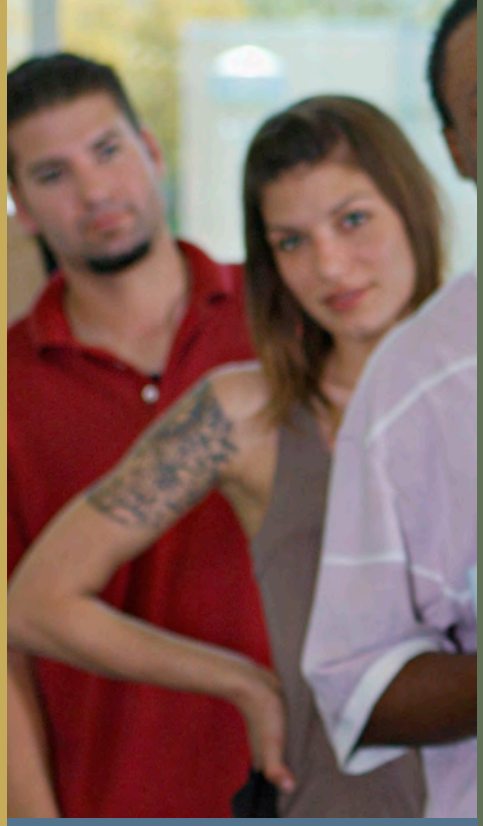

Guidance Document for

Supporting Women in Co-ed Settings

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Supporting Women in Co-ed Settings

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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I. INTRODUCTION AND BACKGROUND

In 2013, nearly 566,000 women, 33.7 percent of the 1.68 million admissions, entered treatment for substance use disorders (SUDs) (Substance Abuse and Mental Health Services Administration [SAMHSA]/Center for Behavioral Health Statistics and Quality, 2015). Most of these women received services in co-ed treatment and recovery centers, where men outnumber women. Yet women and men with SUDs differ from each other in many respects. These include sex and gender differences, reasons for initiating substance use, consequences of use, barriers and motivations for entering treatment, and treatment and recovery needs (Brady, 2005; Covington, 2007; Greenfield et al., 2007; Grella et al., 2005; Fiorentine et al., 1999).

Data from SAMHSA's 2013 *National Survey of Substance Abuse Treatment Services* (N-SSATS) show that less than half (44 percent) of SUD centers have women-specific programming or groups (SAMHSA, 2014b). This includes co-ed programs that offer services or programs for women, such as women-only counseling groups. This document's purpose is to offer principles and practices that co-ed centers can use to assess and improve their programs to better serve women. The majority of women entering treatment for an SUD have co-occurring mental disorders, such as depression, anxiety, posttraumatic stress disorder (PTSD), eating disorders, and personality disorders (SAMHSA, 2009). Thus, throughout this document, "women with SUDs" includes women with co-occurring disorders. In addition, service recipients are referred to in different ways by different provider agencies. Throughout this document, women engaged in services are referred to as "participants," which includes "clients," "patients," and "consumers."

SAMHSA has supported the creation of many resources focusing on the unique characteristics of women with SUDs and effective interventions that support their recovery. These resources include:

- *Treatment Improvement Protocol (TIP) 51: Addressing the Specific Needs of Women*
- *Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals*
- *Using Matrix with Women Clients: A Supplement to the Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders*
- *Family-Centered Treatment for Women with Substance Use Disorders—History, Key Elements and Challenges*
- *Guidance to States: Treatment Standards for Women with Substance Use Disorders*

Since the early 1990s, SAMHSA has supported gender-responsive treatment for women through the women's set-aside in the Substance Abuse Prevention and Treatment Block Grant. As a result, every state has funding for treatment to address the needs of pregnant women. SAMHSA also funds discretionary grant programs for pregnant and parenting women.

Much published research about best practices for women is based on studies of participants in women-only residential treatment centers with comprehensive, gender-responsive, trauma-informed, family-centered, and strength-based programming. Yet very little published research explains how to offer effective, gender-responsive services for women in co-ed settings. It is important to ensure that the needs of women are not overlooked in these settings. Because most women are served in co-ed settings and few guidelines or materials exist for supporting

women in co-ed SUD centers, SAMHSA's Center for Substance Abuse Treatment (CSAT) created this guidance document.

SEX AND GENDER DIFFERENCES

Nearly all bookstores contain rows of books that explore the nature of men, women, and relationships. These books explore why men and women have trouble understanding each other and ways to better communicate (e.g., "Why can't men just listen when I want to talk about a problem, instead of telling me how to fix it?" or "Why do women always want to talk about feelings?"). In their personal lives, people often talk about these differences and work to better understand the opposite sex. However, the design of behavioral health services rarely takes sex and gender differences into account. Instead, providers too often give the *same* services in the *same* way for men and women.

DEVELOPMENT OF THIS DOCUMENT

To guide this project, SAMHSA asked, "Given what we know about high-quality women's centers, what guidance can we provide for serving women in co-ed settings?"

SAMHSA followed a four-step process to gain feedback on draft principles, guidelines, and materials for increased use and acceptance by a variety of stakeholders:

1. ***Resource and Research Review.*** SAMHSA conducted a resource and literature review of journals and other sources for best practices. Other information about effective programming, treatment, and recovery for women in co-ed settings came from the Women's Services Network of the National Association of State Alcohol and Drug Abuse Directors.
2. ***Expert Panel.*** SAMHSA convened an expert panel of 12 nationally known leaders, including researchers, treatment and service providers, recovery community representatives, and policy experts. The members came from a range of backgrounds and experience, including a mix of research/treatment/peer recovery agencies, diverse cultural/geographic demographics, and lived experience. The panel members took part in a two-part discussion to share their knowledge about best practices in high-quality women's centers and how these practices might apply to co-ed centers. Members discussed their experiences with and uses of research about women in co-ed residential and non-residential settings. Their input served as the basis for this guidance document. They also provided resources, reviewed drafts, and discussed stakeholder comments. (See **Appendix 1** for the list of expert panel members.)
3. ***Stakeholder Input.*** SAMHSA asked for stakeholder input from the Women's Addiction Services Leadership Institute (WASLI) network to learn more about treatment and recovery service providers' views on serving women in co-ed settings. Initial input from the WASLI network was also used to inform the expert panel. SAMHSA also invited WASLI members to review the draft guidance document. SAMHSA staff from other program areas and other federal partners provided additional input. Feedback from all stakeholders was woven into the final document. (See **Appendix 2** for the list of stakeholders.)
4. ***Development of Self-Assessment Tool.*** A self-assessment tool was created for co-ed centers after development of the guidance document. The tool can be used to evaluate strengths and weaknesses in providing gender-responsive services for women and to find ways to improve. A small group of providers in Colorado tested a draft version and offered feedback. Their recommendations were used to finalize the tool. (See **Appendix 3** for the assessment tool.)

Sex and gender are not the same thing, and there are both sex and gender differences that influence men and women.

Sex differences are the biological differences between men and women. These include reproductive organs, body size, and bone structure.

Gender differences refer to ideas about what characteristics, roles, and expectations are considered masculine or feminine. A person's sense of masculinity or femininity is part of his or her identity. People measure their femaleness and maleness against certain accepted norms and what it means to be a "man" or a "woman" in one's cultural groups. Cultural groups, including religion, race, and ethnicity, greatly contribute to norms about gender differences and gender identity. Yet many women have masculine traits, and many men have feminine traits, no matter their background, gender identity, or sexual orientation.

No matter what sex a person was assigned at birth, that person may identify as a woman, a man, a transgender man or woman, gender non-conforming, gender fluid, or another gender identity. In this document, the term "woman" refers to anyone who identifies as female. Centers should expect to have transgender women in treatment and recovery. If a service recipient identifies as a woman, staff should treat her as such.

Examples of Gender and Sex Differences

Women and men have both sex and gender differences, but those differences are not absolutes. Instead, they tend to occur on two bell curves, like those shown in Figure 1. The blue (left) curve is men and the red (right) curve is women. Traits linked to men and masculinity are on the left of the spectrum, and traits linked to women and femininity are on the right. As one can see, men and women overlap quite a bit. For example, men as a whole have more physical strength than women, but there are women who are physically stronger than most men, and men who are physically weaker than many women.

Typical gender differences between men and women affect how they communicate, make decisions, store knowledge, and prioritize. For example, women tend to prioritize relationships as a means of growth and development. Thus, recognizing and understanding the value of relationships in women's lives is important when working with them. Women often have "focus on children" as their first treatment goal, and "get a job" as a lower priority. For men, it is often the opposite. They may focus on finding a job first and children later. Men may view getting a job as the most important and tangible way to take care of their children, whereas women may focus more on spending time with their children. Relationships are important to men, too, but they may prioritize them differently or have a different viewpoint about them.

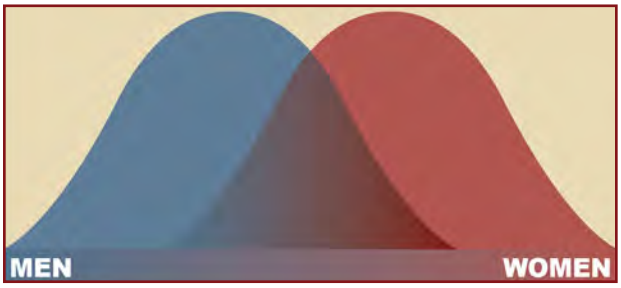

Figure 1: Spectrum of Traits Linked to Masculinity/Men and Femininity/Women

As other examples, when communicating, men may focus on "report talk," which includes talking about events and factual information. In contrast, women may focus on "rapport talk," which focuses on building a relationship. For example, when women get together, their purpose is often to talk and share thoughts, feelings, and experiences without a specific agenda. When men get together, their purpose is often more "activity oriented"—for example, to watch a sporting event with a few friends. Also, when women talk about the challenges of their day, it is likely that they simply want to be heard, because they are in the process of thinking through the issues. Men are more likely to focus on solving problems and sharing challenges in order to talk about solutions.

But these examples are all generalizations, and people fall along the bell curve in terms of both gender and sex differences. Some men are oriented toward processing emotions or building rapport, and some women are oriented toward problem solving or reporting facts. No gender or sex differences fit all men or all women.

Gender and Sex Differences in Substance Use and the Recovery Process

The National Institutes of Health's website A to Z Guide: Sex and Gender Influences on Health (National Institutes of Health, Office of Research on Women's Health, n.d.) provides information about research and clinical trials that document sex- and gender-based health and disease differences between females and males. This knowledge can be used to understand differences and improve healthcare services for both women and men. Because of sex differences, men and women "may experience the same diseases at different rates or with different symptoms, or they may experience different kinds of illness altogether" (Brittle & Bird, 2007, p. 18). This finding holds true with SUDs.

Women develop SUDs and related medical disorders faster than men. This is known as the "telescoping effect" (SAMHSA, 2009, p. 27). For example, "women develop alcohol-related physical health problems at lower doses and over shorter periods of time than do men" (SAMHSA, 2009, p. 7). The difference is linked to two possible causes. First, women have higher body fat and a lower volume of water in their bodies, even compared with men of the same size. Thus, alcohol is less diluted in women's bodies. Second, women have less of the gastric enzyme that metabolizes alcohol, which means alcohol remains in women's bodies longer. The combination of higher concentrations of alcohol and longer exposure of organs to alcohol's effects leads to women having greater alcohol-related health risks than men (SAMHSA, 2009, p. 40).

The expert panel stressed that societal expectations about relationships, families, communities, and employment also come into play for women and men receiving services for SUDs. Power differences in society influence who speaks, who is silent, and whose voice is heard, along with who sets norms and who does not. The panel noted that treatment and recovery centers are a microcosm of our society. Thus, centers reflect the same power dynamics among staff and participants. Co-ed treatment settings should take these dynamics into account and address them when needed.

Despite the differences between men and women with SUDs, recovery services and training of staff members have been based on health research on men's experiences, ignoring sex and gender differences (Bentley, 2005; NIH, 2009). Going back to Figure 1, when services are designed based on the blue (left) curve, ignoring the red (right) curve, some women are comfortable with these services. Other women are able to adapt and still succeed. But many women cannot relate and are unable to benefit from the services offered. This is why gender-responsive services are needed.

