Substance Use, HIV, and Women: What Clinicians Need to Know

Trainer Guide

Pacific Southwest ATTC (HHS Region 9)

CDU Charles Drew University of Medicine and Science

AETC AIDS Education & Training Center Program Pacific

Substance Use, HIV, and Women:

What Clinicians Need to Know

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Background Information

The purpose of this introductory training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with a detailed overview of substance abuse and HIV among women. The curriculum reviews important epidemiological data focused on substance use trends in women and HIV prevalence; reviews standardized screening and assessment techniques to support the move to improve treatment effectiveness; and concludes with evidence-based and promising clinical strategies. The introductory training includes a 112-slide PowerPoint presentation, Trainer Guide, and a companion 2-page fact sheet. The duration of the training is approximately 90-120 minutes, depending on whether the trainer chooses to present all of the slides, or a selection of slides. For example, slides 83-102 represent information about interventions, and can be eliminated if you choose to end the training with the discussion about gender-responsive care on slide 82.

"Test Your Knowledge" questions have been inserted at the beginning and end of the presentation to assess a change in the audience's level knowledge after the key content has been presented. An answer key is provided in the Trainer's notes for slides 6-10 and slides 107-111.

What Does the Training Package Contain?

- PowerPoint Training Slides (with notes)
- Trainer's Guide with detailed instructions for how to convey the information and conduct the interactive exercises
- Two-Page Fact Sheet entitled, "*Tips for HIV Clinicians Working with Women*"

What Does This Trainer's Manual Contain?

- Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves
- Supplemental information for select content to enhance the quality of instruction
- Suggestions for facilitating the "Test Your Knowledge" questions and group activities/role plays

How is This Trainer's Guide Organized?

For this manual, text that is shown in bold italics is a "***Note to the Trainer.***" Text that is shown in normal font relates to the "Trainer's Script" for the slide.

It is important to note that several slides throughout the PowerPoint presentation contain animation, some of which is complicated to navigate. Animations are used to call attention to particular aspects of the information or to present the information in a stepwise fashion to facilitate both the presentation of information and participant understanding. Getting acquainted with the slides, and practicing delivering the content of the presentation are essential steps for ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in medium-sized groups (30-50 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises and discussions to ensure that there is adequate time to cover all of the content.

Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2003 or higher version) and LCD projector to show the PowerPoint training slides.
- When making photocopies of the PowerPoint presentation to provide as a handout to training participants, it is recommended that you print the slides three slides per page with lines for notes. Select "pure black and white" as the color option. This will ensure that all text, graphs, tables, and images print clearly.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key case study discussion points.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.

Icon Key

	Note to Trainer		Activity
	References		Audience Response System (ARS)-Compatible Slide
	Image Credit		

Substance Use, HIV, and Women:

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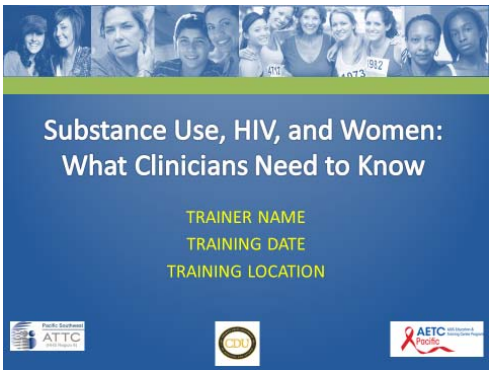
Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).



Slide 1: [Title Slide]

Before you begin, welcome participants and take care of housekeeping announcements, such as location of restrooms, turning off cell phones, participating actively, etc.

The purpose of this introductory training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with a detailed overview of substance abuse and HIV among women. The curriculum reviews important epidemiological data focused on substance use trends in women and HIV prevalence; reviews standardized screening and assessment techniques to support the move to improve treatment effectiveness; and concludes with evidence-based and promising clinical strategies. The introductory training includes a 112-slide PowerPoint presentation, Trainer Guide, and a companion 2-page fact sheet. The duration of the training is approximately 90-120 minutes, depending on whether the trainer chooses to present all of the slides, or a selection of slides.

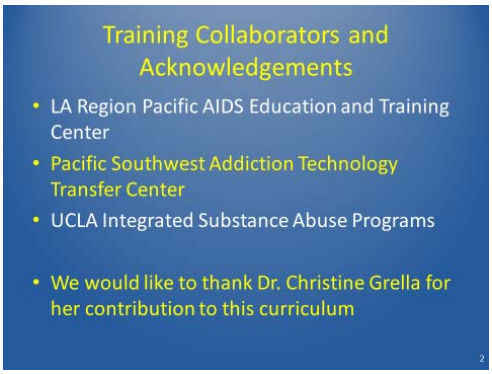
(Notes for Slide 1, continued)

Slide 1: [Title Slide]

For example, slides 83-102 represent information about interventions, and can be eliminated if you choose to end the training with the discussion about gender-responsive care on slide 82.

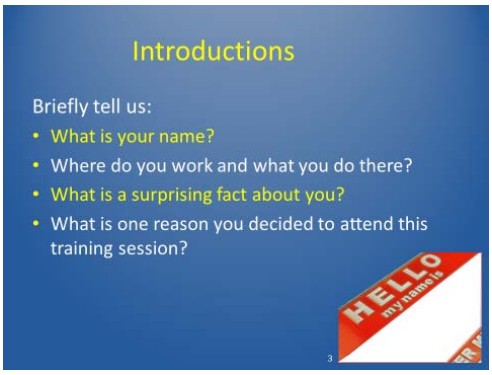
"Test Your Knowledge" questions have been inserted at the beginning and end of the presentation to assess a change in the audience's level knowledge after the key content has been presented. An answer key is provided in the Trainer's notes for slides 6-10 and slides 107-111.

IMAGE CREDITS (Left to Right):
Fotolia, 2016 (purchased image); Fotolia, 2016 (purchased image); Fotolia, 2016 (purchased image) ; Fotolia, 2016 (purchased image); Fotolia, 2016 (purchased image).



Slide 2: Training Collaborators and Acknowledgements

This PowerPoint presentation, Trainer Guide, and companion fact sheet were developed by Gloria Miele, PhD, in collaboration with Beth Rutkowski, MPH (Associate Director of Training of UCLA ISAP) and Thomas E. Freese, PhD (Director of Training of UCLA ISAP and Principal Investigator/Director of the Pacific Southwest ATTC) through supplemental funding provided by the Pacific AIDS Education and Training Center, based at Charles R. Drew University of Medicine and Science. We wish to acknowledge Phil Meyer, LCSW, Kevin-Paul Johnson, Maya Gil Cantu, MPH, and Thomas Donohoe, MBA, from the LA Region PAETC. We would also like to acknowledge the contributions of Dr. Christine Grella, UCLA Integrated Substance Abuse Programs.

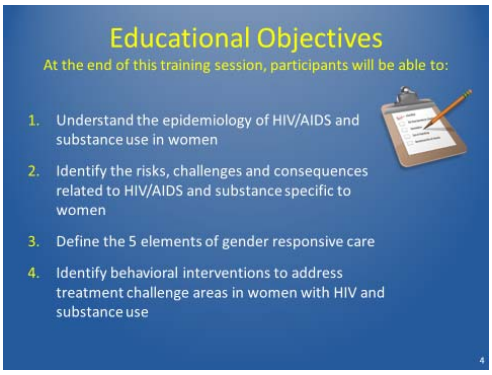


Slide 3: Introductions

In an effort to break the ice and encourage group interaction, take a few minutes to ask training participants to briefly share the answers to these four questions. You can ask for several volunteers to share their responses, if the size of your audience prevents all participants from sharing.

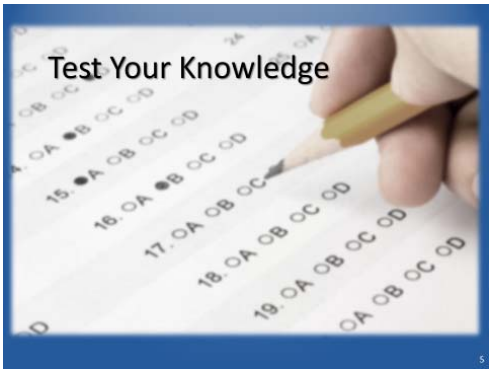
If the group is too large for formal introductions, the trainer can quickly ask participants the following two questions to gauge their work setting and professional training:

1. ***How many [case managers, MFTs or LCSWs, counselors, administrators, physicians, PAs, nurse practitioners, nurses, medical assistants, dentists, etc.] are in the room? Did I miss anyone? {elicit responses}***
2. ***How many people work in a [substance abuse, mental health, primary care, infectious disease] setting? Did I miss any settings? {elicit responses}***



Slide 4: Educational Objectives

Briefly review each of the educational objectives with the audience.



Slide 5: Test Your Knowledge

The purpose of the following five questions is to test the pre-training level of substance use and HIV knowledge amongst training participants. The questions are formatted as either multiple choice or true/false questions. Read each question and the possible responses aloud, and give training participants time to jot down their response before moving on to the next question.

<u>Do not</u> reveal the answers to the questions until the end of the training session (when you re-administer the questions that appear on slides 107-111).

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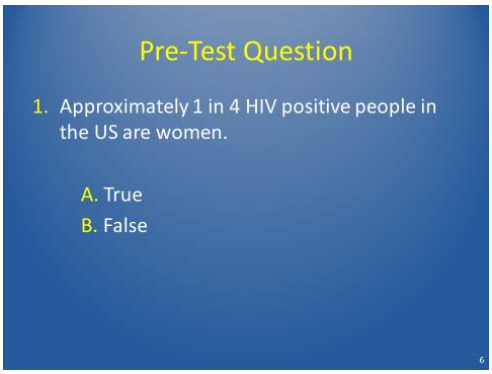
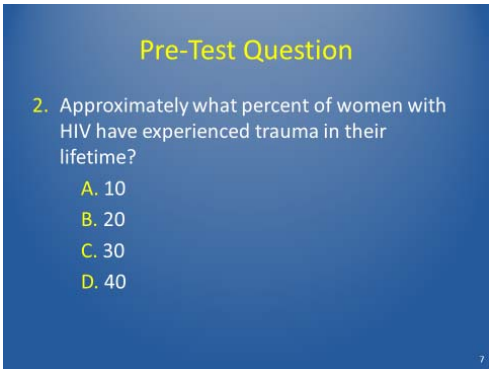


Slide 6: Pre-Test Question #1

Read the question and choices, and review audience responses out loud.

**Audience Response System (ARS)-compatible slide



Slide 7: Pre-Test Question #2

Read the question and answer choices, and review audience responses out loud.

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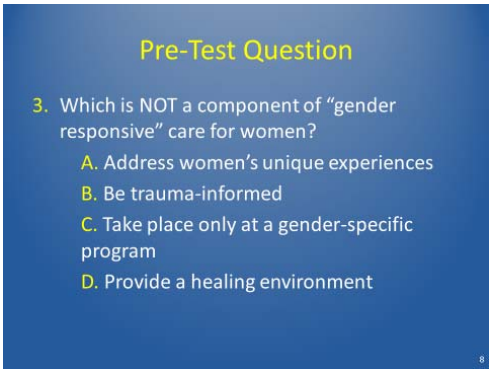

Slide 8: Pre-Test Question #3

Read the question and answer choices, and review audience responses out loud.

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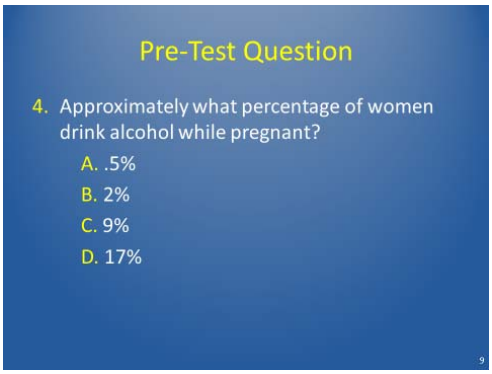

Slide 9: Pre-Test Question #4

Read the question and answer choices, and review audience responses out loud.

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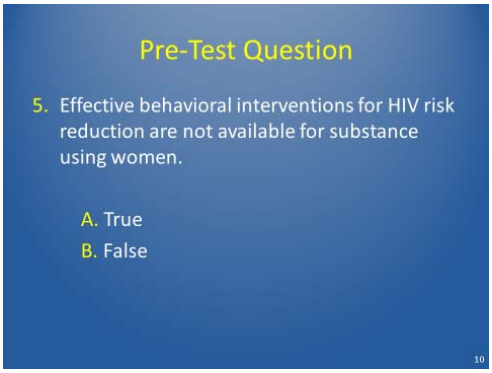

Slide 10: Pre-Test Question #5

Read the question and answer choices, and review audience responses out loud.

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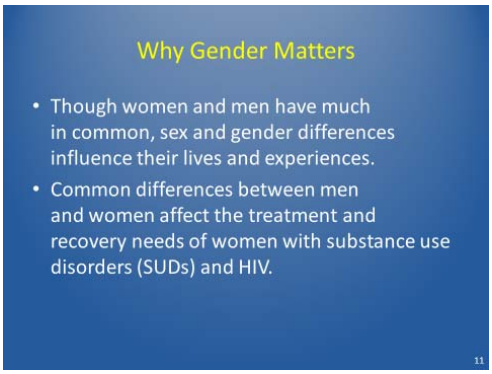


Slide 11: Why Gender Matters

Both sex and gender differences have an impact on the development of SUDs and on the treatment and recovery service needs of women and girls with SUDs.

Differences between men and women include biological, as well as social and environmental factors.

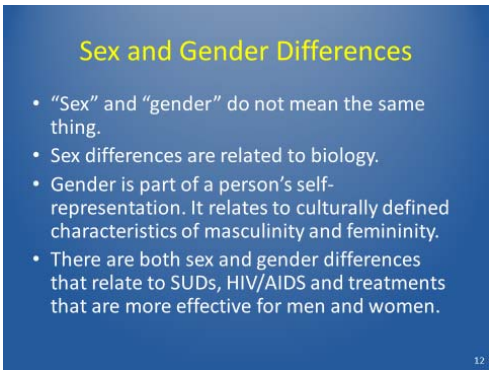
REFERENCES

Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals (pp. 2-9).

Guidance to States: Treatment Standards for Women with Substance Use Disorders, "Introduction and Background" (pp. 6-8).

TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, "Executive Summary" (pp. xvii-xxiii).

Full citation for TIP 51: Substance Abuse and Mental Health Services Administration. (2013). *Treatment Improvement Protocol (TIP) 51: Substance Abuse Treatment: Addressing the Specific Needs of Women.* Rockville, MD: U.S. Department of Health and Human Services. Accessed November 8, 2015 from http://store.samhsa.gov/shin/content/SMA13-4426/SMA13-4426.pdf.



Slide 12: Sex and Gender Differences

The terms sex and gender are often used interchangeably in today's world, but their root meanings are not the same.

Sex differences relate to biology. Differences between males and females include reproductive organs, hormones, body size, metabolism, and bone mass.

Gender differences refer to the characteristics, roles, and expectations constructed by culture and social norms about what it means to be *masculine* or *feminine,* or to be a *man* or a *woman.*

Sex differences related to substance use, for women include developing SUDs and health-related problems more quickly than men, which is called the telescoping effect. As another example, women and girls have less of the gastric enzyme that metabolizes alcohol, so they have higher blood alcohol levels for a longer period of time when they consume the same amounts of alcohol as their male counterparts.

(Notes for Slide 12, continued)

Slide 12: Sex and Gender Differences

REFERENCES

For more information about sex differences, see: Tip 51: Chapter 3, "Physiological Effects of Alcohol, Drugs, and Tobacco on Women" (pp. 37-56) and "Biological and Psychological" (pp. 7-9).

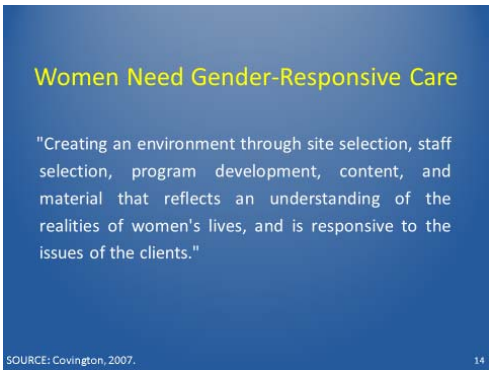
National Institutes of Health's Office of Research on Women's Health website "*A to Z Guide: Sex and Gender Influences on Health*" at http://orwh.od.nih.gov/resources/sexgenderhealth/index.asp.

Slide 13: Sex and Gender Differences

The sense of masculinity or femininity is part of one's identity. People measure their femaleness and maleness against certain accepted norms and what it means to be a "man" or a "woman" in one's culture, religion, race, and so on. Certain characteristics are common among women and should be taken into consideration, but don't assume a woman fits common gender characteristics simply because she is female.

Gender characteristics are not absolutes, and no two women are the same. Even women with the similar backgrounds can have very different ideas about what it means to be a woman. Many women have traits that are associated with being masculine, and many men have feminine traits, regardless of their background, gender identity, or sexual orientation.

