

Module 3: Treatment of Substance Abuse

Duration: 90 minutes

Goal:

- ♦ To provide health care providers with a basic understanding of their role in treating substance abuse problems in women and subsequent treatment options available.

Objectives:

Following this module the participant will be able to:

- ♦ Recognize the role of health care professionals in the prevention of substance abuse in women.
- ♦ Identify barriers to accessing substance abuse treatment services for women.
- ♦ Describe various modalities in the treatment of substance abuse.
- ♦ Describe the components of a women-oriented treatment program.
- ♦ Recognize unique treatment considerations as they relate to substance-abusing pregnant women.
- ♦ Recognize unique treatment considerations as they relate to the elderly.
- ♦ Recognize and appreciate ethnic differences as they relate to substance abuse and women.
- ♦ Describe predictors of treatment outcomes for women with substance abuse problems.
- ♦ Describe methods to improve access to substance abuse treatment for women.
- ♦ In a simulated or actual patient interview, conduct a brief intervention and negotiate a treatment plan or referral.

Teaching Activities

Introduction	5 minutes
Prevention through education	5 minutes
The current state of services for substance-abusing women	5 minutes
Barriers to accessing treatment	10 minutes
Treatment methods	15 minutes
Components of women-oriented treatment programs	5 minutes
Special groups	15 minutes
Predictors of treatment outcomes for women with substance abuse problems	10 minutes
Do treatment outcomes differ for women and men?	10 minutes
How can treatment access for women be improved?	10 minutes

Optional Exercises

If additional time is available, or a second session can be scheduled, consider including the following:

Practice role plays <i>Participants practice skills in role play in small groups.</i>	15 minutes each; allot 20 minutes additional time if reviewing role plays with video.
Discussion	15 minutes

Teaching Format

As with other modules, the materials presented here will incorporate a lecture format and small group work.

Role Play Format

The role play is best conducted in a small group teaching setting. Ideally each participant will have the opportunity to play both the provider and patient roles. This will provide the maximum benefit- both for skills practice and for developing a better understanding of, and empathy for, the patient's experience.

For use as a demonstration, select a patient from the role plays provided. Identify an individual to play the patient ahead of time. When demonstrating the skills, keep the health care provider sheet accessible and refer to it as needed. You may stop the demonstration role play at any time to comment or ask for feedback. For practice role plays, select a case to copy and distribute to participants. Health Care Providers should refer only to the "Health Care Provider Sheet" and patients to the "Patient Information" only.

It is important that participants get an opportunity to practice intervention skills and experience some success in their role play. To optimize practice opportunities, pair participants in diads - one playing the health care provider, one playing the patient.

Each role play can last up to 15 minutes. If you use video to record and review the role play, you are encouraged to stop the video frequently to analyze and comment on the interaction. Review of the role play will take at least 20 minutes.

Patient Information

This information is intended for use by the participant playing the patient. It provides information about the patient's symptoms and instructions about how the patient is to respond to screening questions.

Health Care Provider Sheet

This information provides the participant playing the health care provider with introductory information about the patient.

Suggested Literature

Beckman, . L. J. (1994). Treatment needs of women with alcohol problems. Alcohol Health & Research World, 18, 206-211.

Goldberg, M. E. (1995). Substance-abusing women: False stereotypes and real needs. Social Work, 40, 789-798.

Kaufman, E. (1996). Diagnosis and treatment of drug and alcohol abuse in women. American Journal of Obstetrics and Gynecology, 174, 21-27.

Stein, M. D., & Cyr, M. G. (1997). Women and substance abuse. Medical Clinics of North America, 81, 979-998.

Yaffe, J., Jenson, J. M., & Howard, M. O. (1995). Women and substance abuse: Implications for treatment. Alcoholism Treatment Quarterly, 13, 1-15.

Teaching Outline

Module 3: Treatment of Substance Abuse

Note to Instructors:

Before starting to teach you may want to review the goal and objectives of this module.