This document speaks to the needs of women with SUDs being served in co-ed centers. It is worth noting that gender-responsive services are important for men, as well. Programs designed for women that do not take men's needs and priorities into account are likely to experience poorer engagement and outcomes for male participants. However, far fewer men participate in SUD services designed specifically for women than the number of women participating in general-purpose services, where men significantly outnumber women.

The following guidance statements, and the strategies and practices that flow from them, can help improve outcomes for women in co-ed centers.

II. GUIDANCE STATEMENTS

INTRODUCTION

The expert panel developed guidance statements to offer a general understanding of the context and why it is important to address the specific needs of women. These guidance statements provide information about sex and gender differences, women's experiences, and delivery of substance use treatment and recovery services. The statements are meant to help providers understand how women's experiences impact their recovery, regardless of service delivery setting.

Women are diverse, and their individual cultural backgrounds, family histories, and life experiences influence their treatment and recovery needs. The guidance statements are based on experiences and characteristics frequently seen among women and will help providers better respond to and serve women in their centers.

These statements serve as overarching concepts that guide the more specific practices and strategies described in the next section. The statements are organized into six primary groups: women's unique needs and experiences, gender dynamics, trauma, physical health, mental health, and relationships.

A. ADDRESSING WOMEN'S UNIQUE NEEDS AND EXPERIENCES

- ***Effective treatment and recovery services for women are person-centered, taking into account gender and the priorities, interests, and experiences of individual women.*** Women's pathways to substance use are different from those of men. Women also have different motivations for treatment, treatment barriers, and treatment and recovery support needs from men. These differences impact women's treatment and recovery process.
- ***Providers of effective treatment and recovery services consider how the treatment environment influences women's treatment experience, and they plan accordingly.*** The expert panelists noted that a center's environment is particularly important for women. Women thrive in welcoming, safe, calm, and well-kept environments. Conversely, a chaotic and unattractive environment that does not feel safe to a woman can be an obstacle to her treatment and recovery.
- ***Effective treatment and recovery services are responsive to both culture and gender, holding respect as a core value.*** Women's cultural backgrounds shape their world views, priorities, values, experiences, gender expression, and treatment and recovery needs. In culturally competent services, staff members are familiar with and respectful of the cultural populations they are serving. Ideally, staff are also culturally representative of the women being served. When staff practice cultural humility, it means they are aware of their own culture and how it influences

their work and world view. This allows them to better understand other people's experiences. This approach helps staff communicate with women participants in a way that is respectful of both gender expression and cultural background.

- ***Sexuality (including sexual orientation) and patterns in a woman's sexual history are important considerations in effective treatment and recovery planning.*** Having an SUD can affect a woman's emotional capacity for romantic and sexual feelings, and her experiences with sex. It also influences others' perceptions of her sexuality and sexual history. Lesbian, bisexual, and transgender women often face discrimination and other unique experiences that can affect the recovery process. Exploring and establishing healthy sexuality, sexual boundaries, and relationships is often an important part of women's recovery.
- ***Effective treatment and recovery providers acknowledge that women with SUDs are more likely to live in poverty than their male counterparts.*** Many women seeking services rely on men or other family members for financial support. In general, women with SUDs have less education and employment experience than men with SUDs. They often have different obstacles to economic well-being and benefit from different education and employment services. Staff members should be sensitive to and respond to the socioeconomic factors that shape women's lives.

B. GENDER DYNAMICS

- ***Women benefit from support and activities that develop their voices and self-identities and from sharing their stories.*** Women often enter services for SUDs having been silent or silenced by others. They may have had few chances to think about or express what they want, to speak for themselves, or to share their personal stories. Having someone actively listening to them as they share their experiences can be both nurturing and empowering.
- ***Effective treatment and recovery services acknowledge unintended biases that favor men.*** Both staff and participants can have biases, which may arise in individual counseling, groups, and other programming. No matter their beliefs about gender roles, female staff and participants often defer (consciously or unconsciously) to male staff and male participants. For example, people often listen more closely when men speak and respond better to their ideas, even when a woman suggested the same idea earlier. Also, in co-ed groups, men may talk more than women or interrupt others who are speaking. Or the women may focus too much on helping the men open up and responding to their needs. Many women with SUDs have had less power in life than other women. Many also have histories of abuse that make them more likely to defer to men. Training and clinical supervision can address the various types of biases that favor men. Staff can adopt strategies to ensure that women share their voices and perspectives, and get their needs met.

C. TRAUMA

- ***Physical and psychological safety are of paramount importance when treating women with SUDs.*** Women with SUDs have high rates of adverse childhood experiences, intimate partner violence, and other forms of current and past trauma. Women with a history of childhood trauma are also more likely to have experienced trauma as adults. Both the physical setting for treatment and recovery services, and interpersonal interactions between staff and female participants, should promote a sense of safety.
- ***Providers of effective treatment and recovery services for women adopt and adhere to trauma-informed, recovery-oriented principles and practices.*** Trauma-informed and recovery-oriented approaches include safety, respect, and empowerment, all of which are particularly important for women. The principles should be established, discussed, and built into center operations and be visible in the organizational culture, staff attitudes, service design, and participant experiences.
- ***Effective treatment and recovery services use strength-building approaches and avoid punitive strategies that further reduce self-efficacy and engagement.*** Women with substance use problems, especially women with complex trauma histories, often have low self-efficacy and self-esteem. This can impact engagement and ongoing recovery. These women have often been coerced or forced to do things against their will. Thus, making choices and having chances for shared decision-making, goal-setting, and voicing their ideas helps build confidence and courage.
- ***Effective treatment and recovery services for women offer an array of trauma-specific and trauma-informed services that build coping strategies.*** Trauma and violence can have significant short- and long-term neurological, biological, psychological, and social effects. Trauma histories can have profound effects on all aspects of women's lives, including their relationships. Trauma-informed staff and trauma-specific interventions help women learn healthier ways of coping with the long-term effects of trauma, which improves health, healing, and recovery.

D. PHYSICAL HEALTH

- ***Women benefit when their physical healthcare needs are addressed and integrated into treatment and recovery planning.*** Women with SUDs often have a range of health concerns and chronic health problems that require prevention, primary, gynecological, and other specialized care and wellness services. These women may have personal and systemic barriers to accessing health and wellness services that impede their recovery. Navigator services, as well as integrated health and behavioral health services, help women to overcome obstacles and obtain health care, which can also improve SUD outcomes.
- ***Effective treatment and recovery services include a plan to screen for, and address, pregnancy and related treatment/recovery considerations.*** Pregnancy is a pivotal time in a woman's life and a critical time for addressing SUDs and getting support. Pregnant women are often motivated to change. Though they may still struggle to stop their alcohol or drug use, most of them care about their unborn children and want to deliver healthy babies. Women with SUDs benefit from early identification of pregnancy and an informed team response that considers symptoms,

pharmacological risks and options, and prenatal care. Women with SUDs who are pregnant also benefit from learning how to lower the risks to their fetuses' health. Risks include miscarriage, premature births, fetal alcohol spectrum disorder, and neonatal abstinence syndrome (NAS). NAS occurs from exposure to addictive opiate drugs while in the womb.

E. MENTAL HEALTH

- ***Women with SUDs have increased prevalence of co-occurring mental disorders, which can affect SUD treatment and recovery outcomes.*** Effective treatment and recovery programs ensure that women can access screening, assessment, and services for mental health conditions, such as depression, eating disorders, anxiety, and PTSD. These conditions need to be addressed for women to fully engage in treatment and embrace recovery. All of the practices and strategies in this guidance document can be helpful when serving women with co-occurring mental disorders.
- ***Effective treatment and recovery services use an integrated approach that addresses both mental and substance use disorders at the same time.*** Services include screening, assessment, intervention, pharmacological services, cognitive behavioral treatment, and recovery supports. Integrated treatment is an evidence-based practice proven effective for women. It is holistic and uses a collaborative, multidisciplinary team. This collaboration allows the treatment team to address both substance use and mental disorders at the same time—through one team and one plan. This increases a woman's chances of recovery from both disorders.

F. RELATIONSHIPS

- ***Effective treatment and recovery services have highly qualified staff members who attend to the therapeutic alliance.*** Relationships are often of primary importance to women. Thus, the therapeutic alliance between staff and the woman participant is a critical factor in treatment and recovery services. A therapeutic alliance takes time and effort to build, but it is key to creating trusting relationships and an environment where healing can occur. Having therapeutic relationships that offer both boundaries and consistent support creates a safe space for women. Through these relationships women are able to explore their experiences and feelings, learn new skills, and share their successes.
- ***Effective treatment and recovery services for women are person-centered and support them within the context of their lives.*** Women have many roles and responsibilities, often including taking care of children and other family members. These responsibilities can be barriers to treatment engagement and participation. Women often have fewer economic resources than men, which can make finding child care and support more difficult. Women may also attach a higher priority to their relationships with others than to their own recovery and service needs. Effective centers maintain flexibility and offer to connect women with resources when possible. They also avoid the use of punitive or shaming strategies when women cannot attend or meet treatment expectations.

- ***Effective treatment/recovery services provide formal and informal opportunities for women to meet and build relationships with each other.*** Women benefit from supportive relationships with other women. Effective centers have female recovery coaches or peer specialists who can share their experiences and support women. Encouraging mutual self-help among female participants and with other volunteers and community members can further build women's recovery capital and engagement. Recovery capital includes a woman's internal and external resources to begin and sustain recovery. Recovery capital is influenced by providers who can support a woman's development of resilience and protective factors, wellness, self-efficacy, hopefulness about her future, new or repaired social networks of family and friends, and resources in the community to support recovery.

- ***Effective co-ed treatment and recovery services create a venue for women to learn about healthy interactions and friendships with men, including respect, boundaries, and communication.*** Women with SUDs often have histories of poor relationships with men. Treatment and recovery centers can be safe places for women and men to build healthy friendships. Both women and men can listen to the struggles of the other sex and become more aware of their own behavior and expectations. Skilled facilitators can address communication dynamics in a safe, respectful manner.

III. PRACTICES AND STRATEGIES

This section presents some of the strategies for evaluating an organization's responsiveness to women and putting new practices into place. SUD treatment has evolved over the last few decades and will continue to evolve as populations change, more becomes known about effective interventions, new treatments are developed and disseminated, and policy and funding requirements shift in ways that impact treatment and recovery services. Shifts made to integrate the research on sex and gender differences into practices and policies for gender-responsive services are an example of this change. Many of these practices have been put into place in specific programs for women; applying this information to co-ed settings is an important next step.

Practices and strategies related to staffing are discussed first, then environment and facilities, assessment and treatment/recovery planning, interventions and groups, and recovery support services. The practices described here are broad; they can be adapted to meet the specific needs of different types of programs or specific-subpopulations of women.

A. STAFFING ISSUES

Well-qualified, effective staff and a workable staffing plan are the most essential ingredients in SUD treatment and recovery services. The term "staff" refers to both paid staff and volunteer staff in treatment/recovery centers. This includes clinicians, counselors, peer specialists, recovery coaches, and other professional, paraprofessional, administrative, and support staff. Other elements that contribute to a center's success include an organizational culture that supports women and offers relevant staff training and supervision. Effective supervision is fundamental to putting the practices and strategies discussed in this document into place. All staff—not just clinicians—benefit from supervision.

Staffing Plan

Effective treatment/recovery services for women have sufficient staff and a staffing plan that allows for strong rapport, therapeutic alliances, and true partnerships. These are built through consistent interactions between staff and participants. Adequate staffing allows for reasonable caseloads, which are needed to build supportive therapeutic relationships and let staff be aware of participants' progress and setbacks. Effective centers also have sufficient program and clinical management, and an array of specialized staff, including case managers, housing specialists, and peer specialist/recovery coaches—all with experience in gender-responsive approaches.

Hiring professional and paraprofessional staff who have specific knowledge and experience in gender-sensitive treatment increases a center's ability to reach and retain women in treatment/recovery. Centers are encouraged to ask job candidates about gender-specific issues. For example, interviewers could ask a candidate how his/her experience working with women with SUDs differs from his/her experience working with men, or about his/her training in gender-specific approaches.

