Domestic Violence*. Treatment Improvement Protocol (TIP) Series 25. DHHS Publication No. (SMA) 00-3406. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2000). *Integrating substance abuse treatment and vocational service*. Treatment Improvement Protocol (TIP) Series 38. DHHS Publication No. (SMA) 00-3470. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (1999). *Screening and assessing adolescents for substance use disorders*. Treatment Improvement Protocol (TIP) Series 31. DHHS Publication No. (SMA) 99-3282. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (1999). *Treatment for stimulant abuse disorders*. Treatment Improvement Protocol (TIP) Series 33 DHHS Publication NO. (SMA) 99-3296 Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (1998). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Clark, C., & Fearday, F. (eds). (2003). *Triad women's project: Group facilitators manual*. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

Clark, H.W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. *Child Welfare, 80*(2), 179-198.

Collins, C.C., Grella, C.E., & Hser, Y.I. (2003). Effects of gender and level of parental involvement among parents in drug treatment. *American Journal of Drug and Alcohol Abuse 29*(2):237–261.

Conners, N.A., Bradley, R.H., Mansell, L.W., Liu, J.Y., Roberts, T.J., & Burgdorf, K. (2004). Children of mothers with serious substance abuse problems: An accumulation of risks. *American Journal of Drug and Alcohol Abuse 30*(1):85–100.

Covington, S., & Surrey, J. (1997). The relational model of women's psychological development: Implications for substance abuse. In S. Wilnsak & R. Wilnsak (Eds.), *Gender and alcohol: Individual and social perspectives* (pp. 335-351). Piscataway, NJ: Rutgers University Press.

Finkelstein, N. (2004, July 13). *Trauma and substance abuse*. Paper presented at the Women across the Life Span: A National Conference on Women, Addiction, and Recovery, Baltimore, MD.

Greenfield, S., Brooks, A., Gordon, S., Green, C., Kropp, F., McHugh, R., Lincoln, M., Hien, D., Miele, G. (2007) Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and Alcohol Dependence* 86(1) pp.1-21

Greenfield, S. (2006, July 12). *Substance abuse outcomes in women*. Presented at A National Conference on Women, Addiction, and Recovery: News You Can Use. Anaheim, California.

Grella, C.E., Scott, C.K., & Foss, M.A. (2005). Gender differences in long-term drug treatment outcomes in Chicago PETS. *Journal of Substance Abuse Treatment* 28(2):S3-S12.

Harris, M., & Fallot, R.D. (2001). Envisioning a trauma-informed service system: a vital paradigm shift. *New Directions in Mental Health Services*, Spring(89):3-22.

Hser, Y., Huang, Y.C., Teruya, C., Anglin, M.D. (2004). Gender Differences in treatment outcomes over a three-year period: A PATH model analysis. *Journal of Drug Issues* 34(2), 419-439.

Joint Commission on Accreditation of Healthcare Organizations. (1995). *Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/ Developmental Disabilities Services. Vol. 1, Standards*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.

McLellan, A.T., Kushner, H., & Metzger, D. (1992). The Fifth Edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9(3):199-213.

Mercer, D.E. (2000). Description of an addiction counseling approach. In Boren, J.J, Onken, L.S., Carroll, K.M. (eds), *Approaches to drug abuse counseling*, Washington, DC: National Institute on Drug Abuse.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. *New Directions for Mental Health Services* 50:3-27.

Morrissey, J.P., Ellis, A.R., Gatz, M., Amaro, H., Reed, B.G., Savage, A., et al.. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *Journal of Substance Abuse Treatment* 28(2):121-133.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003) *Integrated Dual Diagnosis Treatment: Effective intervention for severe mental illness and substance abuse*. New York: Guilford Publications.

Najavits L.M., Rosier, M. Lee Nolan, A., Freeman M.C., (2007). A new gender-based model for women's recovery from substance abuse: Results of a pilot outcome study. *American Journal of Drug and Alcohol Abuse* 33:5–11.

Price, A., & Simmel, C. (2002). *Partners' Influence on Women's Addiction and Recovery: The Connection Between Substance Abuse, Trauma and Intimate Relationships*. Berkeley, CA: National Abandoned Infants Assistance Resource Center, University of California at Berkeley.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Survey on Drug Use and Health. (2006). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Rahdert, E.R. (1991). *The adolescent assessment/referral system manual*. DHHS Publ. No. (ADM)91-1735. Rockville, MD: U.S. Department of Health and Human Services, ADAMHA, National Institute on Drug Abuse.

Substance Abuse and Mental Health Services Administration (2008) "Report to Congress: Addictions Treatment Workforce Development." Substance Abuse and Mental Health Services Administration. <http://pfr.samhsa.gov/docs/Report%20to%20Congress.pdf>

United Nations Office on Drugs and Crime (2004). *Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned*. ISBN 92-1-148194-5. Sales No. E.04.XI.24. New York: United Nations Publications. [www.unodc.org/pdf/report\\_2004-08-30\\_1.pdf](http://www.unodc.org/pdf/report_2004-08-30_1.pdf)

Werner, D., Young, N.K., Dennis, K, & Amatetti, S. (2007) *Family-centered treatment for women with substance use disorders: History, key elements and challenges*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Wetherington, C.L. (2006, July). *Substance abuse: Does gender matter?* Presented at National Conference on Women, Addiction & Recovery: News You Can Use. Anaheim, California.

Young, N.K., Nakashian, M., Yeh, S., & Amatetti, S. (2007). *Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)*. DHHS Pub. No. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration.