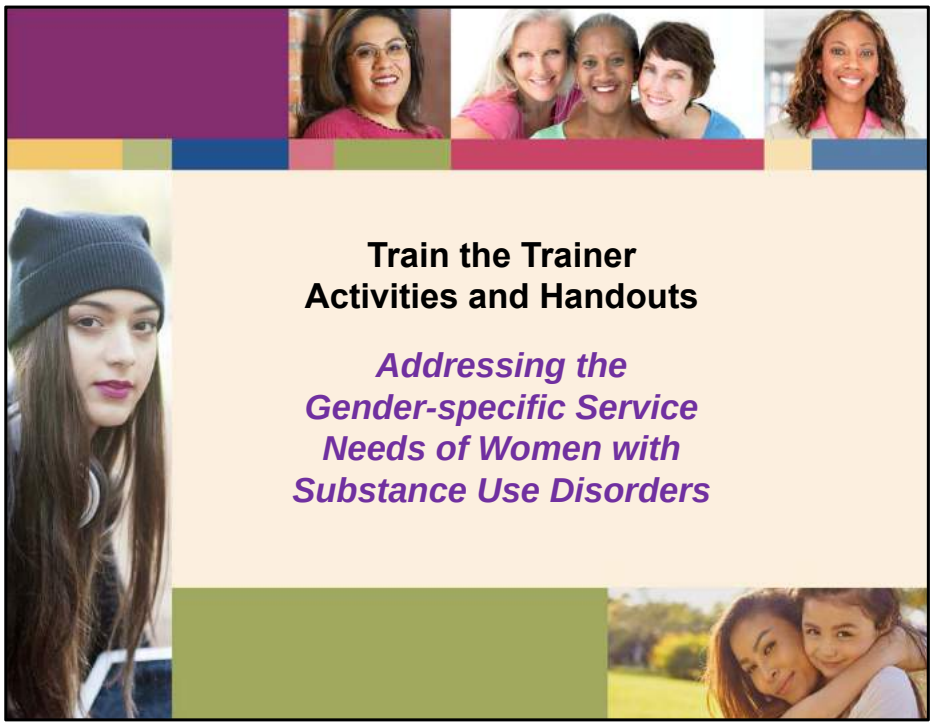
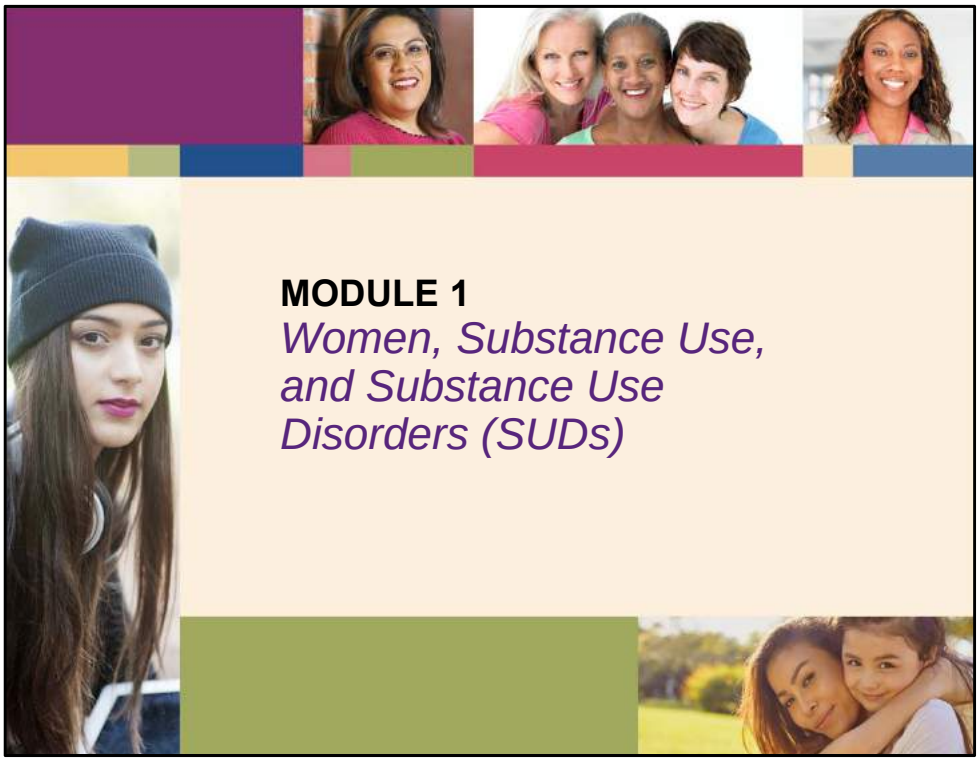


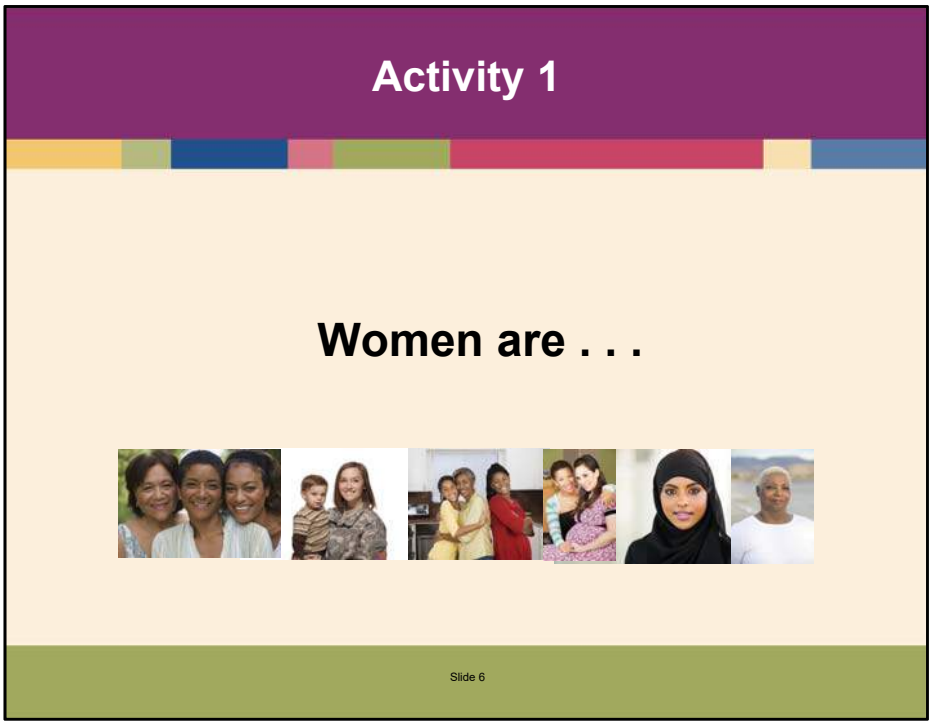
Note: Numbers at the bottom of the slides correspond to their slide number in the actual modules.



Trainer Notes: Possible <u>Pre-training</u> Activity (use flipchart)

Brainstorm Risk and Protective Factors for Girls/Young Women/Women:
Prior to the start of training, have flip chart pages posted in each corner of the room and markers available. As people arrive, ask them to walk around the room and add words or phrases to the charts before the training begins. Refer to these charts during those sections of the presentation.

<u>Topics for flip chart pages:</u>
Pathways to substance use
Risk factors for use
Consequences of use
Barriers to treatment/recovery
Recovery support needs
Variation: Use two instead of five flip chart pages; label one “Risk factors for SUDs” and the other “Protective factors against SUDs.”

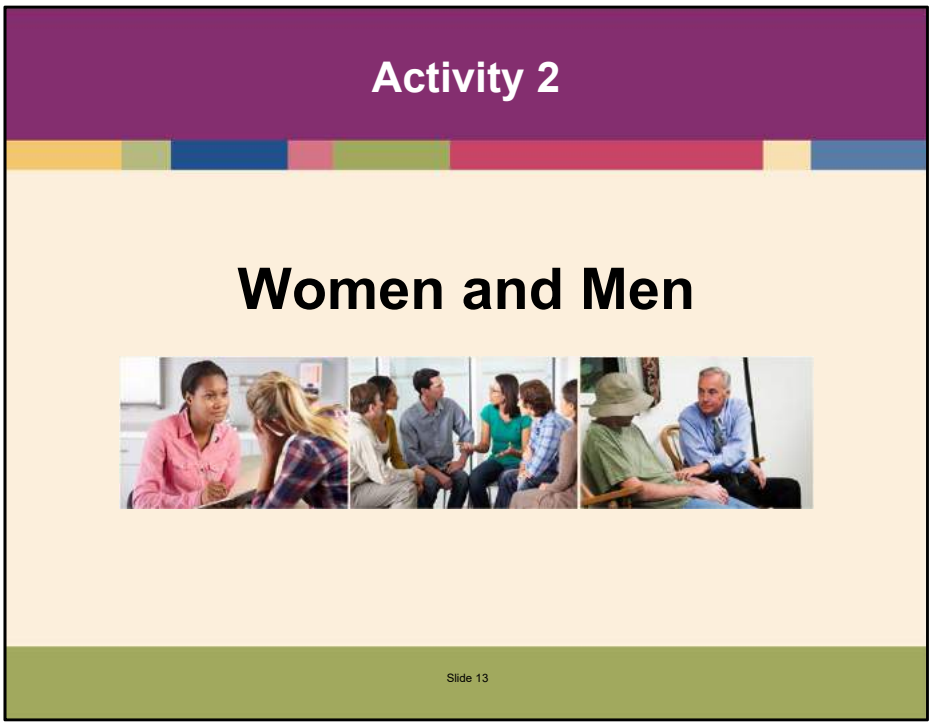


Trainer Notes: Women Are" Icebreaker, Full Group Discussion

Have everyone go around the room and respond with one **strengths-based** word to complete the sentence: "Women are . . . " (or can use "Women who come to our program are . . . " or "Women I see in my practice are . . . ").

Tell participants that if the word they thought of has already been said by someone else, they should pick another word. Write the words on a flip chart page and post them for everyone to see.

This exercise will capture the diversity and strengths of women, and the perspectives of participants.



Trainer Notes: Women and Men, Small-Group Discussion (write questions on flipchart)

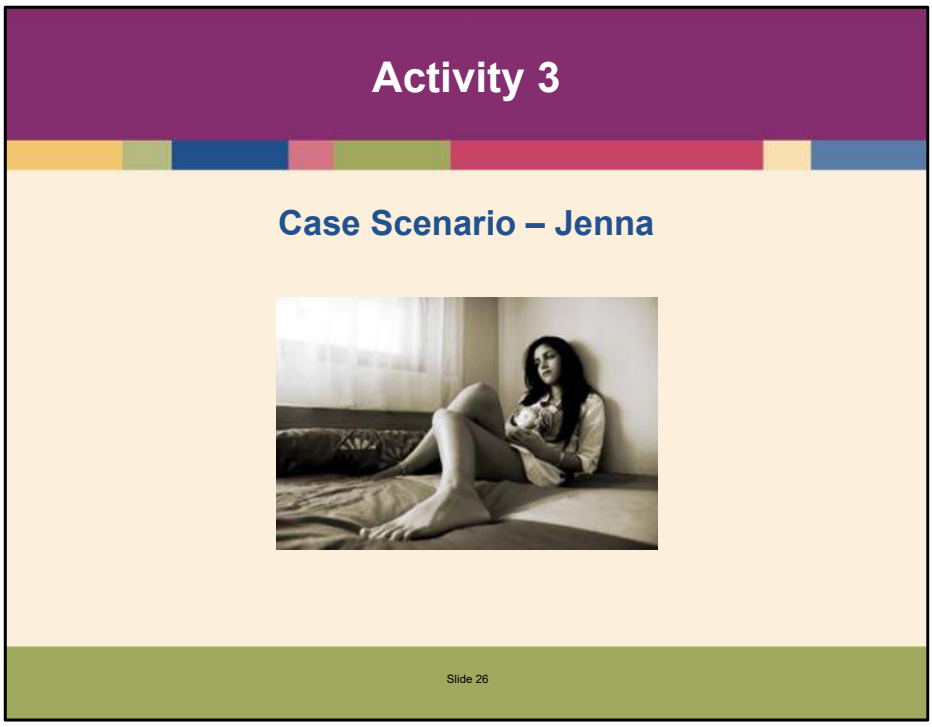
Break participants into small groups, and ask them to discuss these questions.

1. *In general, in what ways do you feel the needs of women with SUDs differ from men with SUDs? How are they the same?*

2. *What about in relation to recovery? How do you feel women's recovery experiences compare to men's—what is the same, what is different?*

Ask that each group share one or two of their answers.

After participants have shared ideas, note that the rest of this section will talk about these differing needs in relation to SUD treatment and recovery.



Trainer Notes: Case Scenario Exercise, Small Group Discussion (handout at end of presentation)

Jenna is a 17-year-old honor student who has been awarded a basketball scholarship that will enable her to attend a nearby state university. Other than trying marijuana a few times, she never experimented with drugs in high school. She is captain of the basketball team and spends most of her time at practice or at games during the season. Jenna lives with her mother, who works full time, and helps look after her younger brothers. She rarely drinks alcohol. Her father is an alcoholic and she feels his drinking had a lot to do with her parents' divorce.

During her senior year, Jenna injured her knee during practice before her team was preparing to go to state finals. She began taking OxyContin after the injury so she could continue to play. At first, she took it as prescribed, but then started taking more than she was supposed to after practices and before play-offs got underway. She recently bought some additional pills from a well-known drug user at her school. Now that the season is over, her doctor has her scheduled for ACL surgery. She needs to be completely healed and able to play before she enters college or she could lose her scholarship. She's not sure how she is going to deal with the pain.

What are some of the risk factors in Jenna's case?

What are some of the protective factors?

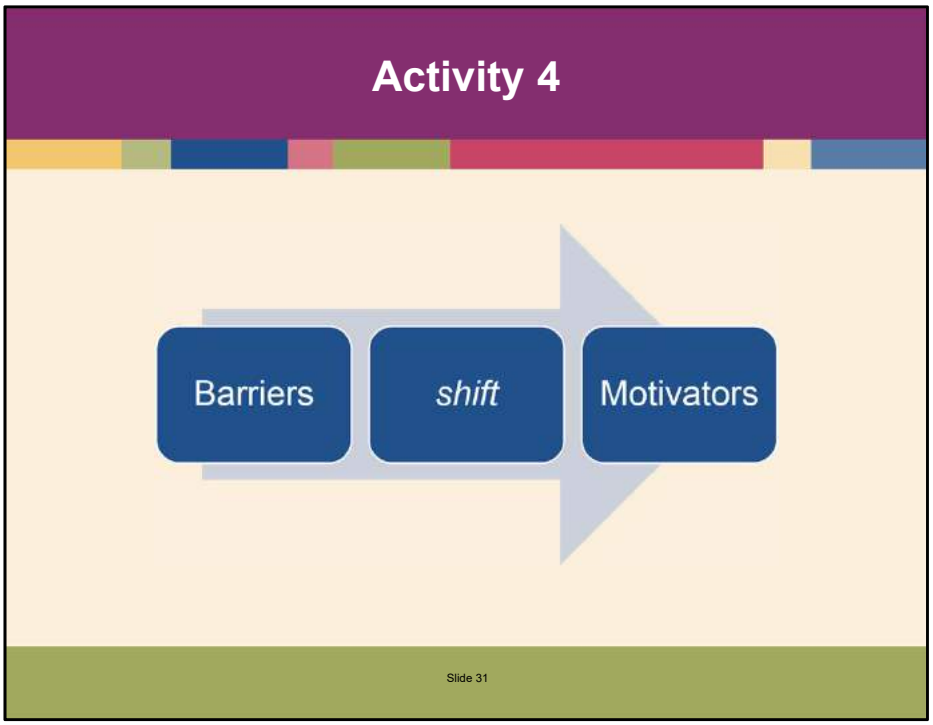
Handout: *Case Scenario – Jenna (Part 1)*

Jenna is a 17-year-old honor student who has been awarded a basketball scholarship that will enable her to attend a nearby state university. Other than trying marijuana a few times, she never experimented with drugs in high school. She is captain of the basketball team and spends most of her time at practice or at games during the season. Jenna lives with her mother, who works full time, and helps look after her younger brothers. She rarely drinks alcohol. Her father is an alcoholic and she feels his drinking had a lot to do with her parents' divorce.

During her senior year, Jenna injured her knee during practice before her team was preparing to go to state finals. She began taking OxyContin after the injury so she could continue to play. At first, she took it as prescribed, but then started taking more than she was supposed to after practices and before play-offs got underway. She recently bought some additional pills from a well-known drug user at her school. Now that the season is over, her doctor has her scheduled for ACL surgery. She needs to be completely healed and able to play before she enters college or she could lose her scholarship. She's not sure how she is going to deal with the pain.

- ***What are some of the risk factors in Jenna's case?***

- ***What are some of the protective factors?***



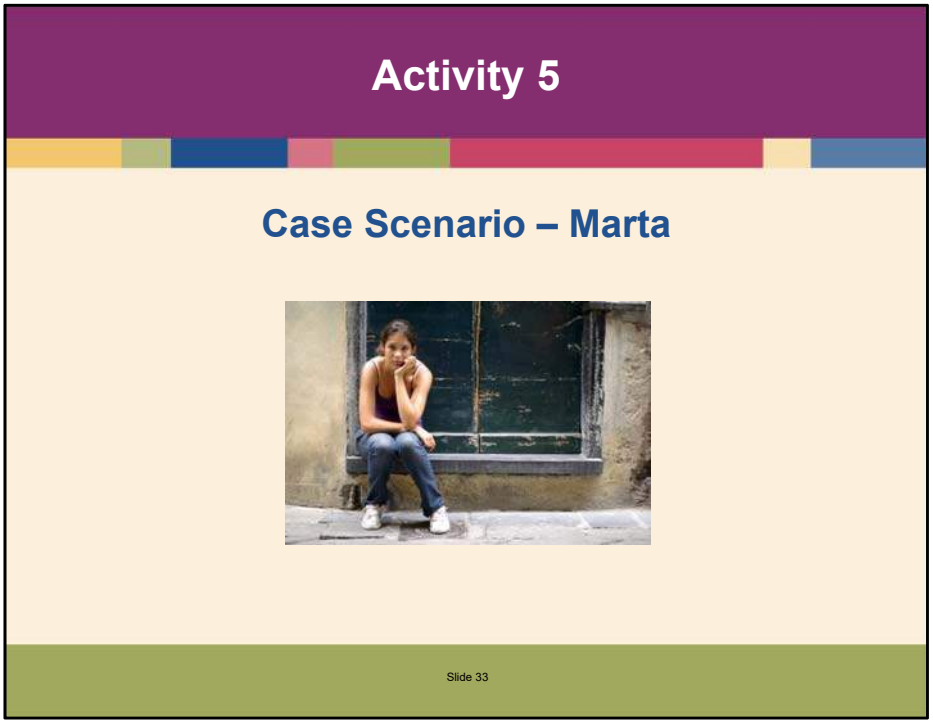
Trainer Notes: Turning Barriers into Motivators, Full Group Discussion (use flip chart)

This activity helps attendees think about barriers and motivators to seeking help for SUDs, and learn to transfer barriers into motivators.

Draw a diagram on a flip chart and ask attendees to first call out barriers. Write them on the flip chart. Then ask attendees to share ideas about how to shift those barriers to motivators.

The flip chart could look like this:

Barriers	**Motivators**	**Shift**
examples:		
1. Children and child care	Wants to be a good mom Family reunification	Motivational Interviewing (MI) Change in environment Onsite child care
2. Pregnant/Worries about being judged for SUD women with SUDs	Wants to have a healthy baby	MI Services at venue with other pregnant MAT
3. Partner uses/drinks involvement	Opportunity to enlist partner's support Chance to improve relationship	Couples counseling and family



Trainer's Note: Barriers Case Scenario, Small Group Discussion (handout at end of presentation)

Read or provide copies of the following scenario to participants, and then ask participants to identify and discuss the barriers in the scenario and how to address them through the questions below.

A woman named Marta calls your agency to inquire about treatment services. She asks, "When a person enters services, who has access to that information?" She goes on to say "Is this a state-run program? If not, how much are services? I lost my job, so I can't pay for treatment." When you begin to tell her about the services, she says "My car broke down last week and I don't have anyone to keep my children, so it would be hard to come in for services. I know I need help though. I need to get another job. My time is very limited. Oops, I have to hang up now."

Identify and discuss the barriers in this situation.

How could staff engage Marta or any other client who calls for information but is hesitant to commit to an appointment?

What could providers do to remove barriers to care starting with the first phone call for information on programs and services?

Trainer's note*: Although transportation, child care, cost, and concern for confidentiality are all real concerns, Marta is identifying every reason why she cannot come and offering no solutions. One of her barriers may be ambivalence to getting help and/or fear of entering treatment. Use this exercise to illicit discussion of using motivational techniques to address ambivalence and barriers to engagement in services by women.*

Handout: *Case Scenario – Marta*

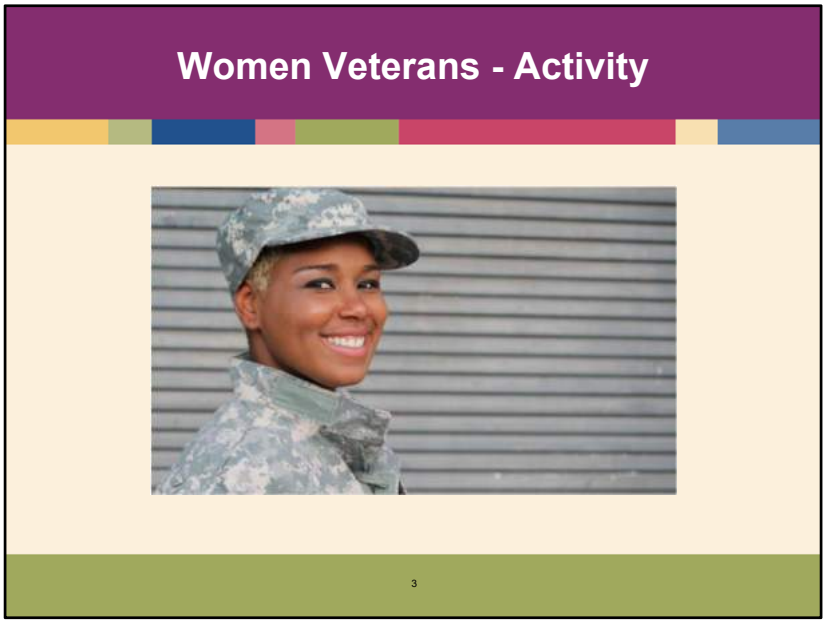
A woman named Marta calls your agency to inquire about treatment services. She asks, "When a person enters services, who has access to that information?" She goes on to add "Is this a state-run program? If not, how much are services? I lost my job, so I can't pay for treatment."

When you begin to tell her about the services, she says "My car broke down last week and I don't have anyone to keep my children, so it would be hard to come in for services. I know I need help, though. I need to get another job. My time is very limited. Oops, I have to hang up now."

- ***Identify and discuss the barriers in this situation.***

- ***How could staff engage Marta or any other client who calls for information but is hesitant to commit to an appointment?***

- ***What could providers do to remove barriers to care starting with the first phone call for information on programs and services?***



Trainer's Note: A complete list of references is included at the end of the presentation.

Activity – Women Veterans

Ask participants the following questions as a group or break them into small groups and let them discuss their answers.

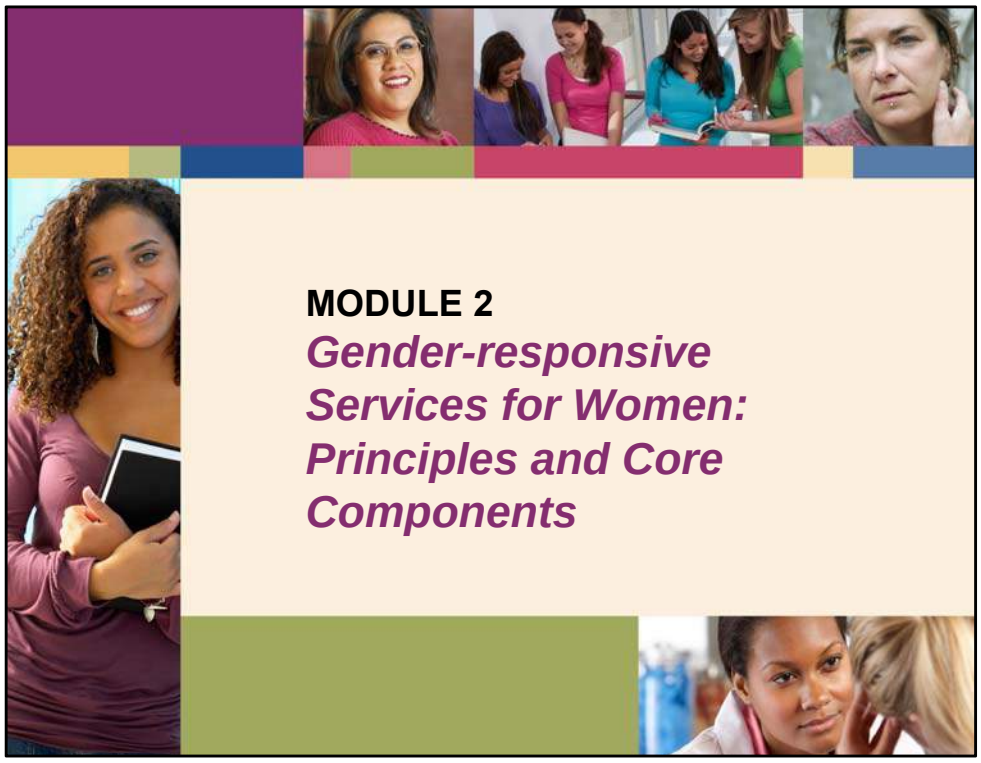
Begin by telling them to "Make note of any images, words, or characteristics that come to mind during this exercise."

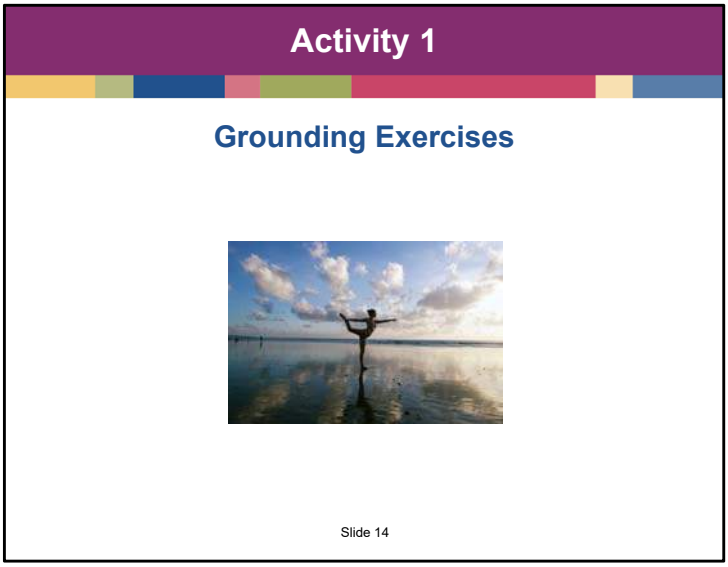
1. Have you ever met a woman service member? Would you know for certain if you had without asking or being told?
2. If you have, have you noticed any defining characteristics that seem to relate to her time in the military?
3. If you have not, think for a moment about what words or phrases come to mind when you think about women who are serving or have served in the military.

Ask participants to share their answers and thoughts with the group.

Often, when we think about women in the military, we have preconceived notions and assumptions that may affect how we interact with them. This exercise is designed to have participants consider their own assumptions and preconceptions about women who have spent time in the military.

From: Veteran's Supplement


MODULE 2
Gender-responsive Services for Women: Principles and Core Components



Trainer Notes: Trauma Informed Approaches – Grounding Exercises (pass out the handout after doing a grounding exercise as a group)

- Grounding exercises can be taught as a stabilizing strategy that women can use when they are dealing with stressful or triggering situations.
- Grounding is also an important tool for caregivers who work with populations with high levels of trauma exposure. You can introduce this section by acknowledging that talking or hearing about trauma and traumatic experiences can be difficult, especially when many treatment providers have also lived through traumatic experiences.
- Encourage attendees to make self-care a priority during this training and as a regular part of their work day. Remind them that when they make self-care a priority, it reduces workplace stress and models healthy boundaries and behaviors for others.
- Explain that "*grounding exercises are things that you can do (and teach others to do) that help people stay connected with the here and now through one or more of the five senses. We will practice one of these now.*" (Note to trainer: Other grounding techniques are available online, if you prefer to find other activities.)
- Explain that additional grounding exercises are described on the handout.

<u>Choose one activity to do with participants:</u>

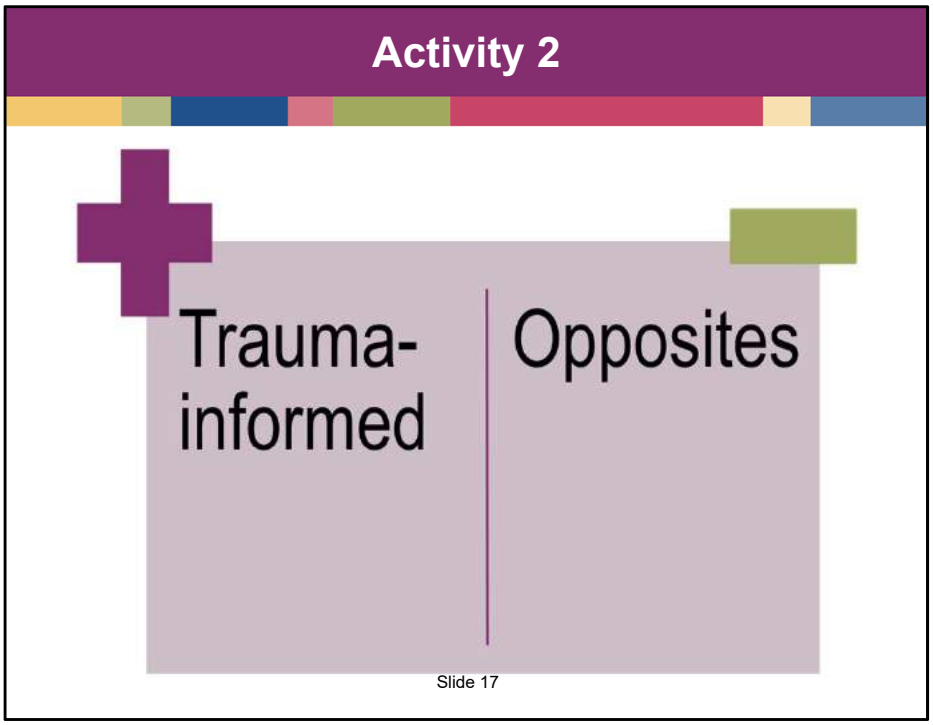
One foot: Tell participants to stand up and organize themselves into pairs. Tell participants to now stand on one foot and while standing on one foot, tell the other person about something that makes each of them angry. (Note: it is hard to be angry on one foot because focus is diverted to balance.)

Breathing: Ask participants to slowly breathe in while you count aloud to 8, then hold their breath for a count of 8, and slowly release the breath for a count of 8. Shorten to a count of 4 or increase to 16, whatever is comfortable, but stay consistent. Acknowledge that this may have a calming effect for many, but occasionally may have the opposite effect on those with trauma histories. Emphasize that trying these techniques should always be voluntary and should be done with eyes open, so as to continue to connect clients with the external experience and distract them from difficult internal states.

Handout: *Grounding Exercises*

Grounding exercises are things you can do (and teach others to do) that help us stay connected with the here and now through one or more of the five senses. There are many different grounding techniques; below are just a few.

- **Counting:** Tell participants to count objects around them. Give them specific guidance, such as count five things that are blue, count four things that are tools you use, or count three things you have touched in the room. (Note: Counting distracts people from their internal thoughts and brings them back to the present moment and surroundings.)
- **Grasping an object:** Have participants place a small stone or an ice cube in the palm of their hand. Instruct them to hold it tightly for one minute, then to hold it less tightly for one minute. (Note: Using tactile sensations can help keep people focused on where they are and what they are feeling, such as the cold of a melting ice cube or cold pack from the freezer, or the object or stone they choose to hold tightly in their palm.)
- **Breathing:** Ask participants to slowly breathe in while you count aloud to 8, then hold their breath for a count of 8, and then slowly release the breath for a count of 8. You can shorten to a count of 4 or increase to 16—whatever is comfortable, but stay consistent. Acknowledge that this may have a calming effect for many, but that, occasionally, it may have the opposite effect on people with trauma histories. Emphasize that trying these techniques should always be voluntary and should be done with the eyes open to continue to connect clients with the external experience and distract them from difficult internal states.
- **Personal strategies:** Have participants identify and write down something that helps center them when they feel unsettled. (Depending on the group, participants may be invited to share their strategies with each other.) Ask for examples of things that have worked for some of the women they serve. (Note: Trainers can prompt the group with examples—*taking my dog to the woods, listening to music, going to the gym after work…and so forth.)*
- **Mental grounding:** Grounding may employ techniques that connect people with a physical, sensory experience, as in some of the examples above. It can also employ cognitive techniques that help people occupy their minds with other thoughts. For example, ask people to think about a favorite TV show or cartoon. Have them mentally picture the characters and list them by name. Have them think about an episode or scene they liked and replay it in their minds.
- **Self-soothing:** Many people find it helpful to make a list of thoughts, words, or activities they find soothing. Having the list available when negative emotions overwhelm them and they can't come up with a way to soothe themselves on the spot can be a lifeline.
  Here are some things women have included in their lists:
  - *"I think of my grandmother and I sing the song she sang to me when I was afraid."*
  - *"I call my sponsor and let her remind me of some of the positive things I have done."*
  - *"I leave myself a voicemail with the phrase 'I know I can get through this. I have gotten through this many times,' and listen to it as many time as I need to."*



Trainer Notes: Trauma Informed – Opposites (handout at end of presentation or flipchart)

Provide a handout or write on a flip chart the six principles of trauma-informed care.

Ask participants: *What is the opposite of each of these words?*

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

Discuss the list of opposites and how they affect women and the program environment.