The expert panel recommended giving priority to matching women with female primary counselors. Ideally, when assigning counselors, centers should consider:

- A woman's engagement with staff thus far
- The woman's goals and expectations of counselors
- How likely the woman and counselor are to create rapport

Matching women with female staff who have common experiences and understanding, such as similar age and racial/ethnic/cultural background, can help build rapport. However, a counselor's perceived empathy is also a key factor and may be just as important as gender and common life experiences. The use of female peer specialists or recovery coaches, especially those in long-term recovery, early in the treatment/recovery process can be very effective in building a woman's hopeful view of the future and building a supportive community.

Clinical Supervision and Training

Centers striving to enhance or maintain their ability to provide gender-responsive services make clinical supervision a priority and ensure it happens on a regular basis. Such centers also ensure supervisors receive training in effective supervision and how to address gender-specific issues. Supervisors may need specialized training in many other areas, including mental health, support of staff with trauma histories, prevention of secondary trauma, gender dynamics in co-ed groups, trauma-informed care, identification and understanding of staff members' biases (e.g., judging women who use alcohol or drugs during pregnancy or who stay with abusive partners), and gender dynamics in co-ed groups.

During supervisory sessions, supervisors and staff may talk about resources and potential organizations for collaboration. They can also discuss referrals for child care, child welfare, reproductive health care, and other services necessary for comprehensive support of female participants, when the center does not offer these services.

Ongoing staff training is also important. It helps build staff members' capacities to serve women and should take into account the needs of a variety of employees, including both new hires and long-term employees. A good place to start is with the core competencies described in *Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Professionals* (SAMHSA, 2011). The core competencies can be used to inventory staff training needs prior to creating a training program. Training strategies can include brown-bag lunch sessions, webinars, longer in-service training programs, local college offerings, and incentives to staff that enroll in professional development programs. One helpful resource is the online course *Introduction to Women and SUDs*,[1] developed with SAMHSA support.

Beyond initial training, staff need follow-up support to effectively apply training content to actual work with women participants. Ongoing discussions during clinical supervision and staff meetings about how to implement what is learned from training, clinical supervision, and staff meetings will result in better application of content.

Because trauma is so common in women with SUDs and has such a profound impact on their experience of services, all staff—including administrative and support staff—should receive training on trauma-informed approaches to behavioral health. This may include support and training around preventing and addressing secondary trauma and creating an environment that is trauma informed. For practitioners, an important aspect of trauma-informed care is recognizing their vulnerability in the work setting, including their personal history and potential for secondary trauma. This requires appropriate and frequent clinical support, mentoring, and coaching.

[1] *Introduction to Women with Substance Use Disorders* is offered by the Addiction Technology Transfer Center Network's online distance education program. Continuing education hours are available for a nominal fee.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (SAMHSA, 2014c) defines a trauma-informed program, organization, or system as one that:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*.

The concept document further defines a trauma-informed approach as one that follows six key principles:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

Many of these principles are discussed within this document. For a more comprehensive understanding, see SAMHSA's site about trauma-informed approaches and interventions at http://www.samhsa.gov/nctic/trauma-interventions.

To ensure a full understanding of trauma-informed approaches, centers can provide staff training based on *TIP 57: Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014d). This publication discusses patient assessment, treatment planning strategies that support recovery, and how to build a trauma-informed workforce.

Depending on the level of service, philosophy, and evidence-based practices of the center, training programs can address other topics, such as:

- The range of women's experiences (e.g., needs of sub groups of women);
- Gender awareness (i.e., understanding the economic, status, and power issues facing women);
- Differences between men and women in processing and problem-solving;
- Issues relating to pregnancy and parenting; and
- Gender dynamic considerations in group facilitation.

Organizational Culture

When the organizational culture respects women and actively takes gender into account, female participants are more likely to engage and actively participate in their treatment/recovery services. This improves participant retention and, ultimately, outcomes. A respectful, gender-responsive culture also creates a healthy environment in which staff members feel supported as they integrate gender-specific content and considerations into service delivery. This can help reduce staff turnover, which is important because frequent staff turnover can negatively affect women in treatment by causing instability in relationships. Staff benefit from opportunities to discuss, explore, and find ways to respectfully and effectively address gender dynamics in co-ed settings and relationships.

Centers can build a culture that supports gender-responsive services in many ways. They can consider putting some of these examples into place:

- Integrate facilitated discussions about working with women as part of staff and supervision meetings.
- Review outcome data on women's engagement, retention, and progress and use the data to discuss process improvement.

- Provide visible leadership opportunities for female staff and support them in becoming advocates for women's services. For example, centers can create mentoring and leadership programs to promote and integrate women at all levels of the organization. Doing this sends a positive message and provides models for the women receiving services.
- Join women's service provider networks in the community.
- Provide staff with follow-up discussions, coaching, and supervision to help build a safe and supportive environment for staff and women served.

A culture of support can help staff members keep healthy views and attitudes about their work and the women they serve. It also helps staff have positive outlooks about participants and their ability to recover. This support includes understanding participants' experiences and showing respect and empathy. Staff may also need practice to shift their views and attitudes about women with SUDS from negative judgments to more positive approaches. For example, rather than viewing a woman as "manipulative," the same behavior can be viewed as "strategic" or as "strong survival skills."

Putting the above practices and strategies into place will help centers build a healthy and healing organizational culture and treatment setting for women, as well as men.

B. ENVIRONMENT/FACILITIES

A center's environment and physical facilities set a tone that may impact women's expectations and contribute to their experiences of treatment/recovery services. When the setting looks pleasant, professional, and comfortable, it builds a sense of competency, comfort, and promise. On the other hand, run-down environments may lower expectations and imply a lower level of respect. The center's location, its presentation of physical and emotional safety, and general warmth can all influence women's initial perception of the center as a whole. The setting should contribute to the treatment environment, encourage relationship building, and provide a sense of safety.

Physical Environment

A top consideration is whether women can safely access the center's services. Consider the following questions.

- If services are offered at night, is parking or bus transportation located in a well-lit location?
- When women walk to the door, do they pass by a group of male smokers, possibly feeling exposed, vulnerable, or "on display" as they enter the center?
- Sometimes centers are located in high-risk neighborhoods to make access easier for people living nearby; in those cases, does the inside of the center feel like a safe haven? Or does it mirror the negative features of the "outside" world from which women are seeking respite?

After talking with various stakeholders (e.g., participants, staff, collaborators), centers may decide to make physical or administrative changes to address physical safety concerns. Such changes could include offering group transportation, providing safety patrols/escorts to parking lots or transportation locations, adding more outside lighting, increasing daytime hours, or making the inside of the center feel more calming and safe.

It is also helpful to consider the type/arrangement of furniture and the goals of the center. When placing chairs or couches in waiting rooms, group rooms, or any group setting, there should be enough space allowed to acknowledge personal space and provide a sense of security and safety. Some of the furniture can be arranged to encourage interaction and allow for conversation, and other seating can be positioned to allow for privacy.

Ideally, centers serving women include a child- and family-friendly environment. This can involve offering appropriate child care for infants, toddlers, and older children who participate in family services. Even if a center does not offer child care, female participants might bring children with them. Accommodations, such as a few books, toys, clean floors, and a small area for children to play in, build a sense of safety and offer a sensitive atmosphere for the woman whose child is with her.

Preferably, co-ed centers provide chances for women to "hang out" without men present. A dedicated women's space (e.g., women's lounge area) allows women to gather in a safe space. This helps foster connection, interactions, and formal and informal recovery supports. This space may be a dedicated spot within the center, or a location that is used as a "women's space" during certain hours. Centers can consider the clientele, neighborhood, and other resources to best shape these opportunities.

More treatment/recovery centers are starting to use virtual meeting and counseling spaces and other ways for participants to interact through private social media venues. With etherapies and social media supports, security and monitoring help ensure confidentiality and prevent online harassment. Having access to a virtual women's space can also enhance recovery support for women while they are not at the center. Such spaces can be valuable for women who have trouble accessing services in person, such as women in rural areas or who have young children.

Personal Safety

Because women with SUDs often arrive at a facility worried and vulnerable, centers should consider how to create a sense of sanctuary within the facility. For example:

- Does the inside environment of the center provide a sense of welcome and safety?
- Does the artwork portray diversity and convey a sense of hope or positivity?
- Does the environment promote a sense of well-being and feelings of security and comfort for participants and staff?

Signage in the center's reception area can add to or reduce a woman's sense of safety. Signs that are meant to convey rules and guidelines may instead make people feel unsafe, uncomfortable, or unwelcome. For example, a waiting room sign that says "no weapons" generally does not make people feel safe or reduce the prevalence of weapons. An alternative is to replace the sign with calming artwork and have everyone sign an acknowledgement of a "no weapons policy," along with the other required paperwork. If guidelines about the waiting room are necessary, it is helpful to share the content in a way that builds community and respect.

Reception staff also play an important role in setting the initial "feel" of the center and helping participants feel safe. When a woman checks in at the reception desk, greeting her with a smile and openness may help her begin to let her guard down and feel more comfortable. Centers can offer training for receptionists, intake counselors, and others who meet women soon after they enter the center to teach them how to recognize deep distress or signs of trauma. Protocols can also be set up and taught to help support staff reduce participants' anxieties. Some initial ways to increase comfort and feelings of safety are to offer water or healthy snacks, point out where the restrooms are located, and inform the woman of how long she might need to wait. All of this can help a woman's first encounter with the center feel

peaceful and supportive. Creating a sense of calm and welcome for male participants also improves the overall environment and will impact women's sense of safety.

When participants have a voice in center rules and guidelines, it increases their sense of safety, belonging, and investment. It also helps them feel respected and heard. For example, a center may hold group discussions about center and group safety, and allow participants to help develop guidelines for attire, conduct, and communication. This builds a sense of investment, awareness, and empowerment among participants. In groups, especially those that are co-ed, a lack of community-established guidelines can lead to feelings of being unsafe or vulnerable. For example, some people may wear distracting clothes or make others feel uncomfortable by sitting too close to them, using profanity or sexual terms, or being too physical during interactions. Staff should ask participants what makes them feel safe and whether there is anything that would help them feel safer. When they answer, staff should acknowledge their answers and try to accommodate their needs as much as possible (e.g., "I need to sit near the door," "I need to sit where I can see everyone coming in the door," or "I need to sit by another female participant").

C. ASSESSMENT AND TREATMENT/ RECOVERY PLANNING

Assessment and treatment/recovery planning set the foundation for the services a center will use to help a woman meet her program participation goals. Treatment/recovery planning may occur together or as separate processes. In this document, they are discussed together. To learn more on assessment, treatment, and recovery planning for women, see Guidance to States: Treatment Standards for Women with Substance Use Disorders (Mandell & Werner, 2008). In addition to substance use, participants may have many challenges, such as trauma histories, single parenting, co-occurring mental disorders, or intimate partner violence. The expert panel noted that assessment and treatment/recovery planning activities that do not address women's experiences or priorities become barriers to engagement and activation, which may lead to a return to substance use. Patient activation refers to a person's ability to manage his/her health and health care. Activation is an important element of recovery in that the woman develops her capacity to participate in services, make decisions, and, ultimately, reduce substance use. Centers can promote engagement and activation by adopting woman-responsive assessment and treatment/recovery planning tools and processes.

Younger women have very different cultural values, relationships, and experiences than do older women. A woman's experiences, needs, and priorities are impacted by age, stage of life (e.g., adolescence, young adult, parent, senior), gender identity, sexual orientation, prior participation in treatment/recovery, and cultural background. Assessment and treatment/recovery planning need to identify and consider women's specific needs. Programs need flexibility to respond to the specific treatment/recovery needs of women of all ages and diverse cultural backgrounds.

Assessment gathers information about a woman's history of substance use, and associated experiences such as physical health, mental health, family, employment, education, and legal concerns. The information gathered through assessment then informs the treatment/recovery plan and services provided. This section discusses assessment and then treatment/recovery planning, followed by a discussion of a few essential elements of assessment and treatment planning: trauma, mental health, physical health, relationships, and intimate partner violence.

