- What may be a side effect of withdrawal?
- Is there cognitive impairment related or unrelated to substance abuse? For example, is the woman limited in her ability to understand treatment components?
- Has the woman been so physically and/or sexually abused that she will be unable to focus on her substance abuse problem?

It needs to be emphasized again that differential diagnosis of a co-occurring mental or emotional disorder is likely to be difficult at intake. Relevant information needs to be collected, recorded, and used throughout the treatment process.

If the woman has a mental health condition co-occurring with the substance abuse, it should be diagnosed and addressed as early as possible in the treatment process.

Many women suffer from depression and/or anxiety when they are admitted to a substance abuse treatment program. In some cases, psychological problems, whether or not clinically diagnosed, can be directly related to substance abuse and, once the substance abuse stops, these problems disappear. However, if the woman has a mental health condition co-occurring with the substance abuse (e.g., depression or PTSD), it should be diagnosed and addressed as early as possible in the treatment process.

The manner and timing of symptomatology varies with the condition and the individual woman and her substance abuse history. For example, a panic or anxiety disorder can become more pronounced as the substance abuse stops. Cocaine-addicted clients may require more frequent psychiatric assessments because of the paranoia that can accompany heavy crack/cocaine use and the depression that often follows the cocaine euphoria. Symptoms of AIDS dementia in women infected with HIV will occur later in the progression of AIDS, which can be at any point in the substance abuse treatment process. According to many experts, in order to make an appropriate diagnosis, the client should be drug-free for a period of time so

that the symptoms of alcohol and other drug use can abate. However, clinicians do not agree on the appropriate length of time between onset of abstinence and diagnosis.[4] The range is two weeks to two months or more. Dual diagnosis is also discussed in Chapters 2 and 3.

In addition to performing the medical and mental health assessment, the counselor should obtain as much information as possible concerning the woman's family and social history and her current life status to ensure that her immediate and long-term needs will be met as completely and as quickly as possible. If possible, the information obtained during the intake process (and used in the initial and on-going assessment of the client's needs) should include the following:

- substance abuse history, including previous treatment experiences;
- family history and current status (in general, and history of substance abuse);
- employment history and status;
- living arrangements;
- legal or criminal justice status;
- financial information;
- educational history;
- longest friendships and relationships;
- current relationship status;
- sexual orientation;

- country of origin, circumstances concerning arrival in this country and citizenship status;
- primary language spoken;
- death or current terminal illness of loved ones (to identify grief issues);
- pregnancies, children, etc.; and
- birth control knowledge.

Information concerning child care, abusive relationships, sexual abuse or harassment, and other issues of particular importance for women are often overlooked by counselors during intake interviews. However, as with the medical and mental health histories, if the standard form used in the program does not request such information, it should be recorded separately and updated during the course of treatment. This information (including results of referrals for services) should be maintained in the woman's treatment record.

Information concerning child care, abusive relationships, sexual abuse or harassment, and other issues of particular importance for women are often overlooked by counselors during intake interviews.

At intake, the client may not divulge information about medical problems, psychological problems, or behavioral or familial circumstances of which she is ashamed, about which she feels guilty or is unwilling to accept help, or which she believes would result in further stigma or legal penalties if known to the treatment program. This reluctance to divulge information (or to disclose) is particularly evident early in the intake and assessment process, because some clients may think staff members will reject them if they reveal certain details about their lives. This can be a particular problem in rural areas where almost everyone may "know everyone else."

Women may also fear that what they say will be repeated by another client or staff member (who may know their family or friends in

the community). This "talking outside," whether real or perceived, may be a major problem in community-based outpatient substance abuse treatment programs and can be a particular problem for women who fear losing custody of their children. Women need to be assured that the information they disclose to treatment program staff will remain confidential for use only in the treatment process or when otherwise approved by the client for release. The client should be helped to feel empowered to disclose sensitive information.

5.2.2 Orientation to Treatment

The orientation process is another crucial step in building trust between the client and the program staff. To the extent that the client can become comfortable in the treatment setting, acquire confidence that staff members will respond to her questions and needs clearly and sensitively, and understand the scope of the treatment program and her role in the treatment process, she is more likely to fully engage in and complete treatment. During orientation, the client should be fully informed about such matters as:

- the nature and goals of the program, the program's philosophy and specific modalities of care and services;
- the physical facility (this should include a tour of the facility);
- client rights and privileges (See appendix B for sample principles of conduct and client rights statements.);
- the rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program;
- the hours during which services are available; and
- treatment costs and payment procedures, if any.

