

**SERVICE PLANNING GUIDELINES
SUBSTANCE USE, ABUSE, AND/OR DEPENDENCE
IN PREGNANT AND POSTPARTUM WOMEN**

- I. Target Group:** Pregnant/postpartum women with substance use, abuse, or dependence, with or without co-occurring psychiatric disorders
- Diagnosis: Alcohol, and/or other drug abuse or dependence
(DSM-IV 304.xx, 305.xx, 303.xx, 291.xx, 292.xx, 292.89)
- Severity: Moderate to severe

II. Background and Overview

Women and men differ significantly in their responses to alcohol and other drug (AOD) use. Women exhibit unique predisposing factors, vulnerabilities to addiction, consequences of AOD use, patterns of addiction, needs for addiction treatment, and responses to treatment.

Substance use, abuse, and dependence are associated with an array of medical, psychological and social problems. The abuse of AOD by a pregnant woman often has unfavorable effects on the woman and her unborn child. Problems associated with AOD use also may include health degradation, violence, child abuse and neglect, and family dysfunction. AOD use may impact a pregnant woman's health, the course of her pregnancy, and the development of her fetus. Harmful effects to children whose mothers abuse substances during pregnancy are often extensive and may impact both their physical and cognitive development. Prenatal exposure to alcohol or other drugs can result in intrauterine growth retardation, prematurity, low birth weight, birth complications, central nervous system damage, and congenital physical malformations.

Continued substance use can cause significant and deleterious effects on parenting behavior, as well as social, psychological, financial and medical consequences across the spectrum of a woman's life. Substance-using women often live in stressful environments that may include physical and sexual abuse, single parenthood, and limited financial and social support, or other serious problems such as homelessness, legal problems or health problems.

Pregnancy can be a window of opportunity to approach and intervene with substance-using women. Women are more likely to abstain from AOD use during pregnancy; pregnancy and/or a child's birth may be powerful motivators for a woman to seek addiction treatment. Treatment for substance abuse during pregnancy is significantly more effective than at other times in a woman's life. Outreach services, early recognition, early intervention, timely entry into treatment, and a sustained, long-term treatment regimen minimize the fetal impacts of AOD use and improve a woman's prognosis for successful, ongoing recovery from AOD abuse or dependence.

Core Components of Addiction Treatment

Treatment of pregnant and postpartum women should be based on universal principles of effective addiction treatment but also must include a variety of specialized interventions and services specifically designed for pregnant women and women with dependent children.

Outreach, screening, referral, early intervention, case management, child care services, and

continuity of addiction treatment are required components for all pregnant, substance-using women. Interventions should be designed to eliminate or minimize barriers women face in accessing and receiving substance abuse treatment.

Continuity and Coordination of Care

Pregnant, substance-using women have many special needs that must be considered in their overall care. Continuity of care through pregnancy and in the early postpartum period, case management, minimization of barriers to treatment, and continued addiction treatment must be assured for all pregnant women, regardless of their health benefit eligibility status. Additional supports, such as food for the woman and her family, are also necessary for pregnant substance-using women. Coordination of medical screening and treatment referral ensures the earliest possible interventions for AOD-using pregnant women. Coordination of care and case management also contribute to successful outcomes for pregnant and postpartum women in treatment by focusing a variety of supports and optimizing their cumulative effectiveness. Behavioral health, physical health, mental health, developmental disabilities, social services, family and child welfare, and substance abuse systems, as well as other systems should be coordinated when applicable.

Gender-Specific Treatment

Effective women-focused addiction treatment is based on a biopsychosocial treatment and recovery model, augmented by a relational/cultural approach that focuses on the centrality of relationships in women's lives. Gender-specific, gender-responsive treatment is based on respect, caring, and compassion and is directed to address the unique needs of women in treatment. A supportive, empowering, relational, strengths-focused approach is used, and issues specific to women are addressed in a variety of ways. Treatment must be provided in the format most responsive to addressing issues specific to women, including: women-only groups, female recovery coaches, and individual and family counseling using female therapists.

Role of Medical Providers

Pregnant, substance-using women also have special medical needs. Medical providers can play a significant role by providing services for substance-using women that help reduce substance abuse during pregnancy. Primary care physicians, obstetrician-gynecologists, pediatricians, nurses and others should be involved in a woman's medical and prenatal, delivery and postpartum care and/or the care of her children.

Specific Outcomes

The overall goal in a continuum of comprehensive addiction treatment is long-term abstinence from all psychoactive substances and improved life functioning and well-being, as measured by reductions in the medical, psychosocial, spiritual, social, and family consequences of addiction. Goals of women-focused treatment include reducing fetal exposure to alcohol/drugs and ensuring a healthy birth outcome as an immediate priority, and addressing issues which support addictions lifestyles in women (domestic abuse and violence, demands of child-rearing, lack of vocational and employment skills, etc.) over the long term.

These service planning guidelines outline nationally accepted best practices in the biopsychosocial intervention with and treatment of pregnant and postpartum women who use substances or have a DSM-IV diagnosis of substance dependence and/or substance abuse. The guidelines describe

interventions to increase the overall effectiveness of addiction treatment for women. These guidelines are designed to be used by Arizona treatment providers involved in addiction treatment in a variety of settings, such as physicians' offices, opioid maintenance treatment programs, intensive outpatient treatment programs, residential programs, and hospitals.

III. Desired Outcomes

A. Overview

Desired outcomes for pregnant/postpartum women with substance use, abuse and/or dependence include generally-accepted addiction treatment outcomes and some outcomes specific to gender and pregnancy status. Outreach, case management, child care services, and continuity of addiction treatment are required components for all pregnant, substance-using women.

Complete abstinence from all AOD use during pregnancy and postpartum is the most desirable "gold standard" outcome, since any AOD use during pregnancy is potentially harmful. [Psychoactive substances administered as part of medically-monitored maintenance therapy are an exception to this rule.] All pregnant women should be encouraged to abstain totally from AOD use and supported in this goal through intensive case management, relapse prevention and support and care coordination and monitoring.

