
**TREATMENT GUIDELINES
GENDER RESPONSIVE TREATMENT OF WOMEN
WITH SUBSTANCE USE DISORDERS**

FULL TREATMENT GUIDELINES

April 2013 Revision

Connecticut Department of Mental Health and Addiction Services
Women's Services Practice Improvement Collaborative (WSPIC)
Guidelines compiled by *David J. Berkowitz, Ph.D.*

Introduction

This document presents a series of guidelines to insure responsiveness to the particular characteristics and needs of women in treatment programs at all levels of care (residential, intensive, outpatient). Some of the specific guidelines may apply differently to programs with different emphases. For example, a primarily short-term, crisis intervention and stabilization program will have a somewhat different subset of guidelines that are relevant to it than a longer term program will. These guidelines apply to programs treating women exclusively, or, within a larger mixed gender population of consumers.

It is understood that movement towards these guidelines will be a process that will take time and will involve collaborative efforts and changes on the part of providers and funders. Some of the guidelines may require specific regulatory changes or changes in funding mechanisms before they can be fully implemented. Many will require staff training and shifts in philosophy and model.

The purpose of these guidelines is to give direction and facilitate change in the treatment system. At this time they are not fixed standards upon which providers will be judged or criticized. It is likely that they will continue to evolve as they are worked with and as a broader community has an opportunity for input.

New feature of this version: Core Women's Program Guidelines

This version has included core women's program guidelines. These guidelines, appearing throughout the guidelines are highlighted in yellow. These core women's program guideline areas are features of the program that are fundamental for women's programs in particular. All the guidelines are important for a high quality program, however the highlighted guidelines are meant to be those that are particularly critical and specific to the unique needs of women in these programs. In addition to appearing throughout the overall guidelines, at the end of the guidelines there is a new section, "Core Women's Program Guidelines" that just presents the core guidelines.

These Guidelines were developed by the Women's Services Practice Improvement Collaborative, sponsored by the Connecticut Department of Mental Health and Addiction Services, with participation of the provider community, Advanced Behavioral Health, The Connecticut Women's Consortium, Connecticut Community for Addiction Recovery. Please do not disseminate or modify these guidelines without the consent of Karen Ohrenberger, Director of Early Interventions and Specialty Programs, CT DMHAS, e-mail: Karen.Ohrenberger@ct.gov. April 2013.

The Context of the Recovery System of Care

The intent of these guidelines is to emphasize those factors that are of particular importance in the treatment of women. However, many of the treatment approaches that are part of the general shift to a recovery oriented system of care are also important for women's treatment. Therefore, many of the guidelines proposed here are also appropriate in the larger context of the new recovery based approach to care for all consumers. Therefore, these guidelines are constructed to provide a comprehensive set of practices that, if achieved, will constitute the most up to date best practices in gender responsive treatment and in recovery-oriented treatment in general. More detailed "Standards of Practice for Recovery-Oriented Behavioral Health Care" have been disseminated by the Connecticut Department of Mental Health and Addiction Services. These Treatment Guidelines for Gender Responsive Treatment of Women are highly consistent with the DMHAS Recovery Guidelines.

Guiding Principles for Gender Responsive Treatment Guidelines *(from Covington and Bloom, 2004)*

1. **Gender:** Acknowledge that gender makes a difference.
2. **Environment:** Create an environment based on safety, respect, dignity.
3. **Relationships:** Develop policies, practices and programs that are relational and promote healthy connections to children, family, significant others and the community.
4. **Services:** Address substance abuse, trauma, and mental health issues through comprehensive, integrated and culturally relevant services.
5. **Socioeconomic status:** Provide women with opportunities to improve their socioeconomic conditions.
6. **Community:** Establish a system of comprehensive and collaborative community services.

Guiding Principles for Behavioral Health Recovery Management *(from Boyle, White, Corrigan and Loveland, 2005)*

1. **Recovery Focus:** Emphasize hope for high quality of life while managing recurring episodes of illness, client strengths and resilience
2. **Client Empowerment:** Clients are involved in all aspects of service delivery and design.
3. **De-stigmatization of Experience:** Experiences with behavioral health disorders are normalized to the extent possible.
4. **Evidence-based Interventions:** Scientific evidence and broad professional consensus are used to inform interventions at all stages of treatment and recovery.