I. Introduction

To fully appreciate the information presented in this lecture, participants should already be conversant with how to place drugs of abuse into categories (based on the usual effects at the usual doses), and have knowledge about the appropriate diagnostic criteria for substance abuse and dependence.

Present the following information to the class.

II. Prevention Through Education

OHD 3.1 on screen.

Refer to HO3.1.

- A. Health care providers play a key role in the prevention of alcohol, tobacco, and other drug use.
- B. Health care providers have unique opportunities for prevention that are not available to other professionals.
- C. Physicians and other health care providers can incorporate an alcohol and drug use history into the patient evaluation; they can educate and counsel patients about their individual risk factors for the development of substance abuse.
- D. It is important to stress to women that they are more sensitive to the effects of alcohol and substance abuse than men in terms of its long-term health consequences; only 21% of women in an internal medicine practice for women reported that their MDs provided information about alcohol and its effects.
- E. Need to inform patients about specific medical complications, including:
 1. Obstetrical and gynecological complications of alcohol and other substances (data from 1985 National Health Interview Survey):
 - ♦ 62% of women knew about fetal alcohol syndrome
 - ♦ 70% thought the primary problem was that the baby was born addicted to alcohol

2. “Telescoping” Phenomenon—women suffer more serious medical consequences in a shorter amount of time and with less alcohol and other substance use than men.

III. The Current State of Services for Substance Abusing Women

OHD 3.2 on screen.

Refer to HO3.2.

- A. Ratios of men to women in treatment programs ranges from 2:1 to 10:1.
 1. This is far below even the lowest estimates of the incidence and prevalence of alcohol and substance abuse in which there is approximately a 2:1 male-to-female ratio (although this ratio varies greatly depending on the type of drug used).
 2. Women make up only about 8% of research subjects in studies to date.
 3. Approximately 30% of substance abuse treatment programs have specialized programs for women.
- B. Substance abuse by men is more likely linked to other forms of socially disruptive behaviors
 - ♦ violence
 - ♦ drunk driving
 - ♦ crime
 - ♦ work-performance problems
- C. Male substance abuse is costly to society, thus many programs are developed to try to reduce these costs.
- D. Consequences
 1. Substance abuse is defined and treatment programs are developed using the “White male” as the standard.
 2. People begin to associate the above behaviors with substance abuse in general and tend to overlook the fact that women present with different

symptoms.

- E. Women who abuse substances are more likely than male substance abusers to use or be referred to other health care settings, particularly mental health treatment services and primary care physicians.
- F. Few studies are available detailing what types of treatment work best for women.

IV. Barriers to Accessing Treatment

OHD 3.3 on screen.

Refer to HO3.3.

A. Internal barriers

- ◆ denial or minimization of problem
- ◆ guilt and shame
- ◆ fear of stigmatization, perceived sexual promiscuity
- ◆ lack of self-esteem
- ◆ role obligations
- ◆ costs of treatment

B. Interpersonal barriers

1. The role of relationships with men/significant others in initiating and perpetuating addiction:
 - ◆ men as supplier/substance use partner
 - ◆ violence
 - ◆ opposition to treatment
 - ◆ fear that partner would leave if woman is treated
 - ◆ partner unable to support habit on his/her own—some women resort to prostitution to support habits of both
2. Opposition to treatment by family and friends.

3. Denial of substance abuse problem by family and friends.
4. Relationships with children; concern about leaving/losing children if she enters treatment.

Refer to HO3.4.