B. Outcome categories

Changes in target signs, symptom, and behaviors, such as the ones outlined in the following tables, should be measured at baseline and at regular intervals during treatment (e.g., after 30 days, 60 days, and 90 days of treatment, then every 1 to 2 months throughout treatment; at discharge, and at change in treatment level of service). The following tables outline generic and gender-specific signs, symptoms, and behaviors of AOD use, target outcomes, and outcome measurements.

OVERALL SYMPTOMS OF AOD USE AND PSYCHIATRIC SYMPTOMS			
	Signs, Symptoms, and Behaviors	Targets	Measurements
Addiction Treatment	Use of alcohol and other drugs (AOD)* *except in accordance with a structured medical maintenance program (such as medication for mental illness or opioid maintenance therapy programs)	Abstinence from alcohol and other drugs (AOD) Negative drug screens	Random drug screens Addiction Severity Index (ASI) and/or Psycho-Social History (PSH) scores
	Psychiatric symptoms	Observable improvement in symptoms	Psychiatric rating scale scores ASI or PSH scores

OVERALL SYMPTOMS OF AOD USE AND PSYCHIATRIC SYMPTOMS			
	Signs, Symptoms, and Behaviors	Targets	Measurements
	Harmful behaviors, such as risky sexual behavior, needle-sharing, etc.	Decrease in harmful behaviors	Client report Documentation in record of frequency of behaviors ASI or PSH scores
Gender-specific Treatment	AOD problems during pregnancy	Identification via outreach activities Recognition and identification by medical care providers Intervention during the first trimester Referral to treatment during the first trimester Initiation of treatment during the first trimester Continuous care regardless of health benefit eligibility status	Documentation of setting for identification Documentation of appropriate referral Documentation of trimester(s) during which identification, referral, and/or successful entry into treatment occurred Documentation of care continuity
	AOD use during pregnancy	Zero AOD use	Random drug screens Client report Documentation in record of days of drug use, drugs, used, amounts used PSH scores
	AOD use after birth of a child	Zero AOD use	Random drug screens Client report Documentation in record of days of drug use, drugs, used, amounts used PSH scores

RELAPSE PREVENTION			
	Signs, Symptoms, and Behaviors	Targets	Measurements
Addiction Treatment	Strategies for avoiding or coping with relapse or addiction-exacerbating factors.	Client participation in development and use of effective strategies	Documentation in record of client participation Client identified list of strategies Documentation in record of client use of strategies.
	Interest in and/or involvement with substance-involved peers and activities.	Discontinuation or reduction	Client report Documentation of behavior change in client record ASI or PSH scores
	Engagement in and commitment to regular attendance in a self-help/support groups, such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous	Client participation in support groups Work on steps Work with appropriate sponsor, etc.	Client report and attendance sheets Documentation in record of client attendance Recovery activity survey Recovery assessment instruments (RAATE and others)
Gender-specific Treatment	Participation in gender-specific self-help/support groups.	Regular participation Increase in attendance	Client report and attendance sheets Documentation in record of client attendance Recovery activity survey Recovery assessment instruments (RAATE and others)
	Interpersonal boundaries and relationships (e.g., with other women, male partners, family members)	Able to establish and maintain healthy boundaries and relationships	Client report Documentation in client record PSH scores
	Self-esteem	Healthy self-esteem	Client report Self-esteem rating scales Documentation in client record

RELAPSE PREVENTION			
	Signs, Symptoms, and Behaviors	Targets	Measurements
	Substance use exacerbating emotions, thoughts or behaviors	Recognition and acceptance of personal relapse factors and boundaries	Client report Documentation in client record Recovery assessment instruments (RAATE and others)

FUNCTIONAL IMPROVEMENTS			
	Signs, Symptoms, and Behaviors	Targets	Measurements
Addiction Treatment	Overall physical health, psychological functioning, and quality of family life	Decrease in STDs Decrease in emergency care visits Increase in healthy family function	Number of STDs ER encounter data Client report Documentation in client record ASI or PSH scores
	Employment	Attainment of gainful employment Retention of employment	Documentation of employment status Length of successful employment Number of job turnovers ASI or PSH scores
	Educational and/or vocational activities.	Increased participation in school or training activities Attainment of GED Attainment of credit hours in school or training	Report cards GED certification Graduation diploma Documentation of credit hours ASI or PSH scores
	Criminal justice system involvement	Decreased involvement Compliance with conditions of probation or parole	ASI or PSH scores Arrest records Court records Probation and parole reports

FUNCTIONAL IMPROVEMENTS			
	Signs, Symptoms, and Behaviors	Targets	Measurements
Gender-specific Treatment	Overall functioning	Improvement in functioning Provision and coordination of quality, appropriate case management Cooperation with case management	PSH scores Case management documentation in client record
	Child custody status	Retention of child custody or, where children have been placed in foster care, restoration of custody when appropriate	Report(s) of child protective service workers Child protective service records PSH scores
	Ability to care for children	Improved parenting skills Improved stress management skills Decrease in child abuse and/or neglect behaviors	Direct observation of client skills Client report Documentation in client record Return of custody Number of abuse and neglect reports
	Neonatal health	Healthy and drug-free births for pregnant women entering treatment before the third trimester Normal infant outcomes	Infant toxicology screens Mother toxicology screens Apgar scores at 1 and 5 minutes
	Prenatal, delivery and postpartum care	Compliance with recommended prenatal, delivery and post-partum care Attendance at 90% or more of care visits Initiation of prenatal care in first trimester Increased time between pregnancies	Date of initial prenatal care visit Notation of date care initiated Encounter data Number of prenatal visits Documentation in client record Interval between pregnancies.