The program should make the intake interview and orientation setting as comfortable and private as possible for the client and her family. They should be informed by the treatment staff about the disease of addiction and its physical and mental health effects. Written and audiovisual information (e.g., booklets, flyers, and videotapes) should be available and include materials that the woman and her family can keep. Many of these resources can be obtained from the National Clearinghouse on Alcohol and Drug Information (NCADI), state and local clearinghouses, libraries, and elsewhere. The counselor should also give to each woman a resource directory of public health and social services available in the community, particularly those with which the program has agreements for provision of services. Information and resources should be available in alternative formats to accommodate women with disabilities and those who are not functionally literate.

Female staff members should be available to meet with the woman during orientation. Otherwise, the counselor should try to refer the client to a local woman's self-help group, taking the client to the meetings, if possible and if appropriate. Having a female staff member as the first contact during orientation to the program can help the client understand how women feel during treatment, how they cope with the realities of daily life during treatment (e.g., child care, relationships, housing), and how barriers to recovery (e.g., emotional obstacles) can be overcome.

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5.2.3 Comprehensive Assessment

To develop a treatment plan that addresses a woman's specific needs and keeps her engaged in the treatment process, it is essential to prepare a comprehensive assessment. The International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA) has defined the assessment process as including the following:

> ...those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems, and needs for the development of the treatment plan.[5]

This assessment is based on information obtained during intake (and recorded on intake and standardized assessment forms) and on the counselor's, case manager's, or team's clinical observations. Staff preparing assessments of client's needs should acknowledge that clients may not have disclosed fully information related to their substance abuse, physical and mental health, and social needs. The assessments will, in many cases, be provisional, contingent on the program staff building trust throughout the treatment process. This requires flexibility in both assessment and treatment planning. It necessitates ensuring that relevant information (e.g., regarding history of exposure to violence) is recorded in the client's file, reported to the clinical team, and used in revising her treatment plan and in providing services.

The counselor should negotiate with the client to determine in what format she will deal with issues that she would be uncomfortable discussing in the group.

The counselor should negotiate with the client to determine in what format she will deal with issues that she would be uncomfortable discussing in a group. If a program does not respond appropriately to such concerns, there is a high probability that the client will not remain in treatment or maintain recovery over a long period.

The client assessment is, essentially, a synthesis of information gathered during intake. It should include a summary of the client's strengths and factors that may impede recovery. It should include space to record the basis for the determinations (e.g., program intake forms, standardized assessment instruments, clinical observation). The assessment should include issues related to basic living skills, such as the following:

- developing and maintaining personal health and hygiene;
- finding and retaining a job;

- obtaining housing;
- managing money;
- maintaining a household; and
- parenting.

The assessment is critical to the program's determination of what specific treatment methods will help empower the client to set and achieve her own treatment goals and make necessary changes to achieve those goals. In that regard, clinical staff must recognize that some women may find it difficult to address immediately the broad range of problems associated with substance abuse, co-occurring mental disorders, physical health problems, or life skills areas. For example, some women who have been unemployed for some time may find it difficult to re-enter the work force, become independent from social support systems (e.g., AFDC) and become drug-free at the same time. (Strategies related to providing services in life skills areas are presented in Section 5.3.1: Providing Comprehensive Treatment Services.)

5.2.4 Treatment Plan

The treatment plan serves as the fundamental basis for providing care to the client throughout her treatment process. While most programs have standardized forms for the treatment plan, each plan needs to address the specific needs of each client, based on the assessment described above. The assessment form should clearly delineate the relationship between the findings of the assessment and recommendations to be included in the treatment plan. The counselor or case manager works with the client to determine the following:

- the priority of the full range of problems that need to be addressed (including those directly and indirectly related to

substance abuse and other physical and mental health and social service issues related to the woman and her family);

- immediate and long-term treatment goals; and
- the most appropriate treatment methods and resources to be used.

