



Health
Canada

Santé
Canada

Best Practices

Early Intervention, Outreach and
Community Linkages for Women
with Substance Use Problems



Canada

Prevention

Treatment

Enforcement

Harm Reduction

Canada's Drug Strategy

*Working together to reduce
the harmful use of substances*

Best Practices

Early Intervention, Outreach and
Community Linkages for Women
with Substance Use Problems

Our mission is to help the people of Canada
maintain and improve their health.

Health Canada

Published by authority of the Minister of Health.

Best Practices – Early Intervention, Outreach and Community
Linkages for Women with Substance Use Problems
is available on Internet at the following address:
<http://www.healthcanada.gc.ca/>

Également disponible en français sous le titre :
*Meilleures pratiques – Intervention précoce, services d'approche et liens
communautaires pour les femmes ayant des problèmes attribuables à la
consommation d'alcool et d'autres drogues*

This publication can be made available on request on
diskette, large print, audio-cassette and braille.

For further information or to obtain additional copies, please contact:

Publications
Health Canada
Ottawa, Ontario K1A 0K9
Tel.: (613) 954-5995
Fax: (613) 941-5366
E-Mail: info@hc-sc.gc.ca

© Her Majesty the Queen in Right of Canada, represented by the Minister of Health Canada, 2006

This publication may be reproduced for personal or internal use only without permission provided the source is fully acknowledged. However, multiple copy reproduction of this publication in whole or in part for purposes of resale or redistribution requires the prior written permission from the Minister of Public Works and Government Services Canada, Ottawa, Ontario K1A 0S5 or copyright.droitdauteur@pwgsc.gc.ca

HC Pub.: 4658
Cat.: H128-1/06-460E
ISBN: 0-662-42819-6

Acknowledgements

This report involved the collaborative efforts of Health Canada, the ADTR Working Group and W. Morrison & Associates, Inc. We would like to express our appreciation to the ADTR Working Group and other experts who reviewed drafts of the document, the key informants who participated in interviews, and the focus group participants who gave up their time to advance the research on best practices in early intervention, outreach and community linkages for women with substance use problems.

Project Team Members of W. Morrison & Associates, Inc.

Dr. William Morrison, Project Director

Dr. Cynthia Doucet, Research Coordinator

Nancy Hicks, Focus Group Facilitator

Maurice LeBlanc, Content Area Expert and Research Consultant

Julie Hall, Researcher and Administrative Staff

Table of Contents

Executive Summary	1
1. Introduction	9
1.1 Methodology	10
1.2 Scope and Limitations	12
2. Literature Review	13
2.1 Introduction	13
2.2 Gender Differences	14
2.2.1 Physiological Differences	14
2.2.2 Patterns of Use	14
2.2.3 Social Context and Relationships	15
2.3 Barriers to Accessing Intervention Services for Problem Substance Use	16
2.3.1 Experiences of Violence	16
2.3.2 Stigmatization	16
2.3.3 Shame and Guilt	17
2.3.4 Lack of Social Support	17
2.3.5 Fear of Repercussions	17
2.3.6 Decreased Hope	17
2.4 Specific Client-related Considerations and Needs	18
2.4.1 Pregnant Women	18
2.4.2 Women with Children	18
2.4.3 Women with Concurrent Mental Health Problems	19
2.4.4 Homeless and Transient Women	20
2.4.5 Rural Women	20

2.4.6	Injection Drug Use	20
2.4.7	Aboriginal Women	21
2.4.8	Ethnic Minority Women	21
2.4.9	Senior Women	22
2.4.10	Sex Trade Workers	23
2.4.11	Women in Conflict with the Law	23
2.5	Early Intervention	24
2.5.1	Screening for Substance Use	25
2.5.2	Screening for Readiness to Change	29
2.5.3	Brief Interventions	31
2.5.4	Motivational Interviewing	33
2.5.5	Brief Negotiation Interview	35
2.5.6	Family Participation in Early Intervention Approaches	35
2.5.7	Self-help Resources	36
2.5.8	Settings for Early Intervention	37
2.5.9	Specialized Consultation and Training for Health Care Providers	39
2.6	Outreach	40
2.6.1	Location of Outreach Services	41
2.6.2	Structuring Outreach Interventions	41
2.6.3	Outreach Personnel	42
2.6.4	Key Outreach Activities	44
2.6.5	Research Related to Outreach to Women	44
2.7	Community Linkages	46
2.7.1	Relevant Community-based Linkages for Women	47
2.7.2	Benefits Associated with Developing Community Linkages	49
2.7.3	Service Linkage Models	49