FUNCTIONAL IMPROVEMENTS			
	Signs, Symptoms, and Behaviors	Targets	Measurements
	Pregnancy outcomes	Uncomplicated pregnancy 40-42 week pregnancy Planned delivery with attendant clinician in hospital Normal length of stay in hospital	Gestational length Number of pregnancy complications Prenatal and delivery care documented in client record
	Infant outcomes	Birth weight 5 lbs. or greater Apgar score of 7-10 at 1 and 5 minutes Negative toxicology screen of newborn No symptoms of neonatal drug exposure No congenital abnormalities Normal length of stay in hospital No neonatal intensive care services required	Birth weight documented in client record Apgar scores documented Neonatal toxicology screen Physical examination findings Neonatal screening tests Documentation of hospital days and intensity of services required

IV. Intervention, screening and assessment

A. Interventions and referral to care

Providers must begin their intervention efforts with outreach to pregnant women, provide pregnant women with priority access to treatment, and provide interim services for pregnant women who cannot be admitted immediately to an appropriate level of care and full treatment services.

1. Outreach

- a. Conduct comprehensive outreach efforts, including identification of potential clients and communication with community agencies, to extend early intervention to as many pregnant, substance-using women as possible.
- b. Vigorously promote program staff and community awareness of the requirement for preferential intake of pregnant women for addiction treatment.
- c. Assure that substance abusing women who become pregnant are aware they have priority access to services.

- d. Assure that women are aware that they will not suffer penalties for seeking or accepting help.
2. Priority access to treatment
- a. Provide pregnant women with priority access to treatment services, including immediate intake, assessment and commencement of services within 48 hours of presentation. Whenever possible, intake should be completed within 8 hours and assessment within 24 hours of presentation.
 - b. Provide interim services for all pregnant women within 48 hours. If full treatment services are not immediately available, interim substance abuse services, i.e., services that are provided until an individual is admitted to a substance abuse treatment program, must be initiated within 48 hours of presentation. The purposes of these interim services are to reduce the adverse health effects of AOD use, promote the health of the woman, and reduce the risk of transmission of disease. At a minimum, interim services include counseling on the effects of alcohol and drug use on the fetus; referral for prenatal care; counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur; and referral for HIV or TB treatment services if necessary.
 - c. Maintain and monitor a waiting list for persons in line for treatment to ensure service priority for pregnant women. Systemic wait list systems should be implemented, including standardized cross-agency referral mechanisms, aggressive re-engagement and immediate availability of interim services for women who cannot immediately be placed.

B. Screening

Behavioral health providers and medical providers should implement a screening process for all pregnant and postpartum women that begins on intake, continues throughout pregnancy and the postpartum period and includes (at a minimum) notation of:

1. Results of standardized brief alcohol and drug screening instruments (e.g., TWEAK, AUDIT, DAST-10, Short Trauma History) utilizing norms for women
2. Observable behaviors or conditions suggesting substance use
3. Behaviors or conditions indicative of substance-related problems
4. Self-disclosure of AOD use or past AOD use
5. Previous or current DSM-IV diagnosis of substance abuse or dependence
6. Family history of substance-related problems
7. Recommendations for further assessment and/or treatment when screening suggests AOD use or problems
8. Reports from allied service fields (child protective services, criminal justice, domestic violence, etc.)

C. Brief Interventions

Medical care providers can play an essential role in helping a woman reduce or discontinue AOD use. Brief feedback and advice by primary care physicians and other medical providers to discontinue AOD use is associated with a significant decrease in AOD use, especially by persons in the early phases of AOD use, abuse, or problems. Feedback and advice should be the initial intervention for AOD-using pregnant women, followed by referral for assessment and possible treatment.

Medical providers should:

1. In a caring, positive, supportive and nonjudgmental way, give pregnant women feedback about AOD use and clear advice to discontinue use.
2. Help pregnant women under their care understand the risks of AOD use and the benefits of discontinuing AOD use.
3. Convey the message that recovery is possible and that treatment for AOD problems is important for a healthier pregnancy and parenting.
4. Link women to adequate behavioral health treatment.
5. Refer AOD-using pregnant women to experts on substance abuse identification and treatment and stay in close communication with those experts after referral.
6. Utilize the FRAMES approach: provide clear personalized Feedback, emphasize the client's Responsibility for change, give clear Advice to discontinue use, provide a Menu of options, use an approach based on Empathy, and emphasize the client's Self-efficacy and ability to change.

D. Assessment

1. Assessment of AOD-using women should be female-specific and culturally relevant.
2. Use objective standardized addiction assessment tools and placement criteria for initial and subsequent assessments and appropriate service placement, ideally, instruments developed or adapted specifically for use with addicted women, e.g., the Psychosocial History (PSH), an adaptation of the Addiction Severity Index (ASI) for women.
3. Address biopsychosocial aspects by using a comprehensive diagnostic interview and standardized assessment instruments that assess problems and symptoms in multiple domains, including female-specific elements and questions (see below).
4. Establish AOD use patterns, evaluate for female-specific patterns of use and progression (e.g., "telescoping" of symptoms), and if relevant, establish a DSM-IV substance abuse or dependence diagnosis. Evaluate for psychiatric symptoms and conditions, and medical/physical symptoms and conditions specific to AOD-using women. Include pregnancy testing and testing for sexually transmitted diseases (STDs), tuberculosis, hepatitis, and other infectious diseases (including HIV, if consent is given for testing) in the initial medical evaluation.
5. A number of specific assessment elements should be explored when evaluating AOD-using women. These psychosocial factors, medical factors and indicators related to children are outlined in the tables below. In keeping with the relational approach for gender-specific treatment, the strengths and problems in primary relationships should inform the assessment of all AOD-using pregnant women and their families.