Handout: Trauma-informed Principles – Opposites

Trauma-informed Principle	Opposite
Safety	
Trustworthiness	
Peer support	
Collaboration and mutuality	
Empowerment, voice, and choice	
Cultural, historical, and gender issues	

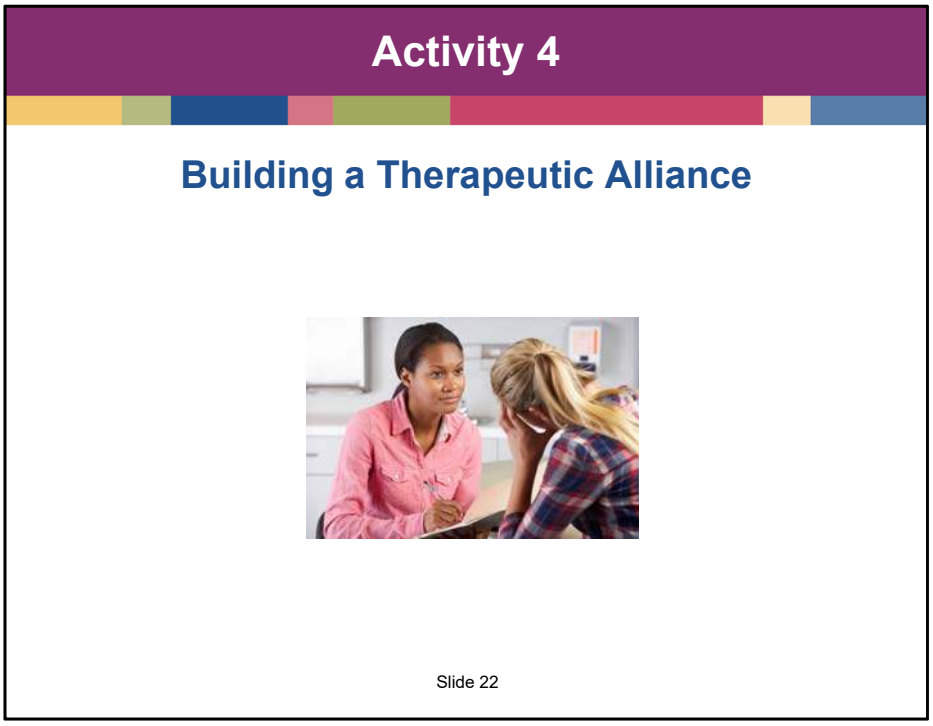
Trainer Notes: Small Group Discussion

Break participants into small groups of three or four people. Ask them to discuss the following:

- *A time they felt very connected to others and a time they felt very disconnected from others.*
- *The value of connection and the impact that disconnection can have on the women they serve.*

Break into groups for 10 minutes

If there is time, ask groups to share with the full group their key agreements about the value of connection and the impact of disconnection.



Trainer Notes: Small Group Discussion

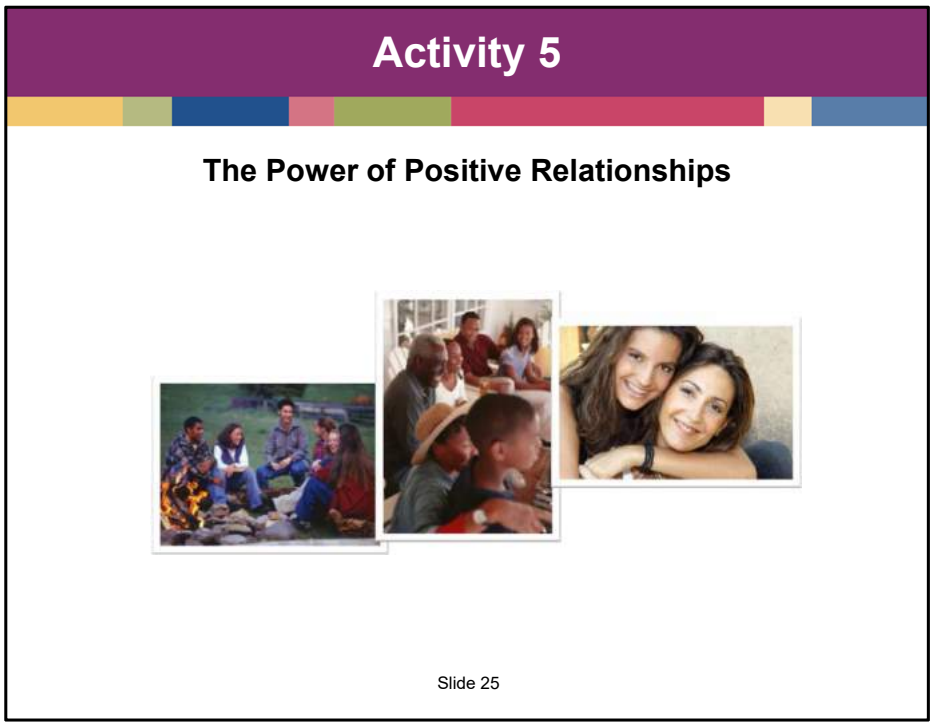
Divide attendees into small groups and ask them to think about ways to build therapeutic alliance. Ask them to discuss:

- *What are some techniques to help build the relationships quickly?*
- *What counselor attitudes or characteristics are important for building therapeutic relationships with women?"*

Break into groups for 10 minutes

Have each group report back to the other attendees with their techniques and their lists of counselor attitudes and characteristics.

(**Note**: *There is likely to be overlap between groups. Trainers may wish to use a flip chart and put a hash mark next to each one when more than one group mentions it).*



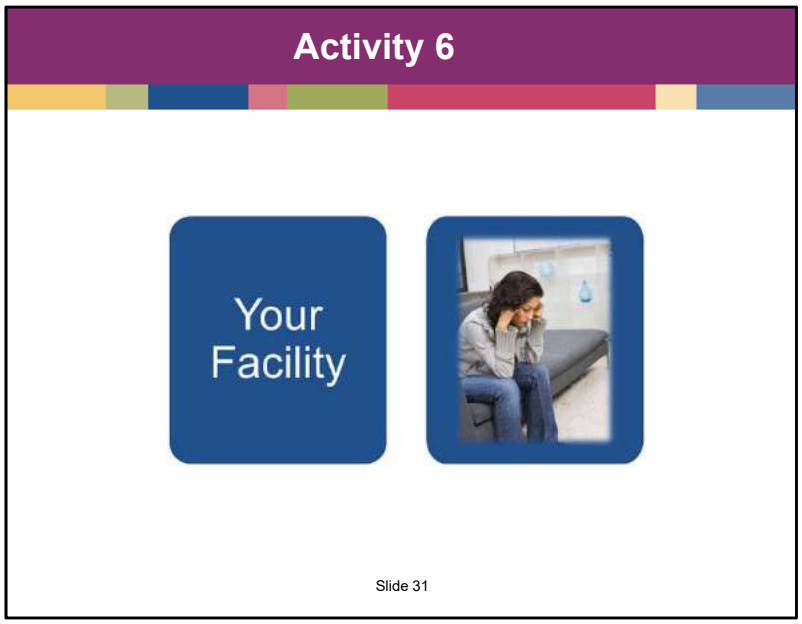
Trainers Notes: Positive Relationships

Ask participants to think about an important person or relationship that positively influenced their lives and the decisions and choices they have made.

Ask:
- *How was this relationship helpful?*
- *What makes this person safe and supportive?*

Ask for volunteers who are comfortable sharing an example.

Facilitate a discussion on relationships that support women in recovery, how women develop these relationships, and what they offer to women in early recovery.



Trainer Notes: Let's See It: Imagine Walking into Your Facility

Ask participants to take a minute to imagine walking into their facility program as a new participant. Ask the following questions:

- *Think about what you would see upon walking from the parking lot or front of the building into the lobby.*
- *What would you see when you entered the waiting room and walked up to the reception desk.*
- *Where would you sit while waiting and what would that environment feel like?*
- *What would you feel, hear, and do while you waited?*

You can ask additional questions (or others that you wish to ask) and ask them to think about the answers, or you can give them a **handout** with the questions and let them fill in the answers:

- *Does your building feel safe and welcoming upon entrance? (what makes it safe, what might get in the way of safety?)*
- *Is the building easy to locate? Can it be accessed by public transit?*
- *Would a woman feel safe walking to or from your location with children?*
- *How do staff greet people who enter the reception area? Are the receptionists friendly?*
- *Is privacy available while talking to the receptionists?*
- *Does the waiting room feel safe and welcoming? (If yes, what makes it feel this way?)*
- *Is the waiting room comfortable? Can people sit? what does it sound like? Is there enough space between chairs?*
- *Is there a space for children to play or books/toys for them?*
- *Consider the experience as people walk inside. How are the offices? Group rooms? Overall facility?*
- *Are there ways that the environment is not welcoming or reduces a sense of safety for women?*
- *Are there some low-cost ways that you could make the environment more welcoming or safe?*

Mention that "walking through aspects of your program to experience things from the client perspective is a powerful tool for identifying ways to create a gender-responsive atmosphere."

Trainer's Note: You can refer people to the *Guidance Document for Supporting Women in Co-ed Settings* (SAMHSA, 2016a), which has a comprehensive Self-Assessment Tool for determining the level of gender-responsiveness in a program/facility.

Handout: *Let's See It: Imagine Walking Into Your Facility*

Doing a walk-through of your service environment can be a valuable tool for identifying things that may improve women's experience of your program. To begin, take a minute to imagine walking into your facility program as a new participant. Think about what you would see upon walking in from the parking lot or front of the building into the lobby. What would you see when you entered the waiting room and walked up to the reception desk. Where would you sit while waiting, and what would that environment feel like? What would you feel, hear, and do while you waited?

Answer the following questions:

- *Does your building feel safe and welcoming upon entrance? (What makes it safe? What might get in the way of safety?)*
- *Is the building easy to locate? Can it be accessed by public transit?*
- *Would a woman feel safe walking to or from your location with children?*
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- *Are there ways that the environment is not welcoming or reduces the sense of safety for women?*
- *Are there some low-cost ways that you could make the environment more welcoming or safe?*

Activity 7

Case Scenario – Mary

Slide 33

Trainer Notes: Case Scenario (handout at end of presentation)

Read following scenario to participants, and then ask the bulleted questions. Or break participants into small groups for a group discussion. Then allow groups to share their answers with the full group.

Mary walks into a treatment center with her two small children. She's worked hard to get up the courage to come here. She has a long history of trauma, mostly due to abusive encounters with men. She felt safe coming to this program at the Women's Center.

The walls are fuchsia; the chairs are covered in a floral-patterned material. Two women behind a glass window are engrossed in conversation. Neither looks up to speak. Mary can hear them talking about a co-worker they clearly do not like. There is a lot of laughing and eye-rolling.

She settles her children, looking for children's magazine to distract them, but there's nothing. "Just be quiet," she whispers to them. "And sit still." She walks up to the counter.

"What can I do for you?" asks one of the women. Mary answers quietly, "I need to set up an appointment with a counselor." The woman pulls out a form, and asks, "Do you have insurance?"

Questions for the group:

- Would you consider this service provider "gender neutral," "gender specific," or "gender responsive?" (This is "gender specific" because it is reserved for women, but it shows no evidence of being responsive to their needs.)
- What are some of the ways this program failed to be gender responsive? (There is no safe, comfortable place for Mary's children to play while they wait. She was not warmly greeted and was treated rudely. The women are setting a negative tone by talking badly about a co-worker in public.)
- Follow-up question: What changes would you suggest?

Handout: *Case Scenario – Mary*

Mary walks into a treatment center with her two small children. She's worked hard to get up the courage to come here. She has a long history of trauma, mostly due to abusive encounters with men. She felt safe coming to this program at the Women's Center.

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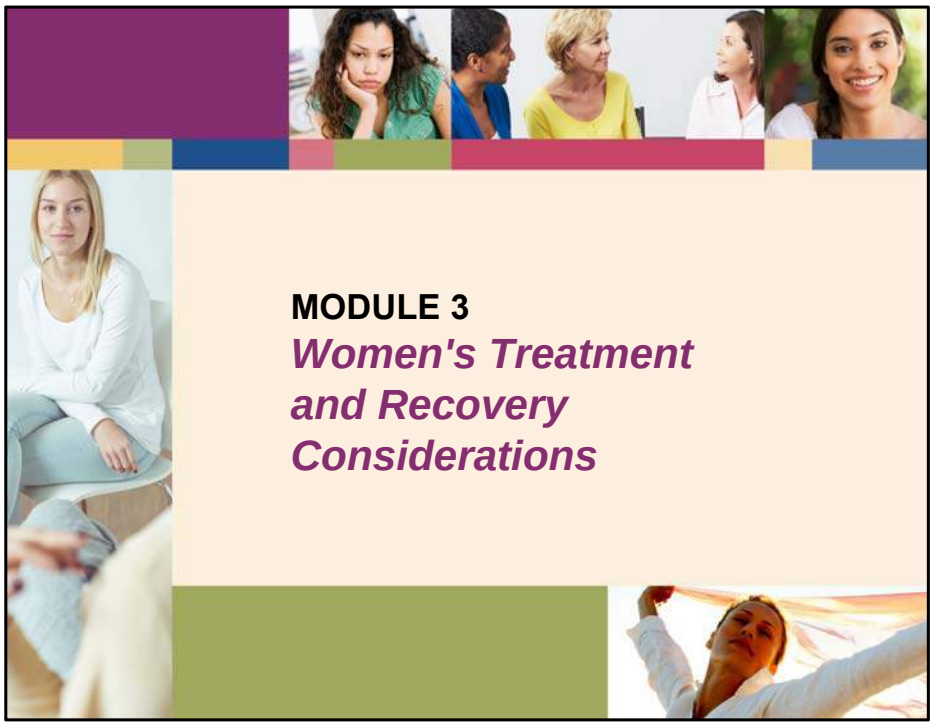
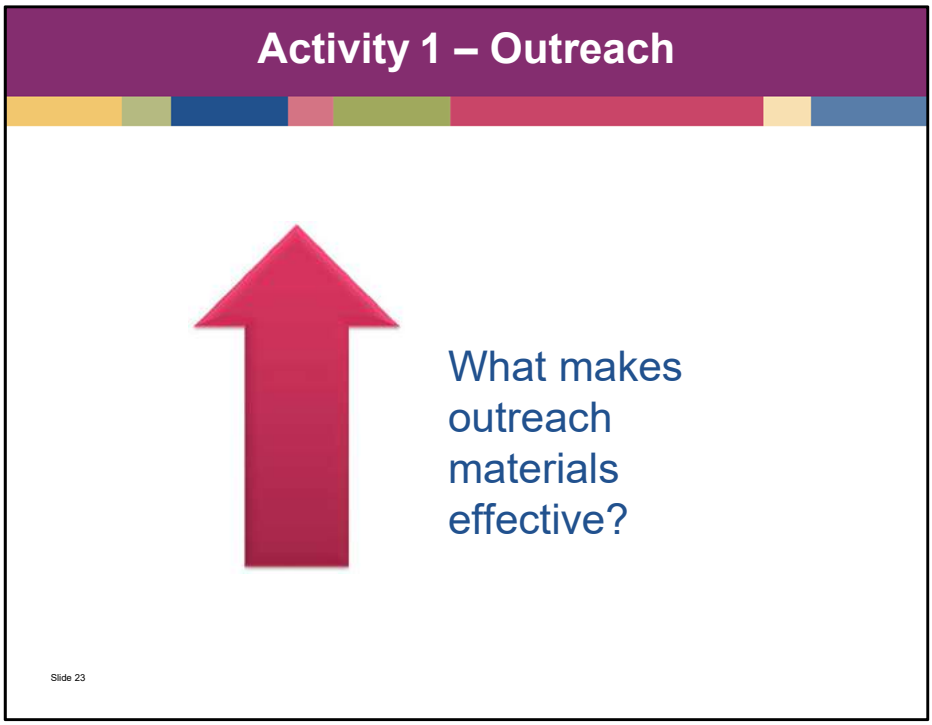
"What can I do for you?" asks one of the women. Mary answers quietly, "I need to set up an appointment with a counselor." The woman pulls out a form and asks, "Do you have insurance?"

- **Would you consider this service provider gender neutral, gender specific, or gender responsive?**

- **What are some of the ways this program failed to be gender responsive?**


MODULE 3
Women's Treatment and Recovery Considerations



Trainer Notes: Outreach Brainstorm/Discussion (sheets of paper/pencils)

1. Ask participants to make a list of ways their program currently conducts outreach to women (list may include flyers, websites, PSAs, partner agencies, resources listings and so forth). Also, discuss any targeted outreach strategies that help engage specific female subgroups with SUDs and that are more relevant for some target populations than others, including teenage girls, domestic violence survivors, college students, pregnant and parenting women, older women, Latinas, or other cultural groups.

2. Then discuss:
   - What role these outreach materials may play in helping women access care; and
   - The role they play in helping women access care (e.g., education, build trust, information on what's available, build hope).

Activity 2 – Engagement

Client Engagement Role Play

Trainer's Note: Client Engagement Role Play

- Break participants into groups of two to four people. Assign one participant to be the role of client, one to play the role of a staff member, and others in the group to be observers.

- Ask the participant in the client role to think about a woman she knows who was having difficulty staying in services. Ask her to try and put herself into that client's shoes and role play her experience, barriers, cultural considerations, feelings, and needs. Have the participant playing the staff member pick a staff role and respond to the client in ways that address her stated needs and concerns as part of this role play.

- The participant in the client role should make every effort to share the client's story. The participant in the staff member role should focus on responding to the client's story in ways that make an effort to engage her and suggest resources to address her needs. Other group members should observe the interaction.

- At the end of the role play timeframe, ask the groups to debrief and discus ongoing engagement techniques and what else could have been offered by the staff member.

Trainer Notes: Participant-Driven Case Study - Assessment, Service Planning, and Treatment Planning for Individuals (handout at end of presentation)

Break participants into groups of five or six people. Either ask for a volunteer from each group to identify a scenario of a woman they have worked with in the past or are currently working with. Have the volunteer describe the case. Alternatively, you can describe a scenario from your work or use one of the longer case studies in the handout resources.