No matter what sex a person was assigned at birth, that person may identify as a woman, man, transgender man or woman, gender non-conforming, or another gender identity. The term women is used in this presentation to mean anyone who identifies as female. If a client woman identifies as a woman, she should be considered as such by treatment staff.



Slide 14: Women Need Gender-Responsive Care

Review the definition of "gender responsive" by reading the quote or allowing time for trainees to read aloud or silently. How can gender-responsiveness help women in treatment?

REFERENCES

Covington, S. S. (2007). *Women and addiction: A gender-responsive approach (The clinical innovators series)*. Center City, MN: Hazelden.

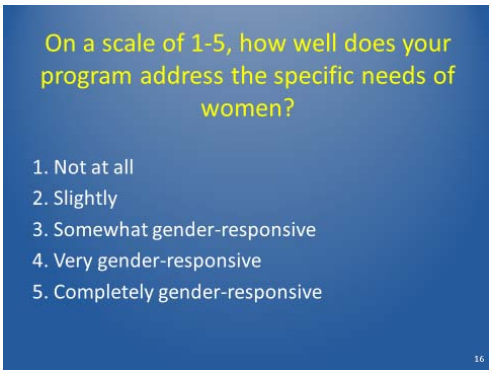
Covington, S. S., & Surrey, J. L. (1997). The relational model of women's psychological development: Implications for substance abuse. In R. W. Wilsnack & S. C Wilsnack (Eds.), *Gender and alcohol: Individual and social perspectives* (335–351). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Slide 15: Why Be Gender-Responsive?

Mention that more on gender-responsive care will be addressed later in the training when we talk about treatment.

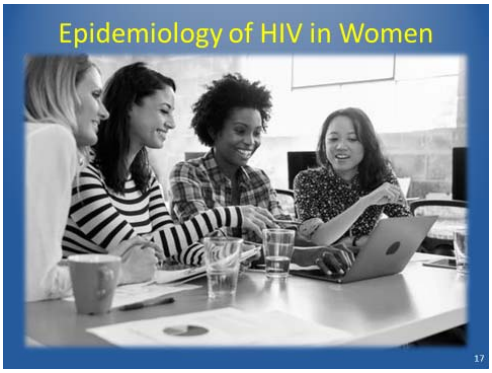
Learning about, and implementing, gender-responsive principles can help improve prevention, treatment, and recovery programs for women and lead to more positive outcomes. Gender-responsive differs from gender-specific in that gender-specific are services those designed solely for women. Gender-responsive is a broader way of looking at services, environment, and experiences and how they address the lives of women.

IMAGE CREDIT: SAMHSA, "*Addressing the gender-specific treatment needs of women*." Training of Trainers, March, 2016.



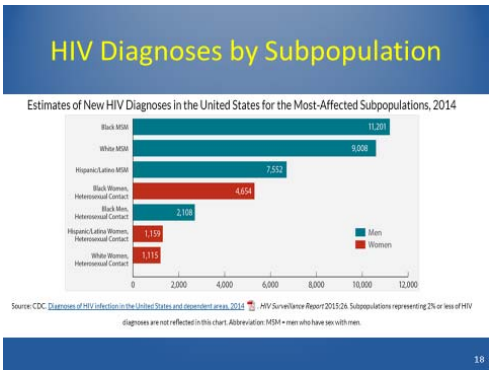
Slide 16: On a scale of 1-5, how well does your program address the specific needs of women?

Ask the question using the automated response system, if available. Consider staffing, programming, environment. Alternately, have trainees break into small groups to discuss examples of what their organizations do to address the specific needs of women.



Slide 17 [Transition Slide]: Epidemiology of HIV in Women

This slide serves as the transition from setting the context of women's treatment needs to beginning a discussion specifically about women and HIV.



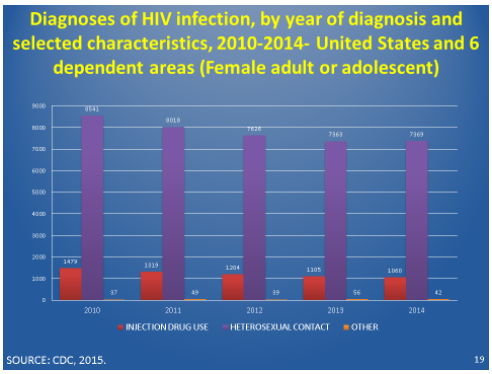
Slide 18: HIV Diagnoses by Subpopulation

Approximately 1 in 4 individuals diagnosed with HIV are women. New HIV diagnoses among women are primarily among women of color and a result of heterosexual contact. Black women are most affected, followed by Latinas and then whites (CDC, *HIV among Women*). An estimated 88% of women who are living with HIV are diagnosed, but only 32% have the virus under control.

These findings are based on CDC surveillance data. Surveillance is the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event. HIV surveillance collects, analyzes, and disseminates information about new and existing cases of HIV infection (including AIDS) throughout the US.

REFERENCE

Centers for Disease Control and Prevention. (2015). *HIV Surveillance Report, 2014, Volume 26*. Accessed June 20, 2016 from http://www.cdc.gov/hiv/library/reports/surveillance/.



Slide 19: Diagnoses of HIV infection, by year of diagnosis and selected characteristics, 2010-2014- United States and 6 dependent areas (Female adult or adolescent)

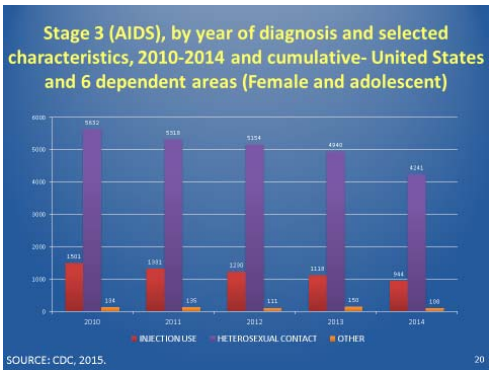
According to the CDC, the number of adult or adolescent females that were diagnosed with HIV in the US has been decreasing from 2010 to 2014.

Modes of contraction include:

- Injection drug use, heterosexual contact or other, which includes hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or identified.
- Women contract HIV from heterosexual contact at more than five times the rate than through IV drug use.
- Contraction of HIV through heterosexual contact and Injection drug use decreased slightly every year from 2010 to 2014 with a slight rise in IV drug use from 2013 to 2014.
- Contraction of HIV through other means is quite low.

REFERENCE

Centers for Disease Control and Prevention. (2015). *HIV Surveillance Report, 2014, Volume 26*. Accessed May 26, 2016 from http://www.cdc.gov/hiv/library/reports/surveillance/.

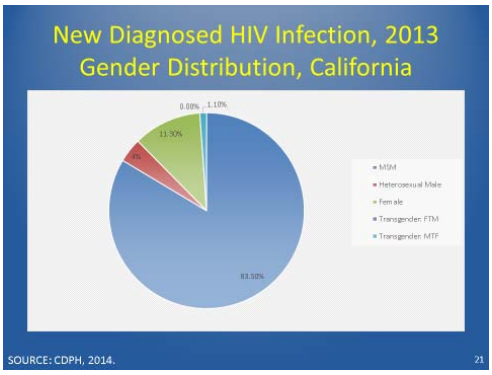


Slide 20: Stage 3 (AIDS), by year of diagnosis and selected characteristics, 2010-2014 and cumulative- United States and 6 dependent areas (Female and adolescent)

A similar pattern emerges for AIDS diagnosis from the 2010 to 2014, with decreasing rates of diagnosis for women and adolescents for all methods of contraction. Women are nearly 4 times as likely to contract AIDS through heterosexual contact than IV drug use.

REFERENCE

Centers for Disease Control and Prevention. (2015). *HIV Surveillance Report, 2014, Volume 26*. Accessed May 26, 2016 from http://www.cdc.gov/hiv/library/reports/surveillance/.

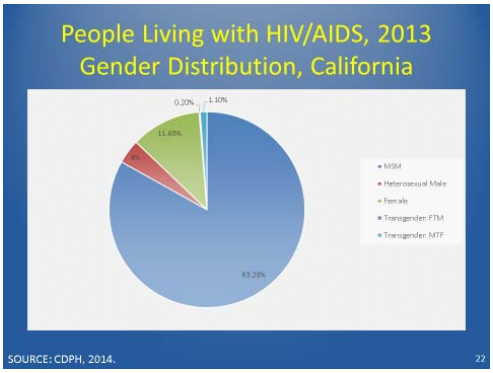


Slide 21: New Diagnosed HIV Infection, 2013: Gender Distribution, California

In California in 2013, 11.3% of newly diagnosed HIV infections were women. All but approximately 4% of the males were MSM.

REFERENCE

California Department of Public Health, Office of AIDS. (2014). *The continuum of HIV Care – California, 2014*. Accessed June 22, 2016 from http://www.cdph.ca.gov/programs/aids/Documents/HIVCareContinuum-2014.pdf.



Slide 22: People Living with HIV/AIDS, 2013: Gender Distribution, California

In California in 2013, 11.6% of PLWHA were women. All but approximately 4% of the males were MSM.

REFERENCE

California Department of Public Health, Office of AIDS. (2014). *The continuum of HIV Care – California, 2014*. Accessed June 22, 2016 from http://www.cdph.ca.gov/programs/aids/Documents/HIVCareContinuum-2014.pdf.

Slide 23: Prevention Challenges for Women

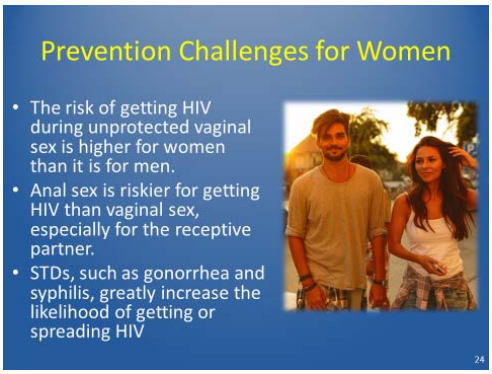
A few challenges get in the way of prevention, especially for women of color. For example, the majority of people living with HIV (prevalence) are in African American and Hispanic/Latino communities. People tend to have sex with partners of the same race/ethnicity, so women from these communities face a greater risk of HIV infection with each new sexual encounter.

Some women may be unaware of their male partner's risk factors for HIV (e.g., IV drug use or having sex with men) and may not use condoms. They may assume that being in a monogamous relationship eliminates their risk. Women who have been sexually abused may be more likely than women with no abuse history to engage in sexual behaviors like exchanging sex for drugs, having multiple partners, or having sex without a condom.

REFERENCES

Cramer, R.J., et al. (2015). Substance-related coping, HIV-related factors, and mental health among an HIV-positive sexual minority community sample. *BMJ Open, 3*(2), e001928.

Tross, S.T., Campbell, A.N.C., Cohoen, L.R., Calsyn, D., Pavlicova, M., et al. (2008). Effectiveness of HIV/STD sexual risk reduction groups for women in substance abuse treatment programs: Results of a NIDA Clinical Trials Network Trial. *Journal of Acquired Immune Deficiency Syndromes, 48*(5), 581-589.

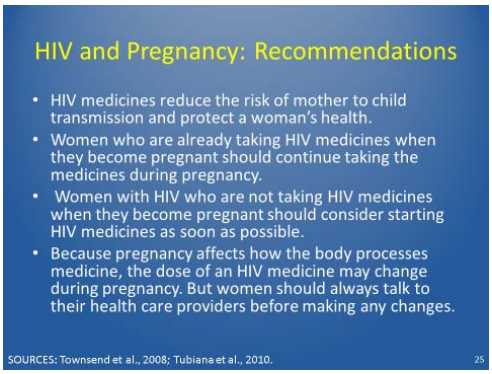


Slide 24: Prevention Challenges for Women

Women are at greater risk of getting HIV during unprotected vaginal sex than men. Anal sex is riskier for getting HIV than vaginal sex, especially for the receptive partner. In a behavioral survey of heterosexual women at increased risk of HIV infection, 25% of HIV-negative women reported having anal sex without a condom in the previous year. STDs and other infections also increase the likelihood of contracting or spreading the HIV virus.

REFERENCE

Cramer, R.J., et al. (2015). Substance-related coping, HIV-related factors, and mental health among an HIV-positive sexual minority community sample. *BMJ Open, 3*(2), e001928.



Slide 25: HIV and Pregnancy: Recommendations

NIH recommends that pregnant women with HIV take HIV medications to reduce the risk of mother to child transmission and protect their own health. Women who are HIV positive and are or may become pregnant should be assured that medication can almost entirely eliminate the risk of the baby becoming infected with HIV.

Women who are already taking HIV medicines when they become pregnant should continue taking the medicines during pregnancy. Women with HIV who are not taking HIV medicines when they become pregnant should consider starting HIV medicines as soon as possible.

Pregnant women with HIV can safely use many HIV medicines during pregnancy. Pregnant women and their health care providers carefully consider the benefits and the risks of specific HIV medicines when choosing an HIV regimen to use during pregnancy.

Because pregnancy affects how the body processes medicine, the dose of an HIV medicine may change during pregnancy. But women should always talk to their health care providers before making any changes.

(Notes for Slide 25, continued)

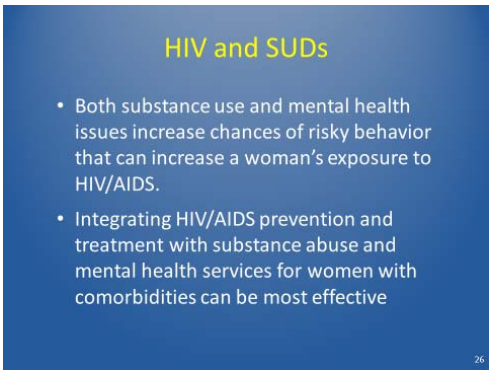
Slide 25: HIV and Pregnancy: Recommendations

In the setting of maternal viral load suppressed to <50 copies/mL near delivery, use of combination ART during pregnancy has reduced the rate of perinatal transmission of HIV from approximately 20% to 30% to 0.1% to 0.5%. ART is thus recommended for all HIV-infected pregnant women, for both maternal health and for prevention of HIV transmission to the newborn. In ART-naive pregnant women ART should be initiated as soon as possible, with the goal of suppressing plasma viremia throughout pregnancy.

REFERENCES

Townsend, C.L., Cortina-Borja, M., Peckham, C.S., de Ruiter, A., Lyall, H., & Tookey, P.A. (2008). Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000-2006. *AIDS, 22*(8), 973-981. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=18453857.

Tubiana, R., Le Chenadec, J., Rouzioux, C., et al. (2010). Factors associated with mother-to-child transmission of HIV-1 despite a maternal viral load <500 copies/ml at delivery: A case-control study nested in the French perinatal cohort (EPF-ANRS CO1). *Clin Infect Dis, 50*(4), 585-596.



Slide 26: HIV and SUDs

Active substance use can put a woman at greater risk of HIV. Women who are HIV negative and using substances may lack power or skills that still put them at risk.

Role play possible ways to behave differently and talk about strategies for managing risky situations, such as a partner who refuses to wear condoms or wants to share needles for drug injection.

HIV counseling and testing; have standard procedures to ensure women who receive testing receive counseling about what the results mean and what to do; and refer women who test positive for HIV treatment.

Build a close relationship with HIV/AIDS medical care providers within the community. Medical providers and substance use counselors can work together closely to support medical and substance abuse treatment and adherence to treatment goals. This includes establishing agency agreements and creating formal referral mechanisms.

REFERENCES

Chapter 5, "Integrating Treatment Services," 2008.

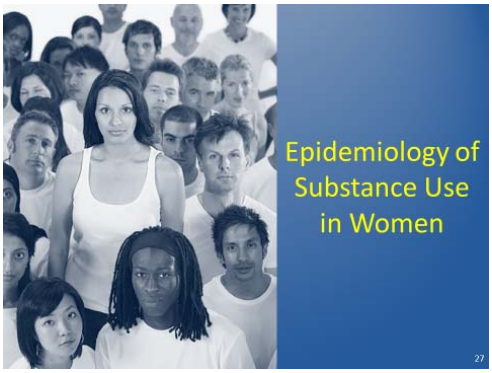
(Notes for Slide 26, continued)

Slide 26: HIV and SUDs

REFERENCES

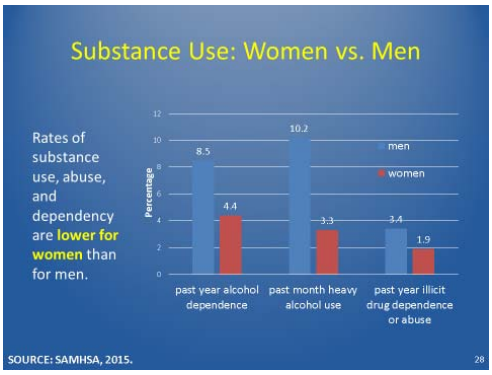
TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders (pp. 9-10).

CDC, HIV among Women, http://www.cdc.gov/hiv/group/gender/women/.



Slide 27 [Transition Slide]: Epidemiology of Substance Use in Women

The purpose of the following section is to introduce issues of substance use in women and begin to develop an understanding of the importance of focusing on the relationship between women's substance use and HIV.