2.7.4	Establishing Links with Health Care Providers	51
2.7.5	Establishing Links with Other Community Services	52
2.7.6	Key Challenges in the Development of Community Linkages	53
3.	Interviews with Key Experts	55
3.1.	Selection of Key Experts	55
3.2	Key Expert Interview Process	57
3.3	Key Client Considerations	58
3.3.1	Circumstances and Needs of Women with Substance Use Problems	58
3.3.2	Service Delivery Considerations for Specific Groups of Women	58
3.4	Early Intervention and Outreach Approaches	61
3.4.1	Theoretical or Applied Orientations for Early Intervention and Outreach ...	61
3.4.2	Early Intervention Approaches	61
3.4.3	Outreach Approaches	63
3.4.4	Roles for Individuals Supporting Early Intervention and Outreach	65
3.4.5	Evaluation of Early Intervention and Outreach Strategies	67
3.5	Community Linkages	67
3.5.1	Essential Community-based Services and Supports	67
3.5.2	Barriers to Linking Community-based Programs and Treatment Services	68
3.5.3	Working Toward Coordinated Service Delivery	68
3.5.4	Strategies for Promoting Effective Consultation and Community Linkages ..	69
3.5.5	Gaps and Inconsistencies in Services or Policies	69
3.5.6	Challenges and Strengths of Integrative Approaches	70
4.	Focus Groups	71
4.1	Introduction	71
4.2	Participant Demographics	72

4.3	Key Challenges: Priority Concerns	73
4.3.1	Accessing Treatment Services	74
4.3.2	Recognizing Problem Substance Use	74
4.3.3	Securing Personal Supports	74
4.3.4	Coping with Difficult Emotions	74
4.3.5	Obtaining Essential Treatment Information and Support	75
4.3.6	Maintaining Treatment Gains	75
4.3.7	Experiencing the Fear of Losing Children	75
4.3.8	Ensuring Confidentiality	75
4.4	Additional Challenges	76
4.4.1	Addressing Negative Stereotypes	76
4.4.2	Coping with Employment Issues and Financial Challenges	76
4.4.3	Experiencing Disrespect	76
4.4.4	Living with Health and Safety Concerns	76
4.5	Early Intervention	77
4.5.1	Intervene Early with Adolescents	77
4.5.2	Enhance Community Awareness and Knowledge	77
4.5.3	Foster and Maintain Sources of Support	78
4.5.4	Provide Individual Counselling Services	78
4.5.5	Implement Community-based Early Intervention Programs	78
4.5.6	Maintain Parental Bonds	78
4.5.7	Provide Toll-free Help Lines	78
4.5.8	Ask Screening Questions	78
4.6	Outreach Services	79
4.6.1	Enhance Community Service Provider Capacity to Reach Out	79
4.6.2	Increase Awareness of Community Resources and Referral Processes	79

4.6.3	Enhance Accessibility of Services	80
4.6.4	Foster Collaborative Actions	80
4.6.5	Strengthen Advocacy for Gender-specific Approaches	80
4.7	Community Services and Linkages	81
4.7.1	Support Groups	81
4.7.2	Child Care Services	81
4.7.3	Service Descriptions	81
4.7.4	Crisis Intervention Services	81
4.7.5	Housing and Shelter	82
4.7.6	Community-based Educational Programs	82
4.7.7	Transition Supports and Aftercare Programs	82
5.	Best Practice Statements	83
5.1	Introduction	83
5.2	General Considerations	84
5.3	Screening Processes	85
5.4	Early Intervention Strategies	86
5.5	Outreach Services	87
5.6	Relevant Community-based Support Programming	88
5.7	Community Linkages and Integrative Approaches	89
6.	Future Research	91
	References	93
	Appendix	101
	Appendix A: Document Sections Supporting the Best Practice Statements	101

List of Tables

Table 1: Practical Questions About Alcohol and Other Drug Use	28
Table 2: The Evidence for Brief Intervention	32
Table 3: A Menu of Interviewing Strategies	34
Table 4: Potential Benefits of Linking Primary Care and Substance Abuse Care Services ..	50
Table 5: Geographical Distribution of Key Experts	55
Table 6: Professional Roles of Key Experts	56
Table 7: Academic Background of Key Experts	56
Table 8: Focus Group Participant Demographics	72

Executive Summary

The purpose of this project is to present best practice guidelines related to early intervention, outreach and community linkages for women with substance use problems. The project was initiated by Health Canada as part of a research agenda developed by the Federal/ Provincial/ Territorial Working Group on Accountability and Evaluation Framework and Research Agenda (ADTR Working Group).