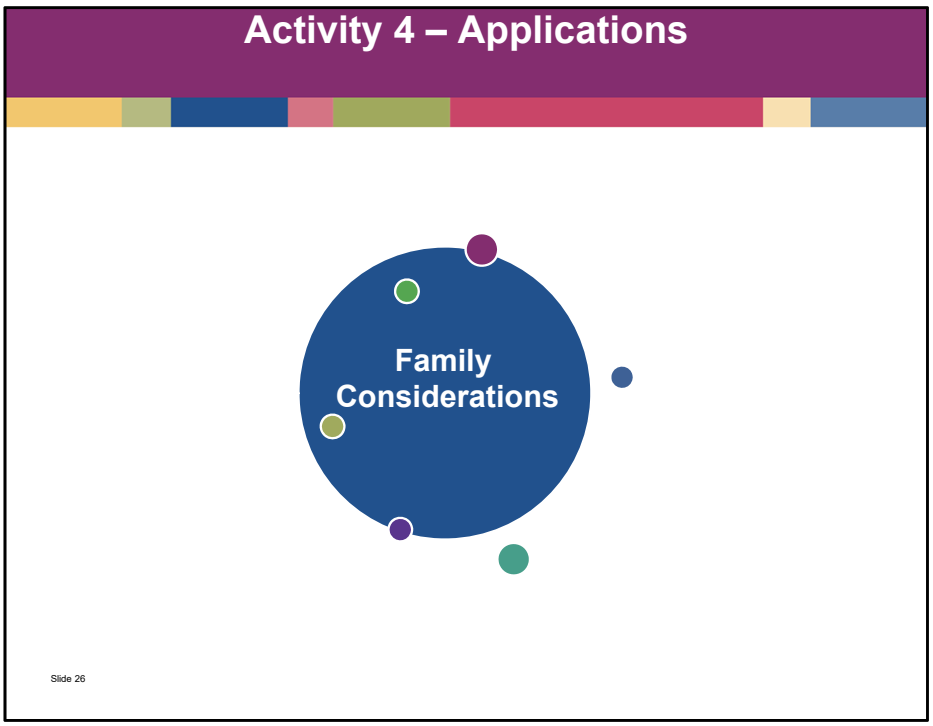
Have the groups discuss the following questions on the handout:

- *Was the client given a full assessment that was trauma informed? If so, in what ways was it trauma informed?*
- *What challenges, barriers to care, or needs were identified during the assessment?*
- *Did communication across different agencies take place? Was it effective? Why or why not?*
- *Discuss the treatment plan that was put in place for the client. Was it effective? Why or why not?*
- *What did you learn from this case?*

Handout: *Assessment, Service Planning, and Treatment Planning for Individuals*

Identify a case you or your group has worked on in the past or are currently working on. (Or use one of the longer case studies in the modules). With your group, discuss the following questions:

- *Was the client given a full assessment and was it trauma informed? If so, in what ways was it trauma informed?*
- *What challenges, barriers to care, or needs were identified during the assessment?*
- *Did communication across different agencies take place? Was it effective? Why or why not?*
- *Discuss the treatment plan that was put in place for the client. Was it effective? Why or why not?*
- *What did you learn from this case?*



Trainer Notes: Participant-Driven Case Study - Treatment Planning for Families (handout at end of presentation)

Break participants into groups of five or six people. Beforehand, identify a case that you/they worked with in the past or are currently working with that involves a family, or use one of the longer case studies in the modules.

Ask for a volunteer from each group to identify a family they have worked with and have the volunteer describe the family. Be prepared to describe a family you have worked with in case no one in the group have direct experience working with families.

Have the groups discuss the following questions on the handout:

- *Did the family influence client's drug use? (i.e.: intergenerational use; trigger for use; motivation for recovery, etc.). How were those influences addressed to make recovery possible?*
- *Did you assess for family's needs (e.g., child care, housing, parenting classes, food). Were those needs met? If so, how?*
- *Did you identify any of the family's unique qualities or strengths that could be used to support strategies to meet the family's needs? If so, what were they?*
- *How was the family incorporated into the treatment plan or services?*
- *What could have been done differently to have made services more effective?*
- *What did we learn from this case?*

Handout: *Treatment Planning for Families*

Discuss the following questions in relation to the family in your case study:

- *Did the family influence the client's drug use (e.g., intergenerational use, trigger for use, motivation for recovery)? How were those influences addressed to make recovery possible?*

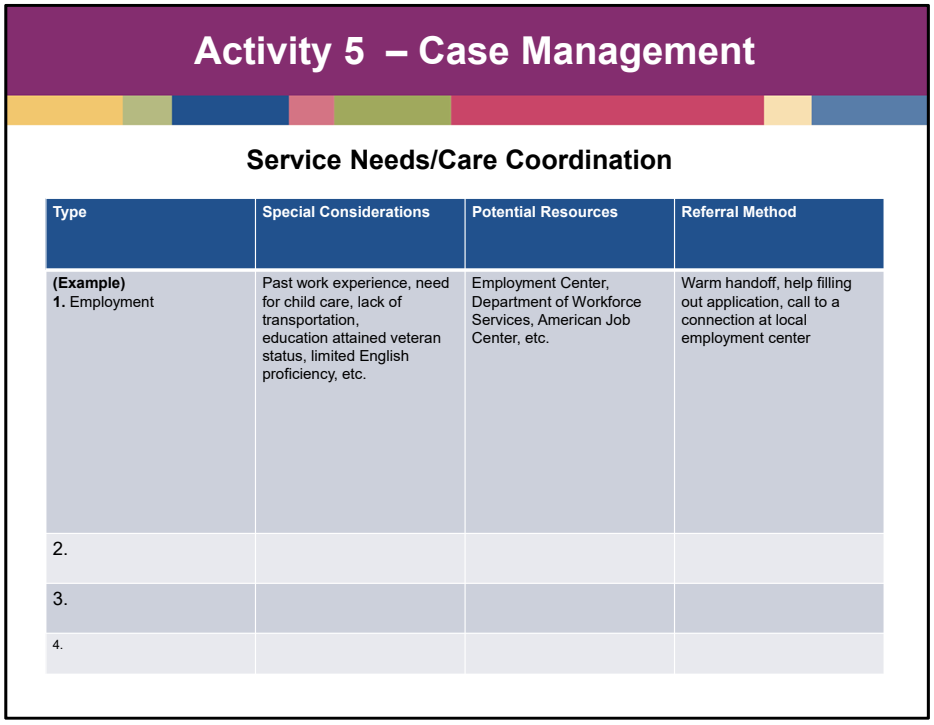
- *Did you assess the family's needs (e.g., child care, housing, parenting classes, food)? Were those needs met? If so, how?*

- *Did you identify any of the family's unique qualities or strengths that could be used to support strategies to meet the family's needs? If so, what were they?*

- *How was the family incorporated into the treatment plan or services?*

- *What could have been done differently to make the services more effective?*

- *What did we learn from this case?*



Trainer Notes: Case Management Matrix (flip chart or handout at end of presentation)

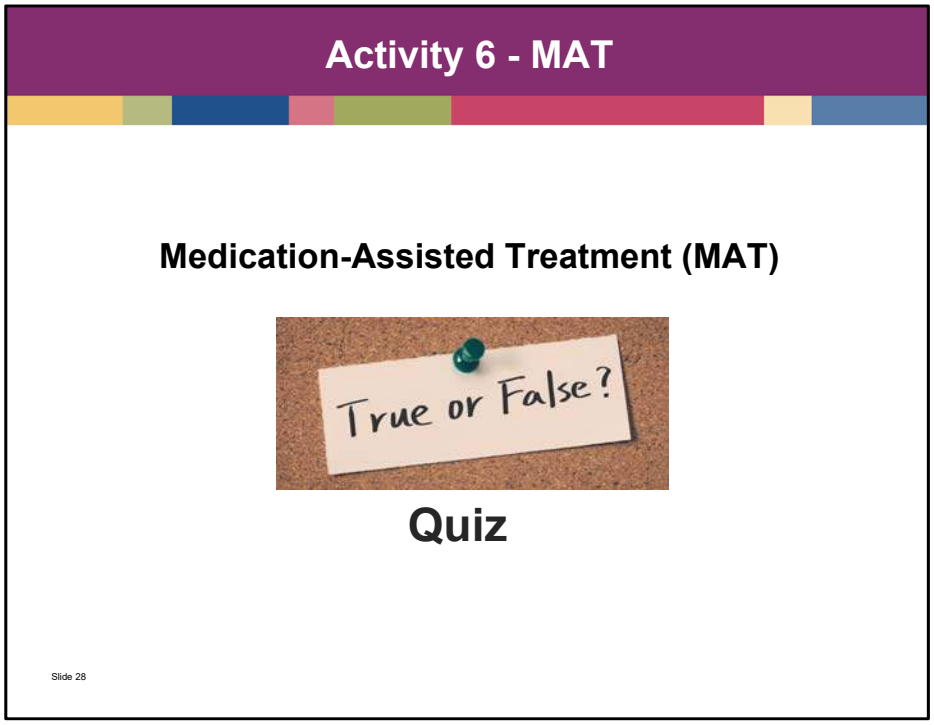
Use this grid to help identify service needs, special considerations, potential resources, and the available referral method.

Make copies of this grid from the handout resources, or create this chart on a large flipchart. You can either have participants work alone, in small groups, or as a large group to come up with examples of types of service needs and care coordination needed through case management. These could include Medicaid enrollment, parenting support, pre-natal care, immigration/resettlement, medical care, housing, etc. It could also include legal care, such as drug court and family reunification requirements; protective orders; probation, and parole/re-entry and confidentiality.

If participants work alone or in small groups, permit time for sharing of examples and brainstorming about local resources.

Handout: *Case Management — Service Needs/Care Coordination*

Type	Special Considerations	Potential Resources	Referral Method
1.			
2.			
3.			
4.			
5.			
6.			
7.			



Trainer Notes: MAT Quiz (handout)

Make copies of the MAT quiz in the handout resources and have participants take a few minutes to answer the questions. Answers are below at the end of each question.

Then go through the answers as a group. This quiz can be used to get a baseline understanding of what participants understand and believe about MAT and if participants need more training on medications in recovery.

The answers are after each statement.

A. MAT refers to an approach that uses FDA-approved pharmacological therapies as a component of treatment for opioid or alcohol use disorders. **T**
B. When prescribed medications are combined with counseling and recovery support to treat SUDs in women, it can improve outcomes. **T**
C. Pregnant women with opioid use disorders are not candidates for medication-assisted treatment until after they give birth. **F**
D. Neonatal Abstinence Syndrome (NAS) refers to symptoms that occur in newborns whose opioid dependent mothers continue to use illicit or prescribed opioids during pregnancy. **T**
E. NAS is prevented in newborns when their mothers are receiving medication-assisted maintenance treatment with methadone or buprenorphine during pregnancy. **F**
F. Individuals with opioid use disorders stabilized on a daily dose of methadone experience a milder version of the analgesic and euphoric effects associated with heroin. **F**
G. When people with opioid use disorders are treated with an opioid antagonist medication (naltrexone) that entirely blocks the effects of opioids, they do not require additional interventions to successfully function at work and at home. **F**
H. Individuals in need of MAT can access this treatment on demand in their communities. **F**
I. A patient with an opioid use disorder can obtain a prescription for buprenorphine from a trained primary care physician who has completed the certification process. **T**

Handout: *MAT True False Quiz*

Medication-Assisted Treatment (MAT) <u>True/False</u> Quiz

A. MAT refers to an approach that uses FDA-approved pharmacological therapies as a component of treatment for opioid or alcohol use disorders. _____

B. When prescribed medications are combined with counseling and recovery support to treat SUDs in women, it can improve outcomes. _____

C. Pregnant women with opioid use disorders are not candidates for medication-assisted treatment until after they give birth. _____

D. Neonatal Abstinence Syndrome (NAS) refers to symptoms that occur in newborns whose opioid-dependent mothers continue to use illicit or prescribed opioids during pregnancy. _____

E. NAS is prevented in newborns when their mothers are receiving medication-assisted maintenance treatment with methadone or buprenorphine during pregnancy. _____

F. Individuals with opioid use disorders stabilized on a daily dose of methadone experience a milder version of the analgesic and euphoric effects associated with heroin. _____

G. When people with opioid use disorders are treated with an opioid antagonist medication (naltrexone) that entirely blocks the effects of opioids, they do not require additional interventions to successfully function at work and at home. _____

H. Individuals in need of MAT can access this treatment on demand in their communities. _____

I. A patient with an opioid use disorder can obtain a prescription for buprenorphine from a trained primary care physician who has completed the certification process. _____

SAMHSA's Training Tool Box for Addressing the Gender-Specific Service Needs of Women with Substance Use Disorders

Medication-Assisted Treatment (MAT) Quiz Answers, Discussion & Resources

***Disclaimer**: The views, opinions, and content of this quiz are those of the authors and contributors and do not necessarily reflect the views, opinions, or policies of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the Department of Health and Human Services (HHS). This quiz and discussion provides introductory information and should not be considered clinical guidance. It is not to be considered a substitute for individualized client care or a protocol for treatment decisions. Resources listed in this quiz are not all inclusive. Inclusion as a resource does not constitute an endorsement by SAMHSA or HHS.*

a. When prescribed medications are combined with counseling and recovery support to treat SUDs in women, it can improve outcomes. True

Discussion

An important principle of evidence-based addiction treatment, according to the National Institute on Drug Abuse, is *"No single treatment is appropriate for everyone"* (2012). Treatment and recovery pathways should be individualized, driven by comprehensive assessment and client choice. However, many research studies clearly demonstrate that using medications approved for treating alcohol or opioid use disorders is more effective than behavioral treatments alone.

Medication-Assisted Treatment (MAT) is the use of U.S. Food and Drug Administration (FDA)-approved medications to *augment*, not replace, behavioral treatments and other recovery supports. MAT is not a cure-all, nor is it appropriate for every individual, but it is an effective component of a comprehensive bio-psychosocial approach to treating substance use disorders.

Research shows MAT can increase the chances of successful recovery, but medication alone is seldom enough. Recovery support is essential and may include help from family or friends, connections to other people in recovery, and periods of professional treatment. The longer individuals stay in treatment and use recovery supports, the more apt they are to abstain from compulsive substance use.

Resources

- **Getting started with Medication-assisted Treatment with lessons from Advancing Recovery**. NIATx and the University of Wisconsin–Madison: www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf
- **Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.** Center for Substance Abuse Treatment: http://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907

- **Medication-assisted Treatment of Opioid Use Disorder Pocket Guides.** Center for Substance Abuse Treatment**:** http://store.samhsa.gov/product/SMA16-4892PG

b. Pregnant women with opioid use disorders are not candidates for MAT until after they give birth.* **False**
(*See discussion below statement "d" for more information)

c. Neonatal Abstinence Syndrome (NAS) refers to symptoms that occur in newborns whose opioid-dependent mothers continue to use illicit or prescribed opioids during pregnancy. **True**

d. Newborns whose mothers received MAT with methadone or buprenorphine during pregnancy are not affected by the MAT. **False**

Discussion

NAS affects newborns whether the mother is using prescribed or illicit opioid drugs or is receiving MAT during pregnancy. Although none of the medications for opioid addiction are FDA-approved for use during pregnancy, methadone has been used safely for many years and has been widely researched. When administered under close medical supervision, it helps control withdrawal symptoms, and stabilizes heart rate, blood pressure, and other maternal and fetal functions.

Because buprenorphine was approved for MAT more recently than methadone, there are fewer long-term studies on its safety and effectiveness. To date, the research suggests that buprenorphine is safe and effective when combined with counseling and recovery support, and may result in shorter and milder neonatal withdrawal symptoms when used to treat pregnant women (American College of Obstetrics and Gynecology, 2012; Gebhart, 2010; Jones, Finnegan, & Kaltenback, 2012).

Opioids cross over into the bloodstream of the developing fetus and affect the baby, but withdrawing from opioid use too quickly during pregnancy is risky. If the woman suddenly quits and begins to go through withdrawal, the baby also experiences withdrawal. This can result in dangerous complications, such as sudden miscarriage and early birth. It is important for women who become pregnant while using opioids to have immediate regular pre-natal care from a qualified medical provider, and to seek care and consultation regarding treatment for opioid use from an experienced doctor.

The risks associated with MAT are weighed against the risks faced by pregnant women with untreated opioid addiction. Infants born to mothers who continue to use opioids during pregnancy are at high risk for NAS. The NAS infant-withdrawal symptoms are sometimes severe enough to require medication and delay discharge from the hospital. These symptoms can be monitored, and usually managed, in most hospitals.

Resources

- **Methadone Treatment for Pregnant Women.** Center for Substance Abuse Treatment**:** store.samhsa.gov/product/Methadone-Treatment-for-Pregnant-Women/SMA14-4124

- **Neonatal Opioid Withdrawal Syndrome and Medication-assisted Treatment with Methadone and Buprenorphine.** FDA**:** http://www.fda.gov/Drugs/DrugSafety/ucm503630.htm

e. Individuals with opioid use disorders who are stabilized on a daily dose of methadone experience a milder version of the analgesic and euphoric effects associated with heroin. False

Discussion

Methadone is a long-acting opioid medication that satisfies the areas of the brain affected by opioids, calms withdrawal symptoms, and reduces drug cravings. It can block the intense euphoric effects of heroin and other short-acting opioids. Individuals taking a prescribed dose of methadone work closely with a physician or other qualified medical provider to adjust their starting dose so that it provides maximum relief from withdrawal symptoms and minimal side effects.

When individuals receive the appropriate individualized dose for maintenance treatment, they can function normally, continue to work, drive a car, and do not experience the euphoric or analgesic effects. Methadone treatment does not prevent individuals from obtaining a driver's license, as long as they are not using illegal drugs or abusing prescription medications. However, methadone for MAT is only taken once a day, which may not be enough to control pain, especially in women with a tolerance for opioids.