**ELEMENTS THAT SHOULD BE EXPLORED
IN THE ASSESSMENT OF AOD-USING PREGNANT WOMEN**

Psychosocial Factors or Historical Indicators

Psychosocial Factors or Historical Indicators : Family, Relationships, Social	<ul style="list-style-type: none"> History of childhood abuse or neglect Inadequate or neglectful parenting behaviors Family chaos, violence AOD using partner Primary relationships with family, children and others: strengths and problems Unhealthy, unequal, dysfunctional personal relationships Support systems Child custody status: placement of children outside the home Interpersonal violence Unstable or inadequate living arrangements Gender discrimination and harassment, stigma Few or no positive role models for healthy relationships
Psychosocial Factors or Historical Indicators : Psychological and Behavioral	<ul style="list-style-type: none"> Use to relieve distress, early AOD use and intoxication Feelings of alienation, isolation or disenfranchisement Low self-esteem, limited coping skills Feelings of guilt and shame, no sense of self Issues of grief and loss Poor communication skills Sexuality, sexual functioning, sexual orientation Non-medical use of psychotropic drugs HIV/STD risk behaviors Assault history Job problems, unemployment Criminal history, history of incarceration, probation or parole status Failure to follow prenatal care regimen, missed prenatal care appointments, initiation of prenatal care in second trimester or later
Medical Elements	
Medical Elements: Addiction	<ul style="list-style-type: none"> Pattern of progression of symptoms of addiction, “telescoping” of symptoms Emergency room contacts, multiple physician contacts History of physical trauma, accidents

**ELEMENTS THAT SHOULD BE EXPLORED
IN THE ASSESSMENT OF AOD-USING PREGNANT WOMEN**

Medical Elements: Psychiatric, Behavioral Health	<ul style="list-style-type: none"> Previous psychiatric diagnoses, including postpartum syndromes Inappropriate or erratic behavior Depression or other mood disorders, difficulty concentrating Grief related to loss Suicide attempts Trauma history Anxiety disorders or symptoms Eating disorders or symptoms Dissociative disorders or symptoms
Medical Elements: Women's Health	<ul style="list-style-type: none"> Gynecologic problems or disease: <ul style="list-style-type: none"> Amenorrhea Dysfunctional uterine bleeding Dysmenorrhea Infertility Pre-menstrual syndrome Obstetrical care and complications: <ul style="list-style-type: none"> Number of previous pregnancies History of multiple births Prenatal care history Spontaneous abortion Stillbirth Premature labor Low birth weight infants Fetal alcohol syndrome or effects
Medical Elements: Liver and gastrointestinal disease	<ul style="list-style-type: none"> Fatty liver Hepatitis Cirrhosis Gastrointestinal bleeding
Medical Elements: Other Medical	<ul style="list-style-type: none"> Hypertension Nutritional status: Malnutrition, weight loss Infectious diseases: HIV, STDs, Hepatitis C Hematologic disorders: Anemia Pulmonary or lung disease: Smoking history, emphysema, allergies, asthma Skin/teeth

Indicators in Children

**ELEMENTS THAT SHOULD BE EXPLORED
IN THE ASSESSMENT OF AOD-USING PREGNANT WOMEN**

Indicators in Young Children: Medical	Neonatal narcotic abstinence syndrome Fetal Alcohol Syndrome (FAS) and/or Fetal Alcohol Effects (FAE) Low birth weight Failure to thrive Complex perinatal history and outcome Sudden Infant Death Syndrome (SIDS) Congenital abnormalities Developmental disabilities
Indicators in Older Children: Psychiatric, Behavioral, Social	Placement outside the home Depression or suicide attempts School problems and dropout, acting out in school Learning differences Behavior problems, aggressive acting out AOD use Early sexual behavior Abuse and/or neglect Runaway behavior, seeking solace on the streets

6. Utilize multidimensional means, such as the seven assessment dimensions of the Addiction Severity Index or Psychosocial History and the six dimensions of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) to assess the severity of a woman's AOD use, problems, or illness and her level of functioning (assets and obstacles to improvement).

ASI/PSH Assessment Dimensions	ASAM PPC Dimensions
Medical Status	Dimension 1: Acute Intoxication/Withdrawal Potential
Employment and Support Status	Dimension 2: Biomedical Conditions, Complications
Alcohol/Drug Use	Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications
Legal Status	Dimension 4: Readiness to Change
Family History	Dimension 5: Continued Use or Continued Problem Potential
Social Relationships	Dimension 6: Recovery Environment
Psychiatric Status	

7. The stages of change model (Prochaska and DiClemente) is helpful in evaluating a woman's readiness to change. Assess stage of change and readiness to

change, utilizing instruments such as the Recovery Attitude and Treatment Evaluator (RAATE), Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) and University of Rhode Island Change Assessment Scale (URICA), at baseline and at intervals throughout treatment. Information gathered from stages of change assessment should be used to identify intervention points for aggressive case monitoring and relapse prevention in line with the goals of abstinence and healthy birth outcome.

8. Match severity of use, problems or illness and level of functioning with the appropriate intensity of gender-specific services (treatment modalities, strategies, and sites of care). Treatment may be provided in a variety of settings, such as physicians' offices, opioid maintenance treatment programs, intensive outpatient treatment programs, partial hospitalization programs, residential programs, and hospitals. Consider a woman's needs and situation (e.g., dependent children, child care, transportation) when recommending a treatment setting or level of service. The following table lists examples of treatment settings and levels of service; further detail is available in the latest version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). A level of service is not "attached" to a building, structure, or specific setting. With the exception of the inpatient Levels III.7, III.7-D, IV and IV-D, each of the ASAM Levels of Service may be delivered in a variety of settings.