5. **Service Integration:** Multi-disciplinary, multi-agency models are used that integrate services previously provided in isolation from each other.
6. **Recovery Partnership:** The professional role shifts from purely a “treater” to a “recovery consultant” in partnership with the client. Emphasis on the long term continuity of this relationship over time through various episodes of care.
7. **Ecology of Recovery:** The family and community systems are utilized extensively for long term support of recovery. Multiple connections are promoted between the client and community systems to provide support for recovery.
8. **Sustained monitoring and support:** Flexible monitoring and easy re-engagement at an appropriate level of care if necessary is available, rather than rigid traditional “assess, admit, treat, discharge” process.
9. **Continual evaluation:** Assessment and evaluation are continual throughout treatment episodes, as well as between and across episodes of care.

GUIDELINES

1. Assessment and Engagement

- a. Short waiting period for entry to services (<1 week).
- b. If greater than one week waiting period occurs, then there will be regular ongoing contacts with client until entry to service.
- c. Capacity to include/welcome children throughout assessment process.
- d. Initial assessment is completed within two weeks.
 - i. Assessment is strengths based.
 - ii. In addition to assessment of mental health and substance abuse, assessment must include: relational context, parenting, trauma, grief/loss, domestic violence, safety, sexuality, life skills, vocational, spiritual, cultural, legal issues, gambling, housing, healthcare insurance needs.
 - iii. Assessment must be conducted in a manner that is sensitive to a history of possible sexual abuse or domestic violence and use an appropriate tool to explore these issues, with evidence of sensitivity to re-traumatization.
 - iv. Assessment must include a process to identify priority areas for intervention incorporating the client’s preferences for change.
 - v. Assessment must determine a level of care and modality of care that is responsive to the wishes and needs of the client.
- e. Contact with peers/other consumers occurs early in assessment process.

- f. Assistance with transportation is provided when needed.
- g. Referral for a physical health screening that is gender specific is part of assessment with criteria for securing a full medical assessment if not completed within one year.
- h. Written material (English/Spanish) is available that explains program content, requirements, procedures in clear, non-technical language.
- i. Where the client has difficulty engaging in the assessment process, there is evidence of outreach and other efforts to facilitate the client's involvement in the treatment program, including use of Recovery Centers or other nontraditional supports.
- j. The assessment process should extend beyond the initial assessment as the client's comfort level increases and more information can be collected, resulting in evidence of a revised working assessment and priorities for change that all share.
- k. If client does not qualify for services, assistance is provided with alternate care, or connected to an appropriate resource to provide support and assist with searching for services (e.g. local recovery center).

2. Recovery Planning

- a. An initial recovery plan is developed by the end of the assessment period by the program staff and client, in the client's words, that the client signs [off on] and has a copy. The client is an active participant in this process.
 - i. The initial recovery plan includes concrete initial behaviorally oriented objectives that are practical and when achieved will advance the recovery process for the consumer.
 - ii. Objectives focus on issues client must contend with and coping strategies, versus symptoms or problems.
 - iii. Objectives and interventions must promote self reliance.
 - iv. The initial recovery plan specifies services, interventions, supports and staff necessary to meet identified objectives.
- b. A full individualized recovery plan is completed by the end of a month of care (or 5 outpatient sessions) that expands upon the initial plan and includes concrete, measurable objective(s) in each of the following domains that are identified as priorities in the initial and ongoing assessment. Plans should incorporate a comprehensive scope of services addressing the realities of women's lives:
 - i. Substance use recovery
 - ii. Mental health issues (co-occurring)
 - 1. Must include symptom management strategies
 - 2. Substance use and mental health objectives are coordinated and integrated, not discrete.
 - iii. Trauma, grief/loss, and/or PTSD
 - iv. Domestic violence