Resources

- **Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends.** Center for Substance Abuse Treatment**:** http://www.ct.gov/dmhas/lib/dmhas/publications/MAT-InfoFamilyFriends.pdf
- **Substance Abuse Treatment Advisory: Emerging Issues in the Use of Methadone.** Center for Substance Abuse Treatment**:** https://store.samhsa.gov/shin/content/SMA09-4368/SMA09-4368.pdf
- **Know Your Rights: Rights for Individuals on Medication-assisted Treatment.** Legal Action Center: store.samhsa.gov/product/Rights-for-Individuals-on-Medication-Assisted-Treatment/SMA09-4449

f. MAT refers to an approach that uses FDA-approved pharmacological therapies as a component of treatment for opioid or alcohol use disorders. True

Discussion

The FDA has approved three medications for treating alcohol use disorders and three medications for treating opioid use disorders:

- Acamprosate and disulfiram (Antabuse) are approved for treating alcohol use disorders, but disulfiram is no longer widely used in community-based treatment due to adverse reactions when alcohol is consumed.

- Vivitrol injections and other forms of naltrexone are approved for alcohol or opioid use disorders. When combined with counseling and recovery support, they can be effective for people with alcohol use disorders and for preventing relapse among people with opioid use disorders.
- Methadone and buprenorphine are opioid replacement therapies (ORT) approved for treating opioid use disorders. Both have been shown to be very effective (reducing opioid overdose by as much as 90 percent) and are widely used in combination with counseling and recovery support (World Health Organization, 2010).

Resources

- **Medication-assisted Treatment for Opioid Addiction in Opioid Treatment Programs-Quick Guide for Clinicians Based on TIP 43**. Center for Substance Abuse Treatment**:** https://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/QGCT43

- **Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.** Center for Substance Abuse Treatment**:** http://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907

g. When individuals with opioid use disorders are treated with an opioid antagonist medication (naltrexone) that entirely blocks the effects of opioids, they do not require additional interventions to successfully function at work and at home. **False**

Discussion

Naltrexone does not help with opioid withdrawal symptoms and cannot be started until 7 to 10 days after the last opioid use. It is approved for preventing relapse among people who have stopped using opioids and has been shown to be effective when combined with counseling and other recovery supports.

Naltrexone blocks the ability of opioids to eliminate pain and induce euphoria. This removes the rewarding aspects of opioid use that prompt a desire for more. It can reduce cravings and block the effects of illicit and prescription opioids, which can make it easier for people to avoid returning to opioid use.

Naltrexone is available in pill form and in an extended release injectable form that lasts 30 days. The long-acting injectable form is the most effective for treating opioid use disorders, but is also approved for alcohol use disorder and has been shown to be effective.

Resources

- **The Facts About Naltrexone.** Center for Substance Abuse Treatment**:** https://store.samhsa.gov/shin/content/SMA09-4444/SMA09-4444.pdf
- **An Introduction to Extended-release Injectable Naltrexone for the Treatment of People with Opioid Dependence.** Center for Substance Abuse Treatment**:** https://store.samhsa.gov/product/An-Introduction-to-Extended-Release-Injectable-Naltrexone-for-the-Treatment-of-People-with-Opioid-Dependence/SMA12-4682

h. Individuals in need of MAT can access this treatment on demand in their communities. **False**

Discussion

According to the National Institute on Drug Abuse, less than half of privately funded substance use disorder treatment programs offer MAT and only one third of patients with opioid dependence at these programs receive it. The proportion of opioid treatment admissions with treatment plans that included receiving medications fell from 35 percent in 2002 to 28 percent in 2012 (National Institute on Drug Abused, n.d.). Nearly all U.S. states have insufficient treatment capacity to provide MAT to all patients with an opioid use disorder.

Resources

- **Effective Treatments for Opioid Addiction.** National Institute on Drug Abuse: https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction

i. A patient with an opioid use disorder can obtain a prescription for buprenorphine from a trained physician who has completed the certification process. **True**

Discussion

In response to National Institutes of Health recommendations, the Drug Addiction Treatment Act of 2000 (DATA) was adopted, significantly reducing federal regulations and paving the way for increased access to new pharmacotherapies. In 2002, the FDA approved buprenorphine products for office-based treatment of opioid use disorders by trained physicians. Individuals being treated for an opioid use disorder can receive up to a 30-day supply to take at home once they are stabilized on the medications. In 2016, the passage of the Comprehensive Addiction and Recovery Act raised the maximum number of patients that an experienced physician can treat with buprenorphine to 275 patients in settings that meet specific criteria. It also allows nurse practitioners and physicians' assistants who meet specified criteria to prescribe buprenorphine for treatment of opioid use disorders.

Resources

- **The Facts About Buprenorphine.** Center for Substance Abuse Treatment: http://store.samhsa.gov/shin/content/SMA09-4442/SMA09-4442.pdf
- **Opioid Treatment Regulations.** Substance Abuse and Mental Health Services Administration, Division of Pharmacological Therapies: http://dptbeta.samhsa.gov/regulations/regindex.aspx
- **Text of the S. 524 (114th): Comprehensive Addiction and Recovery Act of 2016:** https://www.govtrack.us/congress/bills/114/s524/text.

References

American College of Obstetrics and Gynecology. (2012). ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy. *Obstetrics & Gynecology*, *119*(5), 1070–1076.

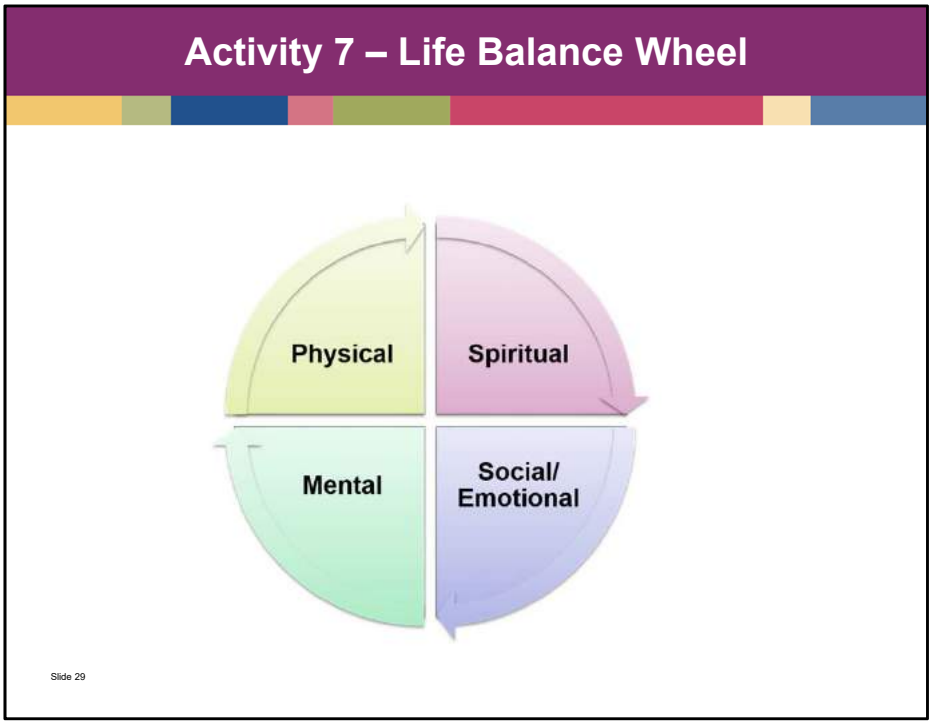
Gebhart, F. (2010). *Buprenorphine Favoured Over Methadone for Opiate Addiction in Pregnancy*. [Oral Presentation]. College of Obstetricians and Gynecologists' (ACOG) 58th Annual Clinical Meeting. Retrieved from http://www.docguide.com/buprenorphine-favoured-over-methadone-opiate-addiction-pregnancy-presented-acog

Jones, H. E., Finnegan, L. P., & Kaltenback, K. (2012). Methadone and buprenorphine for the management of opioid dependence in pregnancy. *Drugs*, 72(6), 747–757.

National Institute on Drug Abuse. (n.d.). *Effective Treatments for Opioid Addiction***.** Retrieved from https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction

National Institute on Drug Abuse. (2012). *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition).* Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface

World Health Organization. (2010). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence.* Retrieved from http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf



Trainer Notes: Life Balance Wheel, also called a Recovery Wheel or a Self-Care Wheel (handout at end of presentation)

Provide each participant with a copy of the diagram on the slide.

Share with participants that it is a wheel, and wheels require spokes to be strong. You may also point out that when a wheel goes flat, it doesn't go flat in just one area, but the entire wheel goes flat. A wheel functions properly when all the spokes are strong.

Invite participants to fill in their wheel with the following instructions: Add spokes to the wheel for activities you do regularly to take care of yourself. For example, sleep 8 hours could go under physical care, talking with someone you trust could go with social/emotional, attending a religious service or walking in nature may fit under spiritual, and practicing Spanish or a musical instrument might fall under mental activities.

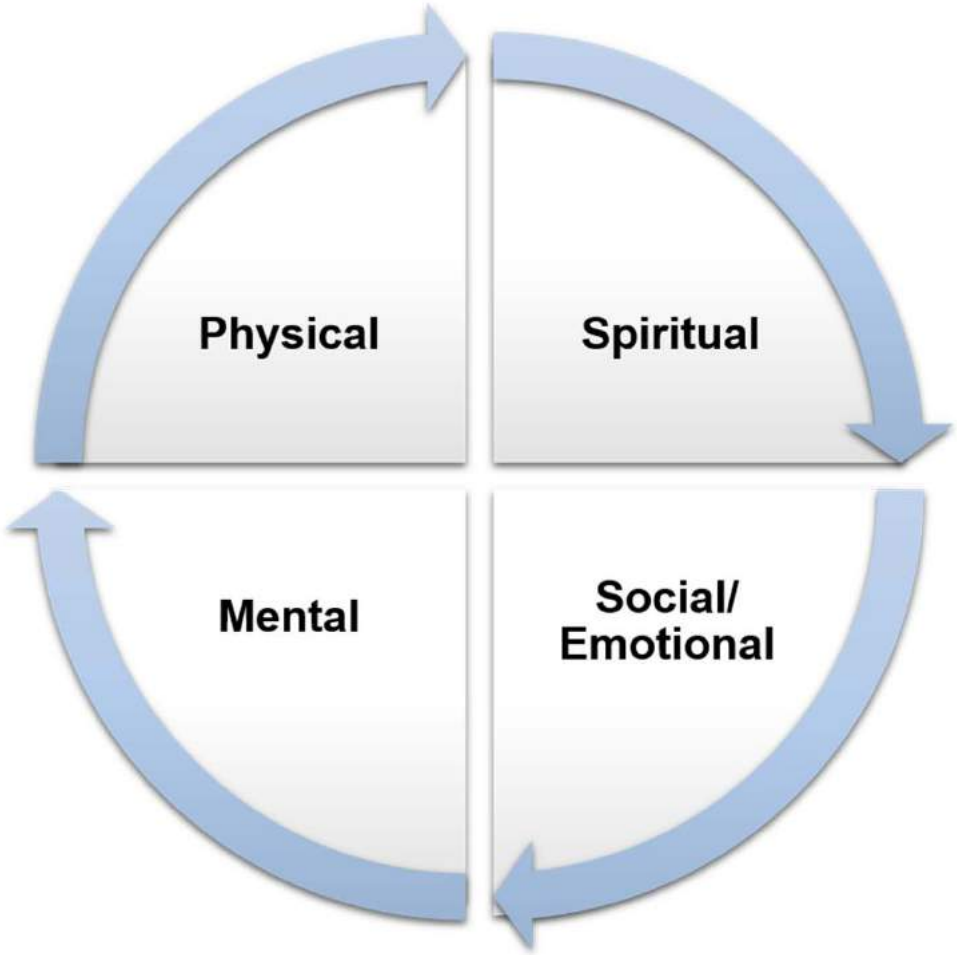
After completion, they can discuss their wheels in small groups. Ask participants to identify whether they have three to four activities in each quadrant. If not, they may want to be more attentive to that area.

Handout: Life Balance Wheel

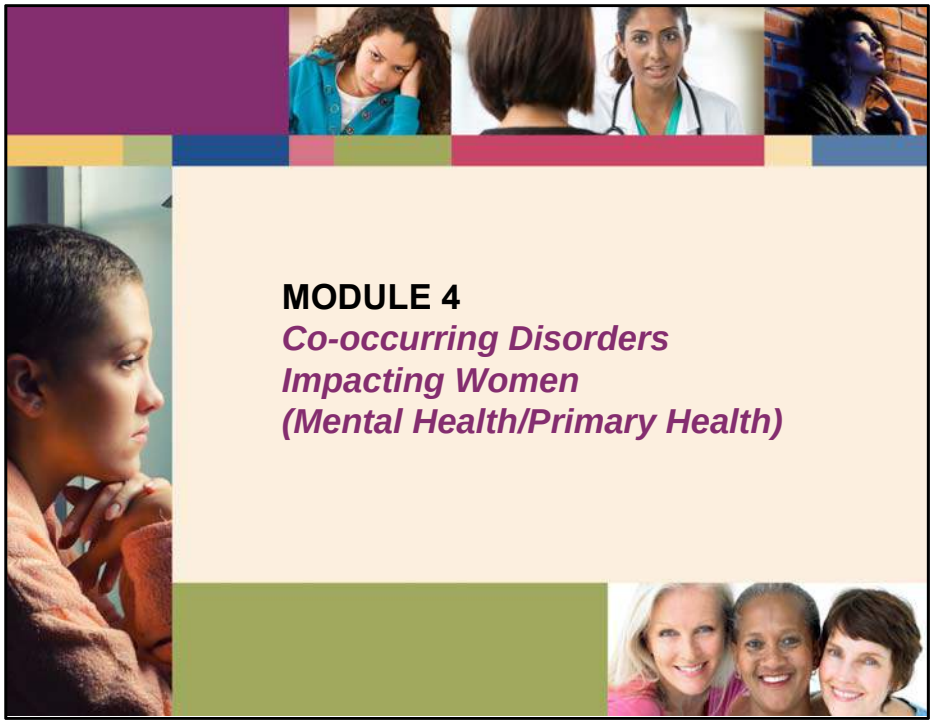
Is your life in balance?

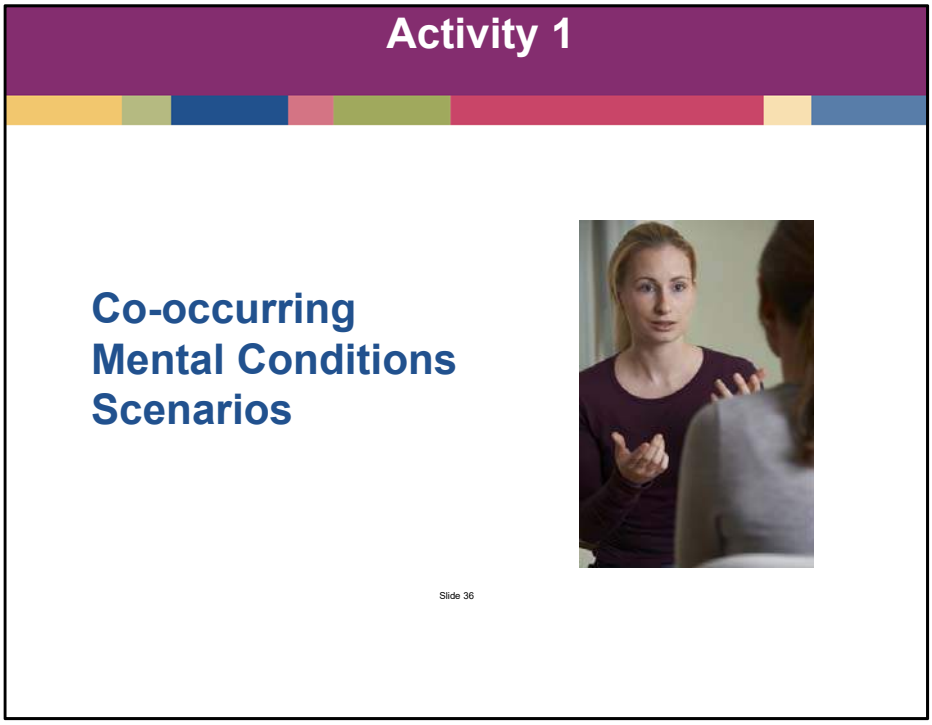
Add spokes to the wheel for each activity you currently do to take care of yourself in each area. Examples include talking with a friend, eating nutritious food, meditating daily.

Do you have at least two spokes in each area? When a wheel goes flat, it does not just go flat in one area—the whole wheel goes flat.



Module 4


MODULE 4
Co-occurring Disorders
Impacting Women
(Mental Health/Primary Health)



Trainer Notes: Co-Occurring Mental Conditions – Scenarios (handout at end of presentation)

In groups of three or four, have participants pick two of the women below to discuss the following questions:

1. What may be going on in this woman's life?
2. What co-occurring mental disorders might she have?
3. If you were her counselor, what would you do to support her.