ASAM Patient Placement Criteria Levels of Service		
Examples		
ASAM PPC Level	Description	Clinical Needs and Treatment Setting Examples
0.5	Early Intervention	Risk factors or problems No DSM-IV diagnosis Psychoeducation, monitoring
OMT	Opioid Maintenance Therapy	Opioid dependence diagnosis Methadone maintenance treatment
I	Outpatient (Individual, Family, Group, Multi-Family Group)	DSM-IV diagnosis Low severity of problems Low-intensity outpatient setting
I-D	Ambulatory Detoxification without Extended Onsite Monitoring	Medically-supervised detoxification Office or clinic setting
II.1	Intensive Outpatient	Intensive outpatient treatment Structured evening program
II-D	Ambulatory Detoxification with Extended Onsite Monitoring	Withdrawal symptoms or needs require medical supervision and treatment Organized outpatient detoxification

ASAM Patient Placement Criteria Levels of Service Examples		
ASAM PPC Level	Description	Clinical Needs and Treatment Setting Examples
II.5	Partial Hospitalization	Clinically intensive outpatient programming needed Structured day program
III.1	Clinically-Managed Low-Intensity Residential	Halfway house with clinical services
III.2-D	Clinically-Managed Residential Detoxification	Social setting detoxification
III.3	Clinically-Managed Medium-Intensity Residential	Long-term residential treatment with intensive case management
III.5	Clinically-Managed High-Intensity Residential	Significant problems with living skills, antisocial traits Residential treatment, structured therapeutic community
III.7	Medically-Monitored Intensive Inpatient	Biomedical and other needs significant enough to require inpatient monitoring Inpatient permanent facility
III.7-D	Medically-Monitored Inpatient Detoxification	Withdrawal symptoms or potential severe enough to require inpatient monitoring Inpatient permanent facility
IV	Medically-Managed Intensive Inpatient Treatment	Biomedical and other needs severe enough to require inpatient care, physician management General or specialty hospital care
IV-D	Medically-Managed Inpatient Detoxification	Withdrawal symptoms or potential severe enough to require inpatient care, physician management General or specialty hospital care

V. Treatment and coordination of care

A. Comprehensive Addiction Treatment (Including Gender-Specific and Gender-Responsive Components)

Addiction is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal and is characterized by continuous or periodic: impaired control over AOD use, preoccupation with AOD, use of AOD despite adverse consequences, and distortions in thinking, most notably denial (adapted from JAMA, 1992).

The biopsychosocial treatment and recovery model of addiction treatment emphasizes that the inherited, genetic, biological, induced, and medical components of addiction do not occur in a vacuum, but interact with and are influenced by a variety of physical, behavioral, psychological, social, cultural, spiritual, family, environmental and political factors that affect its course and outcome. Many factors, such as genetic predisposition, history of trauma, depression, and anxiety may predispose a woman to addiction and affect the course of her problems and illness.

No matter what journey may precede a woman's addiction, her AOD use must be considered a primary problem. Treatment must specifically target a woman's substance use as a primary problem. The recovery model of addiction treatment emphasizes that addiction is a primary, chronic, progressive, potentially fatal disease that must be addressed directly. Women with substance dependence exhibit predictable, definite symptoms and a progression of problems with continued use. Periods of abstinence and relapses to use are common, expected events in the course of the disease. The recovery approach is supportive and not condemning or moralizing. An addicted person is considered to have an illness or set of problems, not to be a "bad" person; she is trying to get well or to heal by responsibly implementing a strong recovery program. Recovery is viewed as an ongoing journey and process, not an event; the term "recovering," not "recovered," reflects this distinction.

Comprehensive gender-specific and gender-responsive addiction treatment:

Eclectic approach: No addiction treatment approach is universally effective; each pregnant woman has a variety of needs that cannot be addressed by an inflexible, "one size fits all" treatment. Effective treatment programs are usually eclectic in their approach, blending many compatible interventions in innovative and creative ways to respond to the needs of clients. Addiction treatment for women must include strategies and approaches that address women's issues in addiction and recovery and support women's needs as primary care-givers including: women-only groups, female counseling staff, and individual, family and multi-family formats. Each woman's strengths and problems should be assessed and the scope, duration, frequency, and intensity of treatment services should be individualized to achieve desired outcomes.

Elements: Comprehensive addiction treatment for women includes many of the following elements: detoxification, treatment orientation classes/groups; treatment readiness groups; case management; individual, group, and family therapy; psychoeducation groups, combining cognitive and emotional learning to facilitate change; relapse prevention groups; practice of relapse management skills; 12-Step or other recovery self-help groups; spiritual groups; treatment planning and life plan development; culturally relevant interventions; recreation therapy; life skills education; attention to appearance and hygiene; parent training; stress management/coping skills; assistance to acquire drug-free transitional housing; facilitation of social services; family planning; legal services; literacy training; GED preparation; educational services; vocational rehabilitation and/or job placement; and ongoing treatment and aftercare.

Setting and Environment: Women recover best in a healing environment that provides safety and facilitates connection and empowerment. Gender-specific addiction treatment should be provided in a supportive, nurturing and non-judgmental environment by staff with genuine respect, compassion, and concern for women in treatment. Personal responsibility and the possibility of recovery must be emphasized. Developmentally appropriate parenting skills are included.

Whenever possible, women should receive treatment in residential, therapeutic community, or supportive living settings that reinforce healthier living and parenting skills. Residential and living environments should allow women to live with their children during treatment. Arrangements for child supervision and therapeutic childcare or other supports must be provided in outpatient settings to ensure that women can participate fully in treatment.

Therapeutic approach and recovery issues: Connection, not separation, is the guiding principle for women. The relational/cultural model developed by Jean Baker Miller defines growth-fostering relationships as a central human need constructed within a cultural context. Covington and Surrey (1997) discuss relationships as central in women's emotional development; nurturing and care giving roles are seen as central organizing principles for women, whose development hinges on connections with others. A relational/cultural model, in conjunction with the addiction and recovery model, has demonstrated effectiveness for women's addiction treatment. In the course of treatment, women must: come to understand what a healthy relationship is; assess their current and past relationships; recognize when they are repressing feelings, neglecting their own needs and not setting boundaries; and build locus of control and healthy boundaries in existing relationships. Treatment programs must demonstrate cultural competence and sensitivity to and respect for different cultural and social backgrounds. Healthy, open discussion about cultural differences and special programming for a variety of cultural groups should occur during treatment. The relational/cultural model facilitates these essential therapeutic tasks.

Women-only treatment services: Women feel safer, share more freely and heal more effectively in single-gender groups. All-female groups led by female group facilitators must be provided to every woman in addiction treatment. In early treatment, women should receive therapy in exclusively female groups; as a woman progresses in her recovery, has increased self-esteem, and feels more empowered, mixed-gender groups can be introduced as a later part of treatment.