- v. Safety
 - vi. Parenting/reunification plan /impact of termination of parental rights or loss of parental role
 - vii. Relationships/sexuality
 - viii. Cultural issues
 - ix. Spirituality
 - x. Life skills
 - xi. Vocational skills
 - xii. Legal issues
 - xiii. Gambling
 - xiv. Safe housing
- c. Each recovery plan lists specific strengths and assets of the client including how these will be used to address issues and challenges and achieve recovery objectives.
 - d. The recovery plan should identify clearly those objectives that are critical for discharge from care or transfer to a lower level of care.
 - e. The recovery plan will identify community resources that will need to be developed to support the client's discharge from the treatment program and continue the recovery process.
 - f. If certain high priority areas of the overall recovery process for a client are beyond the scope of the treatment program, these areas should be included in the recovery plan with identification of how they will be addressed through other community resources.
 - g. The recovery plan is reviewed and revised on an ongoing basis with active participation of the client, goals are achieved or modified, but at a minimum every 90 days.

3. Clinical Treatment Program Design

- a. General features of treatment program
 - i. A therapeutic environment model must be evident that is safe, inviting, non-institutional, homelike, welcoming, with appropriate cultural features.
 - ii. Various treatment and intervention models should be available, depending on individual needs, including behavioral, cognitive, relational, affective and systems approaches.
 - iii. Approaches must be respectful, supportive and empowering, not authoritarian, attacking or demeaning.
 - iv. Treatment must be strength (asset) based, with ongoing opportunities for women to experience, practice and explore positive capabilities.
 - v. Treatment should include psycho-educational input on the impact of gender on development and functioning in society including the strengths associated with gender.

- vi. There should be multiple opportunities for empowerment of women within the community and within the program, including opportunities for input to the program operation and design.
 - vii. Treatment in all-women groups and/or with female therapists and counselors must be available at different stages/levels of treatment. This requirement is particularly relevant to co-ed programs.
 - viii. Opportunities are available for significant others or client identified supports to participate in and assist with the client's recovery.
 - ix. Vocational assessment, training and experience should be available to women within the program (e.g. computer training), including assistance with search for employment, where program duration allows.
 - x. Volunteer or mentoring opportunities should be available within the organization as the client progresses through and leaves the treatment program.
 - xi. Compensation of consumers for work within the organization is provided if available.
 - xii. Treatment must incorporate unique cultural characteristics, strengths and potential supports for each participant.
 - xiii. Program works to maintain, preserve or rebuild the client's attachment to her child(ren) being sensitive to the client's choice.
- b. Specific focus of treatment must include individualized interventions for each area identified in Recovery Planning (2b), using the best available evidenced based approaches for those areas.
 - c. Individualized services should address multiple areas of functioning on an individual, family and community level that all contribute to a woman's overall quality of life.
 - i. Mental health and substance use issues
 - ii. Practical needs, including housing, financial, transportation, child care, vocational training, education, job placement
 - iii. Parenting education and child development
 - iv. Primary health concerns, including nutrition
 - d. Level of care and modality of care must remain flexible, with different modalities and intensities of treatment available over time in a seamless manner, for example, intensive outpatient, and outpatient, group and individual.
 - e. A flexible approach to hours of treatment provided is used that satisfies criteria prescribed for each level of care by state funders and other payers.
 - f. There should be evidence of efforts to arrange services for other family members if needed.
 - g. Care can be provided in conjunction with an opiate replacement program, if appropriate. Participation in such a program is not a basis for exclusion from treatment program.
 - h. Coordination of care – active coordination of care must take place with other providers with whom client is or will be involved. This process must involve the client, e.g. in care coordination meetings.

- i. Program collaborates appropriately with DCF's or other outside agency's assessment of client's parenting ability (with client permission).
- j. Discharge Planning, Aftercare, Relapse Prevention
 - i. Planning for discharge from the treatment program should be evident from the initial assessment throughout the treatment process.
 - ii. Prior to discharge the client will have confirmed appointments with treatment providers who will be providing continuing care in the client's community.
 - iii. In addition to treatment providers, a range of supports in the client's community will be arranged, with the client's input, prior to discharge. (e.g. childcare, transportation, self help groups, health care)
 - iv. By discharge from the program there must be a stable housing plan in place.
 - v. Specific relapse prevention interventions and plans must be developed and written with the client in understandable terms.
 - vi. Re-entry to treatment, if necessary, must be available and accessible.