C. System level barriers

1. Health provider bias

- ◆ lack of understanding/knowledge of addiction which may be influenced by media images and personal beliefs
- ◆ belief that patient's addiction can be "fixed"
- ◆ lack skills needed to determine if woman needs help with substance problem
- ◆ lack knowledge regarding how to make a referral and the available referral resources
- ◆ may make incorrect diagnosis, presuming mental health problems (i.e. anxiety or depression); may give patient medications, including benzodiazepines, causing cross-addictions in some women
- ◆ negative and judgmental attitudes against substance abusing women
- ◆ idea of "double deviance"—women are not viewed as behaving properly if they use alcohol or other drugs and are not seen as properly addicted because their behaviors and psychological profiles do not fit the masculine patterns that are called "alcoholism or addiction"

OHD 3.4 on screen.

2. System barriers specific to women

- ◆ different referral patterns
 - primary sources of referrals for men: criminal justice system, employee assistance programs; these are less effective for identifying women
 - child welfare system as a primary source of referral for women - reason for entering treatment is often externally motivated

- mental health practitioners are another source of referral for women
- ♦ lack of women-sensitive treatment services
 - lack of parenting training
 - lack of adequate child care services
 - lack of understanding of the need for women-sensitive treatment services
- ♦ lack of economic resources
- ♦ inadequate insurance coverage

V. *Treatment Methods*

A. Goal of treatment (September 1990, the Institute of Medicine of the National Academy of Sciences)

1. The ability to function in society is an appropriate treatment goal.
2. Complete abstinence from using alcohol or illicit drugs is desirable.

OHD 3.5 on screen.

Refer to HO3.5.

B. Initiating treatment

1. Assess need for detoxification
 - ♦ for many, outpatient detoxification may be feasible
 - ♦ important to understand what the individual perceives her problems to be; likely to accept help for these problems first
2. Establish goals acceptable to patient and health provider.
3. Develop a treatment plan
 - ♦ need to address and treat concomitantly comorbid mental health issues, health issues, parenting issues and social issues

- ♦ need to develop plan which is culturally acceptable to patient
4. Role of family in treatment— patient’s long-term abstinence often depends greatly on family participation in recovery.

OHD 3.6 on screen.

C. Making a referral

1. Know your community resources
 - ♦ keep information regarding treatment options and programs available to staff
 - ♦ know the available 800 numbers, e.g., 1-800-COCAINE, to offer to patients
2. This often requires team approach, i.e., physicians, physician assistants, nurse practitioners, nurses, social workers, counselors.
3. Monitor the patient through recovery
 - ♦ substance abuse/dependency cannot be “fixed”; there is no cure; however, there is abstinence and the process of recovery
 - ♦ be supportive and non-judgmental
 - ♦ continue to educate
 - ♦ continue to re-assess the treatment plan, even if provider has little direct role in treatment
 - ♦ anticipate relapses and discuss ways to prevent and/or deal with relapses
 - ♦ continue to provide advocacy

OHD 3.7 on screen.

Refer to HO3.6.

D. Specific treatment options

1. Detoxification

- ♦ facilitate safe physiological withdrawal from alcohol or other drugs; possible use of pharmacologic treatments when necessary
- ♦ methadone detoxification
 - uses decreasing amounts of methadone to detoxification clients from opiate usage
 - can be done on an outpatient or inpatient basis

2. Inpatient treatment

- ♦ intensive, medically supervised inpatient treatment with length of stay generally less than 30 days
- ♦ involves intensive counseling to encourage further treatment and find appropriate continuance of treatment
- ♦ may include:
 - nursing care
 - individual, group, and family counseling
 - psychiatric evaluations
 - provision of medications
 - extensive education
 - referral for longer treatment

3. Intensive outpatient treatment

- ♦ day or evening treatment program where patient attends program daily but returns to own home for night
- ♦ may continue to work or attend school while in treatment

4. Outpatient treatment

- ♦ provides from one to several hours of individual, family and/or group counseling weekly
- ♦ clients may live at home and continue with their normal activities
- ♦ lasts from 30 days to a year or more