The report is organized into five main sections:

- *Introduction:* The background, methodology and research activities.
- *Literature review:* A critical analysis of published and unpublished research related to early intervention, outreach and community linkages for women with substance use problems.
- *Interviews with key experts:* A summary of the key insights from experts with various backgrounds, including treatment consultants, managers and clinical professionals from provincial and territorial jurisdictions.
- *Focus groups:* A summary of the perspectives of women who are or have been in need of early intervention, outreach and community linkages to address substance use.
- *Best practices:* Statements gleaned from the synthesis of the literature review, key informant interviews and/or focus groups.

Women with Substance Use Problems

Clinicians and researchers acknowledge the importance of sensitivity to gender differences and needs when developing and delivering treatment services for women with substance use problems. Women differ from men in their patterns and onset of substance use.

According to the Canadian Addiction Survey (CAS)(Adlaf, Begin & Sawka, 2005), undertaken in 2004, of Canadians 15 years and older, men continued to have higher rates of drinking and illicit drug use than women. However, some indicators showed that drinking continued to be a concern for women: 76.8% of females drank alcohol in the past year (compared to 82.0% of males), 32.8% of females drank alcohol at least once a week (compared to 55.2% for males), 8.8% of females drank five or more drinks at a sitting (compared to 23.2% for males), and 3.3% of females drank five or more drinks at a sitting at least once a week (compared to 9.2% for males). As well, 7.1% of females reported at least one harm during the past year from their own drinking, and 32.6% of females reported at least one harm from others' drinking.

For illicit substances, 10.2% of females reported having used cannabis in the past year (compared to 18.2% for males), and of five substances (cocaine, speed, ecstasy, hallucinogens and heroin), 1.8% of females reported using any one of these in the past year (compared to 4.3% for males) (Adlaf et al., 2005).

- Due to differences in the metabolism of alcohol, women are more affected than men by the same amount of alcohol, even after correcting for body weight.
- Women often describe their substance use as having a sudden and heavy onset, often following a traumatic event.
- Relational issues are intricately connected with the onset and progression of substance use problems in women. Families can either help or hinder treatment seeking, but they rarely have a neutral impact.
- Women with children may forgo or postpone treatment entry because they do not have someone they trust to care for their children in their absence.
- Women's fears about the potential for losing custody of their children can be a significant barrier to pursuing treatment services.
- Health care and other service providers are in a unique position to apply early intervention strategies. These include initial screening and identification of problem substance use; disseminating educational and referral information; providing supportive counselling; and ensuring the coordination of referrals to appropriate support and treatment services.
- Early intervention efforts should incorporate strategies that are solution focussed and based on the strengths of the clients to empower them to pursue positive change.
- Recent research supports the use of early intervention strategies within workplace health programs. These may include providing educational messages about problem substance use along with general information on health, diet and exercise.

Early Intervention

Early intervention involves both the initial identification of individuals with substance use problems and the provision of specific intervention activities aimed at removing potential barriers to essential services.

Designing intervention strategies requires an understanding of the unique circumstances of each client and adapting services to facilitate timely access to needed treatment.

- Brief interventions and motivational interviewing techniques are useful methods for enhancing readiness to change.

Outreach Services

Outreach services for women with substance use problems involve meeting clients in their own environments to engage them in treatment or assist them in accessing other needed services. Outreach activities seek to establish links with women who are known to have or be at risk for substance use problems.

- Outreach services provided through drop-in programs, mobile treatment services and street contacts can increase access to needed services by providing flexible hours of operation in accessible locations.
- Outreach is more effective when trust has been established and maintained over multiple brief sessions or meeting times.

- Outreach workers must be committed to engaging women in a personalized assessment of their own risk behaviours, and in realistic discussions of resources available to support sustainable changes.

Community Linkages

Community linkages need to be considered at both the client and systemic level. At the client level, this involves ensuring referral to services that address problem substance use and other related health and basic needs. Systemic applications involve increasing collaboration and coordination among service providers to maximize the use of limited resources and ensure the provision of multidisciplinary services to address the needs of women and their families.

- The application of case management strategies assists in organizing services for women and empowering them to be active collaborators in developing and implementing case plan priorities.
- Ensuring the availability of child care services facilitates women's access to essential community services and treatment options.
- Service providers should be familiar with the range of services and programs available in the community and be knowledgeable about how they may be accessed.
- Service agreements related to interagency referral and treatment protocols have been identified as helpful mechanisms for increasing collaboration and coordination among service providers.