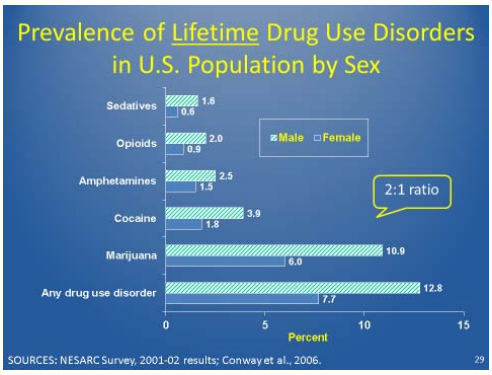
Slide 28: Substance Use: Women vs. Men

Before jumping into some of women's experiences, it is important to look at some of the data in regard to women and SUDs. Overall, women are less likely to develop alcohol or illicit drug dependence than men.

Statistics show 4.4 percent of women ages 12 or older experienced past year alcohol dependence or abuse compared with 8.5% of men. Among adults 21 and older, men are also more likely to engage in heavy alcohol use in the past month (with 10.2 percent of men and 3.3 percent of women). In 2014, among individuals ages 12 and older. 1.9% of females compared with 3.4 percent of males have past year illicit drug dependence or abuse (SAMHSA, 2015).

REFERENCE

Substance Abuse and Mental Health Services Administration. (2015). *Behavioral Health Barometer: United States, 2015.* HHS Publication No. SMA-16-Baro-2015. Rockville, MD: U.S. Department of Health and Human Services.



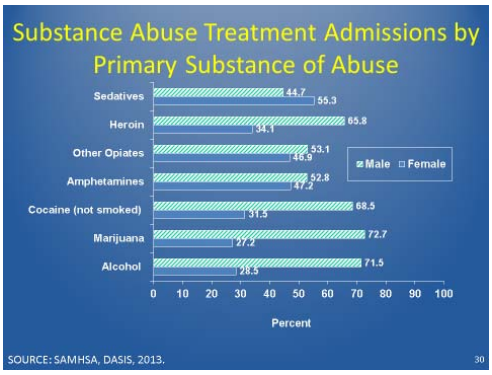
Slide 29: Prevalence of <u>Lifetime</u> Drug Use Disorders in U.S. Population by Sex

Similar to the last graph, here you see an approximately 2:1 ratio in substance use disorders for men compared to women, with men using approximately double the amount that women use across each drug class

REFERENCES

Alcohol Use and Alcohol Use Disorders in the United States: Main Findings from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), Alcohol Epidemiologic Data Reference Manual, Volume 8, Number 1, January 2006, NIH Publications No. 05-5737.

Conway, KP, Compton, W., Stinson, FS, Grant, BF. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 67*, 247-257.



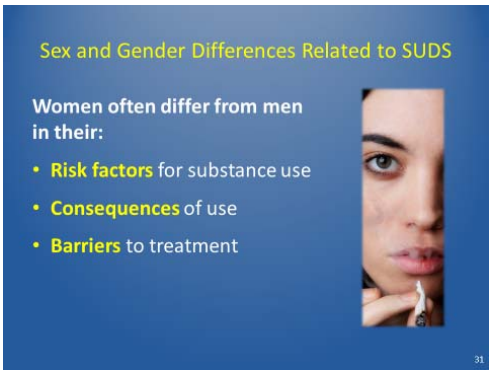
Slide 30: Substance Abuse Treatment Admissions by Primary Substance of Abuse

While the 2:1 ratio holds for drug use disorders, the rates of treatment admission based on primary substance of abuse changes when you compare men to women.

Demographic data collected from the Drug and Alcohol Services Information System (DASIS), the primary source of national information on the services available for substance abuse treatment and the characteristics of individuals admitted to treatment, indicate that men are 2-3 times more likely to be admitted to treatment for heroin, cocaine, marijuana and alcohol. However, the margin narrows when the primary substance is sedatives, other opiates (e.g., painkillers) and amphetamines.

REFERENCE

Substance Abuse and Mental Health Services Administration, Drug and Alcohol Services Information System. (2013). *Substance Abuse Treatment Admissions by Primary Substance of Abuse*. Accessed July 7, 2016 from http://wwwdasis.samhsa.gov/webt/quicklink/US13.htm.



Slide 31: Sex and Gender Differences Related to SUDS

Sex and gender differences means that women and girls have different experiences than men. In regards to substance use, women and girls typically have different pathways to substance use, risk factors for use, consequences for use, barriers to treatment, and recovery support needs. Each of these will be discussed.

REFERENCES

*Addressing the Needs of Women and Girl*s (pp. 2, 10-15, 24).

Introduction to Women and SUDs online course, Module One, *TIP 51* (p. 6).

SAMHSA, "*Addressing the gender-specific treatment needs of women*." Training of Trainers, March 2016.

Slide 32: Common Risks Factors for Initiation of Substance Use

Many pathways and risk factors exist for women to substance use and SUDs, but the following four are among the most common.

Relationships: Women are strongly influenced by familial substance use, friends and partners who use substances. Initiation of substance use often begins after introduction of substance through a significant relationship, such as a family member or intimate partner. Women are more likely than men to define selves in terms of their relationships and obligations.

Co-Occurring Disorders (COD): CODs are more likely for women than men, particularly mood disorders, anxiety disorders, and eating disorders. Women are more likely to use substances to decrease negative mood and increase positive -to relax, reduce stress, focus attention, increase confidence.

May use substances in relation to eating disorders/body image concerns: positive effects such as weight loss, increased energy.

Trauma: Past trauma more likely for women, including rape, sexual assault, intimate partner violence. Women may use substances to cope with emotional effects of trauma. Women who experience child abuse, sexual assault, or intimate partner violence are significantly more likely to develop SUDs than women who do not have traumatic experiences.

(Notes for Slide 32, continued)

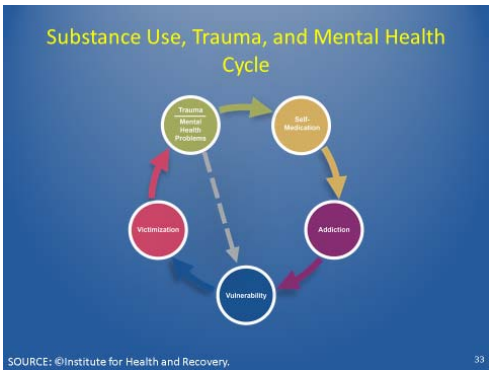
Slide 32: Common Risks Factors for Initiation of Substance Use

Prescription Drugs: Women are much more likely than men to be prescribed potentially addictive drugs by their doctors and to become dependent on them.

REFERENCES

TIP 51, pp. 18-26 under "Risk Factors Associated with Initiation of Substance Use and the Development of Substance Use Disorders Among Women." See page 26 for prescription drug use prevalence.

SAMHSA, "*Addressing the gender-specific treatment needs of women*." Training of Trainers, March 2016.



Slide 33: Substance Use, Trauma, and Mental Health Cycle

Talk through graphic and the cycle of trauma, mental health and substance use.

The is a high prevalence of trauma among women with SUDs, which impacts their treatment needs. Often women may initiate substance use as a way of coping with traumatic experiences. Substance use, though, can then also lead to risky behaviors, which make them more vulnerable to further victimization. If they are victimized while impaired, it is highly likely that they will be blamed, thus increasing shame, guilt, and stigma. Conversely, risky substance use can exacerbate mental health concerns and continued trauma/violence, which then re-traumatizes the woman and leads to continued substance use as an escape.

For women with trauma histories, the issues of trauma, substance use, and mental health concerns are interrelated.

REFERENCE

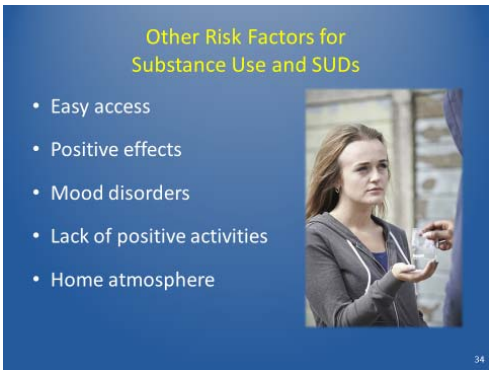
Action Steps for Improving Women's Mental Health (pp. 9-10) and *TIP 51* (pp. 8-9) and Chapter 2, and *TIP 57*, (p. 89).

(Notes for Slide 33, continued)

Slide 33: Substance Use, Trauma, and Mental Health Cycle

REFERENCE

SAMHSA, "*Addressing the gender-specific treatment needs of women*." Training of Trainers, March 2016.



Slide 34: Substance Use, Trauma, and Mental Health Cycle

Some additional risk factors that can lead to substance use and eventual SUDS in women include:

Easy access: Availability of substances in the home or community, affordable price, the ease with which substances can be purchased, and social norms that encourage rather than discourage substance use are all factors that increase the likelihood of girls and women initiating substance use.

Positive effects: If a woman experiences positive effects from her initial substance use such as weight loss, approval of an intimate partner, or stress reduction, her substance use is more likely to continue.

Lack of positive activities: Although involvement in positive activities is a protective factor, girls who are not involved in activities they enjoy and in which they are successful (such as sports, arts, and religious activities) are more vulnerable to substance abuse.

Home atmosphere: Taking on adult responsibilities as a child, including parenting of younger siblings and emotional support of parents, raises a girls' risk of initiating drug and alcohol use. A chaotic, argumentative, blame-oriented, and violent household is also major risk factor for substance initiation and dependence for girls/women.

(Notes for Slide 34, continued)

Slide 34: Substance Use, Trauma, and Mental Health Cycle

REFERENCE

TIP 51, pp 18-26, under "Risk Factors Associated with Initiation of Substance Use and the Development of Substance Use Disorders Among Women."

Slide 35: What is Telescoping?

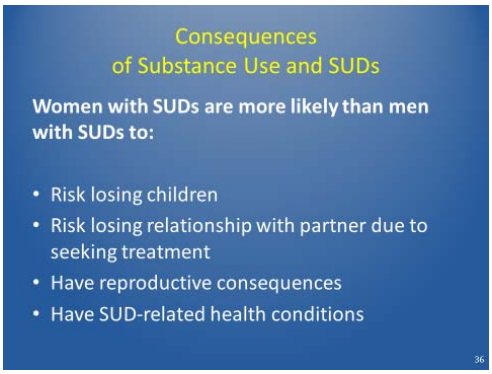
Ask trainees by a show of hands if they know what telescoping is and why it's important for women. Take definitions and explanations.

Clarify, as needed, that women are also more likely than men to experience a phenomenon called telescoping, a term that reflects the more rapid progression from initiation of use to dependence to treatment. With both drinking and using drugs, women have a shorter gap between starting to use drugs or alcohol to developing problems related to substance use. This puts women at more immediate risk of developing a substance use disorder, even with using less of a substance for a shorter amount of time. Telescoping has been found in treatment seeking samples, but is less clear in the general population.

REFERENCES

Randall, C.L., Roberts, J.S., Del Boca, F.K., Carroll, K.M., Connors, G.J., & Mattson, M.E. (1999). Telescoping of landmark events associated with drinking: A gender comparison. *J of Studies on Alcohol, 60*(2), 252-260.

Keyes, K.M., Martins, S.S., Blanco, C., & Hasin, D.S. (2010). Telescoping and gender differences in alcohol dependence: New evidence from two national surveys. *Am J Psychiatry. 167*(8), 969-976.



Slide 36: Consequences of Substance Use and SUDs

Although men and women both have risks and consequences to substance use and abuse, some are greater for women, including:

Children: Because women are more likely to be primary caregivers, they are typically at higher risk of losing custody of their children due to SUDs.

Relationship Loss: Women have patterns of drug abuse that are more socially embedded than men and revolve around their relationships. Drug use is often initiated by sexual partners. For women seeking SUD treatment, there is often difficulty involving male partners in the treatment, and some may prevent their female partners from entering or staying in treatment. Thus, women who fear losing their partner may not seek or stay in treatment.

Reproductive/pregnancy: Pregnant women who continue to use alcohol, illicit, or prescriptions drugs place their unborn babies at risk for a wide range of health issues, including premature birth, death, fetal alcohol syndrome, neonatal abstinence syndrome, etc. This will be further discussed in the section about pregnancy and parenting. Abuse of substances such as stimulants, opioids, and some prescription drugs can also cause adverse effects on women's menstrual cycles and fertility, along with their gastrointestinal, neuromuscular, cardiac systems, etc.

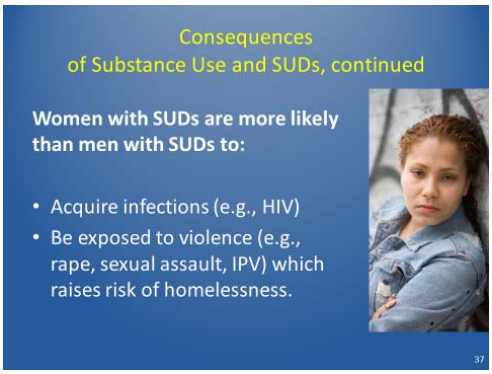
(Notes for Slide 36, continued)

Slide 36: Consequences of Substance Use and SUDs

Health Conditions: Women with SUDS often have more health-related conditions than men, including organ damage, cardiac-related conditions, reproductive consequences, breast and other cancers, osteoporosis, and nutritional deficiencies.

REFERENCE

TIP 51, "Physiological Effects of Alcohol, Drugs, and Tobacco on Women," (pp. 37-55); (pp. xix, 7-14, 20).



Slide 37: Consequences of Substance Use and SUDs, continued

Infections: Women with SUDS are at increased risk of contracting HIV/AIDS and hepatitis from sharing needles or having sexual relations with men who inject drugs of have sex with other men. As noted in *Tip 51*, "Some women may have unrealistic notions about intimacy, assume their partners are monogamous, or fear alienating their partners by demanding safe sex practices. Women with a history of abuse may have particular problems negotiating the use of these practices." (*TIP 51,* p. 20).

Trauma: Trauma can be a pathway to initiation of substance use, and substances can be used as a coping mechanism. But SUDs also increase a woman's vulnerability to additional trauma, decrease her ability to defend herself, alter her judgment, and draw her into unsafe environments." (*TiIP51*, p. 23). Women may also continue to use drugs to cope with abusive relationships. Thus, trauma/violence are both a risk factor and a consequence of substance abuse.

REFERENCES

Messina, N.P., Burdon, W.M., & Prendergast, M.L. (2003). Assessing the needs of women in institutional therapeutic communities. *Journal of Offender Rehabilitation, 37*(2), 89-106.

(Notes for Slide 37, continued)

Slide 37: Consequences of Substance Use and SUDs, continued

Substance Abuse and Mental Health Services Administration. (2013). *Treatment Improvement Protocol (TIP) 51: Substance Abuse Treatment: Addressing the Specific Needs of Women.* Rockville, MD: U.S. Department of Health and Human Services. Accessed November 8, 2015 from http://store.samhsa.gov/shin/content/SMA13-4426/SMA13-4426.pdf.

SAMHSA, "*Addressing the gender-specific treatment needs of women*." Training of Trainers, March 2016.

Slide 38: Pregnancy and Children

Many women with SUDs significantly decrease their use after becoming aware of their pregnancy. A woman often has the motivation to protect her unborn baby's health and this can motivate her to make life changes and enter SUD treatment.

It is often very difficult for women who used substances during their pregnancies to face the possible damage done to their children. It is also very difficult for mothers to admit to themselves and others some of the experiences that their children may have had while they were using, and the effects these experiences had on them. Understanding the dynamics of shame and guilt as these play out is critical to the ability to help women in treatment.

In one study looking at the relationship between pregnancy and motivation for treatment, researchers analyzed data collected from 149 drug-using women between 2000 and 2007; 49 of the drug-using women were pregnant and 100 were non-pregnant. The study found that pregnant women were more than four times as likely as non-pregnant women to express greater motivation for treatment. (Mitchell et al, 2010).

All pregnant drug-using women should be targeted for interventions aimed at increasing motivation for treatment. A pregnant woman who uses drugs endangers not only her own life but also that of an unborn child.

(Notes for Slide 38, continued)

Slide 38: Pregnancy and Children

Non-confrontational interventions such as motivational enhancement therapy (MET) could rapidly increase a pregnant woman's motivation to seek treatment and improve the life of her child in countless immeasurable ways. MET aims to establish an internal motivation for treatment by examining and overcoming ambivalence about change. A study by Ondersma et. al. suggests that setting a clear goal to quit at the start of treatment may improve the efficacy of interventions such as MET (2008). More research is needed to examine how different approaches to drug treatment might affect the motivation among different groups of drug-using pregnant women.

REFERENCES

TIP 51 (p. 10).

Mitchell, M.M., Severtson, S.G., & Latimer, W.W. (2008). Pregnancy and race/ethnicity as predictors of motivation for drug treatment. *American Journal of Drug and Alcohol Abuse, 34*(4), 397-404.