Assessment

In any type of screening or assessment, a center should use instruments that have validity for women and the subgroups of women it frequently treats.[2] Centers can evaluate their assessment tool to determine its sensitivity to women's needs and the need for supplemental questions. They can consider the areas discussed in the guidance statements and whether their assessment tool provides enough information to inform the treatment/recovery planning for women entering the program. Questions to consider include:

- Does it provide enough information to inform the woman's treatment/recovery planning?
- Does it identify strengths, self-efficacy, and recovery capital?
- Are pregnancy-specific questions available and applicable? For example, substance use screening tools for pregnant women need to be able to assess both use and misuse.

Though a primary goal of assessment is to obtain information for developing the treatment/recovery plan, it is also a chance to build rapport and trust, which can result in improved engagement in services and activation.

The intake interview may be the first time a woman has had the chance to talk about herself and her experiences. Giving women the chance to be listened to, heard, and validated is usually of great value to them. An effective assessment takes time—sometimes more than one session. Ideally, it is an ongoing process. It is vital that staff members who conduct assessments avoid stereotypes and maintain a non-judgmental attitude.

It is important to conduct assessment interviews in a trauma-informed manner. Discussing sensitive personal topics is difficult, especially before building trust. Thus, assessment questions should be limited to those that will impact services or build rapport.

Most assessments consider substance use and treatment history, co-occurring mental disorders, family, education, and employment. In each area, women may have different experiences from men. When asked about their initiation of substance use, duration of use, or use patterns, some women may describe their use as minimal and occurring in isolation. Other women's use may be closely linked to a specific person or situational context, while others may have high levels of use and dependence. Some women may knowingly use substances as a way to cope with childhood abuse and other traumas; others may not have, or may be unaware of, a link to trauma. Some women express tremendous shame, grief, and loss when talking about behaviors or situations that occur during substance use; others may present as "tough" or stoic.

When getting to know a woman, staff members should not make assumptions about her or her priorities. For example, the assessment should ask about sexual orientation and gender identity, rather than assuming all women are heterosexual or cisgender. "Cisgender" is a term for people whose gender identity corresponds with the sex the person had or was identified as having at birth (Merriam Webster, n.d.).

[2] SAMHSA's *TIP 51: Addressing the Specific Needs of Women* (2009) discusses the differences between screening and assessment, as well as various assessment issues for women.

Questions about family and education/employment should capture the experiences of women with SUDs. Motherhood is an important part of many women's self-identity, but this is not the case for all women. Staff should not assume every woman wants to be a mother, or that a woman wants to parent the children she already has. Staff should find out a woman's feelings about parenting, rather than assuming she is engaged in motherhood. Some women do not have children, and others have not parented or been involved with their children. Women's caretaking roles may be incentives or obstacles to participation. When assessing a pregnant woman, staff should ask about her experience and reaction to this pregnancy. Staff should also find out the outcome of any past pregnancies and self-care patterns, such as eating and sleeping habits and tobacco use. This is all valuable information for treatment/recovery planning.

Women often experience poverty or have less access to economic resources than men. Thus, identifying financial resources and healthy survival strategies may be an important element in their ongoing treatment/recovery planning. Both younger women (under 25) and older women (60 and older) may be especially dependent upon their families. Employment history and experiences can be a source of strength or an area of anxiety, depending upon a woman's expectations for herself, and her workforce success and experiences.

Women's reasons for entering treatment and priorities for treatment differ. Reasons for being in treatment could stem from an arrest, a desire to rebuild a relationship or change her life, a child welfare case, or an escape from hard life circumstances (e.g., violent relationship, homelessness). Some women may enter treatment only as a last resort, perhaps as a result of a court order, and may say they "don't want to be here." No matter what a woman's reason is for entering treatment, centers should offer a safe environment that allows her to be honest about her goals and engage in a treatment/recovery plan to pursue those goals.

Treatment/Recovery Planning

A treatment/recovery plan provides concrete direction to the woman receiving services and the service delivery team. The plan outlines goals and activities that help the woman eliminate or reduce substance use, develop the skills and resources needed for maintaining a healthy lifestyle, and work toward other desired goals. Individual treatment/recovery plans should reflect women's varying experiences with substance use, consequences of substance use, previous treatment/recovery efforts, recovery capital, and life priorities.

Treatment/recovery planning is a collaborative process, most often involving the woman and a primary counselor. Ideally, the counselor engages the woman as an active participant in developing her treatment/recovery plan. This allows the woman to use her voice, make choices, and feel empowered. However, this is not always an easy process. A woman who "likes" her counselor may seek to please her/him and agree with whatever the counselor suggests.

Other women do not have the hope needed to envision a different future for themselves. Some may say, "I don't know" when asked about they want to get out of treatment. Some of those women may have been silenced or insulted by their partners or family for sharing their thoughts. This could make them nervous about stating their opinions and ideas. Taking the time to build rapport, trust, and hope with these women will help them begin sharing their ideas and goals. Other women are in treatment to fulfil a requirement (e.g., as part of a child welfare case) and may not have motivation to address substance use. Motivational interviewing and focusing the treatment/recovery plan around their current priorities or goals may be a good starting point.

Assessment and Treatment/Recovery Planning: Strength-based Approaches

Women may need clear information about the treatment/recovery process and about what is expected of them while they receive services. Asking a woman about potential barriers to completing treatment allows on-the-spot problem

solving. Whenever possible, staff members should leverage the woman's strengths, passions, and priorities, and integrate them into treatment and recovery plans.

Women entering treatment for SUDs often have very low self-efficacy and low self-esteem, so it is important to help them identify their strengths, passions, and priorities. This can be done through strength-based assessments. Staff should ask a woman to identify positive experiences in her past or activities she enjoys (e.g., "What do you like to do in your free time?" "Do you like to sing, draw, garden, cook, exercise, read, hike, dance, write, etc.?" "Did you have a favorite subject in school?" "What do you do well?" "What do others say you do well?"). Staff should not focus too much on the past, as some women may have trouble thinking of interests because of their substance use or may feel regret about giving up things they once enjoyed.

A treatment/recovery goal that incorporates an interest or strength can be a strong early motivator. For example, a woman who likes to sing might join a choir to enhance her sense of efficacy and growth. A woman who dances may join a salsa class to become physically active and meet new friends. A woman who likes to draw can get a sketch book or share some of her art with her counselor or peers. A woman who takes pride in doing her children's hair can teach other participants styling techniques. These types of goals and activities can help motivate women to stay engaged in services and address complex problems that take time to resolve. Finding strengths and joys can also help women explore new recovery opportunities and recognize their unique skills.

Assessment and Treatment/Recovery Planning: Physical Health Needs

Primary health care is a common need for women with SUDs. Women often develop medical consequences from their substance use in fewer years than men (SAMHSA, 2009, p.7). Also, women often fail to attend to healthcare problems while in active addiction. Screening and assessment should consider a woman's health concerns; possibility of pregnancy; and need for comprehensive, integrated behavioral, reproductive, dental, and primary health care.

A woman's history may include risky sexual behaviors, partners with irresponsible sexual practices, non-consensual sex, sex work, and/or trafficking. Many women have partners who, through violence or intimidation, restrict use of safer sex practices. Often women feel ashamed or scared to be tested for human immunodeficiency virus HIV, viral hepatitis, and other sexually transmitted infections. To promote a sense of safety, hold all talks about recommended testing in a trauma-informed and non-judgmental manner. Screening and assessment for risks of (HIV) and viral hepatitis can help women get early treatment, which can dramatically slow disease progression. If the woman decides to be tested and tests positive for a disease, she will need treatment and appropriate counseling, in addition to SUD treatment. Addressing her physical health needs will be an important element of her treatment/recovery planning.

Assessment and Treatment/Recovery Planning: Co-occurring Mental Health Conditions

Many women entering treatment for SUDs have co-occurring mental health conditions, so it is

important to screen for these conditions during assessment. Depression, anxiety disorders, PTSD, and eating disorders are common among women with SUDs. Many women with SUDs also have a history of suicidal thoughts or attempts. Failure to address co-occurring disorders can result in ineffective treatment and setbacks after SUD treatment is complete, so including integrated treatment in treatment/recovery planning is of benefit to women.

Although the prevalence of co-occurring conditions is high, some women have been misdiagnosed with a mental health condition, such as mania or borderline personality disorder, when clinicians failed to take into account issues such as trauma histories, substance use, or intimate partner violence. Centers working with women should either offer co-occurring services or have links with mental health providers who can address mental health conditions at the same time. Integrated assessment and treatment for co-occurring disorders is an evidence-based practice. Addressing both recovery from substance use and a mental disorder in the same treatment/recovery plan will result in a plan that makes sense for both conditions. It also prevents the confusion of conflicting recommendations from different providers and the stress of having too many treatment/recovery goals.

Assessment and Treatment/Recovery Planning: Trauma Histories

Because the majority of women entering treatment have experienced trauma (SAMHSA, 2009, p.22), trauma-informed assessments are important. Many trauma screening tools[3] are available to screen for adverse or traumatic life experiences. It is important for centers to understand two important factors when screening for trauma. First, to reveal traumatic experiences, the woman must be engaged in a sensitive and caring process that allows her to feel safe and comfortable. Second, a woman may not reveal trauma during intake. Thus, a system should be in place to screen for trauma post-intake and after the development of a trusting relationship with the clinician. All women with SUDs should also be assessed for the need for trauma services.

Common traumatic experiences among women entering SUD treatment include childhood abuse, sexual victimization, and intimate partner violence (IPV). Assess all intimate relationships for IPV, including same-sex relationships. Abuse can be physical, sexual, emotional/verbal, or any combination of the three. Just because a woman is not being physically hurt does not mean she is not being abused. Also, women who have experienced sex work or human trafficking, homelessness, or incarceration typically have higher rates of exposure to violence and trauma than other women entering treatment. Assessing for historical trauma can also help providers understand possible causes for depression, addiction, and other mental issues (Brave Heart, 2003). Historical trauma refers to trauma caused by widespread events affecting an entire culture (SAMHSA, 2014d). Examples of events that have led to historical trauma include: slavery of African Americans, forced assimilation and relocation of Native Americans, the Holocaust, and genocidal practices of Hutus in Rwanda and Khmer Rouge in Cambodia (SAMHSA, 2014d, p. 40). Though further study is needed, historical trauma appears to have "repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity" (SAMHSA, 2014d, p. 40).

Everyone processes trauma differently. Letting women discuss their traumatic experiences in a self-paced and respectful way preserves their dignity. It also allows them to feel heard and validates their feelings. This validation helps provide them with a sense of safety and empowerment, which is necessary for healing to begin.

[3] See SAMHSA-HRSA Center for Integrated Health Solutions, Screening Tools website, listed under "Trauma," and SAMHSA's *TIP 57: Trauma-informed Care in Behavioral Health Services* (2014), Chapter 4.

Women with trauma histories often use substances to cope with and survive traumatic experiences, symptoms, and memories. In these cases, the underlying trauma needs to be addressed. Otherwise she is likely to return to substance use after treatment, particularly if she returns to a traumatic personal/home life. Thus, having access to trauma-specific treatment services is vital to long-term recovery. Treatment/recovery plans may include trauma-specific interventions, psychiatric evaluation and pharmacotherapy, and strategies to build awareness of triggers and coping strategies. Other helpful services include education about self-care, mindfulness, boundary setting, healthy relationships, and alternative coping strategies.

Assessment and Treatment/Recovery Planning: Relationships

Relationships are an important aspect of women's lives. Successful assessment and treatment/recovery planning often involve strategies for addressing caretaking roles, handling relationships with unsupportive family and friends, and building new relationships with people who are supportive. Women with SUDs often report poor relationships with family, friends, co-workers, and others, which may be a result of addiction or lack of relationship skills.

Children. Women entering treatment are likely to be mothers. For many women, the relationships with their children are their most important relationships. Their perception of themselves as a mother may have shaped much of their identity and given them a sense of purpose. Other women may need a safe environment where they can talk about their ambivalence toward motherhood. The expert panel noted the importance of respect, safety, and support for women who do not want to be mothers or do not gain the same level of satisfaction and value from their mothering role.