Mutual help support groups (12-Step groups and others) are essential components of most treatment programs, but are not treatment in and of themselves. Treatment programs should utilize women-focused 12-Step facilitation therapy to enhance and maximize a woman's participation in mutual help support groups.

Strength-based approach: Emphasis should be placed on the assets and strengths that women bring to treatment. Assessing and defining a woman's "level of burden" instead of "problems" is empowering, supportive, and helpful. Motivational enhancement therapy

(Miller and Rollnick) helps women mobilize and apply their own inner resources and supports responsible choices.

Structure and confrontation: Women-focused treatment is not as confrontational as traditional addiction treatment; firm but supportive confrontation is more appropriate for women. Treatment must be firm and structured, but flexible enough to accommodate negotiation of treatment goals and outcomes. Treatment programs must work to encourage the development of trust, caring relationships, intimacy, bonding and empowerment. Women should feel comfortable enough to share feelings, develop trusting, supportive relationships with others, become empowered, build self-esteem, and find their inherent inner strengths. Women should learn to distinguish intimacy and friendship from sexuality. They should also address the common issues of social stigma, shame, secrecy, cultural disapproval, and grief.

Multidimensional approach: Effective women's treatment addresses the domains of self, relationships, sexuality, and spirituality. Group and individual therapies must focus on the affective, cognitive, and behavioral levels. Therapies must help women to: identify who they are and what they feel; connect with each other in relationships of respect, mutuality and compassion; understand the differences between healthy and unhealthy relationships; understand how relationships as children and as adults affect their addiction; become educated about sexuality; restore or develop appreciation for their bodies; support one another in healing sexually; understand what spirituality is; and start a spiritual journey that will continue through life. (Covington, 1999).

Sexuality: Treatment interventions in the domain of sexuality should help clients distinguish between intimacy and sexuality and address issues of sexual identity and self-acceptance, sexual dysfunction, fears, shame, and concerns related to sex work and/or trading sex for drugs.

Interpersonal violence: A history of interpersonal violence is common for women in addiction treatment. Incest, sexual abuse, rape, battering, and other traumatic events should be addressed using the trauma recovery stages outlined by Herman (1992). Safety is the first priority; once physical safety for a woman and her children is established, emotional safety can be addressed and women can confront and deal with feelings (e.g., rage, depression, helplessness) related to abuse and violence. Individual and group therapy and trauma-specific support groups are helpful interventions. After sufficient work on safety, women can move to the next stages of trauma recovery: remembrance and mourning, followed by reconnection. Work on abuse and trauma can only begin in addiction treatment, and will need to continue after discharge.

Treatment team: Biopsychosocial treatment and interventions are most effectively provided by a multidisciplinary treatment team consisting of physicians, nurses, social workers, psychologists, counselors, and others. Staff must include female role models, including women in management positions. Counseling staff should be predominantly female, including women in recovery from addiction. Ideally, supervisors and other staff will possess specific substance abuse credentials and/or experience that includes gender-

specific training and experience. Staff must be trained in: culturally competent interventions; non-confrontational techniques and other therapies; and specific therapies for women and children from traumatic backgrounds and dysfunctional family environments. Staff evaluations should include an assessment of staff members' knowledge about women's treatment, sensitivity to different cultural and social backgrounds and supportive, nurturing and non-judgmental characteristics.

Female sponsors, peer counselors, recovery "coaches," successfully recovering women graduates of treatment programs and other role models should be formally involved in a woman's treatment.

Continuum: The longer the treatment and the more involvement in interventions, the better the outcome. There should be a continuum of interventions and settings for treatment, depending on severity. A long-term comprehensive continuum of care will continue throughout the pregnancy and for at least six months following delivery. Postpartum care should include in-home observation, case management and supports when women return to their home environment.

Children and Family: When appropriate, treatment will involve family relationships, including the woman's spouse or partner. Women will be involved with their newborns during treatment. Ideally, women will live with their children during residential treatment, or appropriate arrangements will be made for childcare or other supports to ensure that women can participate fully in treatment.

Coordination and Care Management: All pregnant women should be assigned a specific staff member (case or care manager) responsible for ongoing and long-term coordination of services. Behavioral health and medical providers and agencies must communicate and collaborate in the care of pregnant and postpartum clients and consult other medical, pediatric, and mental health professionals as needed. Agency relationships must be built to weave a seamless network of support for women facing the special challenges of substance abuse treatment, pregnancy, parenting, and childcare. Every pregnant woman must have a comprehensive discharge and aftercare plan developed that includes collaboration with other agencies to provide wraparound services for women and their children.

B. Medical Care and Linkages

The only medically responsible recommendation for a pregnant woman is to encourage her to abstain totally from AOD use during pregnancy; however, any reduction in AOD use reduces potential harm and is beneficial to a pregnant woman and her fetus.

Prenatal care: Pregnant, substance-using women have many special medical needs that must be considered in their overall care. All clinicians who interact with pregnant women should discuss the importance of prenatal care and assist all pregnant clients in locating convenient and appropriate medical providers. Pregnant women with AOD problems should be connected with appropriate obstetrical care and supported and encouraged to

stay connected with medical providers and compliant with medical regimens. Behavioral health providers should enter into cooperative agreements with medical providers who will provide expedited intake and other services for pregnant AOD users and coordinate behavioral health therapy and care with medical/obstetrical care. Medical providers should work as part of a team, cooperate with identified case managers, and ensure women are connected to necessary social services.

Prioritization of medical needs: The medical safety of pregnant AOD users must come first. Medical needs of pregnant women must be prioritized, including medical stabilization, detoxification, evaluation and treatment for infectious diseases, prenatal care, general medical and gynecologic care, and initiation of monitored medical maintenance therapies.