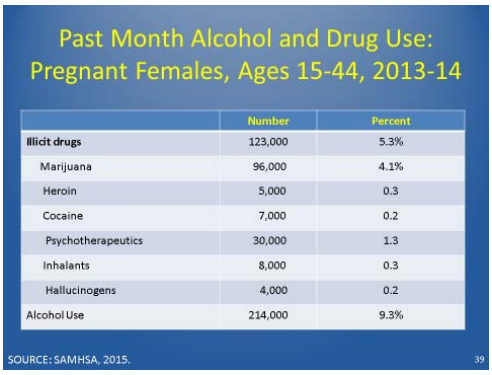
Ondersma, S.J., Winhusen, T., Erickson, S.J., Stine, S.M., & Wang, Y. (2008). Motivation enhancement therapy with pregnant substance-abusing women: Does baseline motivation moderate efficacy? *Drug and Alcohol Dependence, 101*(1-2): 74-79.

(Notes for Slide 38, continued)

Slide 38: Pregnancy and Children

REFERENCE

SAMHSA. (n.d.). *Addressing the Needs of Girls and Women,* pp. 20-21. RWC/PPW Program and Cross-Site Fact Sheets. Retrieved from http://www.samhsa.gov/sites/default/files/women-children-families-rwc-ppw-cross-site-fact-sheets.pdf.



Slide 39: Past Month Alcohol and Drug Use: Pregnant Females, Ages 15-44, 2013-14

Among pregnant women aged 15 to 44, 5.3 percent were current illicit drug users based on data averaged across 2013 and 2014. This was lower than the rate among women in this age group who were not pregnant (11.4 percent). An annual average of 9.3 percent reported current alcohol use. The average rate of current illicit drug use in 2012 to 2013 (5.4 percent) was not significantly different from the rate averaged across 2010 to 2011 (5.0 percent). Current illicit drug use in 2012 to 2013 was lower among pregnant women aged 15 to 44 during the third trimester than during the first and second trimesters (2.4 percent vs. 9.0 and 4.8 percent). (SAMHSA, p. 26).

The rate of current illicit drug use in the combined 2012 to 2013 data was 14.6 percent among pregnant women aged 15 to 17, 8.6 percent among women aged 18 to 25, and 3.2 percent among women aged 26 to 44. These rates were not significantly different from those in the combined 2010 to 2011 data (20.9 percent among pregnant women aged 15 to 17, 8.2 percent among pregnant women aged 18 to 25, and 2.2 percent among pregnant women aged 26 to 44). (SAMHSA, p. 26).

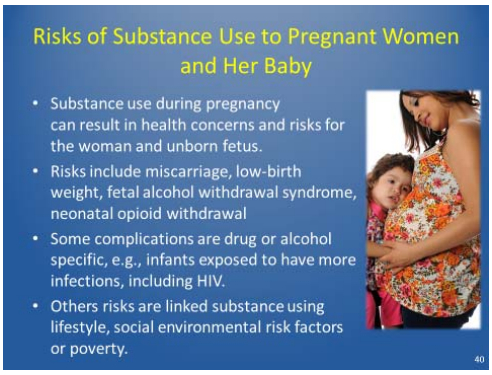
(Notes for Slide 39, continued)

Slide 39: Past Month Alcohol and Drug Use: Pregnant Females, Ages 15-44, 2013-14

REFERENCES

Center for Behavioral Health Statistics and Quality. (2015). *2014 National Survey on Drug Use and Health: Detailed Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: U.S. Department of Health and Human Services.



Slide 40: Risks of Substance Use to Pregnant Women and Her Baby

A number of health concerns are related to substance use during pregnancy, including:

- Miscarriage
- Premature delivery
- Low birth weight
- Infant mortality
- Spontaneous abortion
- Stillbirth
- Smaller head circumference
- Fetal alcohol spectrum disorder (FASD)
- Neonatal abstinence syndrome (NAS) or Neonatal Opioid Withdrawal

Examples of drug/alcohol specific complications include:

- Use and withdrawal from opiates causes significant stress to the developing fetus, which can lead to serious consequences such as stillbirth or loss of the pregnancy.
- Infants exposed to cocaine during pregnancy have more infections, including hepatitis and HIV/AIDS exposure.
- Amphetamine use can cause withdrawal symptoms after birth, and impaired neurological development in infancy and childhood.

(Notes for Slide 40, continued)

Slide 40: Risks of Substance Use to Pregnant Women and Her Baby

- Alcohol exposure can lead to early-onset of alcohol disorders among children and adolescents.
- Social environmental risk factors include higher levels of stress. Challenges to adequate self-care such as rest and nutrition which can be result of poverty, social environment or lifestyle.

Symptoms vary by the infant, but some of the following may result from fetal drug exposure (Medline Plus, 2015):

- Blotchy skin coloring (mottling)
- Diarrhea
- Excessive crying or high-pitched crying
- Excessive sucking
- Fever
- Hyperactive reflexes
- Increased muscle tone
- Irritability
- Poor feeding
- Rapid breathing
- Seizures
- Sleep problems
- Slow weight gain
- Stuffy nose, sneezing
- Sweating

(Notes for Slide 40, continued)

Slide 40: Risks of Substance Use to Pregnant Women and Her Baby

- Trembling (tremors)
- Vomiting

Interventions can reduce these risks. Considerations related to treatment interventions are addressed later on. Other risks after the baby is born include:

- Decreased lactation with breast feeding
- Disrupted infant sleep patterns
- Infant somnolence, which is excess sleepiness
- Irritability
- Sudden infant death syndrome
- Attention problems as the child ages

REFERENCES

Family-Centered Treatment for Women with Substance Use Disorders, pp. 15 -17.

SAMHSA. *Addressing the Gender-Specific Treatment Needs of Women. Training of Trainers*, November 2015.

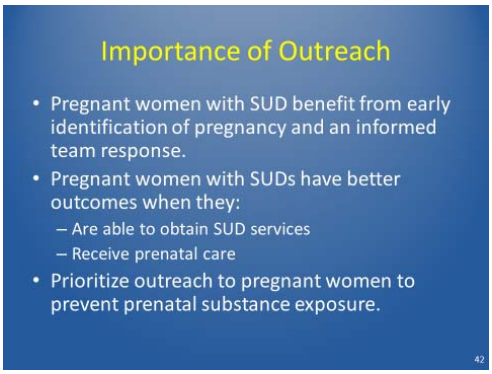
TIP 51, pp. 48-51.

Slide 41: Priority for Services

Federal law requires that pregnant women receive priority admission into substance abuse treatment programs. This allows them to bypass waiting lists and gain immediate admission when a bed in a residential program is available. Also, the primary treatment provider must secure prenatal care if the woman is not already receiving it. They have priority because of the short length of time during which it's possible to intervene (often much shorter than the 9 months a typical pregnancy lasts), and because of possible damage to a fetus that is inflicted by continued substance use. **If a provider is not able to admit a pregnant woman for treatment within 48 hours, interim services should be provided** (e.g., crisis intervention, counseling on the potential effects of alcohol, tobacco and drug use on the fetus; referral to prenatal care; and HIV/TB screening and counseling). Inform individuals, collateral agencies, and the broader community that pregnant women have priority admissions to treatment for SUDs.

REFERENCE

TIP 51, p. 101.



Slide 42: Importance of Outreach

An **informed team response** considers symptoms, pharmacological risks and options, and the possible need for other supports. Many pregnant women with SUDs don't discover their pregnancies right away, and often are ambivalent about seeking care. They may experience fear and shame due to their alcohol or drug use and fear that they will lose the child. Pregnancy also increases stress and for women with SUDs their primary way of coping with stress is alcohol/drug use and they often need assistance to feel ready to reduce or eliminate alcohol/drug use. But many of these women **are** motivated by pregnancy to make changes in their lives for the sake of their baby, and can be very open to treatment/recovery if they can overcome their fears.

REFERENCES

Addressing the Needs of Girls and Women: pp. 20-21.

RWC/PPW Program and Cross-Site Fact Sheets. Retrieved from http://www.samhsa.gov/sites/default/files/women-children-families-rwc-ppw-cross-site-fact-sheets.pdf.

Guidance to the States , pp. 13, 15, 26, and 39.

Slide 43 [Transition Slide]: Alcohol Use in Women

This slide serves to move from discussions of epidemiology and impact of substance use to specific recommendations and impacts of around alcohol use and other substances in women.

Slide 44: Drinking Guidelines

****ANIMATIONS****

This slide animates in four parts. The first half of the slide presents information related to general drinking guidelines for men and women. The subsequent animations will reveal the drinking guidelines for men and women. The information is based on the recommended drinking guidelines of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Click to reveal the first bullet point

For men, the NIAAA recommends no more than 4 drinks on any day and no more than 14 drinks per week.

Click to reveal the second bullet point

For women, the NIAAA recommends no more than 3 drinks on any day and no more than 7 drinks per week. Women and men metabolize alcohol differently, so the drinking guidelines are gender-specific.

Click to reveal the third bullet point

For older adults (>65), the NIAAA recommends no more than 3 drinks on any day and no more than 7 drinks per week.

Click to reveal the fourth and final bullet point

The NIAAA considers 1 drink per day to be the maximum for moderate use.

(Notes for Slide 44, continued)

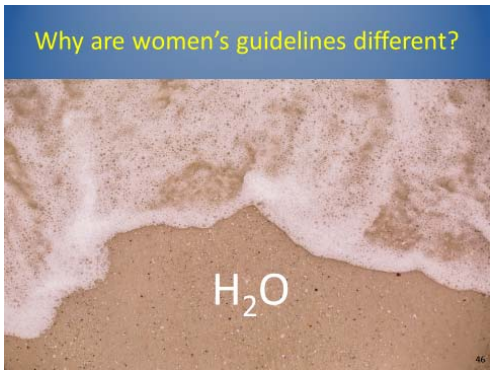
Slide 44: Drinking Guidelines

Additional information for the Trainer(s)

As noted by the NIH, these guidelines are identified for adults who are healthy and do not take any medications. Taking medications or having a health condition may mean reducing drinking or not drinking at all. People have different personal definitions of what exactly constitutes an alcoholic "drink." The National Institute on Alcohol Abuse and Alcoholism has developed a definition of a standard drink. A standard drink can be a 12-ounce beer, 8-9 ounces of malt liquor, 5 ounces of wine, 3-4 ounces of fortified wine, 2-3 ounces of cordial, 1.5 ounces of brandy, or 1.5 ounces of spirits such as vodka, gin, or scotch. So, a drink for one person may be a "40-ouncer" of beer, which, if you use NIAAA's definition of a standard drink, would equal 3 1/3 standard drinks. It is very important for alcohol dependent clients to understand what is meant by "a drink" when you are assessing the extent of their alcohol problem.

Slide 45: Why are women's guidelines different?

On average, women weigh less than men, so effects of alcohol are greater.

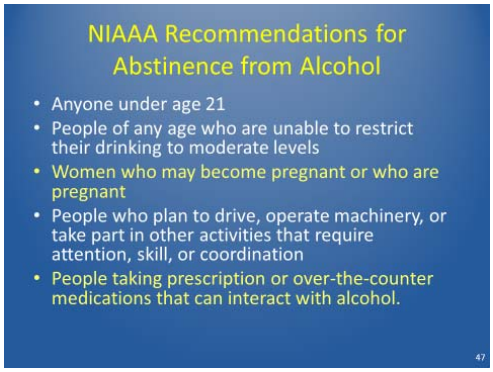


Slide 46: Why are women's guidelines different?

Why are women's guidelines different? It's in the water.

Alcohol passes through the digestive tract and is dispersed in the water in the body. The more water available, the more diluted the alcohol. As a rule, men weigh more than women, and, pound for pound, women have less water in their bodies than men. Therefore, a woman's brain and other organs are exposed to more alcohol and to more of the toxic byproducts that result when the body breaks down and eliminates alcohol.

Other biological and hormonal differences also exist that result in different effects for women and men.



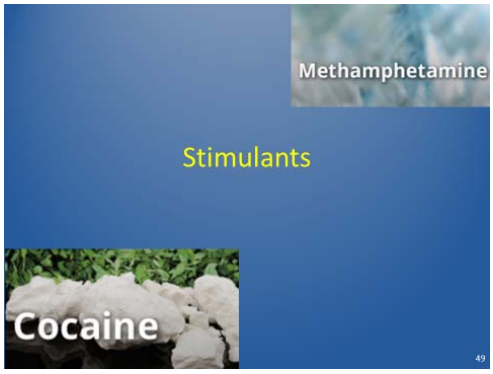
Slide 47: NIAAA Recommendations for Abstinence from Alcohol

The NIAAA has recommendations for abstinence – no drinking – under the following circumstances. Under age 21 (illegal); unable to restrict drinking to moderate levels (lack of control); women who may become pregnant or who are pregnant (there has been no safe level of drinking established during pregnancy); engaging situations that could be hazardous; taking medications that may interact with alcohol.

For women with HIV, the highlighted items are most relevant and should be considered. For pregnant women, there has been no safe level of drinking established. Also, alcohol can interact with antiretrovirals and other medications.

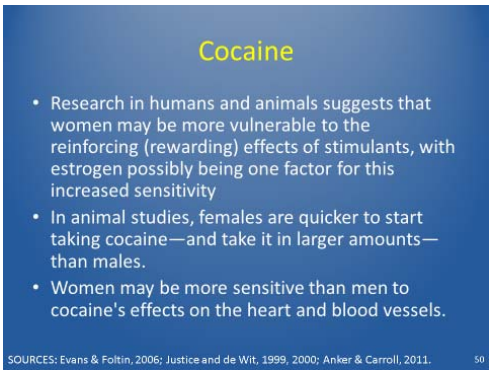
Slide 48 [Transition Slide]: Women and Drug Use

This slide serves to move from discussion of alcohol to other drug use in women.



Slide 49: Stimulants

We will discuss the issues specific to women with two types of stimulants most commonly used: cocaine and methamphetamine.



Slide 50: Cocaine

Research in humans and animals suggests that women may be more vulnerable to the rewarding effects of simulants, with estrogen being one factor in this increased sensitivity. In animal studies, females are quicker to start taking cocaine, and take it in larger amounts, than males. Women may also be more sensitive than men to cocaine's effects on the heart and blood vessels.

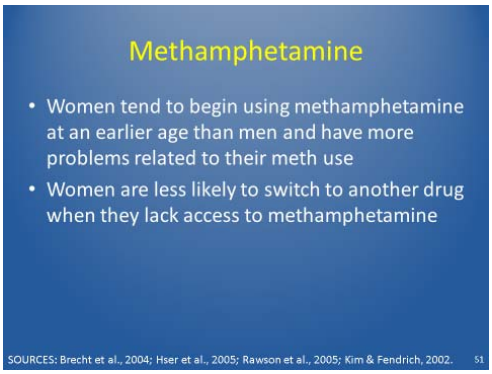
REFERENCES

Evans, S.M., & Foltin, R.W. (2006). Exogenous progesterone attenuates the subjective effects of smoked cocaine in women, but not in men. *Neuropsychopharmacology, 31*, 659-674.

Justice, A.J., & de Wit, H. (1999). Acute effects of d-amphetamine during the follicular and luteal phases of the menstrual cycle in women. *Psychopharmacology (Berl), 145*(1), 67-75.

Justice, A.J., & de Wit, H. (2000). Acute effects of d-amphetamine during the early and late follicular phases of the menstrual cycle in women. *Psychopharmacology, Biochemistry and Behavior. 66*(3), 509-551.

Anker, J.J., & Carroll, M. (2011). Females are more vulnerable to drug abuse than males: evidence from preclinical studies and the role of ovarian hormones. Current Topics in Behavioral *Neurosciences. 8*(8), 73-96.



Slide 51: Methamphetamine

Women tend to begin using the stimulant, methamphetamine, at an earlier age than men. Women also have more problems related to their meth use. Women who use methamphetamine do not tend to use other substances when meth is not available. As noted above, women tend to receive treatment more often for methamphetamine than for other substances.

REFERENCES

Rawson, R.A., Gonzales, R., Obert, J.L., McCann, M.J., & Brethen, P. (2005). Methamphetamine use among treatment-seeking adolescents in Southern California: Participant characteristics and treatment response. *Journal of Substance Abuse Treatment, 29*(2),67-74.

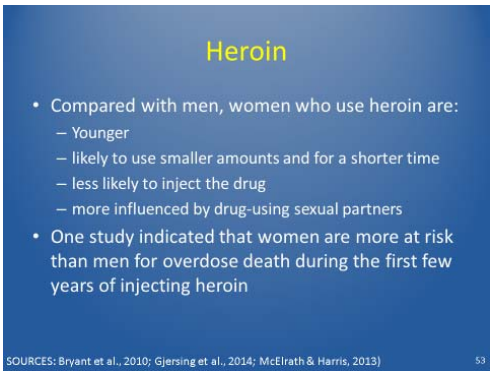
Brecht, M.L., O'Brien, A., von Mayrhauser, C., & Anglin, M.D. (2004). Methamphetamine use behaviors and gender differences. *Addictive Behavior, 29*(1), 89-106.

Hser, Y.-I., Evans, R., & Huang, Y.C. (2005). Treatment outcomes among women and men methamphetamine abusers in California. Journal of Substance Abuse Treatment, 28(1), 77-85.