4. Recovery Supports

- a. Use of peer supports within the program should be established clearly (e.g. women in more advanced levels of treatment mentoring those beginning).
- b. Links to recovery supports in the community must be identified and begun or expanded, including local Recovery Center if available.
- c. Each client must be given the option to participate in an appropriate group peer support system (e.g. AA, NA, AlAnon, or other recovery meetings) including having a sponsor or mentor before discharge.
- d. Client should be assisted to connect to local family support and/or advocacy groups prior to discharge.
- e. Upon client's request, assistance provided to engage in faith based supports.
- f. Program will assist client to develop a vocational plan, or connection to appropriate vocational supports.
- g. Program must assist client to have a viable housing plan that will support recovery.
- h. Assistance is provided to help client maximize healthcare coverage.

5. General program environmental features

- a. Program environment/setting must be safe and secure.
- b. Physical setting of the program must be warm, inviting and comfortable.
- c. Physical setting must include culturally diverse elements and décor.
- d. There should be a majority of female staff members.
- e. Staff must reflect the cultural diversity of the consumer population.
- f. Program must include positive cultural experiences and materials.

- g. There must be comfortable play space for children in the program and areas for mothers and children to interact naturally, as well as age-appropriate activities designed for children.
- h. Mothers can bring children to the program and a supervised safe setting is provided for the child with age appropriate activities.(Program reserves the right to screen for safety in these situations).
- i. When children are presents in the program, program has procedures in place to observe parent child interaction in order to assist in building parenting skills if needed.
- j. Protocols are in place for care of children who are at the program, including emergency procedures, health management or interruptions in parent's ability to provide adequate care.
- k. Transportation supports must be available for women
- l. Outreach to women with transportation challenges must be an available option.

6. Staff competencies and training

- a. The program must include staff with demonstrated competencies in women's issues, cultural issues, substance abuse, mental health, co-occurring, trauma and child/family.
- b. There must be written policy in place regarding physical contact and boundaries between staff and clients, and between clients, to prevent re-traumatization.
- c. A comprehensive staff development program must be in place with the following elements:
 - i. Current theory of women's development from childhood through adulthood
 - ii. Unique characteristics of women with mental health and substance abuse issues
 - iii. Key values and principles in working with women
 - iv. Impact of cultural issues on gender specific programming
 - v. The role of trauma and issues of re-traumatizing
 - vi. Sexuality
 - vii. Sexual abuse
 - viii. Family violence
 - ix. Grief and loss
 - x. Gambling
 - xi. Parenting
 - xii. Spirituality
 - xiii. Traditional and nontraditional community supports.
- d. Supports should be in place to enhance staff morale, address staff communication, and provide care for the caregivers.

7. Program Evaluation

- a. Process evaluation should be in place to insure appropriate utilization of gender responsive treatment services and elements as identified in these guidelines.
- b. Outcome evaluation is in place to measure short and long-term impact of interventions on program participants. Measurements include:

- i. Program participation/completion/discharge
- ii. Alcohol/drug recovery/sobriety*
- iii. Educational attainment*
- iv. Employment*
- v. Housing*
- vi. Improved family and social relationships*
- vii. Parenting and reunification with child*
- viii. Physical Health
- ix. Mental Health
- x. Criminal justice recidivism*

NOTE: * outcome measures: The WSPIC Women’s Outcomes Workgroup identified six domains of outcomes that ideally would be measured for women leaving a residential program. There are seven items starred here because Educational attainment and Employment are separate here but incorporated as one item in the Outcomes Workgroup list. For each domain, one or more potential measures are available, along with some explanatory details. Please contact Karen Ohrenberger for more details.

Primary Sources: DMHAS, “Women’s Services: Developing Preferred Practices in Programming and Services, Literature Review of Best Practices”; CSAT, “Comprehensive Treatment Model for Alcohol and Other Drug-Abusing Women and Their Children” and “Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs; Covington, “Helping Women Recover: Creating Gender-Responsive Treatment”; Covington and Bloom, “Gender-Responsive Treatment and Services in Correctional Settings”; Boyle, White, Corrigan & Loveland, “Behavioral Health Recovery Management: A Statement of Principles”; DMHAS, *Draft Standards of Practice for Recovery-Oriented Behavioral Health Care*.

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