5. Residential treatment

- ♦ structured program with a length of stay from one month to one year
- ♦ education and support groups offered as well as vocational and substance abuse counseling
- ♦ can serve as a transition from inpatient treatment (halfway house)
- ♦ may have additional services, such as
 - employment counseling
 - referral for primary health care
 - social services
 - referral for pregnant women for prenatal care

6. Methadone maintenance

- ♦ outpatient program which maintains opiate addicts on methadone, a synthetic opiate
- ♦ used to reduce cravings and the symptoms of withdrawal
- ♦ reduces the risk of exposure to HIV infection, Hepatitis B, and Hepatitis C from sharing needles

7. Self-help groups

- ♦ Alcoholics Anonymous
- ♦ Cocaine Anonymous
- ♦ Narcotics Anonymous
- ♦ Al-Anon (family members support group)

8. Nontraditional healing, for example,

- ♦ acupuncture
- ♦ biofeedback
- ♦ hypnosis

- ♦ massage

VI. Components of Women-Oriented Treatment Programs

OHD 3.8 on screen.

Refer to HO3.7.

A. Definition of a women-oriented treatment program:

1. A program delivered in a setting that is compatible with women's interactional styles.
2. Women on the staff who can serve as female role models for patients.
3. The program takes into account gender roles, female socialization, and women's status in society (i.e. patriarchal power structure).
4. The program does not exploit women; does not allow sexual harassment of female patients; does not support passive, dependent roles for women.
5. It addresses women-specific treatment issues.
6. Treatment is offered in a safe, supportive environment that also maintains limits and boundaries.

OHD 3.9 on screen.

B. Coordinated treatment components:

- ♦ broad and comprehensive services
- ♦ treatment for other problems:
 - incest, sexual assault, and violence
 - sexual dysfunction
 - other mental health problems
- ♦ health services
- ♦ family services

- ♦ services for children, including preventive (e.g., Children of Alcoholics support groups), psychiatric, and medical services
- ♦ development of parenting skills and daily living skills
- ♦ development of social roles, positive relationships, and social support
- ♦ development of self-esteem and adaptive coping mechanisms
- ♦ employment/vocational counseling
- ♦ legal assistance
- ♦ women's support groups as aftercare
- ♦ advocacy

C. Components can be implemented into a mixed-gender program as well as women-only settings.

VII. *Special Groups*

OHD 3.10 on screen.

Refer to HO3.8.

A. Pregnant women

1. Incidence of alcohol and substance abuse in pregnancy has ranged from 0.5% to 25% in various studies: Largest population-based survey of 29,000 urine samples at delivery estimated the prevalence of perinatal drug use at 5.2% and alcohol use at 6.7% (Vega, et al., 1993).
2. About 80–85% of female heroin and cocaine addicts are of child-bearing age.
3. Alcohol and most psychoactive drugs cross the placenta easily.
4. Effects of alcohol on fetus are variable
 - ♦ depends on degree and timing of exposure, maternal metabolism, interaction with other drugs, as well as the nutritional and smoking status of the mother
 - ♦ no safe level of drinking in pregnancy has been established; abstinence is recommended

5. Consider polysubstance abuse and its implications for mother and child; for example, women who use cocaine are more likely to smoke cigarettes and/or marijuana; they are at higher risk of acquiring STDs and are likely to have a lower weight gain in pregnancy.

OHD 3.11 on screen.

Refer again to HO3.8.

6. Special treatment considerations

- ♦ early intervention highly desirable for health of mother and fetus
 - golden opportunity for intervention—some addicted women view their pregnancy as a motivation for recovery and an opportunity to gain control over their lives
 - alcoholics and other substance abusers tend to delay entry into prenatal care—late and limited utilization of prenatal care may be an indication of a substance abuse problem
 - many women experience fear, guilt, and shame associated with exposing the fetus to alcohol and other drugs
 - some women have poor nutrition and lack access to prenatal care
 - many women have experienced physical, sexual, and emotional abuse that has gone untreated
 - many experience increase in physical abuse from partner once pregnant; 4–8% of pregnant women experience abuse
 - many are victims of poor parenting
 - many addicted women feel ambivalent about their pregnancy

OHD 3.12 on screen.