Kim, J.Y., & Fendrich, M. (2002). Gender differences in juvenile arrestees' drug use, self-reported dependence, and perceived need for treatment. *Psychiatric Services, 53*(1), 70-75.

Slide 52: Opioids

Next we will discuss opioid use in women. As a class of drug, opioids include heroin as well as prescription opioids, such as oxycodone, hydromorphone or other painkillers.



Slide 53: Heroin

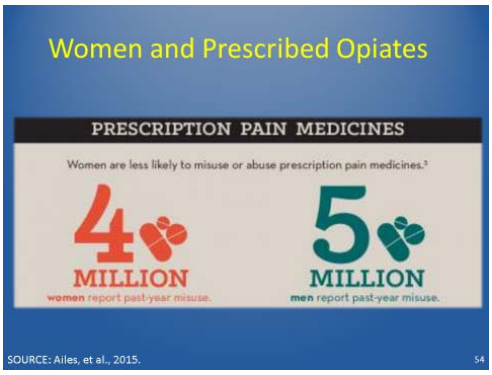
While women may inject less frequently, they also are more influenced by their drug-using sexual partners who may be injection drug users. This puts women at greater risk for HIV infection, not from sharing needles but from having unprotected sex with a drug-using partner. Women also tend to overdose during the first few years of injecting heroin. If they survive past the first few years, they are more likely than men to survive over the long run.

REFERENCES

Bryant, J., Brener, L., Hull, P., Treloar, C. (2010). Needle sharing in regular sexual relationships: An examination of serodiscordance, drug using practices, and the gendered character of injecting. *Drug and Alcohol Dependence, 107*, 182-187.

Gjersing, L., & Bretteville-Jensen, A.L. (2014). Gender differences in mortality and risk factors in a 13-year cohort study of street-recruited injecting drug users. *BMC Public Health, 14,* 440.

McElrath, K., & Harris, J. (2013). Peer injecting: implications for injecting order and blood-borne viruses among men and women who inject heroin. *Journal of Substance Use, 18*(1), 31-45.



Slide 54: Women and Prescribed Opiates

While women are less likely to misuse pain medicines than men, there are still 4 million women who do. Also note that the usual 2:1 ratio of use for men and women increases to 5:4 for opiates.

Women have lower pain tolerance than men, therefore may be more likely to receive prescriptions for pain medications. This leaves them at greater risk for misuse and other negative consequences.

REFERENCES

Ailes, E.C., Dawson, A.L., Lind, J.N., et al. (2015). Opioid prescription claims among women of reproductive age—United States, 2008-2012. *MMWR, 64*(2), 37-41.

Center for Behavioral Health Statistics and Quality (CBHSQ). (2015). *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables*. Rockville, MD, U.S. Department of Health and Human Services.

IMAGE CREDIT: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

Slide 55: Prescription Painkiller Overdose

Although men are still more likely to die of prescription painkiller overdoses (more than 10,000 deaths in 2010), the gap between men and women is closing. Deaths from prescription painkiller overdose among women have risen more sharply than among men; since 1999 the percentage increase in deaths was more than 400% among women compared to 265% in men. This rise relates closely to increased prescribing of these drugs during the past decade.

REFERENCE

Centers for Disease Control and Prevention. (2013). *CDC Vital Signs: Prescription Painkiller Overdoses*. Accessed June 20, 2016 from http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/.

Slide 56: Women and Other Prescribed Drugs

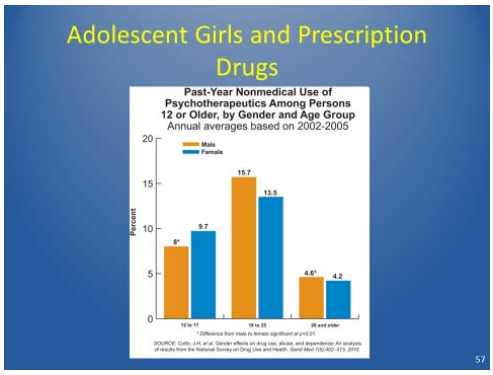
Women are more likely than men to seek treatment for misuse of barbiturates, typically sleep aids prescribed by a physician. The majority of people admitted to treatment for barbiturate misuse are women (55%).

REFERENCES

Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. (2012). *Treatment Episode Data Set (TEDS). Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity, 2012, United States*. Accessed January 6, 2016, from http://www.dasis.samhsa.gov/webt/quicklink/US12.htm.

Also see http://wwwdasis.samhsa.gov/webt/quicklink/US13.htm. Accessed July 7, 2016.

IMAGE CREDIT: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.



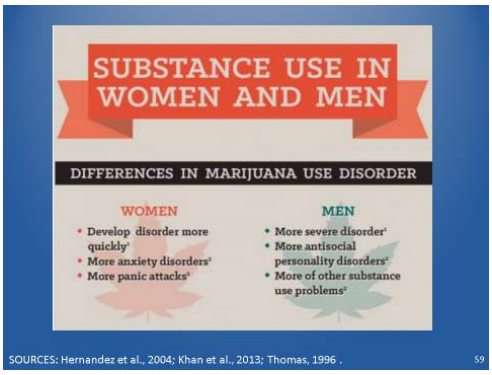
Slide 57: Adolescent Girls and Prescription Drugs

Overall, more males than females abuse prescription drugs in all age groups except the youngest (aged 12 to 17 years); that is, females in this age group exceed males in the nonmedical use of *all* psychotherapeutics, including pain relievers, tranquilizers, and stimulants.

Among *nonmedical users* of prescription drugs, females 12 to 17 years old are also more likely to meet abuse or dependence criteria for psychotherapeutics.

Slide 58: Marijuana

This slide serves to move discussion to marijuana use in women, as well as some general information about medical marijuana that is relevant to people living with HIV and AIDS.



Slide 59: Substance Use in Women and Men

Review the differences in marijuana use disorder for men and women.

With regards to the finding on the similarity between men and women – both have at least one other comorbid mental health issue when there is a cannabis use disorder and both also have a low rate of seeking treatment for cannabis use.

REFERENCES

Hernandez-Avila, C.A., Rounsaville, B.J., & Kranzler, H.R. (2004). Opioid-, cannabis- and alcohol-dependent women show more rapid progression to substance abuse treatment. *Drug Alcohol Depend, 74*(3), 265-272.

Khan, S.S., Secades-Villa, R., Okuda, M., et al. (2013). Gender differences in cannabis use disorders: Results from the National Epidemiologic Survey of Alcohol and Related Conditions. *Drug Alcohol Depend, 130*(1-3),101-108.

Thomas, H. (1996). A community survey of adverse effects of cannabis use. *Drug Alcohol Depend, 42*(3), 201-207.

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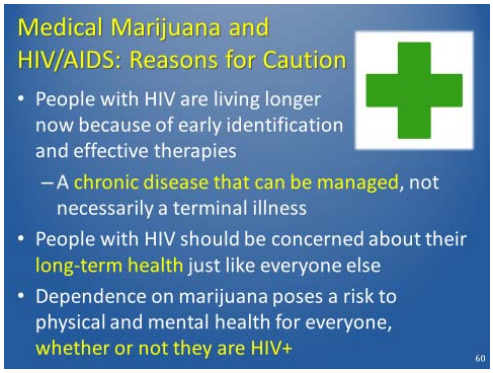
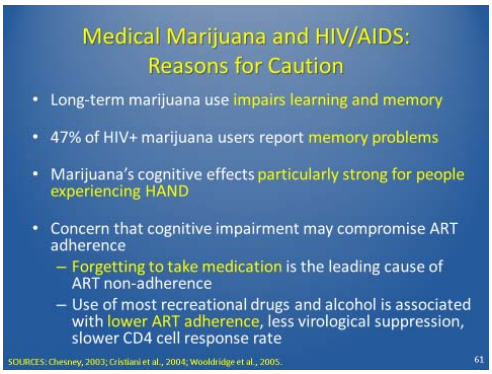


Slide 59: Substance Use in Women and Men

IMAGE CREDIT: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

Slide 60: Medical Marijuana and HIV/AIDS: Reasons for Caution

People with HIV are living longer now than ever before because of early identification and effective medication therapies, treating HIV more like a chronic disease that can be managed rather than a terminal illness. People with HIV should be concerned about their long-term health and risk behaviors that may impact their overall health and well-being just like everyone else. The corollary to this is that dependence on marijuana poses a physical and mental health risk to everyone, regardless of whether or not the individual is HIV positive.



Slide 61: Medical Marijuana and HIV/AIDS: Reasons for Caution

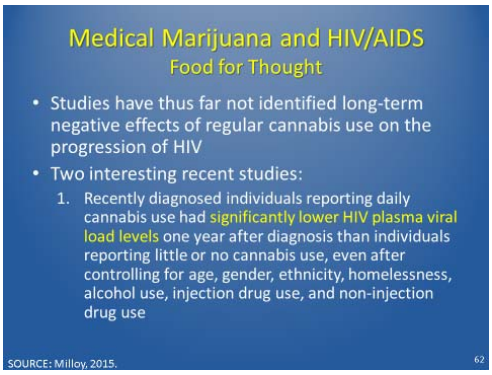
Given the effects HIV can have on cognition, people living with HIV should be careful with marijuana, which also affects learning and memory. Almost half of HIV-positive marijuana users report having memory problems, and the drug's cognitive effects may be particularly strong for people experiencing HAND. Cognitive impairment may also compromise adherence to ART, since forgetting medication is the leading cause for ART non-adherence. Research shows that the use of most recreational drugs and alcohol is associated with lower antiretroviral medication adherence, less virologic suppression, and slower CD4 cell response rate.

REFERENCES

Chesney, M. (2003). Adherence to HAART Regimens. *Aids Patient Care and STDs*, *17*(4), 169-177.

Cristiani, S.A., Pukay-Martin, N.D., & Bornstein, R.A. (2004). Marijuana Use and Cognitive Function in HIV-Infected People. *The Journal of Neuropsychiatry & Clinical Neurosciences*, *16*(3), 330-335.

Woolridge, L., et al. (2005). Interaction between the CD8 Coreceptor and Major Histocompatibility Complex Class I Stabilizes T Cell Receptor-Antigen Complexes at the Cell Surface. *The Journal of Biological Chemistry, 280*, 27491-27501.



Slide 62: Medical Marijuana and HIV/AIDS: Food for Thought

Consider these studies that indicate that the interaction between marijuana and HIV may not be as detrimental as indicated by previous studies (however, take this information with some caution until additional research is able to replicate or broaden findings). Studies have not been able to identify long-term negative effects of regular cannabis use on the progression of HIV for men or women. A recent study found that recently-diagnosed individuals who also used cannabis daily reported lower HIV plasma viral load levels one year following diagnosis than individuals who did not use. This study found these results even after controlling for age, gender, ethnicity, homelessness, and other alcohol/illicit drug use.

REFERENCE

Milloy, M.J. (2015). High-intensity cannabis use associated with lower plasma HIV-1 RNA viral load among recently infected people who use injection drugs. *Drug and Alcohol Review, 34,* 135-140.

Slide 63: Medical Marijuana and HIV/AIDS: Food for Thought

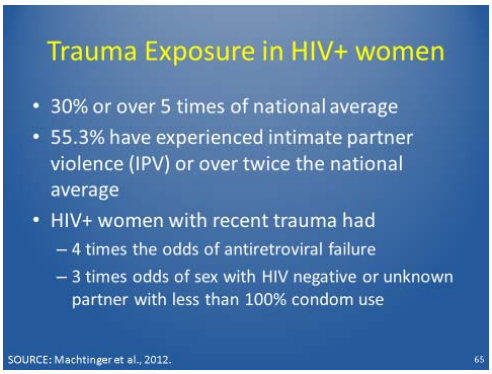
The second study looking at medical marijuana and HIV/AIDS was a longitudinal study of 523 HIV positive illicit drug users with a median age of 45. During this study, researchers found that there was no difference in ART adherence rates between daily cannabis users and individuals infrequently or never using cannabis. However, daily alcohol, heroin, cocaine and crack use were all associated with lower ART adherence. The finding was the same for men and women**.**

REFERENCE

Slawson, G., et al. (2015). High-intensity cannabis use and adherence to antiretroviral therapy among people who use illicit drugs in a Canadian setting. *AIDS & Behavior, 19*, 120-127.

Slide 64 [Transition Slide]: Co-Occurring Conditions

This slide serves to transition to co-occurring mental and physical health issues that women living with HIV or AIDS may be experiencing.



Slide 65: Trauma Exposure in HIV+ women

In a meta-analysis to estimate rates of psychological trauma and posttraumatic stress disorder (PTSD) in HIV-positive women from the United States, the investigators found disproportionate rates of trauma exposure and recent PTSD in HIV-positive women compared to the general population of women. For example, the estimated rate of recent PTSD among HIV-positive women is 30.0% (95% CI 18.8-42.7%), which is over five-times the rate of recent PTSD reported in a national sample of women. The estimated rate of intimate partner violence is 55.3% (95% CI 36.1-73.8%), which is more than twice the national rate. Studies of trauma-prevention and trauma-recovery interventions in this population are greatly needed.

Investigators from the UCSF program also conducted a study analyzing data from a prevention-with-positives program among 113 HIV-positive biological and transgender women to understand if socio-economic, behavioral, and health-related factors are associated with antiretroviral failure and HIV transmission-risk behaviors. Compared to participants without recent trauma, participants reporting recent trauma had over four-times the odds of antiretroviral failure (AOR 4.3; 95% CI 1.1–16.6; $p = 0.04$), and over three-times the odds of reporting sex with an HIV-negative or unknown serostatus partner (AOR 3.9; 95% CI 1.3–11.9;$p = 0.02$) and <100% condom use with these partners (AOR 4.5; 95% CI 1.5–13.3; $p = 0.007$).

(Notes for Slide 65, continued)

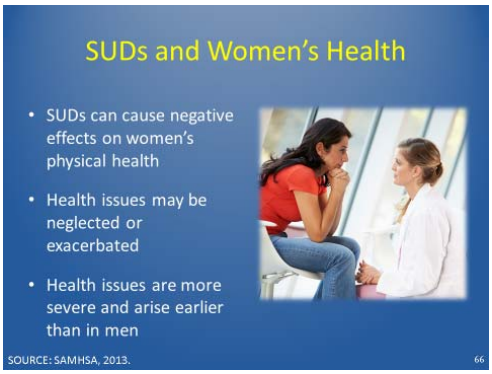
Slide 65: Trauma Exposure in HIV+ women

Screening for recent trauma in HIV-positive biological and transgender women was found to identify patients at high risk for poor health outcomes and HIV transmission-risk behavior.

REFERENCES

Machtinger, E.L., Haberer, J.E., Wilson, T.C., & Weiss, D.C. (2012). Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders. *AIDS and Behavior, 16*(8), 2160-2170.

Machtinger, E.L., Wilson, T.C., Haberer, J.E., & Weiss, D.C. (2012). Psychological trauma and PTSD in HIV-positive women: A meta-analysis. *AIDS and Behavior, 16*(8), 2091-2100.

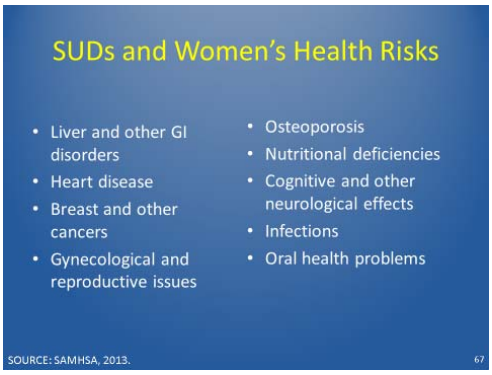


Slide 66: SUDs and Women's Health

Women with SUDS often have co-occurring acute or chronic health problems that have been neglected or exacerbated during substance use. They have greater susceptibility to, and earlier onset of, serious substance use-related medical problems and disorders than do men.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2013). *Treatment Improvement Protocol (TIP) 51: Substance Abuse Treatment: Addressing the Specific Needs of Women.* Rockville, MD: U.S. Department of Health and Human Services. Accessed November 8, 2015 from http://store.samhsa.gov/shin/content/SMA13-4426/SMA13-4426.pdf.



Slide 67: SUDs and Women's Health Risks

These health problems can be caused or made worse by substance use: For example, women who drink are more likely to develop alcoholic hepatitis (liver inflammation) than men who drink the same amount of alcohol. Alcohol hepatitis can lead to cirrhosis. Chronic heavy drinking is a leading cause of heart disease. Among heavy drinkers, women are more susceptible to alcohol-related heart disease than men, even though women drink less alcohol over a lifetime than men do.

An association exists between drinking alcohol and developing breast cancer. Women who consume about one drink per day have a 10% higher chance of developing breast cancer than women who do not drink at all. That risk rises another 10 percent for every extra drink they have per day.

Drinking during pregnancy is risky. A pregnant woman who drinks heavily puts her fetus at risk for Fetal Alcohol Syndrome, that causes learning and behavioral problems and abnormal facial features. Drinking during pregnancy may also increase the risk for preterm labor.