Best Practice Statements

General Considerations

Client Circumstances

Early intervention and outreach strategies require an understanding of the circumstances and needs of each client and/or client groups in order to adapt services and include relevant supports. The goal is to reduce problem substance use as well as enhance overall health and social functioning.

Basic Needs

Basic needs, including adequate resources for food, clothing or housing, must be addressed in conjunction with outreach and early intervention efforts.

Child Custody Concerns

Women's fears about losing custody of their children are significant barriers to pursuing needed treatment services. These concerns should be addressed in a gender-sensitive way in early intervention and outreach efforts.

Rural Challenges

Services are often limited for women with problem substance use in rural communities. Local support groups, help lines and Internet services may provide viable means for connecting with women in more remote locations, and subsequently linking them with early intervention services.

Prescription Drug Misuse

Women are prescribed mood-altering drugs, including tranquillizers and painkillers, more often than men and are at higher risk of experiencing problems with prescription medication. Health care providers should take into account women's potential vulnerability to prescription drug misuse. When appropriate, alternative approaches for managing stress and anxiety without medication should be undertaken.

Cultural Awareness

Cultural awareness should be taken into account when developing and adapting outreach and early intervention strategies. For Aboriginal women, community members, leaders and professionals may be important sources of support and play a valuable role in the delivery of services.

Screening Processes

Client-centred Screening Processes

Screening questions should be completed collaboratively with clients in a manner that is comfortable and safe. Health care and community service providers should approach this with a non-judgmental attitude, conveying respect and an openness to discuss health issues and social concerns related to problem substance use.

Literacy Levels

When completing screening questionnaires, service providers should be sensitive to the varying literacy levels of clients and allow for additional time and accommodations when required.

Areas of Inquiry

Areas of inquiry to be addressed during intake or assessment interviews should include: onset, types of substances and patterns of use; circumstances and consequences related to use; clients' awareness of level of use and readiness to pursue change; and clients' links with community services and intervention programs.

Role of Health and Community-based Service Providers

It is often community-based service providers and health care professionals, rather than addiction specialists, who initially identify women experiencing, or who are at risk for, problem substance use. Family physicians, nurse practitioners, nurses, public health nurses, obstetricians, pediatricians, midwives, mental health personnel and other service providers who counsel women on health or self-care, are in a unique position to provide screening for problem substance use. They are therefore a critical resource for facilitating access to needed services.

Early Intervention Strategies

Theoretical Models of Treatment Readiness

Prochaska's and DiClemente's stages of change theory is a practical framework for understanding and assessing treatment readiness. This model supports the development of collaborative alliances with clients who are at varying levels of readiness to pursue change and is often applied in conjunction with brief interventions and motivational interviewing strategies.

Brief Interventions

Brief interventions and motivational interviewing techniques are useful methods for enhancing readiness to change. Given the evidence for the potential effectiveness of brief interventions and the minimal amount of time they require to implement, health care and other service providers are in a unique position to apply these strategies. Although brief interventions should not be used to replace more intensive treatment services, they can be effective initial engagement strategies for more severely dependent clients.

Workplace Early Intervention Applications

Recent research supports the use of early intervention strategies in workplace health programs. These may include providing educational messages on problem substance use in conjunction with general information on health, diet and exercise.

Outreach Services

Settings

It is critical to take into account the natural living environments of clients when planning and implementing outreach programs. Potential locations or settings may include safe houses, employee assistance programs, health centres, community centres, prisons, mental health facilities, physicians' offices and community educational programs. Outreach can also be done in collaboration with community-based education programs, such as personal

development, parenting, employment readiness, budgeting, self-esteem, nutrition, stress management, assertiveness and interpersonal relationships.

Accessibility

Outreach services provided through drop-in programs, mobile treatment services and street contacts increase access to services by providing flexible hours of operations in accessible locations. They may be particularly crucial for women who are street workers, homeless or injection drug users.

Developing Trust

Outreach is more effective when trust has been established and maintained over multiple brief sessions or meeting times. This may be a particularly important consideration for high-risk groups such as sex trade workers.

Outreach Activities

Outreach activities should include dissemination of health information, education on strategies for harm reduction, provision of information on community-based resources and programs, identification of strategies for accessing these services, and when needed, accompanying clients to preliminary appointments.

Relevant Community-based Support Programming

Gender-specific Programming

Recent research has emphasized the importance of making available gender-specific program approaches for women. These programs can offer women the opportunity to share their experiences in emotionally safe environments, interact with positive role models and build support networks.

Counselling Support

Women often experience feelings of guilt and shame related to their problematic substance use, which contributes to lower self-esteem, decreased hope and continued problem substance use. Counselling services should address these feelings when providing early intervention for women.