Center staff should take the time to learn the names and ages of a woman's children and where each one lives, including those who are living with others or have been removed from her custody. Women who have lost children, whether through death, divorce, or loss of parental rights, often have tremendous grief that is a barrier to recovery.

Substance use, trauma, and co-occurring mental health conditions can affect women's ability to create and maintain a healthy connection to their children. Keeping their children's needs in mind while handling the challenges of treatment/recovery can be hard. These limitations can vastly affect a woman's ability to parent effectively and maintain a mother-child relationship. For women whose caretaking role is central to their identity, addressing their children's concerns may also be part of their treatment/recovery plan.

Family Members. When the center includes a family counseling group or support programming for families, a woman may need help identifying potential "family" members willing to attend counseling sessions and support her. She may also need help in reaching out to family members who may resist participating. Though family is often most important for women, men are more likely to have a family member who is willing to support their recovery efforts and attend family sessions. It is also common that, due to a family history of substance use and violence, a woman may need help figuring out the family member best suited to participating and supporting her. This may not be her partner, or parent, though working on these relationships is likely to be a part of her treatment/recovery plan. The most appropriate choice may instead be another family member or close friend with a healthy, or healthier, relationship and lifestyle.

Assessment and Treatment/Recovery Planning: Intimate Partner Violence

Centers serving women should either develop in-house expertise or develop relationships with agencies specializing in sexual assault, IPV, and other forms of violence. Women may experience IPV regardless of the sex or gender of their partner, though women tend to inflict far fewer physical injuries then men. In some relationships, both partners are violent or emotionally abusive.

IPV can impact how a woman presents herself during treatment, and how she benefits from treatment/recovery services. One woman may feel shame and appear withdrawn. Another may fear that telling staff about the abuse will make her ineligible for services unless she leaves her partner. Some will keep the IPV a secret, and others will feel empowered by entering treatment and will choose to leave abusive partners.

It can be challenging for providers to be both family-centered and sensitive to IPV. Until staff get to know a woman, including understanding her priorities, experiences, and family dynamics, it is best to be very cautious about including her partner. Sometimes a violent partner appears to be the perfect, caring partner, while in reality the woman is actually controlled by and fearful of that person. It is crucial to interview and assess each woman separately from her partner. This allows her to independently decide what groups or programming she wants to attend and what releases she wants to sign for sharing of information.

Women stay in abusive relationships for many reasons, such as emotional ties, financial dependence, access to drugs, children, an emotional bond to the partner, fear, a belief that they do not deserve anything better, and threats of worse violence if they leave. When a woman chooses to stay in an abusive relationship, it is best to honor her choice while also helping her develop a safety plan. Center staff should create chances for her and other women to:

- Identify signs of unhealthy relationships and abuse
- Understand how abusive relationships may trigger trauma or substance use
- Practice setting appropriate boundaries
- Share her voice and make choices
- Access resources and ensure safety

A woman who decides to leave an abusive relationship may need specialized services. Leaving can pose great danger to her life and well-being. It is vital to create well-defined safety protocols for both the woman and the staff members who are working most closely with her.

Access to Services and Supports

When working with a woman to identify possible services and groups, center staff should create informal times to talk and build in time for her to talk about herself. Peer specialists or recovery coaches can also be supportive partners in the conversation. Using input from these talks as a foundation, center staff should work with the woman to identify services and supports that will best meet her needs in terms of content, timing, and group dynamics (e.g., is she likely to be comfortable in a co-ed group?).

Services and supports will be as varied as the women who visit the center. As mentioned earlier, many women have co-occurring health and mental health conditions. Treatment/recovery plans should address those health conditions and any related goals and link the women to needed services. Many women enter treatment as a result of a child welfare or court case and need support meeting and understanding legal requirements. For example, early treatment/recovery goals in such cases may include understanding the process and identifying mandates, supports, and strategies for handling the situation—emotionally and practically. If a woman has an open child welfare case, treatment/recovery planning should prioritize issues related to her case.

Assessment and treatment/recovery planning have limited value if the center is not equipped to help women address problems and priorities identified. Centers need to honestly assess their ability to meet women's needs and offer person-centered planning. Some centers may need additional training or support to enhance clinical expertise in mental health assessment protocols or trauma-informed care. Others may choose to build relationships with outside service providers.

Although treatment/recovery plans may link directly to participation in specific treatment groups or case management services, centers should try not to limit treatment/recovery plans only to services offered by the center. Holistic centers draw on a range of services, and formal and informal resources, within the center and in the community. For example, many women benefit from faith-based programming. Others need help accessing health care, child care and pre-school programs, or food and housing. Treatment/recovery planning may include direct support in accessing these resources or guidance so the woman can learn to access them herself. A woman with low self-efficacy and little experience accessing resources may find this skill challenging. Treatment/recovery plans should allow plenty of time for her to overcome her sense of helplessness and become empowered.

As her recovery strengthens, a woman may develop and maintain her own plan for achieving ongoing health, wellness, and positive life goals. Or she can create one with the help of a recovery coach or peer specialist. Regardless of development approach, these longer-term recovery plans might include a woman's thoughts on contributing to her community, expanding the reach of her "voice," and taking on leadership roles.

D. INTERVENTIONS AND GROUPS

Treatment/recovery planning identifies the objectives and priorities for services. It serves as a road map for the woman's journey. Group, individual, and family counseling and other interventions are the primary services that support the goals of the treatment/recovery plan. This section discusses the array of services available to women, along with co-ed and women-only groups.

Services Offered

The range of services offered should address the physical, financial, emotional, social, cognitive, and spiritual needs of the woman, as well as her priorities. Many interventions and supports can promote wellness, including evidence-based practices (EBPs) and curricula that are highly effective for women. Before selecting one, clinicians should determine whether it has validity with women, as well as men. If possible, clinicians should conduct a trial run in the actual service setting. Evaluations of EBPs are often based on individual counseling sessions; the practices/curricula may not be equally effective in co-ed or single-sex group settings.

Practices the expert panel identified as effective for women include the following.

Motivational interviewing (MI) and motivational enhancement therapy (MET)[4] focus on the priorities set by the woman and her unique needs and circumstances. The MI approach has four principles: expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy and strategies for building it. MI and MET both center on rapid and internally motivated change (CSAT, 1999).

Medication-assisted treatment and recovery (MATR),[5] combined with counseling and recovery supports, has shown positive impacts for opioid-dependent and alcohol-dependent women. MATR is strongly indicated for opioid-dependent pregnant women. Programs offering MATR should set protocols for screening and adjusting for pregnancy. Likewise, all centers

[4] Listed in SAMHSA's National Registry of Evidence-based Programs and Policies (NREPP).

[5] MATR is often referred to as medication-assisted treatment (MAT). Information about different types of MATR is found at SAMHSA's Medication-Assisted Treatment website.

serving pregnant women should have a protocol for assessment and provision of MATR services (CSAT, 2005).

Centers that do not offer MATR can establish a partnership through which to deliver MATR treatment/recovery services. This arrangement will then provide the best therapeutic option for pregnant women and other women needing MATR. Centers may also need to work on the negative judgment that women engaged in MATR may face, particularly in mutual support programs.

Cognitive behavioral therapy (CBT),[6] often used as a part of SUD treatment, is the framework for many curricula. CBT can help women identify challenging thought patterns (e.g., anxiety, negativity, irrationality) that contribute to substance use or addiction and halt the cycle of negative thinking. This type of therapy can also help women engage in self-care. Centers should use CBT topics and curricula that support women who lack self-efficacy and address issues important to women, such as the CBT-based *Using Matrix with Women Clients: A Supplement to the Matrix Intensive Outpatient Treatment for People with Stimulant Disorders* (SAMHSA, 2012c).

Dialectical behavioral therapy (DBT)[7] integrates CBT and mindfulness. DBT was first developed to address borderline personality disorder, but it has since been used for a variety of mental health conditions. DBT is very effective in addressing trauma-related symptoms.

Curricula for integrated trauma/substance misuse coping skills help women identify triggers and develop coping and self-care strategies that reduce substance misuse and other problem behaviors. Examples include *Seeking Safety* (Najavits, 2002), *Beyond Trauma: A Healing Journey for Women* (Covington, 2003), and *The Trauma Recovery and Empowerment Model* (Harris, 1998). *Concurrent Treatment of PTSD and Substance Use Disorders with Prolonged Exposure* (COPE) focuses on treating women with co-occurring PTSD and SUDs (Back et al., 2014).

Integrated co-occurring disorder treatment addresses mental health conditions and SUDs within a unified treatment/recovery plan (SAMHSA, 2010). The expert panel noted that co-occurring disorders should be the expectation rather than the exception and that centers should plan for them accordingly. This planning includes hiring or training staff members who can develop and implement integrated services on site. If unified services are not possible, the treatment/recovery plan should at least acknowledge the need for coordinated care and support access to appropriate mental health providers. Other important issues with co-occurring disorder services include the following:

- Some psychopharmacological medications used to treat disorders may affect women differently than men or have side effects of greater concern for women. Prescribing practitioners who understand and address gender differences can have a positive impact on women's psychiatric care.
- There are informational and decision aids that allow for shared decision-making between women and their mental health providers. Shared decision-making maximizes communication and also enables people to actively manage their own health. This can be particularly empowering for women who have been silent or passive in the past and can benefit from a structured decision aid (SAMHSA, 2012b).

[6] Listed in SAMHSA's NREPP.

[7] Listed in SAMHSA's NREPP.

In addition to traditional group counseling and educational sessions, other interventions of benefit to women include:

- ***Grief counseling***, particularly for women who have lost children through death, termination of parental rights, or other ways. Significant, unaddressed grief issues can be a barrier to recovery.
- ***Workshops or therapies*** that allow women to develop and express their self-identities, self-value, and relationships. Women may be particularly receptive to and benefit from non-verbal forms of expression, such as art therapy, dance, creative writing or journaling, and yoga.
- ***Strength-based case management*** to help women overcome learned helplessness and low self-efficacy while making progress toward their recovery plans. Identifying small action steps and celebrating each success helps build confidence. As successes accumulate, the woman will notice her achievements, and her confidence in her ability and problem-solving skills will grow. This can be a powerful way to build self-efficacy, resilience, and self-determination.

COMBINING CO-ED PROGRAMMING WITH INDIVIDUAL THERAPY

"We have women who participate in gender-specific, home-based treatment [programs], but when they attend an intensive outpatient program or a recovery group, the groups are primarily co-ed. Utilizing more than one program, the women have the opportunity to process their needs in a safe environment with their female therapist and recovery coach and/or attend a female-only trauma group while also receiving the benefits from the additional outpatient programming. Staff from both programs also coordinate care."

— Provider at a women's treatment center

- ***Communication and assertiveness skills workshops*** designed for women.

Note: *Mutual support programs, many of which are backed by research, are described in Section III.E.*

Women-Only Groups

Expert panel members agreed that women are best served if they attend some women-only groups on a regular basis. Thus, co-ed centers are most effective when they offer some single-sex groups. Women-only groups provide a chance for women to explore recovery topics they may be uncomfortable discussing in the presence of men. These groups can also help build mutual support among women. Men may also feel more comfortable in and benefit from men-only groups when talking about certain topics. Ideally, centers offer many choices of co-ed and single-sex groups.

When regularly scheduled women-only groups are not an option, centers could consider offering one-on-one sessions with a female counselor, peer specialist, or recovery coach to talk about gender-specific concerns. Centers can also make arrangements for women to attend women-only groups offered by another agency. This may mean the content will not be specific to women and SUDs (e.g., having a women's group or session focused on eating disorders, HIV prevention, or parenting), but it will create a safe place for women to address some of the life challenges that could contribute to setbacks. Centers can also maximize resources by creating a women's group in conjunction with another agency.

Centers can invite volunteers and community programs to present on parenting, IPV, financial concerns for women, juggling home and work, and other topics important to women. This "normalizes" concerns and shows they affect all women. It also encourages participants to access community resources to support their recovery and personal growth.

Topics for Single-Sex Groups

Women often feel uneasy talking about certain topics in co-ed groups. Such topics include relationships, abuse, body image, anger management, economic insecurity, reproductive health issues, sexual identity, and co-occurring mental disorders (e.g., depression, anxiety, PTSD, and eating disorders).