Women who use substances also have higher rates of osteoporosis, nutritional deficiencies, cognitive deficits, oral health problems and other infections. Health care, health education, and preventive services are important recovery supports for women with SUDs.

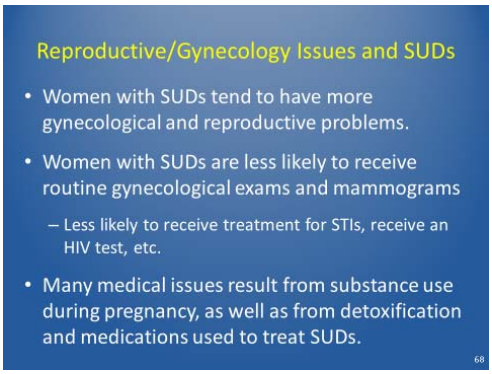
(Notes for Slide 67, continued)

Slide 67: SUDs and Women's Health Risks

Physical health is a priority when figuring out a woman's needs and services during treatment planning. SUD treatment staff should refer women to primary health providers who understand SUDs. They can also help women address any barriers to getting medical services, and follow up to ensure they attend medical appointments. The children of women with SUDs often also need primary health care and services.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2013). *Treatment Improvement Protocol (TIP) 51: Substance Abuse Treatment: Addressing the Specific Needs of Women.* Rockville, MD: U.S. Department of Health and Human Services. Accessed November 8, 2015 from http://store.samhsa.gov/shin/content/SMA13-4426/SMA13-4426.pdf.

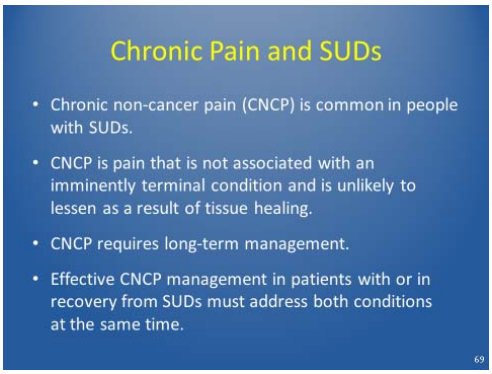


Slide 68: Reproductive/Gynecology Issues and SUDs

Women with SUDs tend to have more gynecological and reproductive problems, including infertility, painful and/or irregular menstruation, cancers, hormonal changes, and sexually transmitted infections. (*TIP51*, p. 41). Substance use and CODs increase women and girls' chances of contracting infectious diseases. (*Addressing the Needs of Women and Girls*, p. 21). Some substances make women more vulnerable to sexually transmitted infections due to physiological changes, (*TIP 41*, p. 52). Substance use during pregnancy can result in fetal alcohol spectrum disorders, low birth weight, miscarriage, etc. (Module 5 of this presentation contains more information about pregnancy and SUDs).

REFERENCE

TIP 51 (pp. 40-55).



Slide 69: Chronic Pain and SUDs

Women with SUDs who have chronic pain may be discouraged by providers from using medicines they need for pain management, yet pain relief medication is needed for quality of life. Since women tend to be more sensitive to pain than men, they are more likely to receive prescription pain medications. Chronic pain issues complicate treatment for opiate or benzodiazepine addiction. Coordination with qualified pain management specialists can reduce risks of SUDs returning after treatment.

Treatment for one condition can support or conflict with treatment for the other; a medication that may be appropriately prescribed for a particular chronic pain condition may be inappropriate given the patient's SUD. Both CNCP and SUDs are associated with high rates of psychiatric comorbidities such as anxiety, PTSD, and depression. The presence of comorbid psychiatric conditions should be assessed regularly in every patient with CNCP.

Holistic approaches to pain management should be discussed and offered, such as nutrition, exercise, physical therapy, acupuncture, etc. A woman with CNCP and SUD should be referred for formal addiction treatment. Once the patient's SUD recovery is stable, the likelihood of managing her pain increases.

(Notes for Slide 69, continued)

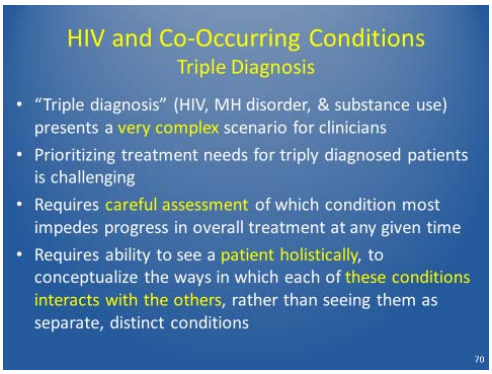
Slide 69: Chronic Pain and SUDs

The need for formal addiction treatment often necessitates a change in the plan for opioids, by discontinuing them or by changing the treatment setting through which they are provided (*TIP 42*, p. 45-46). Integrated treatment is vital with these CODs.

REFERENCES

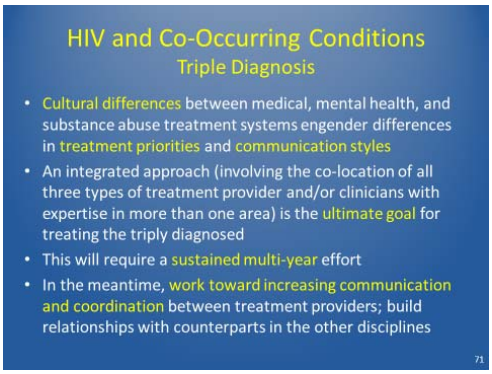
Substance Abuse and Mental Health Services Administration. (2012). *Treatment Improvement Protocol (TIP) 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*. Rockville, MD: U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2012). Managing *Chronic Pain in Adults With or in Recovery From Substance Use Disorders – Quick Guide for Clinicians Based on TIP 54.* Rockville, MD: U.S. Department of Health and Human Services.



Slide 70: HIV and Co-Occurring Conditions: Triple Diagnosis

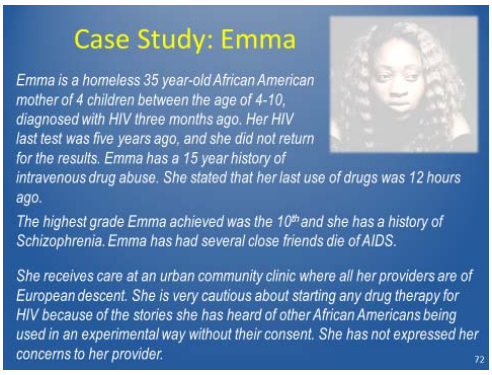
A "triple diagnosis" refers to a patient who is HIV-positive, has a diagnosed mental health disorder and a substance use disorder. These individuals present a very complex situation for clinicians due to the need to prioritize treatment. Patients who are triple diagnosed require very careful assessment as to which condition most impedes the individual's overall progress in treatment at any given time. As the conditions interact with one another and are not truly mutually exclusive in the individual's functioning, the provider must view the patient holistically in order to conceptualize the conditions' effects on one another rather than as three wholly distinct conditions.



Slide 71: HIV and Co-Occurring Conditions: Triple Diagnosis

Additional considerations to make when assessing a patient's functioning with multiple conditions present is to consider the cultural differences between medical, mental health and substance abuse treatment systems that may indicate competing priorities in treatment and communication styles that may prohibit efficient integration of care.

The ultimate goal for providers is to adopt an integrated approach among different treatment providers through co-locations or clinicians with multiple expertise areas. This change process and shift in assessment and treatment requires sustained, multi-year effort. While this is occurring in line with conceptualizations of integrated care, individual providers can begin to work toward increasing communication and coordination between treatment providers, as well as building consultation networks and relationships with providers in other disciplines.



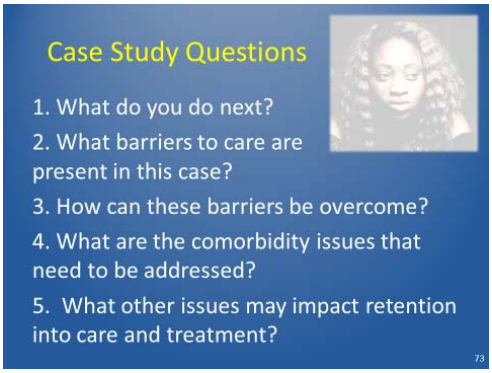
Slide 72: Case Study: Emma

Allow 10 minutes for this activity; individuals can pair up or work in larger groups, depending on audience size*

Read the case example out loud and ask the participants to identify presenting issues that would be clinical focus knowing what they know about the interaction of different substances, HIV, and women up to this point.

Continue with the questions on the next slide.

Adapted from Addressing HIV Care and Substance Abuse (n.d.). Accessed May 31, 2016 from http://www.aetcnmc.org/studies/substance_use_abuse.html.

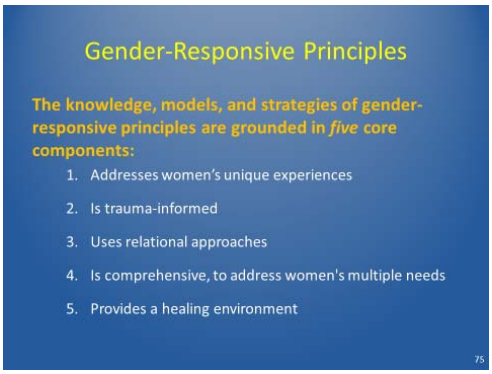


Slide 73: Case Study Questions

Allow 5-7 minutes for a general discussion regarding their impressions and how they would approach the case once groups have had a chance to talk amongst themselves. Ask groups to report out on their discussion.

Slide 74 [Transition Slide]: Making Treatment Gender Responsive

The next segment of the presentation will explore strategies for making treatment gender responsive.



Slide 75: Gender-Responsive Principles

Introduce the core components here. Each will be described in greater detail in the following slides.

It is important to provide ongoing training and supervision to staff to increase understanding and competency around gender-responsive services, and recognize/address their own biases related to gender. Counter-transference is very common when working with women, and clinical supervision is imperative to prevent counselors from doing harm.

REFERENCES

*TIP 51 (*pp. 4, 15, 273).

Harris & Fallot (eds.). (2001). *Using Trauma Theory to Design Service Systems*, San Francisco: Jossey-Bass.

Slides on Gender Responsive Principles adapted from SAMHSA, "*Addressing the gender-specific treatment needs of women*." Training of Trainers, March 2016.

Slide 76: Component 1: *Addresses Women's Unique Experiences*

Acknowledge, address, and respect the vast diversity among women: socioeconomic issues, disability psychological, physical, race, ethnic, sexual orientation, gender identify, cultural, and religious. This can be as simple as considering the types of examples that are provided in an educational program to be sure there are examples that will resonate with female participants. More complex efforts include thinking about the types of services, access and approaches to determine if they fit with the priorities, and the needs and desires of women seeking help.

Promote staff cultural competence specific to women and their experiences within their cultures (ethnic, racial, religious, etc.). Offer staff training and clinical supervision around cultural competence, as all women differ, despite some common experiences, and becoming culturally competent takes time, practice, and knowledge.

Compared to men, women often have more caregiving roles, family responsibilities, higher rates of poverty, and a wider range of mental and physical health needs, leading to more complex overall treatment needs.

Entering treatment settings can feel foreign to women. It is important to normalize this experience for women--it is not easy just to "go to treatment" with all of the other relational and economic barriers that women experience.

(Notes for Slide 76, continued)

Slide 76: Component 1: *Addresses Women's Unique Experiences*

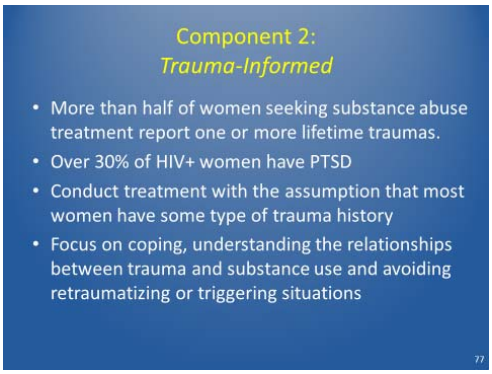
Programs should consider offering gender-specific groups; offering gender-specific curricula and addressing women's issues in treatment.

REFERENCES

Addressing the Needs of Women and Girls (pp. 11-13).

TIP 51 (pp. 4-9).

Using Matrix with Women Clients (p. 3).



Slide 77: Component 2: *Trauma-Informed*

We've already discussed the high rates of trauma in substance using women and women LWHA. The rates of trauma histories among women with SUDs is high enough that many substance abuse treatment settings assume that every woman they see may have had some form of trauma in their background, whether anyone knows about it or not.

Treatment staff can use a trauma-informed approach to help women feel safe, develop effective coping strategies, and recover from the effects of trauma and violence.

REFERENCES

Addressing the Needs of Women and Girls (pp. 4-5 and 17).

TIP 51 (pp. 2, 5-6, 22, 154-157).

TIP 57 (p. 10).

Slide 78: HIV & Trauma

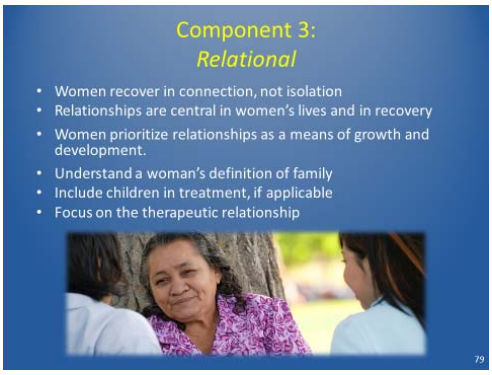
Trauma and posttraumatic stress disorder disproportionally affect HIV-positive women. Studies increasingly demonstrate that both conditions may predict poor HIV-related health outcomes and transmission-risk behaviors.

UCSF's Women's HIV Program provides trauma-informed HIV treatment for women. Part of a national movement to provide trauma-informed primary care, the program addresses the high rates of trauma associated with HIV positive status.

REFERENCES

Machtinger, E.L., Haberer, J.E., Wilson, T.C., & Weiss, D.C. (2012). Recent Trauma is Associated with Antiretroviral Failure and HIV Transmission Risk Behavior Among HIV-Positive Women and Female-Identified Transgenders. *AIDS and Behavior. 16*(8), 2160-2170.

Machtinger, E.L., Wilson, T.C., Haberer, J.E., & Weiss, D.C. (2012). Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS and Behavior. 16*(8), 2091-2100.



Slide 79: Component 3: *Relational*:

Relational model: Traditional developmental models of growth emphasize independence and autonomy. The relational model focuses on women's connections with others.

A relational approach focuses on therapeutic alliance and building connections, rather than instructions and tasks. This person-centered, individualized approach encourages development of self-esteem and self-efficacy to encourage mutual, supportive relationships. Consider relationship and family history, both positive and negative. Take a family-focused perspective, using a broad definition of family that encouraged a woman to define who is in her family or support system. Part of the work might be to assess relationships, e.g., identifying healthy and unhealthy relationships, and improving relationships. This could include the impact relationships have on substance use.

REFERENCES

Addressing the Needs of Women and Girls (pp. 10, 15, and 18-19).

Miller, J. B. (1987). *Toward a New Psychology of Women*. Boston, MA: Beacon Press.

TIP 51 (pp. 143-45).

Slide 80: Component 4: *Comprehensive*

Treatment, clinical support, and community support services for women should be both gender and culturally competent. Be aware that women's physical health issues may be unaddressed and that substance use may have served to mask or anesthetize symptoms of underlying physical health problems. Women with SUDs often do no seek out or receive medical care. Comprehensive, integrated treatment programs are important to address the whole woman's needs.

Women with SUDs are at increased risk for mental-health related consequences, including depression, anxiety and trauma. Screen and assess level of family needs and of involvement individual family members might have in a woman's services and recovery. Assess the need for child care and transportation resources to support access to SUD treatment and various other services. Be culturally competent. Work to understand the sociocultural, gender, and generational dynamics of the woman's family when planning, delivering, and evaluating services. Screen family members/significant others for their own support and/or service needs and provide, procure, or refer for further assessment or services as appropriate.

Slide 81: Component 5: *Healing Environment*

Providing a healing environment for women includes:

Physical safety: As examples, women can access the treatment services safety and feel safe. There is a well-lit parking lot, a safe building location, public transportation that lets off near the location, the women don't have to walk past a lot of men congregated outside the building, there are escorts to cars or public transportation at night, a calm internal environment in waiting room, and the environment is free of physical and sexual harassment.

Psychological safety: Examples include the treatment center has a gender-responsive, trauma-informed environment across all settings (nurturing, supportive, and empowering). There are non-threatening rules and signage. Women are made to feel physically and emotionally safe in their relationships with their counselors. Women can access women-only groups and peer support. Reception staff are friendly, welcoming, and trauma informed. Staff need to minimize power struggles and affect-laden interactions, as these can be triggering not only for women who are involved, but also for women who witness these interactions.

(Notes for Slide 81, continued)

Slide 81: Component 5: *Healing Environment*

Comfort: Treatment environment should be inviting and welcoming, reception staff friendly, and the atmosphere inviting and calm. One technique is to have the check-in/reception area in a separate part of the waiting area from where people wait for services, to minimize overhearing discussions about attendance, fees, and other possible high-conflict topics. There can also be space for privacy and space where women can be quiet and meditative, space for child care and children's activities, and a recreational area.