Child Care Services

The absence of social networks to assist with child care and family responsibilities can impede women from making contact with treatment programs, even when these are available in the community. Research indicates that access to child care services contributes to treatment engagement and enhanced outcomes.

Family Therapy and Support

Concern from family members can be an important motivating factor for women to seek treatment. Family therapy can be beneficial for educating and supporting family members to learn responses that help women in the treatment process. Family members may also be able to provide tangible resources, such as transportation and child care.

Community Linkages and Integrative Approaches

Community Awareness

Social perceptions and disapproval of women's substance use may decrease client willingness to pursue rehabilitative services. Increasing awareness and understanding among employers, community members and primary health care providers can reduce the perceived social barriers associated with accessing treatment.

Knowledge of Services

To be effective referral agents, service providers must be familiar with the full range of government and non-government programs and support services available to women, be knowledgeable about how they are accessed, and develop strong referral and collaborative links with them.

Community Service Provider Agreements

Service agreements or memoranda of understanding related to interagency referral and treatment protocols have been identified as helpful for increasing collaboration and coordination among service providers. Such efforts assist in maximizing the use of limited resources and ensuring that service provision remains responsive to the needs of women and their families.

Consultation Role of Addiction Specialists

Addiction specialists play a critical consultation role for community health care and service providers. Consultation can include disseminating educational information or formalized training sessions on problem substance use, screening approaches and intervention strategies.

Case Management

Case management strategies assist in organizing and integrating services for women. Approaches should empower clients to become active collaborators in developing and implementing case plan priorities.

Treatment Transitions

During times of treatment transition, women often experience increased stress and are more vulnerable to relapse to former substance use patterns. Support services that may be helpful during periods of change include drop-in-centres, outpatient counselling, longer term rehabilitation options, “halfway” support homes, transitional housing programs, in-home services and family programs.

Future Research

This research has pointed to areas related to early intervention, outreach and community linkages where further research is warranted. These include: 1) ethnicity and problem substance use; 2) effectiveness of Internet recovery strategies; and 3) evaluating integrative service delivery models and their cost-effectiveness.

Introduction

The purpose of this project was to develop best practice guidelines related to early intervention, outreach and community linkages for women with substance use problems. The research provides updated information on specific challenges and compensating strategies related to these areas and should encourage continued best practice research.

The project was initiated by Health Canada as part of a research agenda developed by the Federal/ Provincial/Territorial Working Group on Accountability and Evaluation Framework and Research Agenda (ADTR Working Group). Part of the mandate of the working group is to oversee the development and implementation of research studies that contribute to effective and innovative substance abuse treatment and rehabilitation programs by identifying best practices, evaluating model treatment and rehabilitation programs, identifying emerging issues, and disseminating the knowledge across the country.

This project builds on a series of best practices publications, including *Best Practices – Substance Abuse Treatment and Rehabilitation* (Health Canada, 1999); *Best Practices – Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2001a); *Best Practices – Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During*

Pregnancy (Health Canada, 2001b); *Best Practices – Treatment and Rehabilitation for Women with Substance Use Problems* (Health Canada, 2001c); *Best Practices – Treatment and Rehabilitation for Youth with Substance Use Problems* (Health Canada, 2001d); *Best Practices – Methadone Maintenance Treatment* (Health Canada, 2002a); *Best Practices – Treatment and Rehabilitation for Seniors with Substance Use Problems* (Health Canada 2002b) and *Best Practices – Treatment and Rehabilitation for Driving While Impaired Offenders* (Health Canada 2004).

The goal is to make best practice guidelines available to service providers, program planners, policy makers, and other related health and community professionals who are involved in delivering substance abuse programs or services to women. As well, this publication will be a resource to clients of these services, their families and the community.

The report is organized into five main sections:

- *Introduction*: A summary of the methodology and research activities.
- *Literature review*: A critical analysis of published and unpublished research related to early intervention, outreach and community linkages for women with substance use problems.

- *Interviews with key experts:* A summary of the key insights gleaned from identified experts representing treatment consultants, managers and clinical professionals from provincial and territorial jurisdictions.
- *Focus groups:* The perspectives of women who are or have been in need of early intervention, outreach and community linkages to address substance use problems.

- *Best practices:* Statements that have been gleaned from synthesizing the literature review, key informant interviews and/or focus groups.

For those who are interested in a particular topic area, related results from other sections of the document are indicated below the subject headings.

1.1 Methodology

Literature Review

The literature review identified professional and research documents from both Canadian and international sources, and included:

- post-1998 publications, with some exceptions in the case of unique literature;
- professionally reviewed or expert juried research documents;
- summary and literature review articles;
- comparison studies of different approaches or methods;
- controlled trials or quasi-experimental investigations;
- program evaluation reports; and
- theoretical literature relating to best practice research.