Suzette: "*When I went to residential treatment, I thought I would finally be able to change my life and get my kids home. We were required to get up, get ready, and be at a house meeting at 7:30 am…but no matter how hard I tried, I could not get out of bed in the morning. I just lay there knowing I was missing the house meeting and wishing I was there, but I was paralyzed. This proved I was a failure. I could not get out of Level 1.*"
Selma: "*In group, whenever Jonathan looked at me, I could tell he wanted me. I was mad because this was supposed to be a safe place. But I felt his eyes searing into me until I couldn't stand it anymore. No one else was paying attention. I yelled at him and left. The program has a rule about staying in group and not leaving. They told me I had to leave.*"
Lorraine: "*We have a new security door at the program. Every time it closes behind me, I hear it lock. My heart races and I feel trapped. I forget where I am and that I can open the door from the inside.*"
Joelle: "*Sometimes I am just paralyzed with fear. I know I should feel safe here, but there is something wrong with the air. I can't breathe.*"
Marta: *"I wanted to be slender, but I was always a little too chunky, or I thought I was. I started puking as a way to keep my weight down, until I found meth. Meth let me go and go without having to eat. Now, in treatment, I've gained so much weight that I'm secretly purging again."*
Monique: "*I was diagnosed as bipolar when I left my last foster home. They sent me to a group home and gave me medicines that made me feel dead inside. I started using oxy's because it is the only thing that makes me feel normal.*"

Handout: *Co-occurring Mental Conditions Scenarios*

Pick two of the women below to discuss the following questions:

1. *What may be going on in this woman's life?*
2. *What co-occurring mental disorders might she have?*
3. *If you were her counselor, what would you do to support her?*

Suzette: *"When I went to residential treatment, I thought I would finally be able to change my life and get my kids home. We were required to get up, get ready, and be at a house meeting at 7:30 a.m. …but no matter how hard I tried, I could not get out of bed in the morning. I just lay there knowing I was missing the house meeting and wishing I was there, but I was paralyzed. This proved I was a failure. I could not get out of Level 1."*

Selma: *"In group, whenever Jonathan looked at me, I could tell he wanted me. I was mad because this was supposed to be a safe place. But I felt his eyes searing into me until I couldn't stand it anymore. No one else was paying attention. I yelled at him and left. The program has a rule about staying in group and not leaving. They told me I had to leave."*

Lorraine: *"We have a new security door at the program. Every time it closes behind me, I hear it lock. My heart races and I feel trapped. I forget where I am and that I can open the door from the inside."*

Joelle: *"Sometimes I'm just paralyzed with fear. I know I should feel safe here, but there is something wrong with the air. I can't breathe."*

Marta: *"I wanted to be thin, but I was always a little too chunky, or I thought I was. I started puking as a way to keep my weight down, until I found meth. Meth let me go and go without having to eat. Now, in treatment, I've gained so much weight that I'm secretly purging again."*

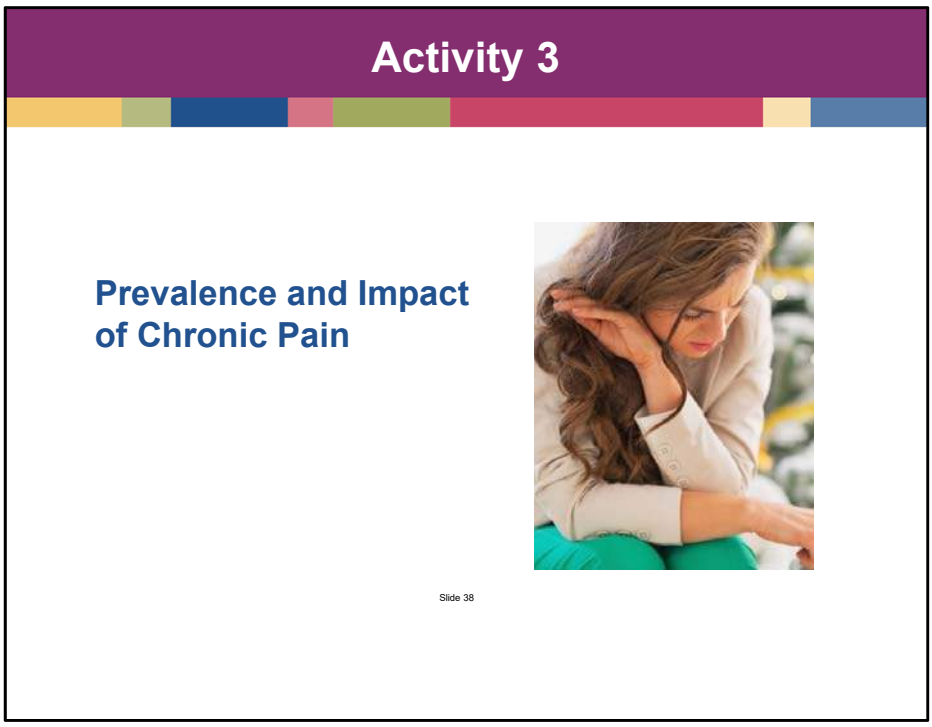
Monique: *"I was diagnosed as bipolar when I left my last foster home. They sent me to a group home and gave me medicines that made me feel dead inside. I started using oxy's because it's the only thing that makes me feel normal."*

Trainer Notes: Accommodations (flip chart)

SUD programs also may need to make accommodations for a range of different groups seeking services. Ask participants to identify at least two accommodations that programs can make that may make it easier for the following groups of women to participate. Women with:

- ADHD
- Physical disabilities
- Deaf and hard of hearing women
- Depression, anxiety, traumatic brain injury, or memory problems.
- Cognitive delays

Write the answers on a flip chart, or have participants come to the front and list ideas on the flip chart under each challenge.



Trainer Notes Chronic Pain Impact – Matching Exercise (handout at end of presentation)

Pass out the chronic pain handouts and ask participants to draw a line between the statements in the first column and the matching correct answer in the second column. Compare responses to the actual answers and discuss the implications for women with SUDs. (Note: can be done as a small or large group exercise).

Talk about the way chronic pain or discomfort can affect a person's ability to concentrate, participate, feel good physically and mentally, and feel motivated to participate in SUD services/programs.

QUIZ ANSWERS

1. People with opioid addiction who report chronic pain (29-60%)
2. People ages 12 and older who report initiating illegal drug use with pain relievers (19%)
3. Chronic pain patients who may have addictive disorders (32%)
4. People experiencing disabling pain in the previous year (36%)
5. People ages 65 and older who experience pain that has lasted more than 12 months (57%)
6. Estimated proportion of medical marijuana users who use it for chronic pain (40%)

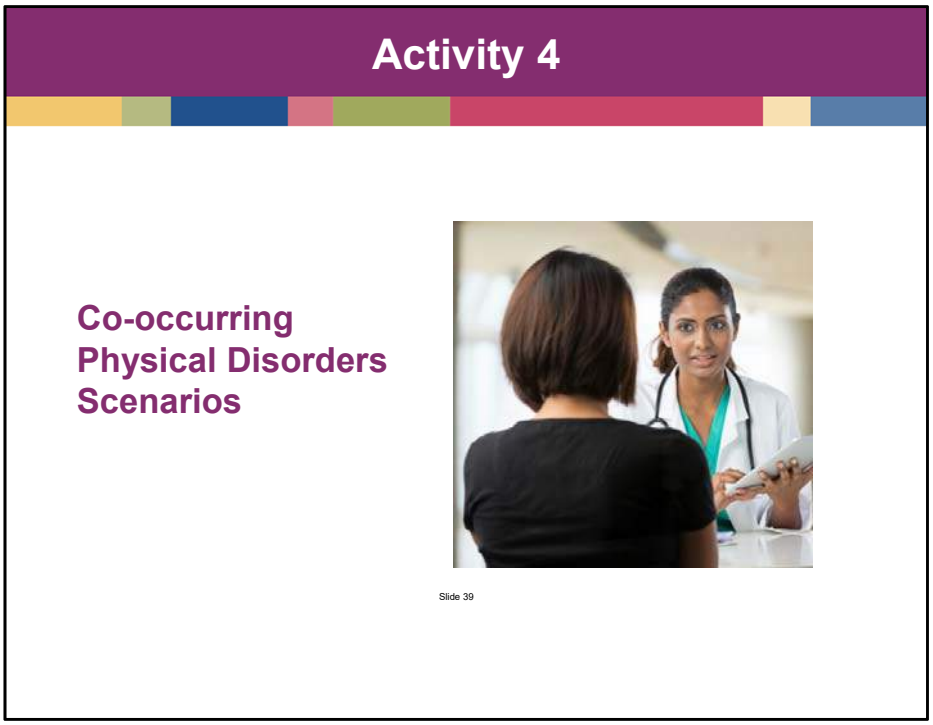
Statistics from: Substance Abuse and Mental Health Services Administration. (2012a). *A Treatment Improvement Protocol: Managing chronic pain in adults with or in recovery from substance use disorders, TIP 54.* (HHS Publication No. SMA 12-4671). Rockville, MD: Author.

Handout: *Prevalence and Impact of Chronic Pain*

Draw a line between the statements in the first column and the matching correct answer in the second column.

Source for statistics:
Substance Abuse and Mental Health Services Administration. (2012a). *A Treatment Improvement Protocol: Managing chronic pain in adults with or in recovery from substance use disorders, TIP 54. (*HHS Publication No. SMA 12-4671). Rockville, MD: Author.

Fact	Percentage
1. People with opioid addiction who report chronic pain	**32%**
2. People ages 12 and older who report initiating illegal drug use with pain relievers	**36%**
3. Chronic pain patients who may have addictive disorders	**57%**
4. People experiencing disabling pain in the previous year	**40%**
5. People ages 65+ who experience pain that has lasted more than 12 months	**29–60%**
6. Estimated proportion of medical marijuana users who use it for chronic pain	**19%**



Trainer Notes: Co-Occurring Physical Disorders Scenarios (handout at end of presentation)

In groups of three or four, have participants pick two of the women below to discuss. What may be going on in this woman's life and with her physical health? If you were her counselor, what would you do to support her?

Charlisa: *They did an HIV test during my prenatal visit and I found out that I am HIV positive. They gave me medications that make it unlikely that I will pass HIV on to my baby. I was happy to take the medication, but now they tell me I am supposed to begin this intense treatment regime as soon as the baby is born. How can I take care of a newborn, get to meetings and counseling appointments, and deal with all the side effects on top of all that? It is overwhelming.*
Justine: *"I drank … I mean I drank a lot. I have diabetes now too, and there are so many things I am not supposed to eat. I feel a huge emptiness inside of me. When I take a drink or eat what I want, it fills the emptiness and for a little while, I feel better."*
Juanita: *"I know I need medication for my cough. It's probably bronchitis, I always have it. I hate going to the doctor so much though that I just won't go."*
Lynn: *"I gained 10 pounds since I came to treatment, so I am just not going to eat for the next three days."*
Wanda: *"I haven't been to the doctor for ten years. If they test me for HIV, Hepatitis, or for cirrhosis, they will probably find it, but how will that help anyone? Besides, they'll try to make me quit smoking too."*
Juliette: *"There is a lump in my breast and they want to do a biopsy. I am just getting my life together and helping my mom and sister again. I just can't deal with this right now."*

Handout: *Co-occurring Physical Health Scenarios*

Pick two of the women below to discuss.

- *What may be going on in this woman's life and with her physical health?*
- *If you were her counselor, what would you do to support her?*

Charlisa: *"They did an HIV test during my prenatal visit and I found out I am HIV positive. They gave me medications that make it unlikely that I will pass HIV onto my baby. I was happy to take the medication, but now they tell me I am supposed to begin this intense treatment regimen as soon as the baby is born. How can I take care of a newborn, get to meetings and counseling appointments, and deal with all the side effects on top of all that? It's overwhelming.*

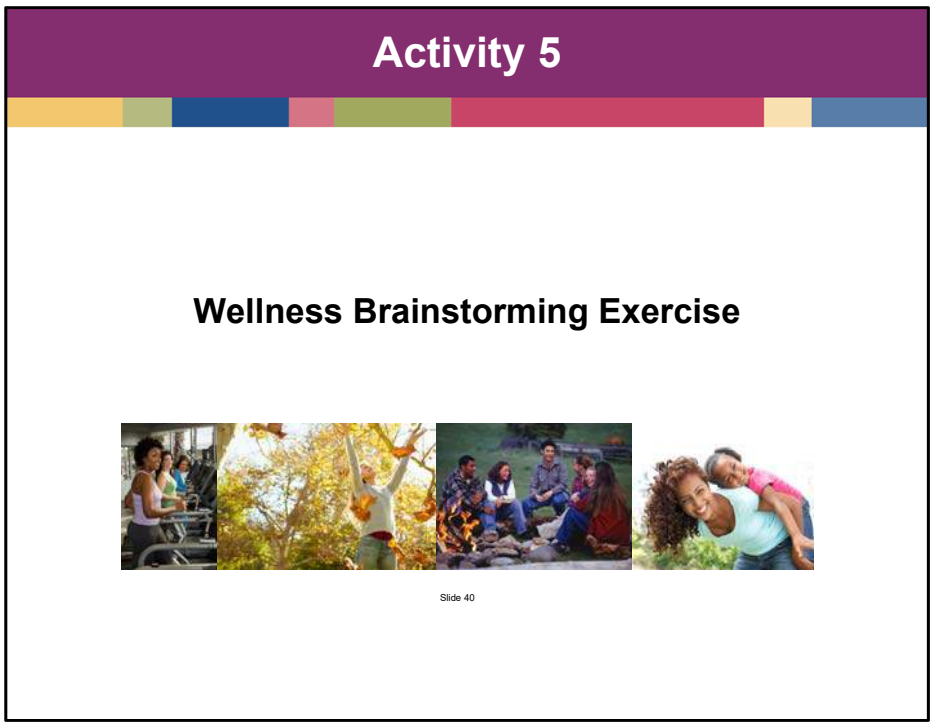
Justine: *"I drank … I mean I drank a lot. I have diabetes now, too, and there are so many things I am not supposed to eat. I feel a huge emptiness inside of me. When I take a drink or eat what I want, it fills the emptiness and, for a little while, I feel better."*

Juanita: *"I know I need medication for my cough. It's probably bronchitis—I always have it. I hate going to the doctor so much though that I just won't go."*

Lynn: *"I gained 10 pounds since I came to treatment, so I am just not going to eat for the next three days."*

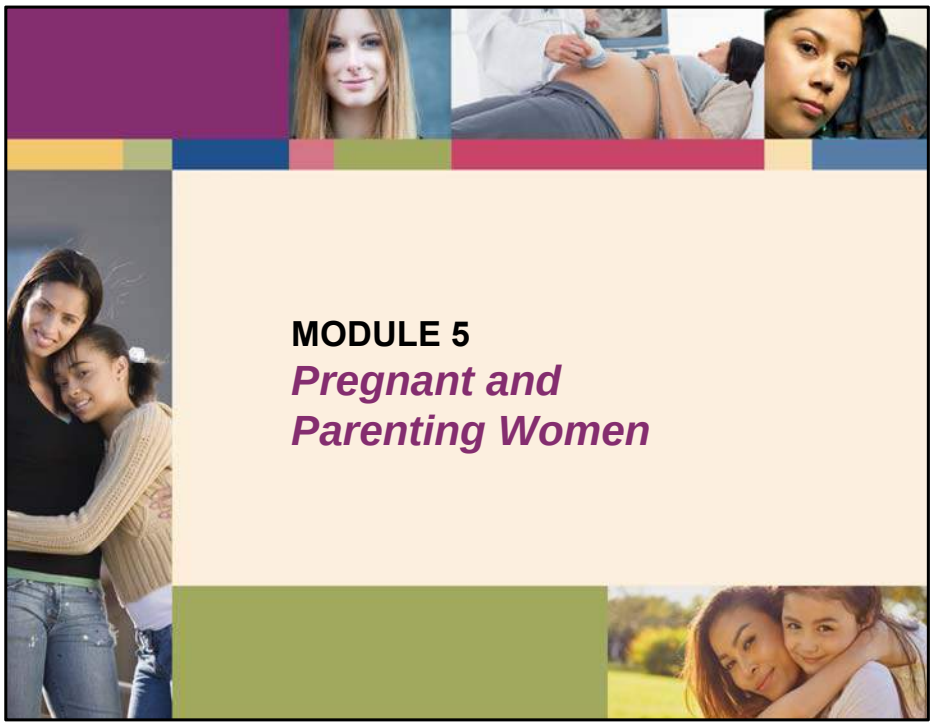
Wanda: *"I haven't been to the doctor in 10 years. If they test me for HIV, hepatitis, or for cirrhosis, they will probably find it, but how will that help anyone? Besides, they'll try to make me quit smoking, too."*

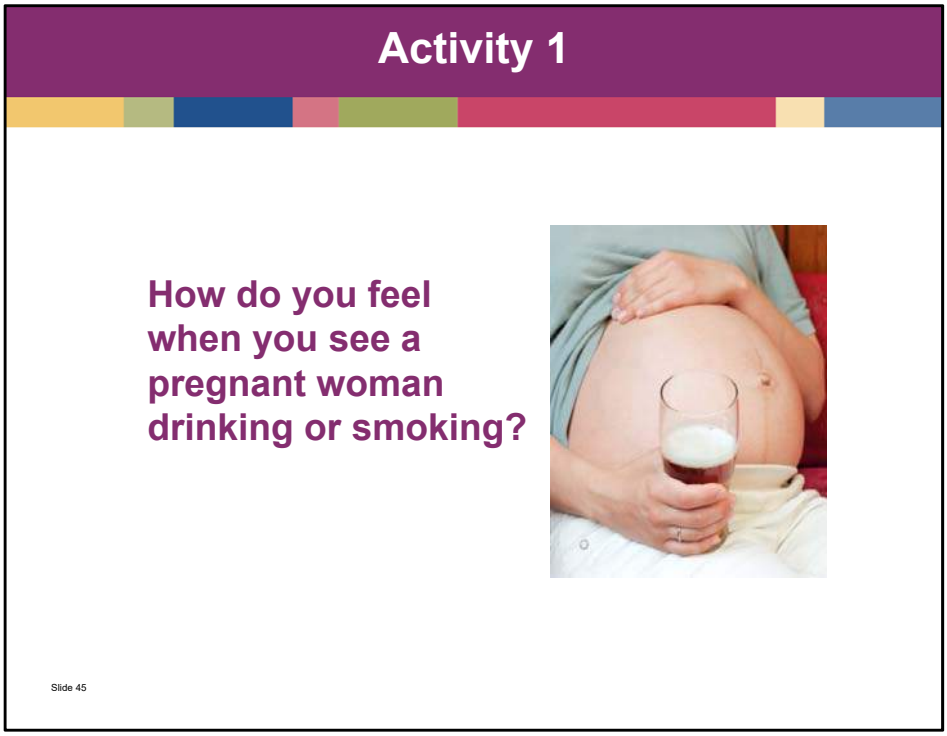
Juliette: *"There's a lump in my breast and they want to do a biopsy. I am just getting my life together and helping my mom and sister again. I just can't deal with this right now."*



Trainer Notes: Wellness Brainstorming Activity (flip chart)

1. Ask participants to identify things that detract from feeling good and healthy, and **make a flip chart page with the list**.
3. Brainstorm things that boost wellness and **make a flip chart with this list**.
4. Put the two pages side by side.
5. Discuss some of the ways to help clients identify ways they can use one of the wellness boosters to mitigate one of the things that detracts from wellness.