Feedback: If you want to know how safe and comfortable your treatment facility and services are, ask your female clients and be open to their suggestions for improvement. Allowing participants to have a voice in creating group rules and guidelines will increase their sense of safety and feeling respected.

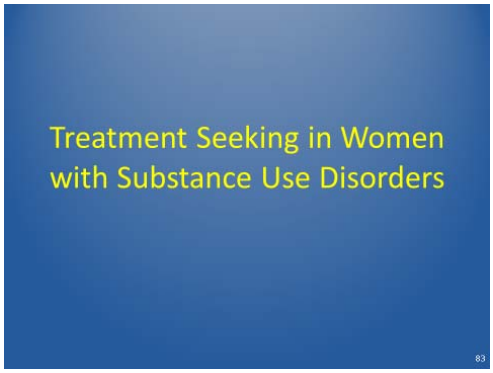
REFERENCES

TIP 51 (p. 188).

Using Matrix with Women Clients (p. 3).

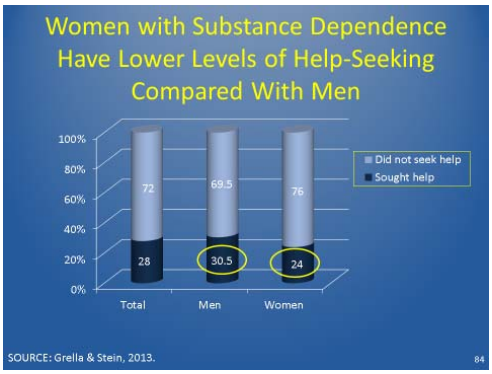
Slide 82: How gender responsive is your program?

Take 5 minutes for participants to rate their programs on gender-responsiveness. Depending on time and format, have participants break into groups of 5-8 to share their results. Where are they doing the best? Where do they need to improve?



Slide 83 [Transition Slide]: Treatment Seeking in Women with Substance Use Disorders

This slide serves as a transition to begin discussing treatment options for women with SUD and HIV.



Slide 84: Women with Substance Dependence Have Lower Levels of Help-Seeking Compared with Men

One of the challenges in treating women with SUDs and HIV is that women have lower levels of help-seeking than men. Getting women into treatment is a priority. This is one of the reasons gender-responsive treatment is so important and can facilitate admission and retention.

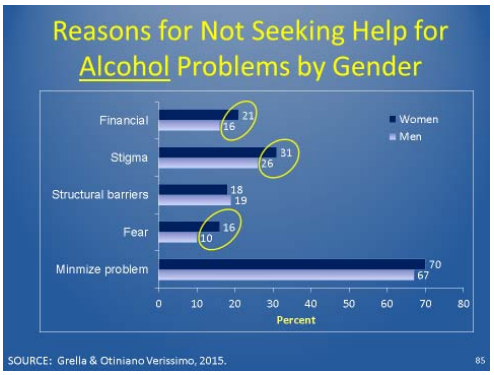
Using the NESARC Wave I sample, Grella and Stein found that women had lower levels of any helpseeking for past-year alcohol or other drug dependence. N = 1,262; $p < .001$.

REFERENCES

Grella, C.E. & Stein, J.A. (2013). Remission from a substance dependence: Differences between individuals in a general population longitudinal survey who do and do not seek help. *Drug and Alcohol Dependence, 133*(1), 146-153.

For more on NESARC data, see, Grant, B.F. & Dawson, D.A. *Introduction to the National Epidemiologic Survey on Alcohol and Related Conditions*. NIAAA Publication. http://pubs.niaaa.nih.gov/publications/arh29-2/74-78.htm (Retrieved June 2016).

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.



Slide 85: Reasons for Not Seeking Help for Alcohol Problems by Gender

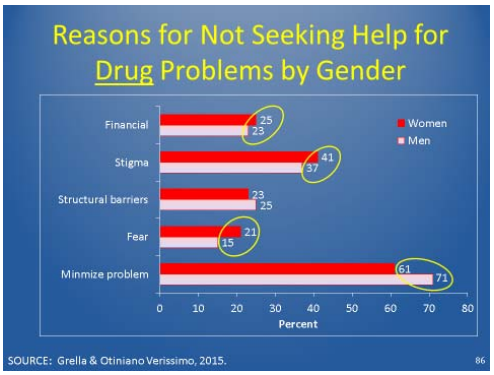
A recent study found that women are less likely to seek help for alcohol problems because of financial issues, stigma and fear.

REFERENCES

Grella, C.E. & Otiniano Verissimo, A.O. (2015). How do gender and race/ethnicity influence perceived barriers to help-seeking for substance use problems? *Drug and Alcohol Dependence, 156*(1), e84.

For more on NESARC data, see, Grant, B.F. & Dawson, D.A. *Introduction to the National Epidemiologic Survey on Alcohol and Related Conditions*. NIAAA Publication. http://pubs.niaaa.nih.gov/publications/arh29-2/74-78.htm (Retrieved June 2016).

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.



Slide 86: Reasons for Not Seeking Help for Drug Problems by Gender

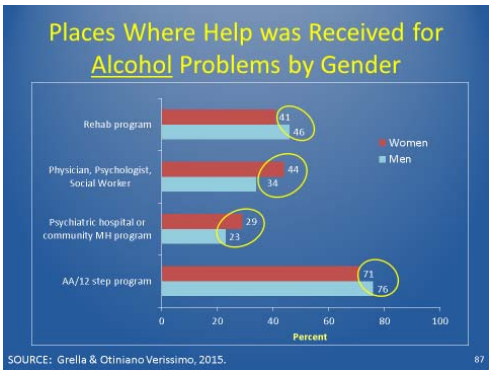
Women are less likely than men to seek treatment for drug problems due to stigma, fear and financial concerns, However, they are less likely to minimize their problems related to help seeking.

REFERENCES

Grella, C.E. & Otiniano Verissimo, A.O. (2015). How do gender and race/ethnicity influence perceived barriers to help-seeking for substance use problems? *Drug and Alcohol Dependence, 156*(1), e84.

For more on NESARC data, see, Grant, B.F. & Dawson, D.A. *Introduction to the National Epidemiologic Survey on Alcohol and Related Conditions*. NIAAA Publication. http://pubs.niaaa.nih.gov/publications/arh29-2/74-78.htm (Retrieved June 2016).

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.



Slide 87: Places Where Help was Received for Alcohol Problems by Gender

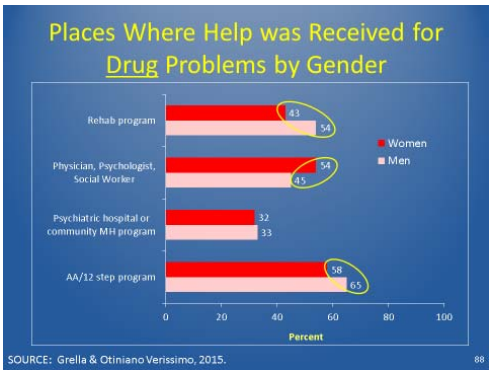
Differences among men and women also exist with regards to where they seek help for alcohol problems. Women are more likely than men to go to private practice clinicians or psychiatric settings to receive treatment. Men are more likely to go to rehab or a 12-step program.

REFERENCES

Grella, C.E. & Otiniano Verissimo, A.O. (2015). How do gender and race/ethnicity influence perceived barriers to help-seeking for substance use problems? *Drug and Alcohol Dependence, 156*(1), e84.

For more on NESARC data, see, Grant, B.F. & Dawson, D.A. *Introduction to the National Epidemiologic Survey on Alcohol and Related Conditions*. NIAAA Publication. http://pubs.niaaa.nih.gov/publications/arh29-2/74-78.htm (Retrieved June 2016).

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.



Slide 88: Places Where Help was Received for Drug Problems by Gender

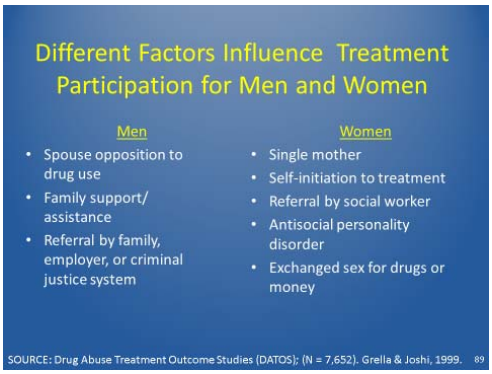
Like with alcohol problems, women seeking help for drug problems are more likely than men to receive help in a private practice setting. Women are less likely to seek help at a psychiatric hospital or mental health program. Like the findings for alcohol, men are more likely to go to rehab and/or attend 12-step programs.

REFERENCES

Grella, C.E. & Otiniano Verissimo, A.O. (2015). How do gender and race/ethnicity influence perceived barriers to help-seeking for substance use problems? *Drug and Alcohol Dependence, 156*(1), e84.

For more on NESARC data, see, Grant, B.F. & Dawson, D.A. *Introduction to the National Epidemiologic Survey on Alcohol and Related Conditions*. NIAAA Publication. http://pubs.niaaa.nih.gov/publications/arh29-2/74-78.htm (Retrieved June 2016).

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.



Slide 89: Different Factors Influence Treatment Participation for Men and Women

A largescale, multisite study (DATOS) found that there were different factors the influenced treatment participation for men and women. Men sought treatment due to social and societal pressures, like a spouse's opposition to use, family support or referral from a family member, employer or CJ. Women are influenced to participate in treatment when they are a single mother, referred by a social worker, have antisocial personality disorder and exchange sex for drugs and money.

REFERENCES

Fletcher, B.W., Tims, F.M., & Brown, B.S. (1997). The Drug Abuse Treatment Outcome Study (DATOS): Treatment evaluation research in the United States. *Psychology of Addictive Behaviors, 11*(4), 216-229.

Grella, C.E., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national Drug Abuse Treatment Outcome Study. *American Journal of Drug and Alcohol Abuse, 25*(3), 385-406.

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.

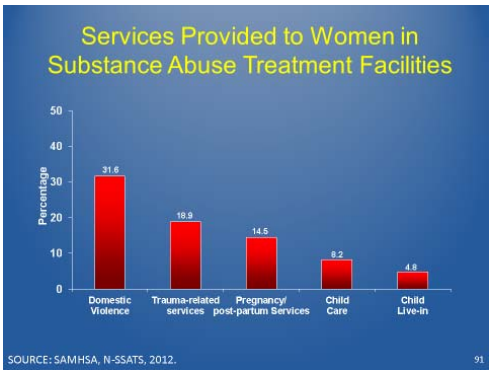
Slide 90: Substance Abuse Treatment Facilities that Provide Special Services or Programs for Women

About one third of substance abuse treatment facilities provide special services or programs for women. In this 2012 survey of nearly 8,000 treatment facilities throughout the country, 35% reported providing services or programs specifically for women.

REFERENCES

Substance Abuse and Mental Health Services Administration (2014). *The N-SSATS Report: Recovery Services Provided by Substance Abuse Treatment Facilities in the United States*. http://www.samhsa.gov/data/sites/default/files/NSSATS-SR175-RecoverySvcs-2014/NSSATS-SR175-RecoverySvcs-2014.pdf (Retrieved June 2016).

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.



Slide 91: Services Provided to Women in Substance Abuse Treatment Facilities

The types of specialized services for women are focused on their individual needs, mainly related to victimization and their childrens' needs. About 30% focused on domestic violence, nearly 19% on trauma-related services, 14% on pregnancy and post-partum services, 8% child care and nearly 5% child live in at residential treatment programs.

REFERENCES

Substance Abuse and Mental Health Services Administration (2014). *The N-SSATS Report: Recovery Services Provided by Substance Abuse Treatment Facilities in the United States*. http://www.samhsa.gov/data/sites/default/files/NSSATS-SR175-RecoverySvcs-2014/NSSATS-SR175-RecoverySvcs-2014.pdf (Retrieved June 2016).

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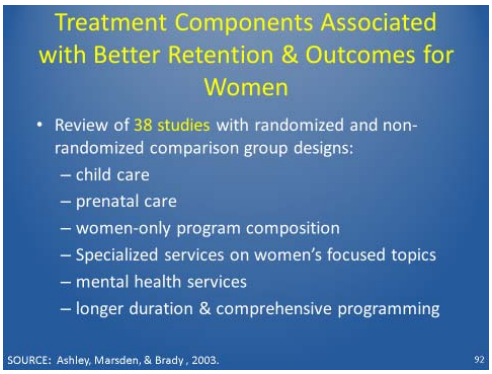


Slide 92: Treatment Components Associated with Better Retention & Outcomes for Women

A review of 38 studies found that a number of factors improved retention in treatment and treatment outcomes for women. included child care, prenatal care, women-only programs, specialized services on women's topics, mental health services, longer program duration and more comprehensive programming. This again points to the need for more comprehensive, gender-responsive services for women with SUDs to be successful.

REFERENCES

Ashley, O.S., Marsden, M.E., & Brady, T.M. (2003). Effectiveness of substance abuse treatment programming for women: a review. *The American Journal of Drug and Alcohol Abuse, 29*(1), 19-53.

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.

Slide 93: Structural Barriers to Drug Treatment

Review each of the structural barriers to drug treatment that exist for women.

REFERENCE

Slide adapted from Dr. Christine E. Grella, February 2016, *Overview: Women and Addiction*. Presented at the CLARE Foundation's State of Addiction Forum, Santa Monica, CA.

Slide 94: Evidence-Based Treatment Options for Substance Use

Motivational Enhancement Therapy (MET) employs a variation of Motivational Interviewing (MI) to analyze and dissect feedback gained from client sessions. MI focuses on re-patterning client behavior that is the result of ambiguous and undefined thoughts. This form of therapy is presented in a direct and client targeted manner that strives to transform undesired behaviors. Motivational Enhancement Therapy was developed by William Miller and Stephen Rollnick. The goal of MET is to aid the client in clarifying his or her own perceptions and beliefs in order to direct him or her in a more decisive way. Most people who respond to this type of treatment have struggled for years in a mire of ambivalence and welcome the opportunity to have vision and focus in their lives.

MET is commonly used for the treatment of addictions, including abuse of alcohol and other substances. MET is administered in a receptive atmosphere that allows a client to receive feedback from the therapist for the purpose of fortifying the client's resolve for transformation and to empower the client with a feeling of self-control. Rather than engaging the client's defense mechanisms through confrontational discourse, the therapist works with the client to create positive affirmations and a sense of inner willingness to facilitate change. Once that is achieved, the client becomes receptive to the healing process and progresses toward wellness.

(Notes for Slide 94, continued)

Slide 94: Evidence-Based Treatment Options for Substance Use

Contingency management utilizes behavioral reinforcement theories to enhance the possibility of favorable outcomes occurring with the patient. Contingency management is a systematic application of positive reinforces/rewards (and sometimes punishments) in order to highlight specific behavior and reinforce the occurrence of the behavior in the future. This can include receiving a voucher that can be redeemed for specific items following a negative urine screen or certain number of months without having used. It may be a point-based system attached to certain privileges or it could be a slight reduction in fee for services with demonstrated success in working toward treatment goals.

Directly-observed therapy is a specific supervisory technique to ensure that the provider is receiving real-time support in addressing issues and interpersonal dynamics between the provider and the patient. It may involve a recorded session that is debriefed later or the use of technology to provide real-time suggestions to the provider during session.

Medication-assisted treatment employs various medications to assist with reducing substance use; specifically demonstrated effects with opioid abuse and alcohol abuse. MAT provides on-going or acute support in assisting an individual to reduce use or detox from use of illicit drugs or alcohol.

(Notes for Slide 94, continued)

Slide 94: Evidence-Based Treatment Options for Substance Use

Integrated health services delivery enhances the communication between providers and with the patient. Integrating different health providers provide the most comprehensive conceptualization and treatment planning for multiple conditions and diagnoses. Communication is critical in establishing goals and maintaining progress in treatment.

CBT and Relapse Prevention involve the identification of the interaction between thoughts, feelings, and behaviors in engaging in maladaptive coping behaviors such as substance use. Increasing insight and awareness assists in identification of appropriate coping skills. Relapse prevention includes specific identification of scenarios in which the patient may be triggered to use and develops specific refusal techniques and coping skills to enhance the individual's feelings of confidence in preventing relapse.

Behavioral interventions for HIV prevention should address the link between substance use and HIV/STD by focusing on high-risk sexual behaviors that are consequences of substance drug use, most commonly alcohol consumption.