Evidence-based documents were drawn from published information and articles in recognized and respected publications, as well as

from recent unpublished reviews by key experts. The scope of the search was limited to the following databases and material published or written between 1998 and 2004:

- Medline (database of medical studies);
- CINAHL (Nursing and Allied Health Literature database);
- PsycInfo (database of psychological studies);
- CCSADOCS (database of the National Clearinghouse on Substance Abuse);
- CDSR (Cochrane Database of Systematic Reviews);
- ETOH (database at the National Institute for Drug Abuse Web site); and
- SAMHSA (Substance Abuse and Mental Health Services Administration – US Department of Health and Human Services).

The review provides a critical analysis of the literature, focussing on key issues related to early intervention, outreach and developing

community linkages for women with substance use problems. It includes considerations such as gender differences, barriers to accessing interventions, screening and brief interventions, clinician consultation and training, and the structure of early intervention, outreach interventions and service linkage models.

Key Expert Interviews

In consultation with members of the ADTR Working Group, key experts with substantial knowledge in the field and representing each province and territory were identified (see Table 5). The 19 key experts who participated in the study had various backgrounds, training and experience (see Tables 6 & 7). All respondents were given the time and opportunity to provide detailed information for each question. Most interviews were completed by telephone however some respondents preferred to answer the questionnaire in written form. Interviews were conducted in either French or English, given the preference of the interviewee.

Focus Groups

Eight focus group sessions across four Canadian regions were included in the research. Initial contact with participants was done in collaboration with local and regionally based treatment service providers. Sixty women participated in the sessions; attendance ranged from five to eleven women per group, with an average attendance of eight (see Table 8 for demographic information).

Definition of Best Practice

The definition of best practice as it relates to program delivery in the health field has been approached with varying degrees of rigour.

Within health care, the application of the idea of “best practice” has ranged from simply publishing particular practices under the rubric of “best,” ... to engaging in a systematic identification of what would constitute “best” within a particular health issue or practice area, ... to a rigorous research-based investigation to identify evidence associated with particular practices (Varcoe, 1998, p. 4).

For the purposes of this project, best practices are emerging guidelines, gleaned from key expert perspectives and client focus groups, and supported by the literature, on the approaches and elements of treatment that appear to result in successful treatment outcomes. Given this definition, best practices are recommendations that may evolve, based on ongoing key expert experience, judgment, perspective and continued research. The best practice guidelines outlined in this report should, therefore, be reviewed as research in this area continues.

1.2 Scope and Limitations

This report focusses on early intervention, outreach and community linkages for adult women with substance use problems. Research related to adolescent women, and other addiction-related substances or activities, such as tobacco use and gambling, was considered to be beyond the scope of this project. The term “substance” includes alcohol, prescription medication and illicit drugs.

Literature Review

2.1 Introduction

Women who have problems with substance use differ from men in their patterns and onset of drug use (Zilberman, Tavares, Blume & el-Guebaly, 2002). According to the Canadian Addiction Survey (CAS) (Adlaf, Begin & Sawka, 2005), undertaken in 2004, of Canadians 15 years and older, men continued to have higher rates of drinking and illicit drug use than women. However, some indicators show that drinking continued to be a concern for women: 76.8% of females drank alcohol in the past year (compared to 82.0% of males), 32.8% of females drank alcohol at least once a week (compared to 55.2% for males), 8.8% of females drank five or more drinks at a sitting (compared to 23.2% for males), and 3.3% of females drank five or more drinks at a sitting at least once a week (compared to 9.2% for males). As well, 7.1% of females reported at least one harm during the past year from their own drinking, and 32.6% of females reported at least one harm from others' drinking.

For illicit substances, 10.2% of females reported having used cannabis in the past year (compared to 18.2% for males), and of five substances (cocaine, speed, ecstasy, hallucinogens and heroin), 1.8% of females reported using any one of these in the past year (compared to 4.3% for males) (Adlaf et al., 2005).

Clinicians and researchers acknowledge the importance of being sensitive to gender differences and needs in the development and delivery of treatment services for women (Covington, 1998). Women are nevertheless a heterogeneous group, with differences among them that impact their needs and strengths, and the appropriateness and effectiveness of interventions.