Refer to HO3.9.

- ♦ significant deterrents to treatment include:
 - no wide-scale provisions for children while mothers go into treatment
 - mothers on public assistance may lose income if they go into residential/inpatient treatment and may risk losing their children
 - fear of reprisal; either in the form of criminalization or loss of children

OHD 3.13 on screen.

- ♦ emphasis on a continuum of care
 - long-term provision of services in support of woman and her family
 - * safe housing
 - * clothes
 - * parenting education
 - * employment
 - * address issues of domestic violence, abuse, and victimization
 - women who are appropriately linked can be effectively supported to recover and to manage their multiple roles
 - federal government is funding several innovative research projects for the treatment of substance-abusing women of childbearing age—preliminary findings from the Boston and Philadelphia Perinatal-20 projects suggest that pregnancy outcomes are dramatically and equally improved by both residential and intensive outpatient programs that include children

OHD 3.14 on screen.

7. Caution with use of pharmacotherapies

- ♦ need to assess pregnancy status and counsel about the detrimental effects of the drug on fetal development
- ♦ need to assess withdrawal effects on pregnancy and balance with the potential side effects of pharmacotherapies
- ♦ Antabuse can cause fetal damage
- ♦ Methadone can produce withdrawal effects in newborns as severe as heroin withdrawal, although long-term outcome similar to children born to nonaddicted mothers; women are often encouraged to remain on methadone while pregnant since, for many, the alternative to methadone would be a return to drug use and its associated risks
- ♦ with non-pregnant women—verify non-pregnant status and ensure appropriate contraceptive means prior to beginning any pharmacotherapies

- ♦ with non-pregnant women—verify non-pregnant status and ensure appropriate contraceptive means prior to beginning any pharmacotherapies

OHD 3.15 on screen.

Refer again to HO3.9.

8. The criminalization of substance abuse during pregnancy

- ♦ several states consider substance use during pregnancy a form of child abuse punishable by imprisonment or removal of the child after birth
- ♦ new level of legal interference with women’s rights over their bodies, an infringement which has no male equivalent
- ♦ in many states, including RI, if an infant tests positive for substances at birth, the health care provider must report this to the state child protection agency
- ♦ criminal charges and child protection interventions more often directed at women of color—although prevalence of drug use likely to be similar for different racial and economic groups, women of color are 10 times more likely to be tested than white women
- ♦ important to offer continued, nonjudgmental advocacy for female patients
- ♦ health care providers should be familiar with the regulations of their state regarding reporting

OHD 3.16 on screen.

Refer to HO3.10.

B. Elderly women

1. “Hidden” addictions

- ♦ outreach, access, treatment may be more difficult
- ♦ the elderly woman may be isolated because she may no longer drive, may be retired, may live alone due to separation or death of partner
- ♦ many older women may have a more moralistic attitude about drinking and substance use, believing you do “not air your dirty laundry in public”—may be more reluctant to acknowledge their own substance use problems

- ♦ health professionals often miss the diagnosis; estimates suggest that physicians identify the problem in approximately 22–37% of elderly alcoholics
- ♦ health professionals may be reluctant to make a diagnosis; may feel uncertain about how to treat the disease or whether treatment will work in this age group

OHD 3.17 on screen.

Refer again to HO3.10.