Withdrawal and detoxification: If detoxification is indicated, the safety of the woman and her fetus must be assured. Appropriate, medically supervised detoxification services must be provided when women present for treatment. Symptoms of withdrawal should be relieved and progression of withdrawal prevented using medications that are safe for use during pregnancy. Medical and other providers should coordinate efforts to ensure a pregnant woman's safe withdrawal from substances and encourage compliance with required therapeutic services. Pediatricians and other medical providers should ensure that babies exhibiting neonatal abstinence symptoms undergo a safe and comfortable detoxification. A pregnant AOD user should be stabilized physically and psychologically until her body is free of the acute effects of AOD use or withdrawal. Concurrently, she can be encouraged to enter long-term treatment.

Opioid addiction: As a general rule, opioid-addicted pregnant women should not undergo opioid detoxification because of risk to the fetus. Instead, opioid dependent pregnant women should be provided with or referred to comprehensive opioid maintenance therapy, which decreases medical complications, improves pregnancy outcomes, and encourages fetal stability and growth. Medically-monitored maintenance therapy, such as methadone maintenance therapy, should be continued throughout the pregnancy.

Other addiction treatment: In addition to detoxification, other medical addiction treatment services may be indicated, such as methadone treatment/maintenance, other (non-methadone) pharmacological treatments, acupuncture treatment, and referral to inpatient treatment. Since nicotine dependence is associated with poorer pregnancy outcomes, treatment for nicotine dependence should be a routine part of addiction treatment for pregnant women.

General health care needs: Pregnant women entering treatment should be provided or referred for general health care, including prenatal care, postnatal care, general primary health care, gynecological care, family planning, nutritional therapy, smoking cessation, dental care and eye care. Every pregnant woman should be encouraged to undergo testing for the human immunodeficiency virus (HIV) and other infectious diseases as a

routine part of prenatal care. Women who test positive for HIV and/or other infectious diseases must be linked to appropriate medical treatment for these conditions.

Medications for AOD-using pregnant women: If a pregnant woman needs medication treatment, teratogenic agents must be avoided. Because of the danger of cross-addiction, psychoactive substances (with the exception of maintenance therapies) should not be prescribed to clients with a history of AOD abuse or dependence, except in the case of a medical or psychiatric emergency.

C. Behavioral health

Psychiatric symptoms, syndromes and disorders may result from intoxication, toxicity, withdrawal, and other states induced by alcohol and other drugs. Substance use and substance-related disorders may coexist with anxiety disorders, mood disorders, personality disorders, psychotic disorders, and other disorders, and may mask, mimic, masquerade as, or unmask them.

Unrecognized, untreated and under treated psychiatric conditions can interfere with successful recovery from addiction. Women with recurrent addiction relapses, exacerbations, and/or failure to improve in treatment should be evaluated for the presence of a co-occurring psychiatric disorder.

Psychiatric conditions commonly co-occurring with substance use and disorders include:

Mood disorders

Anxiety disorders, including Post-Traumatic Stress Disorder

Eating disorders

Psychotic disorders

Dissociative Disorders

Personality disorders (most commonly, Borderline and other Cluster B disorders)

Intrapartum and postpartum psychiatric conditions: All women should be evaluated for intrapartum exacerbations of psychiatric conditions and for postpartum depression and psychosis. The safety and well-being of infants and other children of a woman with active psychiatric symptoms or disorders must be assured.

Trauma-related problems: The majority of women in addiction treatment report a history of traumatic events, such as sexual, emotional, and/or physical abuse in childhood, sexual assault, rape, interpersonal violence, etc. Post-Traumatic Stress Disorder, mood and anxiety disorders, eating disorders, dissociative disorders, and erratic personality traits or disorders are more likely to occur in women who report a history of trauma. Trauma history and problems should be assessed and appropriate treatments provided to all AOD-using women. A consistent treatment program and structured interventions are essential therapeutic elements for all women, but especially for women with a history of trauma and diagnoses of personality disorders.

Eating Disorders: Assess AOD-using pregnant women for the presence of eating disorders or dysfunctional eating behaviors, such as binge-eating and purging. These problems commonly co-occur in AOD-using women and dysfunctional eating behaviors can complicate pregnancy. Eating behaviors should be addressed directly in group and individual therapies. In addition, all AOD-using pregnant women need to learn about healthy nutrition and eating habits and deal with body image concerns. The role of smoking and weight concerns should be addressed.

Psychotropic medications: If medication treatment is indicated for the treatment of pregnant women with co-occurring disorders, non-addicting and non-teratogenic medications should be used.

Refer to the Arizona Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders for additional information on mental health services for people with co-occurring disorders.

D. Social services

Pregnant women face a number of practical barriers to addiction treatment. Providers must identify and mitigate women's barriers to treatment, beginning with the basic needs for transportation, food, housing, personal and child safety and child care services. Any barriers that interfere with a pregnant woman receiving needed treatment must be resolved. Additional areas of need that must be assessed and addressed include: interpersonal violence, personal safety, parenting skills, translation services, legal services, financial support, employment, education and training, and home management issues.

E. Children

Children should be included in all levels of a woman's treatment and recovery. All children should be evaluated for physical, emotional and behavioral problems and for risk factors and sequelae of addiction. Child development services should be provided and interventions made to facilitate bonding between mother and baby, assist mothers in nursing or feeding, and develop healthy attachment and touch response.

Therapeutic interventions for children: Programs should provide supervision and childcare for children while their mothers are participating in treatment and recovery activities. Interventions should address the physical, mental, emotional and social development needs of children by providing therapeutic child care, children of substance abuser groups, a nurturing environment and a healing atmosphere.

Healthier parenting: Most addicted women have limited or no role models for consistent, nurturing, positive parenting; are ignorant about normal child behavior; have unrealistic expectations for their children; and use harsh disciplinary practices. Treatment programs must provide women with healthy parenting role models and training in healthy parenting skills and constructive approaches to children's behavior patterns. Women need formal training and education on child development and reasonable expectations for

children at different developmental stages. Women need training in coping skills to deal with child behaviors, ways to redirect a child's misbehavior, and effective discipline. Cognitive-behavioral interventions, reframing, positive attitude, listening skills, confrontation, conflict resolution, and appropriate expression of emotions must be taught.