2.2 Gender Differences

KEY POINTS

- Due to differences in the metabolism of alcohol, women are more affected than men by the same amount of alcohol, even after correcting for body weight.
- Women often describe their substance use as having a sudden and heavy onset, often following a traumatic event.
- Women may use substances to numb emotional pain from abuse, grief over the death of loved ones, or guilt over injury to loved ones, especially children.
- Relational issues are intricately connected with the onset and progression of substance use problems in women. Families can either help or hinder treatment seeking, but they rarely have a neutral impact.
- Women with children may forgo or postpone treatment entry because they do not have someone they trust to care for their children in their absence.

2.2.1 Physiological Differences

Differences in metabolism between men and women have been well studied with respect to alcohol, but not other substances (Zilberman et al., 2002). Women are more affected than men by the same amount of alcohol, even after correcting for body weight (Mumenthaler, Taylor, O'Hara, & Yesavage, 1999; van der Walde, Urgenson, Weltz, & Hanna, 2002; Zilberman et al.). Evidence indicates that this is partly because alcohol is water soluble, and women have less water in their bodies than men. In addition, an enzyme in the gastric mucosa that breaks down alcohol is less active

in women. Both of these differences contribute to higher blood alcohol concentrations in women than in men, given equivalent amounts of alcohol (Baraona, Abittan, Dohmen et al., 2001, cited in Zilberman et al.; van der Walde et al.). One result of this greater sensitivity is that dependence develops faster in women (Hernandez-Avila, Poling, Rounsaville, & Kranzler, 2002; Smith & Weisner, 2000). Women are also more susceptible to organic damage from alcohol consumption than men (Mumenthaler et al., NIAAA, 1999; van der Walde et al.) For example, women have a higher incidence of liver damage, partly because alcohol increases estrogen levels, which may act to exacerbate hepatic injury (Brady & Randall, 1999, cited in Zilberman et al.; van der Walde et al.).

For substances other than alcohol, women have been shown to have an accelerated progression to dependence on heroin and cannabis (Hernandez-Avila, Poling, Rounsaville, & Kranzler, 2002). Gender studies of dependence on cocaine have shown inconsistent findings (Zilberman et al., 2002).

2.2.2 Patterns of Use

Women often describe their substance use as having a sudden and heavy onset, often following a traumatic event (Woolis, 1998). In contrast, men's patterns of substance use are often described as gradual and progressive (van der Walde et al., 2002). Thus, opportunities for early intervention will occur within a narrower time frame for women (Zilberman et al., 2002).

Women have reported that they use substances to numb emotional pain from issues such as abuse, sex work, grief over the death of loved ones, or guilt over injury to loved ones, especially children (Peterson, Berkowitz, Cart, & Brindis, 2002; Poole & Isaac, 2001; van der Walde et al., 2002). Substance use often increases in response to a life crisis, including loss of significant relationships, death of a loved one and children leaving home (AADAC, 2003; Poole & Isaac). For some women, such losses can also lead to treatment seeking (Poole & Isaac).

Women are prescribed mood-altering drugs, including tranquillizers and painkillers, more often than men and are at higher risk for problems with prescription medication (AADAC, 2003; Vines & Mandell, 1999; Zilberman et al., 2002). These patterns resonate with women seeking treatment for symptoms of depression, anxiety, pain or difficulty sleeping from health care providers rather than from addiction treatment settings (van der Walde et al., 2002; Vines & Mandell; Zilberman et al.). Senior women are particularly at risk for problems with prescription medication (Zilberman et al.).

Some research suggests that women with substance use problems may be exposed more often than men to unsafe sexual practices and drug injection behaviours. These behaviours increase women's risk for sexually transmitted diseases and blood-borne pathogens such as hepatitis B virus, human immunodeficiency virus (HIV) (Zilberman et al., 2002) and hepatitis C virus.

2.2.3 Social Context and Relationships

Relational issues are intricately connected with the onset and progression of substance use problems in women (Poole & Isaac, 2001; Zelvin, 1999). Families of women with substance use problems can either help or hinder treatment seeking, but they rarely have a neutral impact (Poole & Isaac). Women's substance use patterns are influenced by their partners or spouses and their children's functioning and well-being (Zilberman et al., 2002). If problems in these relationships are unresolved, it is difficult for women to sustain any progress made through treatment (Poole & Isaac; Zilberman et al.).

Women are more likely than men to use drugs when they are alone and to be in a relationship with a partner who is a regular substance user (Woolis, 1998; van der Walde et al., 2002). Women with poor coping skills coupled with low self-esteem, tend to have low self-efficacy in managing substance use (Poole & Isaac, 2001; van der Walde et al.; Zilberman et al., 2002).