2. Special treatment considerations

- ♦ health professionals need to maintain an awareness that alcohol and substance abuse problems exist in the elderly
- ♦ when considering substance abuse among this population, the use of alcohol, prescription drugs and over-the-counter medications needs to be examined
- ♦ need to use open-ended questions, create a positive rapport to show you are interested in the patient's health and ability to function, not passing judgment
- ♦ successful treatment often requires participation of family members for support through treatment; family members often need education about not enabling the substance dependence (e.g., the son who purchases his mother a bottle of gin each week)
- ♦ consultation with a psychiatrist if there are concomitant psychiatric problems, such as depression; many women begin drinking after the death of their spouse to deal with depression and loneliness
- ♦ important to recognize that treatment outcomes equal those in younger patients
- ♦ increasing number of treatment facilities have services designed specifically for the elderly, usually oriented toward the positive aspects of a patient's life, attempting to build self-confidence and social supports
- ♦ there is evidence that Alcoholics Anonymous is helpful for elderly women
- ♦ for some elderly women, "one-on-one" counseling may be better; may wish to refer to an office-based addiction specialist

- ♦ when considering treatment options, need to consider distance from home, means of transportation, financial accessibility

C. Ethnic considerations

Note: Alcohol use varies by culture of origin, acculturation status, and by the length of time in the United States.

OHD 3.18 on screen.

Refer to HO3.11.

1. African-American women

- ♦ more likely to abstain from alcohol than Caucasians, but if they drink they are more likely to drink heavily and have alcohol-related problems
- ♦ prevalence of use of other drugs is similar among African-American, Caucasians, and Hispanics, although heroin use is a more serious problem among African-Americans and Hispanics
- ♦ IVDU is a prominent factor in the prevalence of HIV infection in African-American women and children; black female IVDUs report more sex partners and more frequent involvement in exchange of sex for money or drugs
- ♦ treatment needs to involve consideration of cultural factors
 - flexibility in family roles, commitment to religious values and church participation, humanistic orientation, strong education and work-achievement orientation, endurance of suffering, and reliance on extended family networks
 - may distrust institutional medicine and may view mental health therapy to be for the “strange” or “crazy”
- ♦ treatment programs should have relationships with respected African-American members of the community

OHD 3.19 on screen.

2. Native-American women

- ♦ approximately 450 tribes with different customs and about 250 languages

- ♦ urban, rural, on- and off-reservation Native Americans have different treatment needs
- ♦ many barriers to treatment
 - high unemployment rate hinders early detection
 - do not view certain substances as addictive
 - geographic isolation limits access to treatment
 - lack of funding in the Indian Health Service
 - high rate of poverty
 - lack of trust of the majority treatment system
 - may require culturally specific models of treatment

OHD 3.20 on screen.

Refer to HO3.12.

3. Asian /Pacific Islander women

- ♦ important to consider the specific ethnic group, place of birth, generational status, and degree of acculturation
 - difficulty in openly acknowledging personal problems
 - substance abuse is felt to be a serious breach of behavior and, when acknowledged, can lead to loss of self-respect for individual and her family
- ♦ few studies of alcohol and other drug use, but the prevalence is believed to be low compared to white women
- ♦ treatment programs should have bilingual staff and be sensitive to the diverse cultures

OHD 3.21 on screen.

4. Hispanic/Latina women

- ♦ importance of recognizing “Hispanic” as a widely heterogeneous group, representing different cultures and ethnic groups

- ♦ may be many generational differences as well as different degrees of acculturation
- ♦ treatment programs need to be sensitive to these differences
- ♦ many substance abuse programs do not have staff who can speak Spanish, making them less “user-friendly”

OHD 3.22 on screen.

Refer to HO3.13.

D. Lesbians

1. It is estimated that lesbians comprise approximately 10% of the female population, studies have suggested that 25–30% may have serious problems with alcohol and other drugs, although studies to date have some serious methodological flaws.
2. While lesbians are a diverse group, some general factors may place them at an increased risk for developing addiction problems
 - ♦ effects of minority group status, discrimination, and homophobia
 - ♦ role of bars in the lesbian community (provides one of the few social settings in which lesbians can feel safe and open about their sexuality)
 - ♦ lack of services sensitive to the identity and needs of lesbians
3. Special treatment needs
 - ♦ acknowledging and identifying women as lesbians
 - ♦ maintaining a nonjudgmental position of advocacy
 - ♦ helping lesbians to combat isolation and denial of alcohol and drug problems through outreach efforts
 - ♦ offering women-only and/or lesbian-only services
 - ♦ programs can acknowledge that lesbians are included in the service population affirmation through advertisements or having “out” lesbians on staff