At intake, the treatment plan can address only the immediate problems presented by the client and observed by the clinical staff. In fact, some clinicians think it is inappropriate to set long range goals at this point because the client may be concerned only about the immediate needs of herself and her family. The treatment plan should specify the services to which the woman will be referred, including the agency or agencies to which referrals are made. Throughout the course of treatment, results of all referrals must be recorded, including outcomes, if known.

It is important that the treatment plan be prepared or reviewed by a treatment team with gender-specific and culturally relevant expertise.

It is important that the treatment plan be prepared or reviewed by a treatment team with gender-specific and culturally relevant expertise. This team should be comprised of staff members or consultants knowledgeable about substance abuse; physical and mental health professionals (e.g., the consulting physician or nurse practitioner and psychologist or psychiatric social worker); educational and employment specialists; and a child care specialist. The latter is particularly important if the woman's children are in treatment with her. This team will help to determine how many individual counseling sessions are appropriate, whether or not the woman should participate in group counseling sessions at the facility, and which sessions she should attend. They will also determine when to refer her to self-help groups within or external to the program (e.g., AA, NA). Treatment providers should keep in mind that some women may be more guarded in their communications than others. Some women may resist the process of sharing experiences common to support groups, including 12-Step, Women for Sobriety, Save Our Selves, and Rational Recovery pro-

grams. During treatment, clients should be encouraged to build relationships with their peers in the mutual self-help group of their choice. These relationships can easily develop from activities that teach women how to enjoy life without using alcohol or other drugs.

It is important, throughout the course of treatment, that the woman's treatment plan be revised and updated, in consultation with the treatment team and the woman herself.

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5.3 The Treatment Process

As discussed in Chapter 3, the length of the treatment process and the types of modalities used in treatment vary significantly from one program to another. The information provided in this section is intended to be general enough to apply across treatment modalities. Where appropriate, information specific to modalities of care (e.g., inpatient detoxification, outpatient drug free treatment) is provided. Because it is assumed that the reader is a trained substance abuse counselor or administrator and/or has experience in substance abuse counseling, general information concerning approaches to individual, group, and family counseling, and use of medications in treatment (e.g., antabuse and methadone) and other general treatment methods are not addressed. Rather, aspects of the treatment process or of specific modalities of care that relate predominantly to women are described. However, while some treatment strategies may appear to be simple, they have been shown to have demonstrable impact on the success of substance abuse treatment programs—for both women and men.

In planning and implementing treatment services, the program staff should try to ensure that there is a coherent link between the treatment philosophy of the program, the treatment modalities that are used, and the specific services offered for women. This apparently obvious consideration can sometimes be overlooked by programs, particularly when there is

a change in staff leadership and a consequent change in program philosophy, or when funding considerations dictate changes in services. The staff needs to ensure that the weekly schedule of program services — including individual and group counseling, participation in self-help groups on- and off-site, specialized group meetings (e.g., for adolescents, women with a history of sexual or physical abuse, or pregnant women, sessions on spirituality and personal growth), and time for personal activities (e.g., vocational training, GED classes) — not only reflects the program's treatment philosophy but also takes into account the varying needs of the clients and the reality of scheduling comprehensive services outside of the program.

For programs in which children are present with their mothers, the need for personal time between the mother and her child(ren) is critical. Staff should be aware that balancing the substance abuse treatment needs of the woman (with other needs such as addressing mental health disorders) with the needs of her children requires that considerable attention be given to scheduling activities: those that meet collective needs of the clients; the individual needs of the woman; and those of her child(ren). Throughout treatment, the program should ensure that the clients benefit from effective case management.

Most women enter treatment with many problems. They are frightened by the prospect of change, and lack confidence in their abilities to assert themselves and lead healthy lives.

5.3.1 Providing Comprehensive Treatment Services

Most women enter treatment with many problems. They are frightened by the prospect of change, and lack confidence in their abilities to assert themselves and lead healthy lives. Throughout the treatment process, the clinical staff (in particular the counselor or case manager who works most closely with the client) must ensure the following:

- The client is participating in the individual and group counseling sessions as agreed in her treatment plan, including attendance at 12-Step or other self-help group meetings and fulfilling other requirements set by the program;