Sexuality and reproductive choices are important topics that are best discussed in a single-sex group. Groups that focus on integrated trauma and substance use recovery, and coping strategies, are also most often single-sex. Many women with SUDs have difficulty with self-care and benefit from a curriculum focused on taking care of their physical and mental health, which may be most effective in a women-only group.

Women may need to develop drug/alcohol refusal and interpersonal and life skills that differ from those of men entering recovery. Anger management, for example, is an important topic that is hard to adequately address in a co-ed group. This is because women often internalize anger or feel shame when they express it. Many women need a safe place to share their anger and learn how to express it in healthy ways. Those who have experienced trauma often have displaced anger that needs to be addressed.

Sampling of Discussion Topics for Women-only Groups

- Trauma, abuse, and violence
- Managing emotions
- Body image
- Self-care/Loving and valuing yourself
- Caregiver roles
- Parenting and child safety
- Pregnancy and substance use
- Women's sexuality and sexual identity
- Building healthy relationships
- Coping with stress
- HIV/AIDS prevention
- Economic success in recovery
- Pathways to family reunification
- Stages of violence/abuse
- Weight loss/Eating disorders
- Women's reproductive health
- Achieving balance
- Overcoming obstacles to recovery
- Women's mutual support
- Sexism
- Racism and stigma
- Conflict styles/Conflict resolution
- Communication skills

Topics above taken from the following curricula:[8]

- *Using Matrix with Women Clients: A Supplement to the Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders* (SAMHSA, 2012c)
- *Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women* (Amaro et al., 2005)
- *Women's Recovery Group* (Greenfield, 2016)
- *Helping Women Recover: A Program for Treating Addiction, Revised Edition* (Covington, 2008)
- *Conflict Resolution for Recovery and Relapse Prevention* (Moreno-Tuohy, 2011)

[8] Additional evidence-based curricula can be found at SAMHSA's NREPP.

Likewise, many women need to understand they have rights and learn to speak up for themselves by developing assertiveness skills. These needs are very different from most men's anger-management needs. Also, both male and female participants may have experienced interpersonal violence, which can complicate the dynamics of a co-ed anger-management group.

If staff members are uncomfortable discussing the above topics in either group or individual counseling sessions, professional development may be needed to ensure safe and effective discussion environments.

Gender Dynamics in Co-ed Groups

When possible, co-ed groups should be somewhat equally balanced between men and women. Centers serving many more males than females may need to group women to get as close to 50 percent as possible. It is best to avoid having groups with only one or two women among several men.

Many centers operate groups that do not have a beginning or an end date. Instead, a rolling entry point allows women to enter a group at any time. With this in mind, careful planning may be needed to welcome new members, establish and communicate group guidelines, and make an extra effort to accommodate women's needs when the number of women in a group drops to just one or two.

Ideally, co-ed groups have both a male and a female facilitator. One may be a recovery coach or peer specialist. Effective facilitators are trained in group dynamics and skilled in engaging diverse participants. They also help the group meet its objectives. Facilitators should be attuned to possible participant discomfort with the group process and aware of cultural, age, sexual orientation, and other dynamics that can impact group participation and safety. For example, facilitators may need to help women focus on themselves, rather than on the men in the group. This includes identifying caregiving differences between men, who tend to "fix," and women, who tend to "nurture." This focus also includes noting the differences between healthy and unhealthy caretaking behaviors in groups. The facilitators may need to minimize group members' attempts to impress one another. Or they might have to balance an individual's desire to share trauma details with the need to minimize possible trauma reactions in others.

When selecting curricula, facilitators should be sure they are valid for men and women. They should review the curricula, topics, and examples and note any gaps or red-flag areas that could be problematic. Facilitators may need to be prepared and offer other examples as needed. When setting up the group, skilled facilitators help participants meet for the first time; develop group guidelines; and form a group identity, such as coming up with a group name. This can help participants become more comfortable with each other and establish some solidarity.

Issues of Power in Co-ed Groups

Facilitators need to be aware of gender dynamics and power issues that can impact group dynamics and participation, such as differences in communication styles and assertiveness. The group structure and process should also reflect

gender differences. Men are often more goal-oriented and women more process-oriented. Also, women may be more comfortable discussing feelings and exploring ideas while men often prefer to report information and facts. These gender differences are more obvious in co-ed groups than in single-sex groups. A skilled facilitator can help participants recognize and process these behaviors, and can leverage these differences to support the full group.

A highly effective facilitator might address power dynamics and use the group experience itself as an example, when appropriate. Facilitators should have an array of techniques for creating an emotionally safe environment. These techniques include getting all group members to participate, including those who are less likely to jump into a conversation. If the facilitator fails to attend to gender issues, women may feel marginalized, become quiet, or focus on supporting either men or other women in the group, rather than on their own growth and the development needed for lasting recovery.

With a skilled female–male facilitator team, co-ed groups can be a safe environment for discussing gender dynamics. As the need arises, staff can help participants discuss gender differences and how they may affect participants' relationships in recovery. Men and women both benefit from hearing each other speak about needs, frustrations, and concerns.

Co-ed groups offer participants the chance to practice listening to one another and talking about needs and concerns. For women, talking about themselves, their desires, and their vulnerabilities may be hard. Out of habit, the women may focus on the men in the group and try to help them open up and talk about their recovery concerns. An effective facilitator will be aware of this and direct a woman's focus back to herself, helping her open up and address her recovery concerns.

Group Guidelines for Leveling Gender Dynamics

Creating group guidelines can help level an imbalance of power within co-ed groups. Guidelines might include the following:

- Encourage strength-based self-talk among participants
- Avoid self-deprecating statements
- Focus on yourself rather than talking about/judging others in the group
- Avoid teasing and sarcasm
- Avoid dominating the group discussion

It is helpful to train facilitators and participants on maintaining these guidelines. Provide examples of language to use when a line has been crossed. The "Ouch Rule," for example, encourages participants to say "ouch" if someone says something painful or uncomfortable. The group then stops the conversation to address the "ouch."

E. RECOVERY SUPPORT SERVICES

Recovery support services promote wellness and recovery in part by supporting women as they find their voices and self-identity. SAMHSA has identified four pillars of recovery supports: health, home, purpose, and community (SAMHSA, 2012a). For many women with SUDs, developing these four pillars involves a range of community/ancillary services. As noted in the guidance statements, women with SUDs often require health, mental health, and additional services to be successful in treatment/recovery goals. These women also benefit from recovery support services before, during, and following SUD treatment.

This section discusses some of the additional, peer support, recovery support, and case management services that co-ed centers may need to provide to be gender responsive and supportive to women.

Access to Services

Women may need support to access services within the center. Early in assessment and treatment/recovery planning, counselors can work with women to remove barriers to participation and provide resources that will enable women to attend groups and center activities. Whenever possible, counselors should offer an array of groups so women have access to programming, despite any changing demands and scheduling challenges. Employment is not the only limiting feature in a woman's schedule. Women may need to pick up their children from school, or tend to their dinner and bedtime

Tricia is in a counseling group that often has about six men and usually no other women. During the first few sessions, she was an active participant, offering a lot of support to others. In the past two sessions, however, she was quieter. She seemed a bit angry and impatient, sitting with her hands folded across her chest. Steve, the group facilitator, reported this observation to Joann, Tricia's primary counselor. Rather than waiting for Tricia's next scheduled meeting in 2 weeks, Joann called Tricia to ask if they could schedule a check-in appointment. During this check-in, Joann asked Tricia about her impressions of and experiences with the different groups and whether any other resources could help her achieve her goals.

From this conversation, Joann identified two ways the center could improve services for Tricia. First, Tricia was feeling dissatisfied with her life. She didn't want to return to substance use, but felt it was her only option. She had gained a lot of weight, was uncertain about her relationship, hated sex, and was lethargic and angry. Her children were still in foster care. Tricia didn't feel like she could speak about these issues during the group, as she was the only woman.

Finding that the only women's group met at a time that didn't work for Tricia, Joann scheduled an extra 1:1 session with Tricia until a women's group was available. Joann also worked with Tricia to find peer support through child welfare services. During a staff meeting, Joann and Steve brought up the need for gender sensitivity and attention to group dynamics. The Program Director developed a strategy for tracking groups and clustering female participants together to create more balanced groups.

schedules in the early evenings. Lack of safe transportation can also make evening sessions difficult. When possible, centers should make it a priority to create flexible treatment and recovery service schedules. Flexible schedules help services fit the demands and positive activities of women, minimizing stress and increasing opportunities to connect.

Ideally, programs should offer child care, family services, and transportation assistance for women who face these potential barriers to attendance. When this is not possible, formal and informal resources within the community may help women overcome service barriers. These resources could include referrals to child care with sliding-scale fees or programs that provide transportation vouchers.

Peer Supports

As discussed in the staffing section, recovery coaches and peer specialists offer women chances to process their experiences, learn, and develop a sense of hope and self-efficacy. Connecting women in services with female peers and recovery coaches promotes rapport and, thus, better transmission of strength and hope. It can also help prevent uncomfortable gender dynamics (e.g., a woman focusing more on the feelings of her male recovery coach than her own) or possible romantic/sexual feelings within the peer relationship, if the woman is heterosexual.

Many centers offer ongoing services, such as post-treatment check-ups and alumni activities. These activities help relieve a woman's feelings of isolation, which can contribute to setbacks after program completion. Participating in co-ed and women-only recreational and social events allows women to build relationships while engaging in healthy, fun activities. Both co-ed and single-sex alumni activities and recovery support programming are excellent venues for developing healthy relationships. Women and men have the chance to practice communication skills and learn about differences between men and women's perspectives on relationships and

communication. These skills will continue to be helpful long after treatment is over. Women may need support to establish and sustain positive healthy relationships with males and females. Building such relationships can help women create a support network for long-term recovery.

Educational sessions in self-advocacy and understanding rights within the context of the center and the larger health system can help women become advocates for themselves and others while gaining/regaining a sense of empowerment. Another way is to offer women the chance to participate in volunteer and leadership opportunities. Helping others can build self-esteem, a sense of purpose, and solidarity in their recovery. Many women lead very full lives and have limited time to volunteer in recovery support activities. Pressure to volunteer can create guilt or raise levels of stress. Thus, center staff should be sensitive to women's commitments and schedules.

Mutual Support and Self-Help Opportunities

Most communities have a range of in-person and virtual self-help programs and meetings. In mutual support programs, participants support each other's recovery and share tools and techniques that have helped them. Many treatment and recovery programs help women identify and access mutual support services, as well as virtual self-help programs and meetings.

Referrals to community resources might include 12-step groups, such as Alcoholics Anonymous or Narcotics Anonymous, or alternatives, such as Women for Sobriety, Rational Recovery, and faith-based groups. When referring women to mutual support groups, center staff should be aware of the many types of meetings and options available. Even within one kind of mutual support program, participants and tone can vary a lot from one meeting to another.

Within mutual support programs, there are often women-only and special topic meetings that offer women the chance to discuss important gender-specific recovery issues. Center staff should encourage and help women to ask others about programs they like and to explore different options until they find recovery supports that feel safe and comfortable to them.

A woman's sense of safety and comfort are critical to her participation in a mutual support program. It is not uncommon for male participants to far outnumber females. Participants who lack a healthy respect and boundaries for women may say or behave inappropriately or not be respectful, making women feel very uncomfortable. Women's experience in these settings may range from mild unease to severe discomfort. When sexual harassment occurs in a mutual support setting, women can feel particularly vulnerable and betrayed. In those cases, it is important for the woman's recovery that she have a chance to process the experience and her related feelings. Some women with SUDs need coaching on protecting themselves while in the community, such as not walking alone and only going to public venues. Treatment/recovery centers can help by encouraging women to attend specific meetings or attend together. Centers may also decide to provide meetings in their facilities or help women to identify women-only meetings.

Many virtual self-help meetings are available for women who need to be home with children, lack transportation, or have busy work schedules. Virtual meetings allow women to remain connected to a group, which helps them remain on their recovery path.