- ♦ staff and board members that include “out” lesbians to provide validation and positive role models
- ♦ staff trained in and responsive to the needs of lesbians, who are able to identify and address homophobia and to address the psychosocial needs unique to lesbians

VIII. Predictors of Treatment Outcomes for Women with Substance Abuse Problems

OHD 3.23 on screen.

Refer to HO 3.14.

- A. Data is scarce—more research has examined alcohol compared with other substances.
- B. Recent study: Follow-up of 93 alcoholic women who underwent an intensive three phase treatment program at a public hospital in Toronto, Canada; phase one (approximately one week) consisted of treatment of withdrawal or other medical conditions; phase two (3 weeks) consisted of group therapy and educational programs; phase three (2 year educational and supportive aftercare program), the “Continuing Therapy Program.”
 1. Predictors of outcome: number of life problems in addition to ETOH use and the number of primary supportive relationships
 2. Results: 72% of women with ≥ 6 emotionally supportive relationships sober at one year
 - ♦ 21% of women with ≤ 2 close relationships sober at one year
 - ♦ 71% of women with 1 additional life problem were sober at one year
 - ♦ 36% of women with ≥ 3 life problems were sober at one year
- C. Other identified risks for persistent chronic drinking:
 - ♦ sexual dysfunction—continuing belief in the false assumption that alcohol will increase sexual drive and arousal
 - ♦ part-time employment
 - ♦ never being married

- ♦ recent depression
- ♦ untreated mental health problems
- ♦ predictor of remission: divorce or separation

D. Other predictors of treatment success

1. Female patients arrested for prostitution and those whose parents have psychiatric or drug use histories are less likely to remain in treatment.
2. Programs for women that deal directly with sex work (i.e. exchange of sex for drugs) and provide family therapy retain more women.
3. Having services for children increases retention.
4. Offering treatment for both alcohol and other drug problems also increases retention.

IX. Do Treatment Outcomes Differ for Women and Men?

OHD 3.24 on screen.

Refer to HO3.15.

- A. Early literature suggested women had poorer prognoses than men in treatment programs, but more recent reviews of literature show no differences in length of treatment and abstinence rates.
- B. It is widely accepted that specialized treatment programs for women are necessary and probably yield better outcomes, although few studies have directly compared treatment outcomes for women in mainstream versus specialized programs.
- C. Recent meta-analysis of 20 alcohol outcomes studies:
 - ♦ women were more likely to be abstinent or improved in short-term follow-ups
 - ♦ men tended to appear more successful in follow-up of greater than one year
 - ♦ findings may play a role in relapse prevention

X. How Can Treatment Access for Women be Improved?

OHD 3.25 on screen.

Refer again to HO3.15.

- A. Educate the general public—remove the barriers based on the stigmatization of substance abusing women.
- B. Improve outreach to women at risk for drinking and other drug problems.
- C. Increase the knowledge about women’s alcohol and substance abuse problems to improve assessment, counseling, and referral by health providers, the legal system, and employee assistance programs.
- D. Informal referral networks, such as family and friends, should be used more efficiently.
- E. Outreach should target people who see women regularly (e.g., hairdressers), who work with their children or who have some influence with them (clergy, key family members).
- F. Implement routine alcohol and substance abuse screening programs in primary care, OB/GYN offices, and pregnancy and family planning clinics to aid in the identification of women with substance problems.
- G. Improve the availability of services for children
 - ♦ supervision of children
 - ♦ diagnosis and treatment for children with physical and behavioral problems
 - ♦ education about the mother’s substance abuse problem
- H. Increase availability of other women-sensitive services that address gender-specific problems and treatment issues and that consider women’s social contexts.