(Notes for Slide 94, continued)

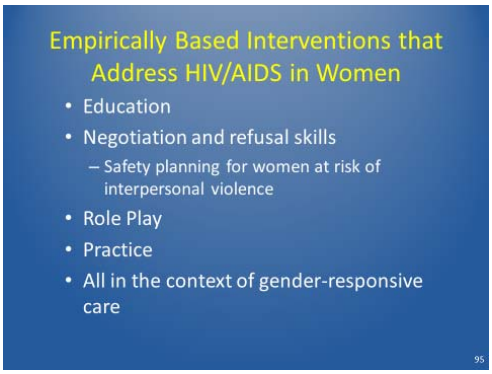
Slide 94: Evidence-Based Treatment Options for Substance Use

The focus for HIV prevention has been on effective interventions such as condom use, testing and counseling, pre- and post-exposure prophylaxis (preventive medicine), male circumcision, needle exchange services to reduce needle sharing that may lead to HIV transmission for injecting drug users. However, there is need to pay more attention now to preventing and treating non-injectable drug use including alcohol, which can interfere with these efforts, impairing people's judgment and making them less likely to use protection during sex. Preventing and treating substance use can reduce the incidence of substance induced high-risk sexual behaviors and subsequently reduce HIV transmission.

REFERENCES

For more information, visit http://drugabuse.gov or http://samhsa.gov/nrepp for the latest on evidence-based practices to treat substance use disorders.

NIDA. (2012). *Principles of Drug Addiction Treatment: A Research-Based Guide* (Third Edition), https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment. (Retrieved Sept. 2016).



Slide 95: Empirically Based Interventions that Address HIV/AIDS in Women

A number of empirically-based interventions exist for women with HIV/AIDS and problems with substance use. The most effective tend to have the following in common:

Education: Knowledge is power. Interventions teach about health, STD transmission and ways to protect themselves. Understanding the effects of substance use on overall health is essential. Knowing about the relationship between trauma, SUD and HIV can help identify triggers that can lead to unsafe behaviors. You can pass along much of what you've learned today to educate your female clients about HIV and SUD.

Negotiation and Refusal Skills: Women benefit from learning how to negotiate. Negotiation is the process of achieving a desired goal through persuasion, bargaining, and compromise. Walk through possible scenarios that put them at risk to help them become more prepared for situations they may encounter. How do you negotiate safe sex with your partner when he comes home late at night and he's intoxicated? How do you negotiate condom use with a partner you've already had unprotected sex with?

Sometimes negotiation falls short and a woman just has to say no. This can be extremely difficult in the heat of the moment, especially if there's fear of interpersonal violence. Safety planning is also an important part of learning.

(Notes for Slide 95, continued)

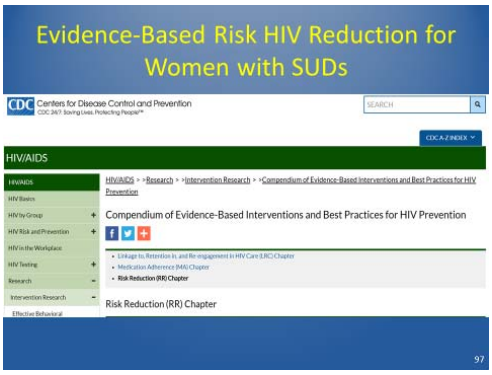
Slide 95: Empirically Based Interventions that Address HIV/AIDS in Women

Role Play: Many of these skills can be practiced through role plays. You can find dozens of scenarios online by searching "Safe sex negotiation skills."

Other Practice: In addition to role play as a form of practice, have supplies available so women can practice using a condom. Allow her to tear open the package and unroll the condom on a penis model (yes, a banana or cucumber could work), going through all the steps to ensure understanding and greater comfort. If female condoms are available, practice with those as well. Make the process light-hearted and educational. Talk about ways to eroticize safe sex so that it may be more appealing.

Slide 96: Provider/Patient: Communication Strategies

Motivational enhancement techniques employ a style that increases the individual's insight and awareness while respecting their choice. The intent is to listen to understand rather than to diagnose and fix. The acceptance of the individual where they are rather than judging their behaviors enhances engagement with the treatment provider. The provider focuses on being genuinely compassionate rather than authoritarian.

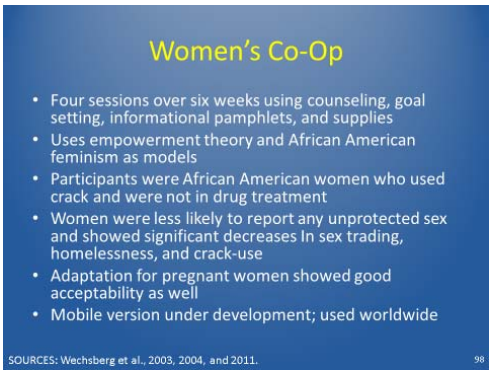


Slide 97: Evidence-Based Risk HIV Reduction for Women with SUDs

The CDC offers a compendium of evidence-based interventions and best practices for HIV prevention. There are 96 total addressing different subgroups. The following are selected interventions shown to have positive results on HIV risk reduction for women with substance use and HIV.

The Compendium can be accessed at: http://www.cdc.gov/hiv/research/interventionresearch/compendium/rr/index.html.

Instructor's Note: Slides 98-102 are optional. Present specific treatments depending upon needs of audience.



Slide 98: Women's Co-Op

Women's Co-Op is a 4-session behavioral intervention developed to reduce HIV risk for African American women who were using crack. Results were positive, with reductions in unprotected sex, sex trading, homelessness and crack use. A pilot study of an adaptation for pregnant women showed promise, with good acceptability (6.5 out of 7) in a sample of 61 women.

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Wechsberg, W.M., Browne, F.A., Poulton, W., Ellerson, R.M., Simons-Rudolph, A., & Haller, D. (2011). Adapting an evidence-based HIV prevention intervention for pregnant African-American women in substance abuse treatment. *Substance Abuse and Rehabilitation*, *2*, 35-42. Available at: http://doi.org/10.2147/SAR.S16370.

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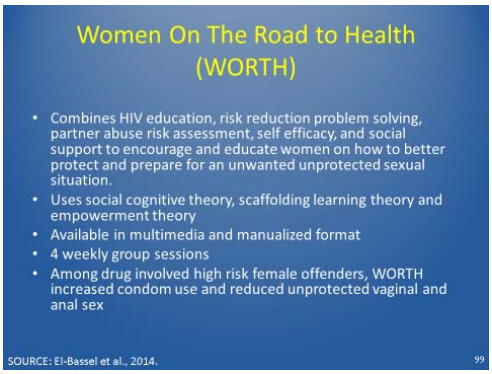

Slide 99: Women On The Road to Health (WORTH)

WORTH is a psychoeducational group intervention that combines HIV education, risk reduction problem solving, partner abuse risk assessment, self-efficacy, and social support to encourage and educate women on how to better protect and prepare for an unwanted unprotected sexual situation. Based on social cognitive theory, scaffolding learning theory and empowerment theory, four group sessions are administered either in standard manualized format or with multimedia (videos demonstrations and video games) enhancements. Among drug involved high risk female offenders, WORTH increased condom use and reduced unprotected vaginal and anal sex.

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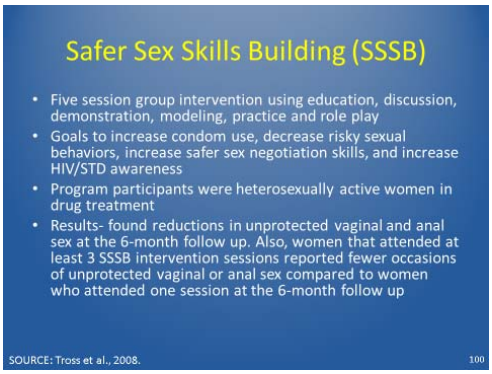

Slide 100: Safer Sex Skills Building (SSSB)

Safer Sex Skill Building (SSSB) is a five session group intervention that was tested in a multi-site study at 12 outpatient drug treatment sites through NIDA's Clinical Trials Network. Heterosexual, drug using women participated. The intervention uses education, discussion, demonstration, practice and role play to develop safer sex negotiation skills and increased HIV/STD awareness. Results found reductions in unprotected vaginal and anal sex at the 6-month follow-up. There was a dose effect, with women who attended at least 3 sessions reporting fewer unprotected sex occasions compared to women who attended only one session.

REFERENCE

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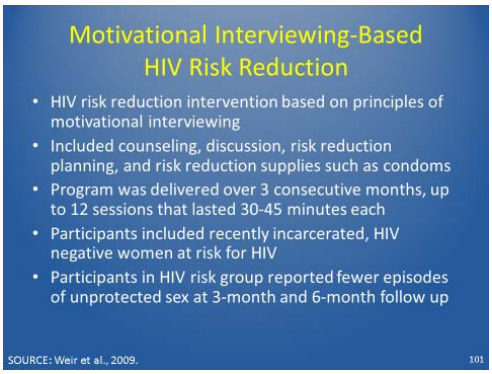
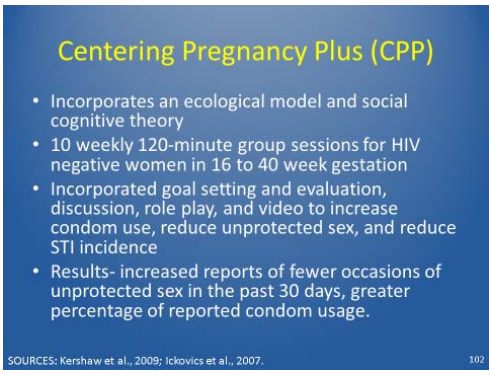


Slide 101: Motivational Interviewing-Based: HIV Risk Reduction

Based on motivational interviewing techniques, MI based risk reduction was tested in recently incarcerated, HIV negative women. The intervention included individual counseling, discussion, risk reduction planning, and risk reduction supplies such as condoms. Participants in the risk reduction group were significantly less likely to report any unprotected vaginal or anal sex at 3 and 6 month follow up.

REFERENCE

Weir, B.W., O'Brien, K., Bard, R.S., Casciato, C.J., Maher, J.E., Dent, C. W., Dougherty, J.A., Stark, M.J. (2009). Reducing HIV and partner violence risk among women with criminal justice system involvement: A randomized controlled trial of 2 motivational interviewing-based interventions. *AIDS and Behavior, 13*, 509-522.



Slide 102: Centering Pregnancy Plus (CPP)

In an intervention delivered during prenatal care, CPP incorporates an ecological model and social cognitive theory to create change in HIV risk behaviors in pregnant women. Delivered in weekly group sessions, HIV negative women in 16-40 weeks of gestation learned goal-setting, evaluation, discussion, role play and video demonstrations to increase condom use and reduce unprotected sex. Participants reported fewer occasions of unprotected sex in the past 30 days and a great percentage of condom usage than baseline.

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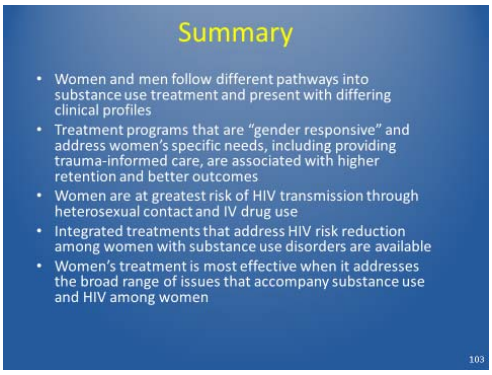
Ickovics, J.R., Kershaw, T.S., Westdahl, C., Magriples, U., Massey, Z., Reynolds, H., Rising, S. S. (2007). Group prenatal care and perinatal outcomes: A randomized controlled trial. *Obstetrics & Gynecology, 110*, 330-339.

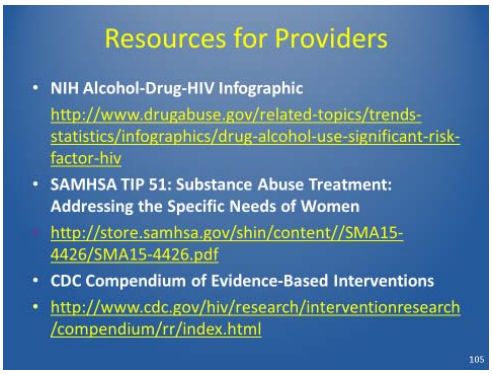


Slide 103: Summary

Women and men have different pathways to problems with substance use and present with different clinical profiles. Treatment programs that are gender responsive and address the specific needs of women are associated with higher retention and better outcomes than those that are not. Paying special attention to trauma-informed care is particularly important for women with HIV/AIDS, since they are likely to have experienced some type of trauma in their lifetime. Integrated treatments that address a broad range of issues relevant for women are most effective in treating women with HIV/AIDS and substance use.

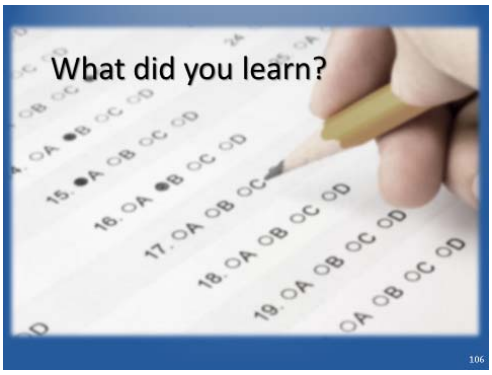
Slide 104: Local Resources

This slide features resources for local referrals.



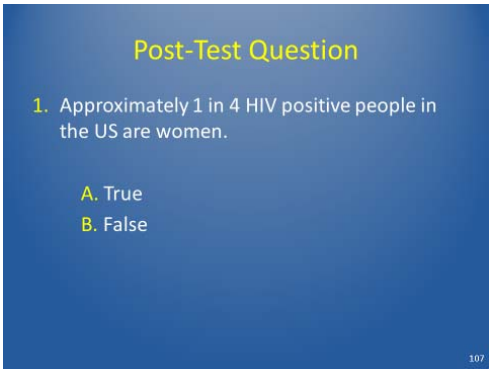
Slide 105: Resources for Providers

This slide features online resources for providers to learn additional information about drug use, HIV, and women.



Slide 106: Resources for Providers

The purpose of the following five questions is to test the post-training knowledge as it relates to the topic of Substance Use, HIV, and Women. The five questions are formatted as either multiple choice or true/false questions. Read each question and the possible responses aloud, and give training participants time to jot down their response before moving on to the next question. Reveal the correct answer to each question.



Slide 107: Post-Test Question

ANSWER KEY: Correct response: **A (True)**

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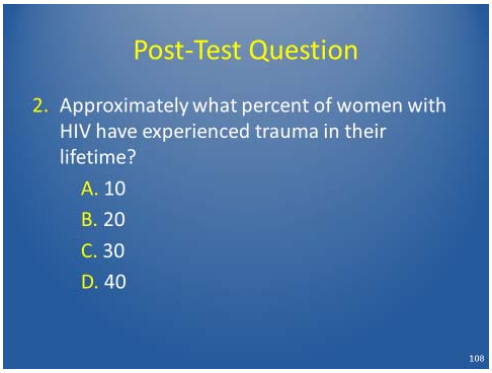

Slide 108: Post-Test Question

ANSWER KEY: Correct response: **C (30%)**

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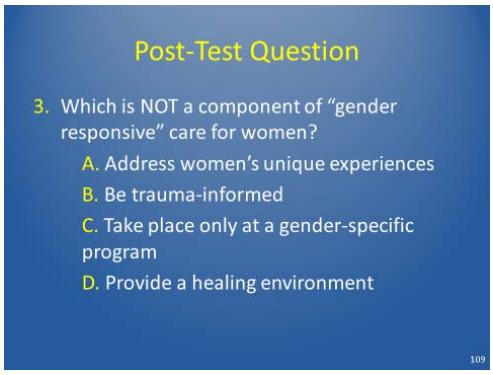

Slide 109:

ANSWER KEY: Correct response: **C (Take place only at a gender-specific program)**

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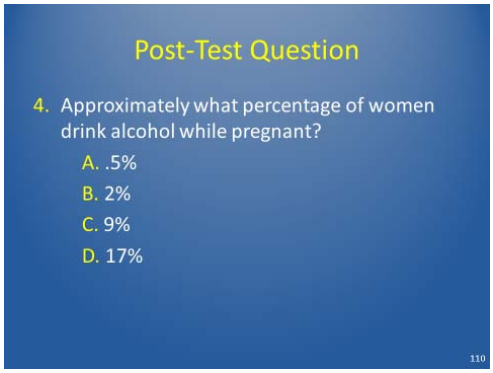

Slide 110:

ANSWER KEY: Correct response: **C (9%)**

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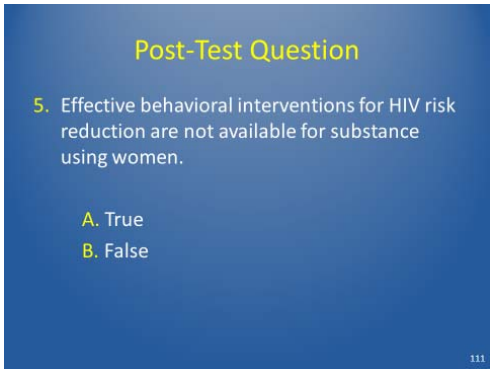

Slide 111: Post-Test Question

ANSWER KEY: Correct response: **B (False)**

**Audience Response System (ARS)-compatible slide

Slide 112: Thank You for Your Time!

This concludes the presentation. Thank the participants for their time and address any last-minute questions about the content. Encourage participants to reach out to the Pacific Southwest ATTC or the LA Region PAETC, should they have questions or concerns following the training session.

Acknowledgements

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