Case Management, Recovery Supports, and Ancillary Services

As noted earlier, women often have needs and responsibilities beyond SUD counseling and services. Failure to meet these needs may result in increased stress and lapses in recovery, which have a tremendous impact on overall health and wellness. Responsive agencies offer access to other community services when participant needs are beyond their scope of services.

Specific areas to consider when providing case management, care coordination, or other forms of advocacy include the following:

- ***Services to address physical and mental health needs.*** Health screening and access to primary care are important for women with SUDs, as they tend to have a broad range of health concerns. Health education services that teach women about their bodies are important for women entering recovery. Center staff should also remember that women with trauma histories often have a hard time seeking and following through with health care. Staff may need to help them identify triggers and find strategies for overcoming them as they access health care. Behavioral health staff can also educate

providers of physical health services about trauma-informed approaches and how to provide services in a trauma-sensitive manner. Health services might be needed for the following:

- Reproductive health, pregnancy, postpartum care, and family planning
- Sexually transmitted infections, HIV, and hepatitis C prevention and treatment
- Prevention and treatment of medical conditions, such as hypertension, diabetes, cardiovascular diseases, and asthma
- Mental health services, including behavioral and pharmacotherapy treatment for co-occurring mental disorders common to women with SUDs

- ***Services to address family needs.*** Women entering treatment may need parenting skills training, trauma-informed parenting education, family counseling, child development education, access to children's services, and supports for other family members' needs. Women may also need help negotiating with the school system to support their children through special education programs/individualized education plans (IEPs), free/reduced price school lunch, and parent-teacher conferences. Families may benefit from child care referrals/linkages to subsidized programs, including Head Start, Early Intervention, and other government programs that offer sliding-scale fees and child care vouchers. Women involved with child welfare agencies may have particular needs, including:
  - ***Parenting education services*** that are trauma-informed, non-judgmental, and culturally responsive, and that focus on child development. These services help reduce family stressors and improve parenting. Also, child welfare agencies often require these services.
  - ***Therapeutic parent/child interventions*** that are trauma-specific and sensitive to the needs of both parent and child, to foster healing from past trauma.
  - ***Family reunification services*** designed to reunite children who have been living outside of their home with their families and to strengthen families in their own homes. Through these services, professionals work with families to make sure children are safe within their home. Family reunification professionals also find and reduce or eliminate risks that may cause children to remain out of the home.
  - ***A safe and child-friendly space*** to have supervised visitation and be able to meet privately with their child's caseworker.
  - ***Planning and family support programs*** that help women learn to build or rebuild family connections and cohesion, develop family rituals, and participate in recreational and social opportunities.
- ***Linkages that address basic needs.*** Though it may be challenging to address or make referrals for all women's needs, it is important for centers to understand that many women enter and leave treatment with very basic needs for food, clothing, and shelter. Centers can help women obtain services to meet basic needs, including:
  - ***Income assistance.*** Women with SUDs may qualify for income assistance programs such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), or local general relief programs. Women may need help meeting the documentation and application requirements.
  - ***Housing and transportation.*** Referrals to subsidized housing programs (e.g., local Housing Authority, homeless programs) and transportation can support women in building lives focused on their recovery.
  - ***Food and nutrition programs.*** Women may need support in applying for the Supplemental Nutrition Assistance Program (SNAP, formerly known as food

stamps) or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). They may also be interested in learning about nutrition; preparation of simple, nutritious meals; and access to healthy foods.

  - ***Health care.*** Some women receiving SUD services will qualify for Medicaid or insurance under the Affordable Care Act. They may need help applying for insurance and understanding their benefits and insurance restrictions.

- ***Assistance obtaining legal assistance.*** Women who are involved with the criminal justice or judicial system must be responsive to the demands of probation, parole, and the courts. They may need legal help with outstanding warrants, pending charges, or court cases. Women may also need legal help for non-criminal legal issues, such as resolving issues with divorce decrees, mortgages, rental disputes, or inheritance; obtaining child support; and addressing debt.
- ***Access to education, employment, and career services.*** Women with SUDs often have less experience in the work world than men with SUDs. These women may need supports related to job readiness, workplace negotiation, training, education, and job development that take into account their skills, resources, interests, and barriers to employment. Women with SUDs often benefit from education on balancing work, family, and self-care and planning for unexpected challenges (e.g., saving paid time off from work to care for a sick child, arranging alternative child care when a daycare provider cancels).
- ***Help with case management and care coordination.*** Case management and care coordination help women access essential recovery and community supports while managing many demands. These demands may stem from multiple service systems, such as:
  - Crisis services (e.g., food, transportation)
  - Child welfare
  - Criminal justice (including probation and parole)
  - TANF and welfare programs
  - Educational and employment services
  - Housing support agencies
  - Children's services (education, developmental service agencies)
  - Health and mental health service systems

By providing access and referrals to the above range of services, centers help women in recovery overcome the broader issues and barriers they face in daily life. This, in turn, helps women maintain abstinence from substance use and achieve SAMHSA's four pillars of recovery: health, home, purpose, and community.

IV. CONCLUSION

As noted throughout this document, most women receive services in co-ed programs. Because women's needs are unique, developing effective co-ed programming with women's needs in mind is of critical importance. Having a better understanding of the needs of women will help support gender-responsive efforts of programs that generally serve more men than women. Some essential ingredients for a center's success include:

- ***Leadership support.*** Senior managers of treatment and recovery centers can prioritize gender-responsive program development and raise the visibility of female staff in leadership positions.
- ***Individualized approach to service delivery.*** An individualized approach benefits women and men because it is more likely to result in better engagement, activation, retention, and outcomes.
- ***Champions.*** These are organizational leaders who are committed to better addressing the needs of women and can support the team through resources or clinical supervision.
- ***Access.*** Successful centers minimize barriers for women to engage in treatment/recovery services.
- ***Trauma-informed approach.*** Centers should adopt a trauma-informed approach and develop an organizational culture, policies, and program that demonstrate being trauma-informed is a priority. This benefits all stakeholders, including staff, and is directly linked to healing and recovery.
- ***Flexibility.*** Centers need flexibility to shift programming and adopt practices that will support women.
- ***Female peers and community.*** Centers may already have a base of female peer specialists, recovery coaches, alumni, women currently receiving services, and volunteers who can establish a community and support each other. Centers can also identify them through alumni communication or meetings and can ask women whether they are interested in further engagement before they leave treatment or formal recovery programming.

Achieving gender-responsive, culturally competent, and trauma-informed services is a continuous improvement process. SAMHSA and the expert panel hope this document helps co-ed centers identify some immediate and longer-term steps they can implement to better respond to women with SUDs in treatment/recovery.

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APPENDIX 1:

Expert Panel to Develop a Co-Ed Guidance Document

The panelists represent a range of backgrounds and experience, including a mix of research/ treatment/peer recovery agencies, and diverse cultural, geographic, and lived experience.

EXPERT PANELISTS

Hortensia Amaro, Ph.D., *Associate Vice Provost,* Community Research Initiatives and Dean's Professor in Social Work and Preventive Medicine, University of Southern California's (USC) School of Social Work

Kimberly Bond, M.Ed., MFT, *President and CEO,* Mental Health Systems, Inc.

Shelly F. Greenfield, M.D., M.P.H., *Chief Academic Officer,* Chief of the Division of Women's Mental Health, Director of Clinical and Health Services Research and Education, Division on Alcohol and Drug Abuse, McLean Hospital; Professor of Psychiatry, Harvard Medical School

Christine E. Grella, Ph.D., *Professor,* Department of Psychiatry and Biobehavioral Sciences; Co-Director UCLA Integrated Substance Abuse Programs (ISAP)

Beverly J. Haberle, M.H.S., LPC, CADC, *Executive Director,* The Council of Southeast Pennsylvania, Inc.

Karen Mooney, M.S.W., LCSW, CACIII, *Manager,* Women's Substance Use Disorder Programs, Office of Behavioral Health, Colorado Department of Human Services

Jeanne Obert, M.A., M.S.M., LMFT, *Executive Director,* Matrix Institute on Addictions

Eva Petoskey, M.S., *Program Director,* Inter-Tribal Council of Michigan, Anishnaabek Healing Circle Access to Recovery (ATR)

Kathleen M. Reynolds, L.M.S.W., ACSW, *Vice President,* Health Integration and Wellness Promotion, National Council for Behavioral Health

Madalynn Rucker, M.A., *Executive Director,* ONTRACK Program Resources

Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, *Executive Director,* NAADAC, The Association for Addiction Professionals

Becky Vaughn, M.S.Ed., *Vice President,* Addiction Services, National Council for Behavioral Health

SAMHSA

Sharon Amatetti, M.P.H., *Women's Issue Coordinator and Project Officer,* Center for Substance Abuse Treatment

ADVOCATES FOR HUMAN POTENTIAL, INC.

Deborah (Deb) Werner, M.A., *Project Director*
Fran Basche, M.A., *Task Co-Lead*
Sarah Farmer, M.A., *Task Co-Lead*
Sherri Downing, M.A., *Reviewer*
Nailah Harrell, M.S., *Reviewer*
Natasha Zaretskaya, *Research Assistant*

APPENDIX 2:

Additional Stakeholder Input

To learn more about treatment and recovery service providers' perspectives and women in recovery, SAMHSA solicited stakeholder input from the Women's Addiction Services Leadership Institute (WASLI) network to inform the expert panel discussions. These stakeholders, as well as SAMHSA staff from other program areas and other federal partners, reviewed the document, and their feedback on the draft was integrated into the final document.

Lonnetta Albright, B.S., CPEC, *Executive Director,* Great Lakes ATTC – University of Illinois at Chicago

Mary Blake, C.R.E., *Public Health Advisor,* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Julie Cushman, LLMSW, ACSW, CAAC, *Associate Executive Director,* Home of New Vision

Susan Dargon-Hart, M.S.W., *Director of Behavioral Health,* Casa Esperanza

Wendi Davis-Cox, M.S.W., LCSW, *Addiction & Recovery Services Program Director,* Weber Human Services

Francine Feinberg, Psy.D., LCSW, *Consultant,* Former Executive Director, Meta House

Martha Kurgans, LCSW, *Program Specialist/ Women's Services Coordinator,* Virginia Department of Behavioral Health & Developmental Services

Christina MacFarlane, M.S.W., LSCSW, LAC-T, *Co-Occurring Program Supervisor,* Area Mental Health Center

Mary M. McCann, LCSW, CAC III, *State Project Officer,* Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration

Samia Dawud Noursi, Ph.D., *Deputy Coordinator,* Women and Sex/Gender Differences Research Program, National Institute on Drug Abuse, National Institutes of Health

Jennifer A. Oppenheim, Psy.D., *Public Health Advisor,* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Deirdre Pearson, M.S.W., LCSW, CSAC, *Program Manager,* Women's Substance Use Disorder Services, Richmond Behavioral Health Authority

Carol G. Renard, CAP, ICADC, *Director of Program and Staff Development,* WestCare Foundation

Mary Roberson, Ed.D., LCPC, CSADC, *Executive Director,* Nicasa

Jessica Tytel, M.P.H., *Senior Advisor for Planning and Evaluation,* Office on Women's Health, U.S. Department of Health and Human Services

Susan Winslow, M.S.W., LICSW, *Human Services Manager,* Ramsey County Mental Health

Cathy Worthem, M.S.W., LMSW, CAADC, CCS, ADS, *Program Manager,* Arbor Circle

APPENDIX 3:

Self-Assessment for Treating Women with SUDs in Co-Ed Settings

This self-assessment tool helps providers detect strengths and potential growth areas in the delivery of gender-responsive co-ed services. It follows the sections of the *Guidance Document for Treating Women in Co-ed Settings*. Please read through the guidance document before filling this out; it will help you better understand the questions and terms.

You can complete this self-assessment for your overall center or a specific program in your center. Some sections may be helpful in evaluating a specific service team or yourself. Before starting the assessment, decide whether you are filling it out for your whole agency, a physical center, a specific program, or a staffing team. Then choose a small group of people to complete the survey. You can work on the survey as a group or have people complete it alone. Afterward, discuss each item as a group and come to an agreement on the response.

After you finish, some questions at the end will help you develop an improvement plan.