XI. Optional Exercises: Practice Role Plays

To the Instructor: Skill learning is greatly enhanced by participant role plays. These role plays are designed to allow participants to apply newly learned skills to an interactive practice situation. Use of video equipment to record role plays for review and feedback is encouraged. For further information on role plays, refer to pages 2-4 in the Introduction.

Treatment: Role Play #1

Patient Information

Demographics: 37 yo Hispanic female

Chief complaint: Heroin use is a “problem”

Past medical history: None

Family history: Father and brother are recovering alcoholics

Social history: Married for five years, husband is also a lawyer
No tobacco use

Present situation:

You are a 37 year old Hispanic female with a two year history of “snorting” heroin. You are presently using about 10 bags per day of heroin. You deny other drug use, except for averaging between 6 and 8 beers on the weekends which you have done since you were about 17 years old. You were introduced to heroin by a partner in your law practice. You initially used heroin once, maybe twice, per week, but now feel the need to use it every day “just to feel normal.” You are at your health care provider’s office because you feel it is now “a problem.”

Your husband does not know about your heroin use, but is becoming suspicious and has been expressing concerns to you. He is worried you are having an affair.

Treatment: Role Play #1

Presentation to Health Care Provider

37 year old Hispanic female with a two year history of “snorting” heroin. She uses about 10 bags per day of heroin. She denies other drug use, except for averaging between 6 and 8 beers on the weekends which she has done since she was about 17 years old. She was introduced to heroin by a partner in her law practice. She states that initially she used heroin once, maybe twice, per week, but now feels that she has to use it every day “just to feel normal.” She is at your office because she feels it is now “a problem.”

Past medical history: none

Social history: Married for five years, husband also a lawyer, does not know about her heroin use, but he is becoming suspicious and has been expressing concerns to her; is worried she is having an affair
- tobacco use

Family history: Alcoholism - father and brother, both in recovery

Exam: BP 140/90 80 14
Weight: 125 lbs.
Rest of exam is entirely normal

Laboratory data: Unremarkable.

Areas to Investigate:

1. Identify the barriers to treatment for her.
2. Identify her sources of support that may help her through recovery.
3. As you begin to discuss treatment issues with her, what specific issues would you like to address?
4. How would you go about making a referral to treatment?
5. From what treatment(s) do you think would benefit?

Treatment: Role Play #2

Patient Information

Demographics: 26 yo pregnant female

Chief complaint: Cocaine use

Social history: Unmarried, four children
Lives with mother
Employed at local strip club
+ tobacco

Present situation:

You are a 26 year old pregnant woman with a history of cocaine use - you mostly snort it, however, occasionally you inject it. You are unmarried and have four children from previous relationships. You are employed as a dancer at a local strip club and occasionally sell sex for drugs. You live with your mother, who assists you in taking care of the children. You occasionally take Valium, and you have a history of tobacco use.

Treatment: Role Play #2

Presentation to Health Care Provider

A 26 year old pregnant woman with history of cocaine use, mostly snorting, with occasional IV use. She is unmarried and has four other children. She is employed as a dancer at a local local strip club and occasionally sells sex for drugs. She presently lives with her mother who assists in taking care of the children. She denies any other drug use, except for occasional Valium use and tobacco.

Exam: Vital signs are stable.
 Thin, appears anxious
 Perforated septum
 Diffuse wheezes
 Old track marks in left antecubital fossa

Laboratory data: Toxicology screen: + benzodiazepines, + cocaine.
 Otherwise labs are unremarkable.

Areas to Investigate:

1. What are her barriers to treatment?
2. Identify her sources of support that may help her through recovery.
3. As you begin to discuss treatment issues with her, what specific issues would you like to address?
4. How would you go about making a referral to treatment?
5. From what treatment(s) do you think she would benefit?