MODULE 5
Pregnant and
Parenting Women

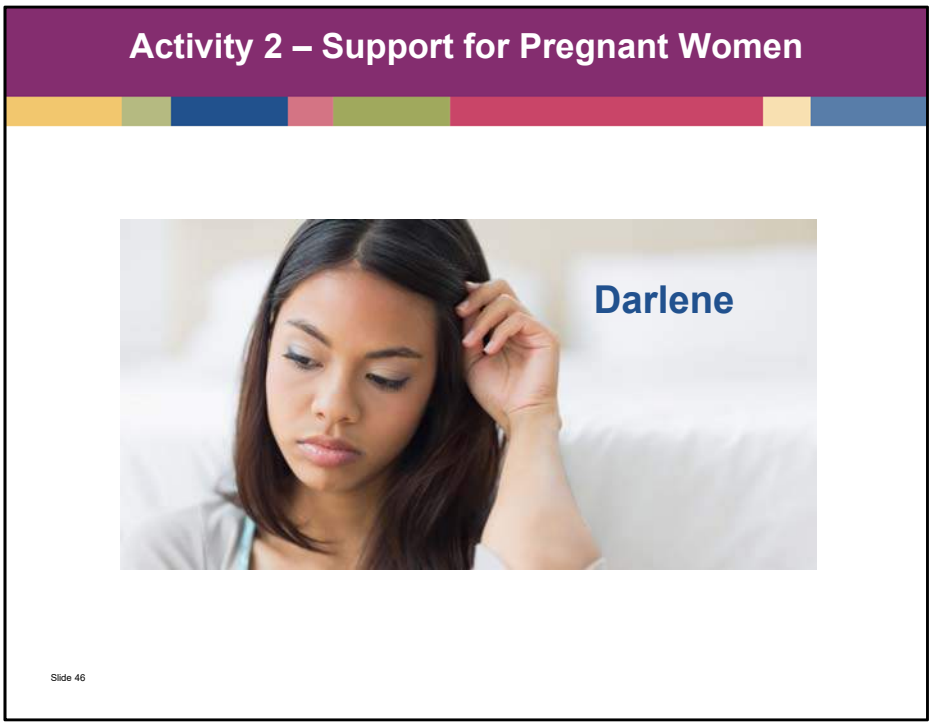


Trainer Notes: How do you feel? (pieces of paper and a basket)

Pass out small pieces of paper. **At the start of the module (or training)** ask people the question "How do you feel when you see a pregnant woman drinking and smoking?" Have participants put their answers on small pieces of paper and into a basket/box.

Later in the training, when talking about how stigma/discrimination can influence how and when pregnant women get help. Return to the box/basket and read some of the answers out loud.

Remind people about the importance of being aware of their own biases and how they can affect service recipients. Acknowledge that this is often a difficult issue for professionals to deal with. Pregnancy and substance use creates strong reactions among family, service providers, and policy makers, which can make it challenging for women to get help. *(Note: in a webinar format, this activity can be done using a word cloud of the answers.)*



Trainer's Note: Support for Pregnant Women

Read the following scenario and ask group to discuss the questions, or break participants into small groups and give them the handout containing the scenario for discussion.

Darlene was removed from her home at age 11, separated from her siblings, and placed in three different foster homes before she became pregnant with her first child at 17. The father was her foster mother's boyfriend. Darlene was removed from placement in her seventh month, after it became impossible for her to continue to hide her pregnancy. There was an investigation and criminal proceeding against her foster mother and the boyfriend after she delivered a son, who was born with fetal alcohol effects. Darlene and her son received intensive services from the state and lived in a supportive housing program, where she received her GED, vocational training, and coordinated development services that helped her son do well in his school.

However, after Darlene completed the program and was expected to work fulltime as a medical records assistant, she could not manage on the income she earned and was overwhelmed by caring for her son. She became involved with an older man who worked for the hospital maintenance crew at her job. When she moved in with him, he introduced her to opioids. She found out she was pregnant with her second child and now wants to quit using them right away.

- What would you recommend for Darlene?
- How would you explain the benefits of medication-assisted treatment?

Handout: *Support for Pregnant Women*

Read the following scenario and discuss the questions with your group members.

Darlene was removed from her home at age 11, separated from her siblings, and placed in three different foster homes before she became pregnant with her first child at 17. The father was her foster mother's boyfriend. Darlene was removed from placement in her seventh month, after it became impossible for her to continue to hide her pregnancy. There was an investigation and criminal proceeding against her foster mother and the boyfriend after she delivered a son, who was born with fetal alcohol effects. Darlene and her son received intensive services from the state and lived in a supportive housing program, where she received her GED, vocational training, and coordinated development services that helped her son do well in his school.

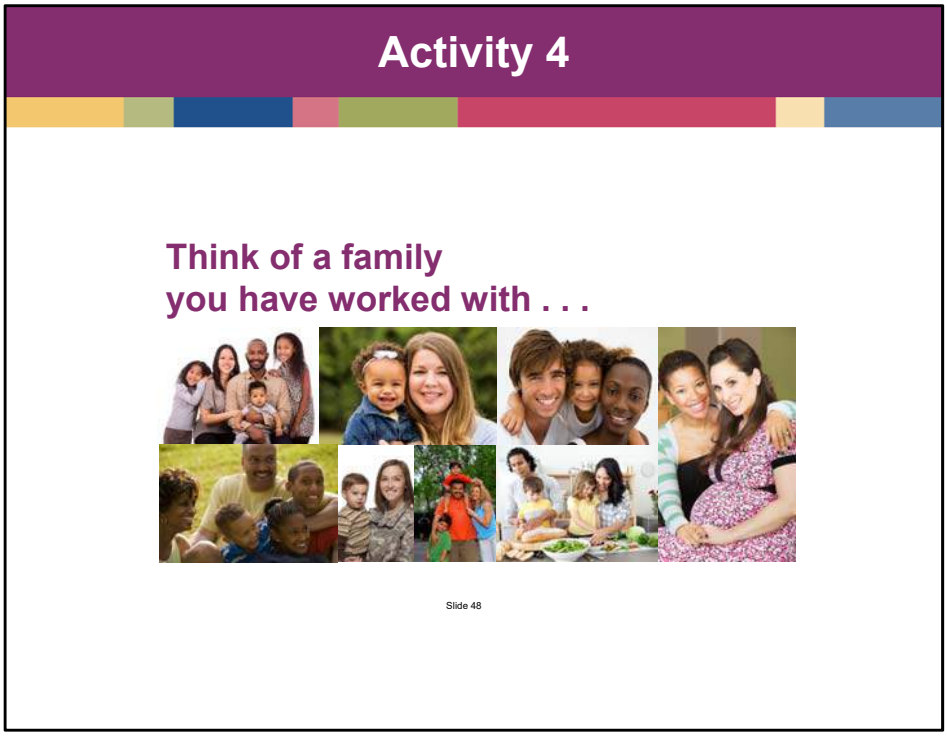
However, after Darlene completed the program and was expected to work full-time as a medical record assistant, she could not manage on the income she earned and was overwhelmed by caring for her son. She became involved with an older man who worked for the hospital maintenance crew at her job. When she moved in with him, he introduced her to opioids. She found out she was pregnant with her second child and now wants to quit using them right away.

- ***What would you recommend for Darlene?***

- ***How would you explain the benefits of medication-assisted treatment?***

Trainer Notes: Draw Your Family (paper or flipchart)

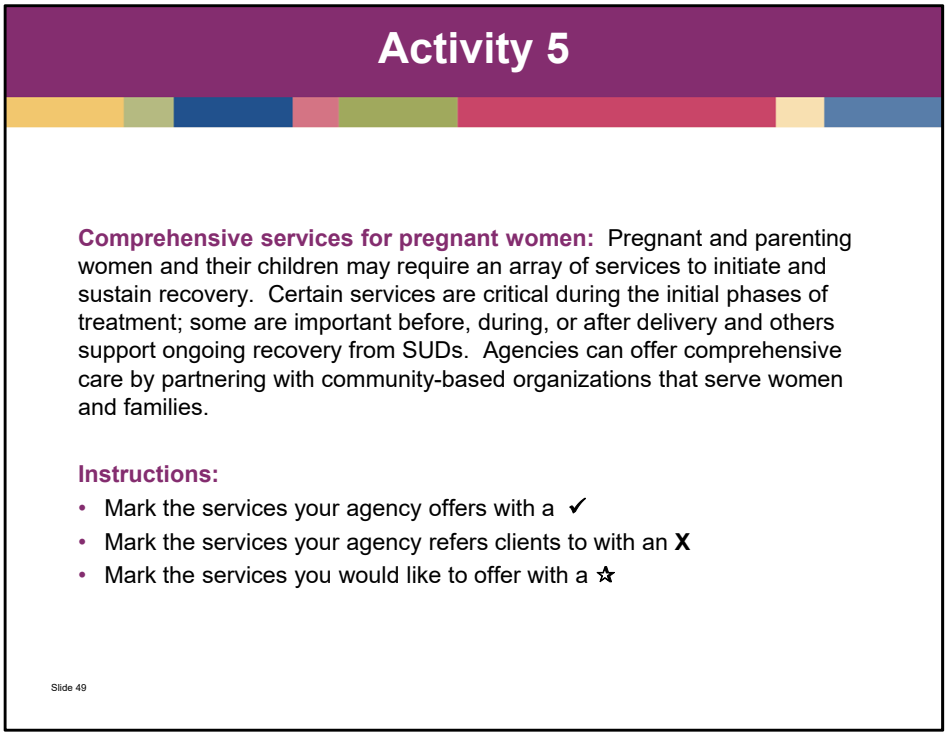
- Pass out markers and paper. If people are seated in rounds, they can use a large flip chart paper and each draw on different parts of the same page.
- Tell participants to “Use the paper and markers to draw your family.” Do not define what you mean by family. Allow about 5 minutes for the activity.
- **Sharing**: Participants can either share their drawing with the person next to them, or if sitting in rounds, with others at the table. OR you can ask for volunteers to share and explain their drawings to the whole training group.
- Ask for participant observations and reflections about what they learned about family.
- People will draw their families differently (e.g., some may include pets, some will have extended/blended/ families, others will include non-blood relatives as family). The key message is that our families are very important to us and come in all different shapes and sizes. This is also true for the people we serve.



Trainers Notes: Think of a Family to Keep in Mind (write questions on flip chart)

Ask participants to think of a family they have worked with that really stands out in their mind—an individual family they have worked with (or have known). The instruct them to pair up, and introduce themselves and the family to their partner, and to answer these questions.

- *What was their story (before you met them)?*
- *What stressors did this family experience?*
- *What strengths did the family have?*
- *What needs did the family have?*
- *How were family members' resources for each other or how were they barriers to the recovery of the family member with an SUD?*



Trainer Notes: Comprehensive Services (handout)

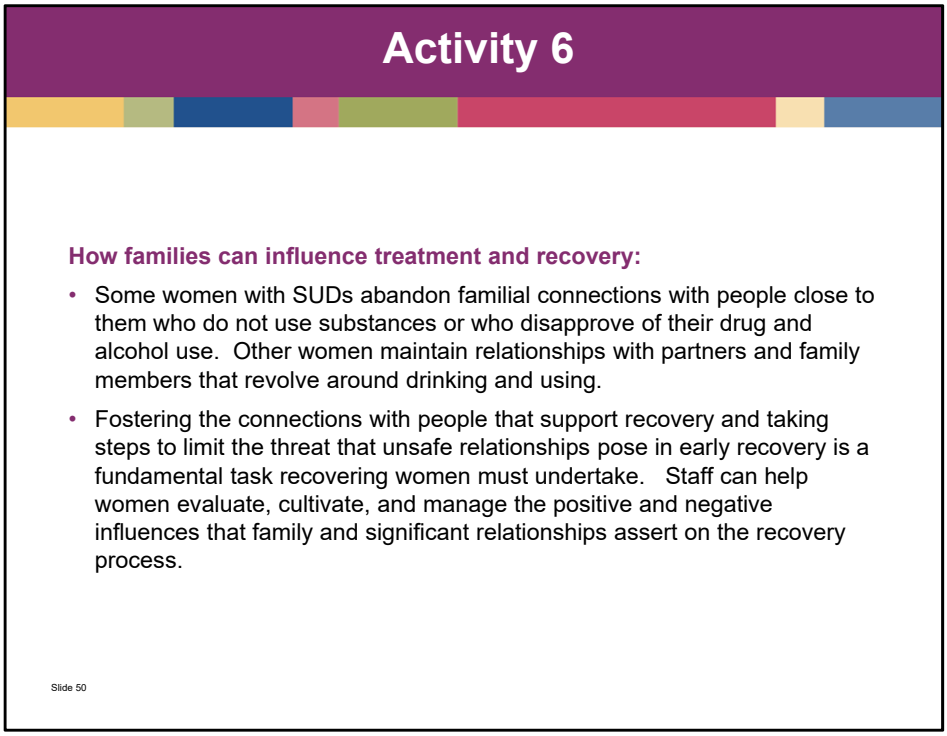
Give all participants a copy of the handout questionnaire and five minutes to complete it.

Discussion questions:
- Are some services best provided by community partners?
- Can some of these services be offered on site to clients?
- What services are difficult for your clients to obtain?

Handout: *Comprehensive Services*

Instructions:
Mark the services your agency offers with a ✓
Mark the services your agency refers clients to with an **X**
Mark the services you would like to offer with a ☆

- ❑ Motivational Interviewing
- ❑ Contingency management
- ❑ Family counseling/couples counseling
- ❑ Cognitive behavioral therapy
- ❑ Integrated trauma and SUD groups
- ❑ Integrated mental health and SUD treatment
- ❑ Family case management and care coordination
- ❑ Single sex programming
- ❑ Residential programs for women with children
- ❑ Peer support, mentoring, or recovery coaching
- ❑ Prenatal care
- ❑ Birthing support/doula services
- ❑ Parenting skills training
- ❑ Developmental testing/children's health services
- ❑ Postpartum support and relapse prevention
- ❑ Supportive safe and sober housing
- ❑ Medication management/medication-assisted treatment
- ❑ Family reunification support
- ❑ Career and technical training/job placement
- ❑ Transportation
- ❑ HIV testing and risk reduction counseling
- ❑ Safety planning and domestic violence services
- ❑ Therapeutic child care/respite services
- ❑ Education on the effects of substance use while pregnant or nursing
- ❑ SUD prevention, screening, and referral for children or partners



Trainer Notes: How Families Can Influence Treatment and Recovery (Handout)

- Read the two bullets out loud.
- Pass out handout and give participants 5-10 minutes to fill in the blanks. Instruct that for each category, they should think of at least one way the relationship could positively or negatively affect a woman's recovery.
- You can give this as an example:

  CHILDREN
  Positive:
  - Desire to be a better parent to her young children helps motivate her to stay sober.
  - Make activities and outings that they enjoy together a part of her recovery plan.

  Negative:
  - Seeks relief from stress of caring for a young special needs child and a rebellious teen by drinking.
  - Arrange respite care for younger child and offer family counseling and support for issues with her teen.

- Ask participants for examples for each category.