Women should be encouraged and mentored to participate in community child development activities, and older children's school activities

F. Criminal justice system

Substance using women in the criminal justice system have alcohol and other drug problems that are severe and chronic. They also suffer from a constellation of high risk factors, and are often victims of violence such as physical, sexual and emotional abuse. Co-occurring mental health problems are common in women with criminal justice involvement. Addiction treatment for women offenders, especially a comprehensive continuum of care, is effective in reducing recidivism.

Pregnant women offenders require specialized addiction treatment, such as that outlined above. In addition, support groups with women ex-offenders who have been through treatment, mentoring programs to match offenders with successful role models in the community, and similar interventions can increase the effectiveness of AOD treatment for women offenders.

VI. Bibliography

American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance Related Disorders, 2nd edition, revised. Chevy Chase, MD, ASAM, 2001.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th edition–Text Revision. Washington, DC, APA, 2000.

Coletti SD; Schinka JA; Hughes PH; Hamilton NL; Renard CG; Sicilian DM; Urmann CF; Neri RL: PAR Village for chemically dependent women: Philosophy and program elements. *Journal of Substance Abuse Treatment*; 12 (4), 289-296, 1995.

Covington SS: *Helping women recover: a program for treating addiction..* San Francisco, CA, Jossey-Bass, 1999.

Covington SS; Surrey JL: The relational model of women's psychological development: implications for substance abuse. In Wilsnack S and Wilsnack R, eds: Gender and Alcohol: Individual and Social Perspectives. New Brunswick NJ: Rutgers Center of Alcohol Studies, 1997.

Dashe JS; Jackson GL; Olscher DA; Zane EH; Wendel GD Jr: Opioid detoxification in pregnancy. *Obstetrics and Gynecology*; 92(5):854-8, 1998.

Evans K; Sullivan JM: *Dual diagnosis: counseling the mentally ill substance abuser.* New York, Guilford Press, 2001.

Herman J: Trauma and recovery. New York, Basic Books, 1992.

Kassebaum PA: Substance Abuse Treatment for Women Offenders: Guide to Promising Practices. Treatment Assistance Publication (TAP) Series 23. Center for Substance Abuse Treatment. Rockville, MD. DHHS Publication No.(SMA) 99-3303, 1999.

Miller WR: Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 35. Center for Substance Abuse Treatment. Rockville, MD. DHHS Publication No. (SMA) 99-3354, 1999.

Miller WR; Rollnick S: Motivational interviewing: preparing people to change addictive behavior. New York , Guilford Press, 1991.

Morse B; Genshan S; Hutchins E: Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health. National Center for Education in Maternal and Child Health, Arlington, Virginia, 1997.

Implementation Oversight Committee on Perinatal Substance Abuse: Community-Based Integrated Model for Pregnant and Parenting Substance Abusing Women, Phoenix, Arizona, 1997.

National Association of State Mental Health Program Directors, Alexandria, VA and National Association of State Alcohol and Drug Abuse Directors, Washington, DC. National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, 1999.

http://www.nasadad.org/Departments/Research/Consensus%20Framework/national_dialogue_on.htm

National Institute on Alcohol Abuse and Alcoholism. Assessing Alcohol Problems: A Guide for Clinicians and Researchers. Treatment Handbook Series 4. Alcoholism Treatment Assessment Instruments.

<http://silk.nih.gov/silk/niaaa1/publication/instable.htm>

National Institute on Drug Abuse. Biological Mechanisms and Perinatal Exposure to Drugs Research Monograph 158. Rockville MD, 1995.

National Institute on Drug Abuse: Principles of Drug Addiction Treatment: A Research-Based Guide. Rockville MD, 1999. <http://www.nida.nih.gov/PODAT/PODATindex.html>

Wesson DR: Detoxification From Alcohol and Other Drugs: Treatment Improvement Protocol (TIP) Series 19. Center for Substance Abuse Treatment. Rockville, MD. DHHS Publication No.(SMA) 95-3046, 1995.

Wetherington CL; Roman AB, eds: Drug Addiction Research and the Health of Women. Rockville MD: National Institute on Drug Abuse, 1998.

**Core Elements
Women's Addiction Treatment**

Outreach & Referral

1.	Active review of network to reduce entry barriers (e.g. arbitrary program rules, pre-determined lengths of stay)
2.	Mechanism to prioritize entry within 48 hours and manage wait list across a network
3.	Mechanism to manage wait list for priority entry (network and freestanding models)
4.	Mechanism to ensure interim service delivery while on the wait list
5.	Mechanism for rapid referral to assessment time frame with other agencies/providers (health plans, county public health, child welfare, justice system)

Assessment/Treatment Plan

1.	Evidence of gender-focused assessment tools
2.	Evidence of addiction specific assessment tools.
3.	Evidence of staff training in addictions assessment / women's treatment
4.	Evidence of assessment for concurrent conditions/needs specific to supporting women in addictions treatment (STDs, HIV, hepatitis C, prenatal care, nutritional support, housing, transportation needs, domestic violence)
5.	Evidence of referral and coordination of care for concurrent conditions and needs
6.	Provision made for dependent children in women's care <ul style="list-style-type: none"> a. Resident with mother b. Child care (supervision) during treatment sessions c. Family contacts for temporary care d. CPS interface

Treatment

1.	Gender-specific groups
2.	Female counseling staff available
3.	Use of recovery coaches
4.	Individual sessions addressing women's issues (e.g. sexuality, relationships) and utilizing a strengths-based approach
5.	Family counseling and multi-family groups
6.	Minimum length of stay = 3 months
7.	Assigned case manager / care coordinator
8.	Evidence of treatment focus on parenting skills

9.	Evidence of treatment focus on services for children (infant and other dependent child): a. Touch / bonding b. Infant care / nursing c. Therapeutic nursery d. Children of substance abusers groups
Discharge Planning / Aftercare	
1.	Case management provided up to 6 months post-partum
2.	Case management includes in-home family support and relapse observation/management (prometora models)
3.	Continuous coordination with medical care providers