Self-Assessment Checklist for:

_____

(Identify whether you are reviewing your whole agency, physical center, a specific program, or a staff cluster.)

For each statement, think about how your activities, policies, and staff training address it and how often it occurs. Then assign a score of U, A, or C.

U = Unable (Do not do this, or do it very rarely.)

A = Aware (Do this some of the time.)

C = Committed (Do this most of the time.)

You may also want to note your strengths, challenges, or improvement ideas while filling in the checklist. This will be helpful when you create a plan of action.

SCORE
(U, A, or C)

ADDRESSING WOMEN'S UNIQUE NEEDS AND EXPERIENCES

Consider each statement below and assign a score based on your assessment.

SCORE	
	We offer person-centered services, taking gender and the priorities, interests, and experiences of each woman into account.
	We respect the cultural diversity of women and know cultural background and experience shape a woman's world view, priorities, values, experiences, and treatment and recovery needs.
	We recognize sexuality (including sexual orientation) and patterns in a woman's sexual history as important elements to consider when developing a treatment and recovery plan.
	We know and take into consideration that women with SUDs often live in poverty and must rely on men or other family members for financial support.

TOTALS ON ADDRESSING WOMEN'S UNIQUE NEEDS

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

GENDER DYNAMICS

Consider each statement below and assign a score based on your assessment.

SCORE	
	We offer support and activities that help develop women's voices and self-identities and allow them to share their stories.
	We recognize that staff and people in treatment and recovery may have subconscious and unintended biases, which result in women deferring to men.
	We encourage staff to address their own personal beliefs and judgments through training and clinical supervision.
	We address patterns of client and staff bias when they arise in client feedback, individual counseling, groups, supervision, case management, and other programming.

TOTALS ON GENDER DYNAMICS

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

SCORE
(U, A, or C)

Trauma

Consider each statement below and assign a score based on your assessment.

SCORE	
	We ensure the physical and psychological safety of women who are being served.
	Our services are trauma informed.
	We avoid punitive actions that can reduce a woman's self-efficacy and engagement with staff and groups.
	Our services follow recovery-oriented principles and practices.

TOTALS ON TRAUMA

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

Physical Health

Consider each statement below and assign a score based on your assessment.

SCORE	
	We take into account a woman's health concerns and the need for comprehensive, integrated behavioral and primary health care, and we address health in treatment and recovery planning.
	We address a woman's need for reproductive health care and have a plan in place to screen for, and address, pregnancy and related treatment/recovery considerations.
	We educate women about their risks for sexually transmitted infections (STIs), HIV, and viral hepatitis and offer testing and early intervention and treatment services as needed.
	We ensure that all conversations about health and recommended testing are held in a trauma-informed, nonjudgmental manner that promotes a sense of safety.

TOTALS ON PHYSICAL HEALTH

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

SCORE
(U, A, or C)

Mental Health

Consider each statement below and assign a score based on your assessment.

SCORE	
	We understand the prevalence and signs of psychiatric disorders and common mental health problems among women with SUDs and know how these disorders can affect recovery.
	We help women access screening, assessment, and services for a variety of mental disorders.
	We help women access screening, assessment, and services for anxiety.
	We help women access screening, assessment, and services for PTSD.
	We help women access screening, assessment, and services for eating disorders.
	We help women access screening, assessment, and services for depression.
	We are sensitive to the needs of women with co-occurring disorders and make accommodations when needed.
	We use an integrated approach to mental health and substance use recovery.

TOTALS ON MENTAL HEALTH

# of Unable = _____ *# of Aware* = _____ *# of Committed* = _____

SCORE
(U, A, or C)

RELATIONSHIPS

Consider each statement below and assign a score based on your assessment.

SCORE	
	We ensure that staff members are qualified and able to build therapeutic alliances.
	We offer person-centered services and support women within the context of their life circumstances, roles, and responsibilities.
	We offer formal and informal chances for women to meet and build relationships with each other.
	We create venues for women to learn more about healthy relationships, respect, boundaries, and communication.

TOTALS ON RELATIONSHIPS

# of Unable = _____ *# of Aware* = _____ *# of Committed* = _____

SPECIALIZED STAFF/STAFFING STRATEGIES

SCORE *(U, A, or C)*

Consider each statement below and assign a score based on your assessment.

SCORE	
	We have adequate program and clinical management, as well as an array of specialized staff (including counselors, clinicians, case managers, and peer specialists/recovery coaches) with experience in gender-responsive approaches.
	We match women with female primary counselors and recovery coaches/peer mentors with some common experiences and understanding (e.g., similar age, cultural background), unless contraindicated.
	We have staff members who communicate well with women in terms of understanding each woman's expression of gender, cultural background, and sexual orientation or identity.
	Our staff members are culturally competent and practice cultural humility.
	We have female peer specialists or recovery coaches.

TOTALS ON SPECIALIZED STAFF/STAFFING STRATEGIES

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

SUPERVISION/MANAGEMENT

Consider each statement below and assign a score based on your assessment.

SCORE	
	We prioritize clinical supervision by making sure it happens often and regularly.
	We have supervisors with specialized training, including those who can support staff in addressing trauma and preventing secondary trauma.
	We have supervisors who can work with staff members to identify and understand their own biases (e.g., judging women who use alcohol or drugs during pregnancy or who stay with abusive partners).

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SCORE
(U, A, or C)

	We have supervisors who are trained to address gender dynamics in co-ed groups.
	Staff—including administrative and support staff—receive ongoing training about trauma-informed approaches.
	We offer training and follow-up support to apply training content to actual work with women (e.g., ongoing discussions of the implementation process during clinical supervision and staff meetings).

TOTALS ON SUPERVISION/MANAGEMENT

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

Organizational Culture

Consider each statement below and assign a score based on your assessment.

	We have an organizational culture that respects women and takes gender into account.
	We consistently review outcome data by gender and look at women's engagement, retention, and progress so we can discuss ways to improve.
	We provide leadership opportunities for female staff members and support them in becoming advocates for women's services.
	We take part in women's service provider community networks.
	We give staff members opportunities for discussions, coaching, and supervision that help build a safe and supportive setting that prevents secondary trauma and encourages self-care.

TOTALS ON ORGANIZATIONAL CULTURE

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

SCORE
(U, A, or C)

Environment/Facilities

Consider each statement below and assign a score based on your assessment.

SCORE (U, A, or C)	
	We have a welcoming, safe, calm, and appealing physical environment.
	Women can safely access our center, and we have ways to provide safe access (e.g., near bus stops, well-lit parking lots and streets, group transportation, escorts to parking lots).
	Furniture is set up in a way that encourages engagement or offers privacy.
	We offer a child- and family-friendly setting.
	We have a women's space (e.g., women's lounge area) that allows a safe space for connection, interaction, and formal and informal recovery support.
	We have friendly reception staff members who make women feel welcome and who are trained to recognize and respond when someone is in deep distress.
	We allow participants to have a voice in center rules and guidelines, and they are encouraged to state what helps them feel safe.

TOTALS ON ENVIRONMENT/FACILITIES

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

SCORE
(U, A, or C)

Assessment and Treatment/Recovery Planning

Consider each statement below and assign a score based on your assessment.

SCORE (U, A, or C)	
	We use screening and assessment tools that have validity for women and the subgroups of women often seen in the center.
	Our assessment interviews are conducted in a trauma-informed manner.
	Staff who conduct assessments avoid stereotypes and maintain a nonjudgmental attitude.
	We regularly evaluate our assessment and treatment/recovery planning protocols to think about whether they address women's experiences and responsibilities.
	We provide women with ongoing screening and assessment for psychiatric disorders and other mental health problems.
	We have protocols for screening, assessment, and prioritization for pregnant women.
	We help women identify strengths, passions, priorities, and unique abilities, and we integrate these into treatment/recovery plans.
	We work with women early in the treatment/recovery process to detect barriers to participation and potential resources that will help them attend groups and center activities.
	We have in-house expertise or partnerships with agencies that offer services for women who have experienced sexual assault, intimate partner violence, or other forms of violence.

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SCORE
(U, A, or C)

When a woman includes her partner in her treatment plan, we interview her away from her partner so she can decide what groups or programming she wants to attend or what information-sharing releases she wants to sign, without her partner's influence.

We address co-occurring physical health and mental health issues and integrate physical health and mental health goals into treatment/recovery plans.

TOTALS ON ASSESSMENT AND TREATMENT/RECOVERY PLANNING

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

Interventions/Groups

Consider each statement below and assign a score based on your assessment.

In co-ed groups, we group women together, so they make up as close to 50 percent of the group as possible.

For co-ed groups, we have one male and one female facilitator.*

Our facilitators* are trained in group dynamics, able to help diverse groups of people engage with each other, and able to ensure that women fully participate.

Our facilitators* are aware of group gender dynamics and power issues and can create a safe environment for discussing gender dynamics.

We offer participants the chance to practice communication skills, including actively listening and communicating their needs and concerns.

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SCORE *(U, A, or C)*	
	Our groups have guidelines (ideally developed by participants) that address gender dynamics, safety, and respect.
	We offer women-only groups that enable women to discuss sensitive topics.
	When there are no women-only groups, we offer other ways for women to build relationships with other women and individual counseling on sensitive topics.
	We provide or offer links to medication-assisted treatment and recovery (MATR) services, along with counseling and recovery supports, especially for pregnant women who are opioid dependent.
	We use evidence-based practices (e.g., motivational interviewing, cognitive behavioral therapy) and curricula that have validity with women and the subgroups of women served.

TOTALS ON INTERVENTIONS/GROUPS

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

**Facilitators may include therapists, counselors, group leaders, peer specialist/recovery coaches, health educators, or anyone leading group services.*

SCORE
(U, A, or C)

Recovery Support Services

Consider each statement below and assign a score based on your assessment.

SCORE	
	We help women identify barriers to participation and community resources that may help them overcome these service barriers (e.g., referrals to child care resources, referral programs).
	We offer child care at our organization while women are attending treatment.
	We offer flexible scheduling for services and programming.
	We offer ongoing services and connections (e.g., alumni activities) upon program completion.
	We help women identify and access safe mutual support services in their communities that are welcoming to women.
	We offer case management and care coordination, or advocacy services, to address women's additional needs (e.g., services to address basic or family needs, legal assistance, educational and career services).
	We are sensitive to and prioritize a woman's need to work with child welfare services, especially if she has an open reunification case.

TOTALS ON RECOVERY SUPPORT SERVICES

# of Unable = ____ *# of Aware* = ____ *# of Committed* = ____

SUMMARIZE YOUR FINDINGS:

In which areas did you score the most Cs (Committed)?

_____

_____

_____

_____

_____

In which areas did you score the most As (Aware)?

_____

_____

_____

_____

_____

In which areas did you score the most Us (Unable)?

_____

_____

_____

_____

_____

ACKNOWLEDGE STRENGTHS AND IDENTIFY IDEAS FOR IMPROVEMENT:

Looking at your assessment and your scores, complete the table below to help evaluate your ability to meet the needs of women in your center.

STRENGTHS	WEAKNESSES
OPPORTUNITIES	CHALLENGES

What are some of the areas in which you are doing well? What has led to your success in these areas?

What are some actions you can put into place now to improve your center's responsiveness to female participants? For example:

- Get the light fixed in the parking lot.
- Identify women-only 12-step meetings in your community.
- Rearrange furniture in the reception area and make the area look more welcoming.

What are some actions you can take in the next few months? For example:

- Improve linkages between substance use and mental health services, so all women entering an SUD program are screened for psychiatric disorders.
- Hold staff discussions about gender dynamics in the program and groups.
- Evaluate women's engagement, retention, and completion data, and their satisfaction surveys.
- Evaluate the research about the validity of specific curricula and practices utilized at the center and identify necessary process improvements.

What are some longer-term steps your center can take? Work as a team to develop a plan for how to prioritize and address them. For example:

- Implement a training program on gender dynamics and facilitating co-ed groups.
- Expand opportunities for women-only groups and informal opportunities for women to build relationships with each other in the center.
- Build relationships with intimate partner violence prevention and intervention services, and expand mutual referrals and supports.
- Hire staff who possess core competencies for working with women.

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