Handout: *How Families Can Influence Treatment and Recovery*

CHILDREN

Positive:

Negative:

INTIMATE PARTNER/SPOUSE

Positive:

Negative:

PARENTS

Positive:

Negative:

SIBLINGS

Positive:

Negative:

GRANDPARENTS AND OTHER EXTENDED FAMILY

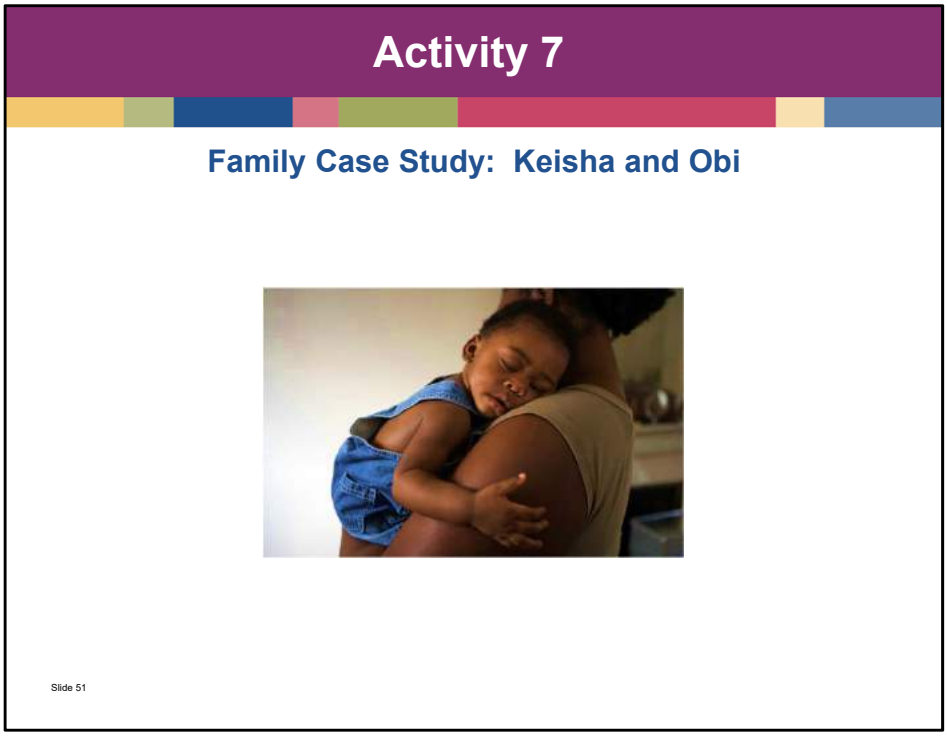
Positive:

Negative:

FRIENDS

Positive:

Negative:



Trainer Notes: Family Case Study: Keisha and Obi (handout at end of presentation)

Break participants into small groups. Ask them to read the story and then answer the questions as a group. Once groups are done, go over the questions and discuss the different ideas and solutions.

Keisha never had it easy. Abused and abandoned as a child, she was raised in multiple foster homes. Stability was never her strong suit. But she is a survivor and has always managed to keep herself fed and clothed – though not always housed. She was referred by a hospital social worker. Homeless and 8 months pregnant, 22-year-old Keisha appeared in the Emergency Room with vaginal bleeding and underwent an emergency Cesarean birth. The hospital social worker encouraged Keisha to give the child up for adoption, but Keisha refused, stating, “He’s the only thing that is all mine. I don’t want him to go through what I did. He needs a mother.” She named him Obi, which she said meant “hope of my heart.” Because Keisha tested positive for methamphetamine when Obi was born, child welfare was called and opened a case. The social worker agreed to allow Obi to remain with Keisha, if Keisha entered a residential treatment program for women and children.

Keisha progressed well in treatment. She also entered a parenting program to learn more about child development and caring for babies. She was enthusiastic and determined. Obi was not an easy child; he cried a lot and did not always respond to comfort or touch. Keisha was tired, but did the best she could.

Keisha has developed a relationship with John who she met when she began attending twelve-step meetings. John has attended AA meeting off and on for two years, but has never been able to achieve more than 3 months of continuous sobriety, although he keeps trying. Keisha says that no one has ever made her feel the way John does and that John acts like a dad for Obi. He avoids her when he is drinking, and she believes that he will eventually stop.

- What are some of the strengths presented in this scenario?
- What are some key questions a service provider may ask?
- Identify one or two treatment/recovery goals for Keisha.
    - What are some possible resources?
    - What are some possible roadblocks?
    - What allies will she need in order to do to achieve these goals?
    - How will you follow up with Keisha?
- Are the goals you selected likely to fit with Keisha’s priorities? If not, how might this affect her progress?

Handout: *Family Case Study: Keisha and Obi*

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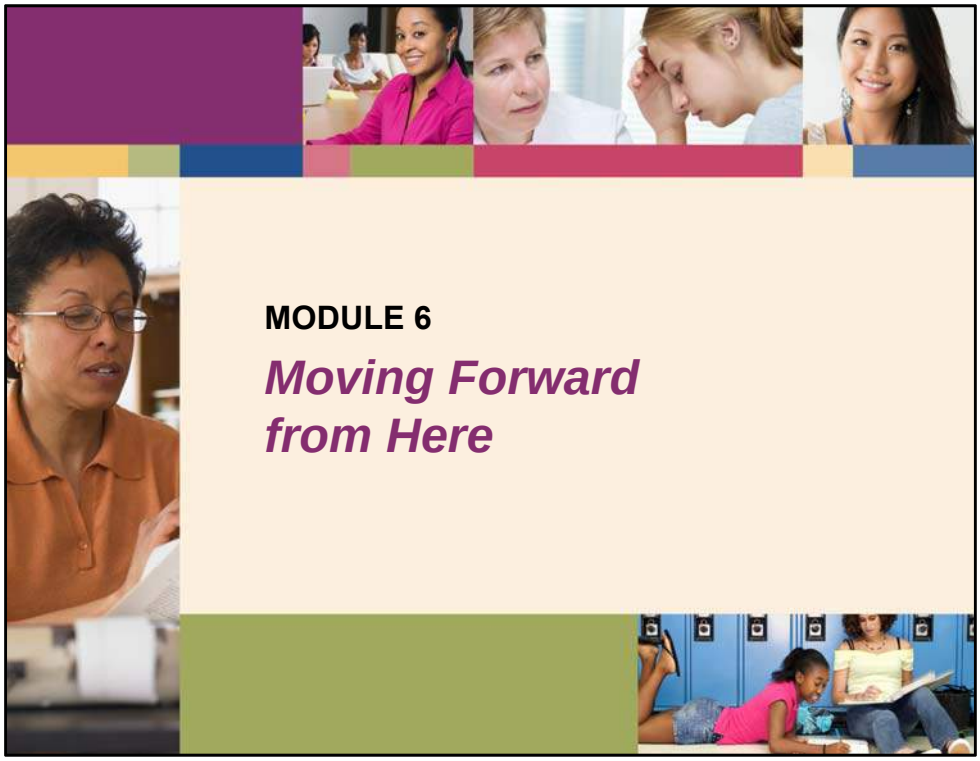
Keisha progressed well in treatment. She also entered a parenting program to learn more about child development and caring for babies. She was enthusiastic and determined. Obi was not an easy child; he cried a lot and did not always respond to comfort or touch. Keisha was tired but did the best she could. Keisha has developed a relationship with John, who she met when she began attending 12-step meetings. John has attended AA meetings off and on for 2 years but has never been able to achieve more than 3 months of continuous sobriety, although he keeps trying. Keisha says that no one has ever made her feel the way John does and that John acts like a dad for Obi. He avoids her when he's drinking, and she believes that he will eventually stop.

- ***What are some of the strengths presented in this scenario?***
- ***What are some key questions a service provider may ask?***
- ***Identify one or two treatment/recovery goals for Keisha:***
  - ***What are some possible resources?***
  - ***What are some possible roadblocks?***
  - ***What allies will she need to achieve these goals?***
  - ***How will you follow up with Keisha?***
- ***Are the goals you selected likely to fit with Keisha's priorities? If not, how might this affect her progress?***


MODULE 6
Moving Forward from Here

Trainer Notes: Strength-based Resources, Self-Reflection Exercise (handout at end of presentation)

Make copies of the handout at the end of the module. Invite participants to consider and write down some things that they are proud of and some things that they are good at, as well as people that they can draw upon as resources in their lives.

Explain that it is important to pay attention to and maintain resources for your own self care. Tools like this may be included in supervision, or staff meetings as well. This could be used as an exercise they can use with women in recovery to identify supports for when they are vulnerable. It can also be helpful for staff to be sure engaging in self care.

Self-Reflection Handout

Some things I am proud of:
Some things that I am good at:
Two people I respect:
Two people I trust:
Two people I can ask for help:
Two people who make me laugh:
Two people who believe in me:

Handout: *Self-care Resources Exercise*

Some things I am proud of:

Some things I am good at:

Two people I respect:

Two people I trust:

Two people I can ask for help:

Two people who make me laugh:

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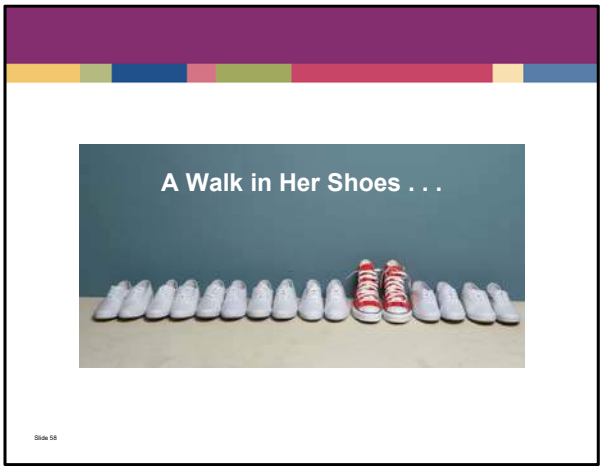
Two people who believe in me:



Trainer Notes: Having Empathy for Financial Challenges and Knowing How to Help (handout at end of presentation)

There are two different scenario approaches below – select one.

Break participants into small groups. Ask them to read the scenario below and discuss their responses to the questions. The goal of the activity is to increase empathy for the women they may be serving, understand the financial challenges they may be facing, and know how to help.

Have participants read the scenarios below and write responses to the questions and then discuss it in small groups.

***#1:**. You have two children, ages 4 and 8. You receive a cash benefit of $487 per month through your state's TANF program. You are expected to spend 20 hours a week in work-related activities. TANF is trying to collect child support from the father of your children, but so far you has only received sporadic distributions from the state's efforts to collect his wages. You have a boyfriend who is unemployed and picks up work when he can. You also receive food stamps and Medicaid. Your 2-bedroom apartment's rent is $750. Rent is due 5 days before you get your TANF, so you also owe a $25 penalty from last month = $775.*

How might this situation affect you physically and emotionally?
- What are some of the stressors you face each month?
- What are some possible things you might do to improve your situation?

***#2:** Wendy, who is early in her recovery from prescription opioids and alcohol use, lives 45 miles south of Charleston, West Virginia with her two young children, ages 3 and 5. Wendy receives a cash benefit of $487 per month through WVWorks, West Virginia's TANF program, along with SNAP (food stamps) and Medicaid. She is expected to spend 20 hours a week in work-related activities. WVWorks is trying to collect child support from the father of her children, but so far Wendy has only received sporadic distributions from the state's efforts to collect his wages. She has a boyfriend who has been unemployed for over a year, but picks up work when he can. Wendy needs her car, not only to look for work and participate in job-training activities, but also to get to counseling and recovery meetings. The rules allow her to keep her car, as it is worth less than $2,000, but she has to buy gas and pay for frequent repairs. Wendy's rent is $600 a month; she also needs to buy diapers and other personal care items. She feels she has two alternatives if she and her children are to survive: her boyfriend can move in with her and help her with the rent if she doesn't tell the state; **or** she can cocktail waitress off the books for an old friend who owns a bar. He'll pay her $50 per shift, plus she gets to keep her tips. Wendy explains her situation to her counselor at her weekly appointment.*

What could Wendy's counselor say to help her? (**Example**) *You have been dealing with a very difficult situation. I can understand why you feel stressed-out. But, I also want to point out that you have faced this situation month after month without using or drinking. That is amazing. I want to applaud your commitment and let you know that I admire the way you care for your children and provide for their needs no matter how challenging the circumstances.*

How could the counselor explore the risks and benefits of each option with Wendy: (Example) *Let's talk about the pros and cons of both possibilities you mentioned. How do you think living with your boyfriend would affect your recovery? How about cocktail waitressing? How much financial relief would you expect from taking each course of action? What type of penalty does TANF impose if you work and don't report the income or if they find out that someone is living with you? If we can come up with a few other possible options that would provide some financial relief without these risks, would you be willing to consider them?*

What options could be available to help Wendy? (Example) Wendy's counselor helped her locate food and clothing pantries and a faith-based organization that helps low income families with car repairs. She also helped arrange for transportation to Wendy's medical appointments, which was covered by Medicaid and had her fill out an application for fuel assistance and WIC. Wendy also contacted an organization that provides eligible families with donated vehicles and got on their waiting list.

Is there anything else a counselor could do to help Wendy?

Handout: *A Walk in Her Shoes (#1)*

Read the scenario below and write responses to the questions, then discuss the responses with your group.

#1: You have two children, ages 4 and 8. You receive a cash benefit of $487 per month through your state's TANF program. You are expected to spend 20 hours a week in work-related activities. TANF is trying to collect child support from the father of your children, but so far you have only received sporadic distributions from the state's efforts to collect his wages. You have a boyfriend who is unemployed and picks up work when he can. You also receive food stamps and Medicaid. Your two-bedroom apartment's rent is $750. Rent is due 5 days before you get your TANF, so you also owe a $25 penalty from last month = $775.

- ***How might this situation affect you physically and emotionally?***

- ***What are some of the stressors you face each month?***

- ***What are some possible things you might do to improve your situation?***

Handout: *A Walk in Her Shoes (#2)*

Read the scenario below and write responses to the questions, then discuss the responses with your group.

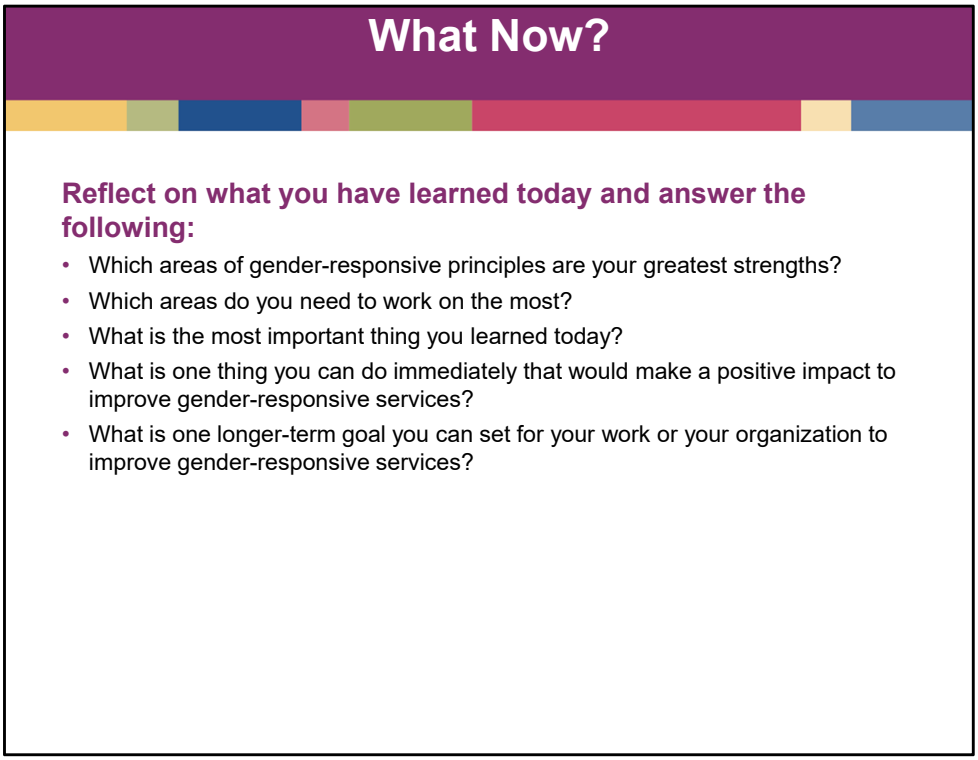
#2: Wendy, who is early in her recovery from prescription opioids and alcohol use, lives 45 miles south of Charleston, West Virginia, with her two young children, ages 3 and 5. Wendy receives a cash benefit of $487 per month through WVWorks, West Virginia's TANF program, along with SNAP (Supplemental Nutrition Assistance Program) and Medicaid. She is expected to spend 20 hours a week in work-related activities. WVWorks is trying to collect child support from the father of her children, but so far Wendy has only received sporadic distributions from the state's efforts to collect his wages. She has a boyfriend who has been unemployed for more than a year but picks up work when he can. Wendy needs her car—not only to look for work and participate in job-training activities but also to get to counseling and recovery meetings. The rules allow her to keep her car because it is worth less than $2,000, but she has to buy gas and pay for frequent repairs. Wendy's rent is $600 a month; she also needs to buy diapers and other personal care items. She feels she has two alternatives if she and her children are to survive: her boyfriend can move in with her and help her with the rent if she doesn't tell the state **or** she can cocktail waitress off the books for an old friend who owns a bar. He'll pay her $50 per shift, plus she gets to keep her tips. Wendy explains her situation to her counselor at her weekly appointment.

What could Wendy's counselor say to help her?

How could the counselor explore the risks and benefits of each option with Wendy?

What options could be available to help Wendy?

Is there anything else a counselor could do to help Wendy?



Instructions for Presenter (handout available)**:**

1) *Let participants have 10 minutes to write down their answers to these questions.*

2) Split participants into groups of 4-6 and ask them to spend 20 minutes "de-briefing" about the modules.

3) Ask participants to share the most important thing they learned and how they will apply it to their work.

4) Ask them to talk together, share some of their answers, ask each other questions, share their perspectives, and listen to each other.

5) After the groups meet, ask for people to share some of their answers to the questions.

Handout: *What Now?*

Reflect on what you have learned today and answer the following:

- Which areas of gender-responsive principles are your greatest strengths?

- Which areas do you need to work on the most?

- What is the most important thing you learned today?

- What is one thing you can do immediately that would make a positive impact to improve gender-responsive services?

- What is one longer-term goal you can set for your work or your organization to improve gender-responsive services?