Some women may find their roles as caregivers incompatible with treatment seeking (AADAC, 2003). One strong recurring theme in the literature is that women forgo or postpone treatment entry because they do not have someone they trust to care for their children in their absence (Poole & Isaac, 2001). Women often fear that they will lose custody of their children if they indicate a need for substance use treatment. In some cases, women will enter treatment in an effort to try to regain custody of their children (Poole & Isaac).

2.3 Barriers to Accessing Intervention Services for Problem Substance Use

For related results from Key Informant Interviews, see section 3.3

For related results from Focus Groups, see sections 4.3 and 4.4

KEY POINTS

- Negative stereotypes are often held of women who have substance use problems.
- Experiences of neglect, violence and abuse contribute to the likelihood of developing problems with alcohol in woman.
- Some women report that shame and guilt are factors that motivate them to continue to use substances and prevent them from seeking treatment.
- Women who perceive that they have minimal support from significant relationships are less likely to access or initiate treatment.
- The fear of repercussions may also influence women's decisions not to access or pursue treatment.

Women are known to have rates of substance use problems approximating those of men, yet they present for treatment at approximately one-third the rate, which points to various issues and barriers that impede their access to or willingness to seek rehabilitative services (OSAB, 1996; van der Walde et al., 2002).

2.3.1 Experiences of Violence

Experiences of neglect, violence and abuse among women contribute to their likelihood of developing problems with alcohol use (Jarvis, Copeland, & Walton, 1998;

Langeland & Hartgers, 1998 cited in Zilberman et al., 2002; MacMillan et al., 2001, cited in Zilberman et al., 2002; NIAAA, 1999). Women have indicated that they use substances to cope with feelings of depression, devaluation and low self-esteem, and to numb emotional pain from abusive encounters (Bush-Baskette, 2000; Yahne, Miller, Irvin Vitela, & Tonigan, 2002). In addition, experiences of domestic violence can contribute to poor decision-making skills or reluctance to make decisions at all (Brown, Melchior, Panter, Slaughter, & Huba, 2000).

2.3.2 Stigmatization

Negative stereotypes tend to be held of women with substance use problems (AADAC, 2003; van der Walde et al., 2002; Zilberman et al., 2002), which can prevent them from identifying their own use as problematic (OSAB, 1996). Researchers have interpreted direct links between women's self-image, stigmatization and their denial (Poole & Isaac, 2001). Stigmatization increases the likelihood that personal needs will not be acknowledged or shared with others (Health Canada, 2001c). Treatment experts indicate that disapproval by society of substance use by women decreases their willingness to pursue rehabilitative services (Health Canada, 2001c; Swift & Copeland, 1998; Zilberman et al., 2002).

When negative stereotypes are held by professionals in health and other helping fields, they are more likely to be reluctant to ask women about their substance use. Stigmatization can therefore contribute to missed opportunities for early intervention or proper referral (Zilberman et al., 2002).

2.3.3 Shame and Guilt

Some women report that shame and guilt are factors that motivate them to continue to use substances and prevent them from seeking treatment (Tait, 2000; van der Walde et al., 2002). Women, more often than men, use prescription drugs to address feelings of shame and discouragement (Vines & Mandell, 1999). Shame and guilt are often tied to their roles as mothers and caregivers (Poole & Isaac, 2001). Rural women cite feelings of shame as potent barriers, given that anonymity may be more difficult to maintain in small, closely knit communities (Poole & Isaac, 2001).

2.3.4 Lack of Social Support

Women are strongly influenced by their peers, significant others and family members (Poole & Isaac, 2001; van der Walde et al., 2002; Zilberman et al., 2002). Women who perceive that they have minimal support from significant relationships are less likely to access or initiate treatment (Riehman, Hser, & Zeller, 2000). In one study, women who had support only from other substance users experienced similar difficulties accessing community services, as did those who had minimal or no identified social supports (Nyamathi, Leake, Keenan, & Gelberg, 2000).

In some instances, a partner or significant other may not support women who try to access treatment and may actively seek to discourage such efforts (OSAB, 1996; Zilberman et al., 2002). Resistance from male partners who use drugs has been identified as a major barrier for women who want to seek treatment. Resistance from a partner or significant other may prompt women to withdraw from services after treatment has been undertaken (Poole & Isaac, 2001; Riehman et al., 2000).

2.3.5 Fear of Repercussions

The fear of repercussions may influence women's decisions not to pursue treatment. The fear of losing their children to a spouse or social service agency can make women reluctant to seek treatment (Health Canada, 2001c; Poole & Isaac, 2001; Powis, Gossop, Bury, Payne, & Griffiths, 2000). Friends and employers may also become aware of the problem where it was previously hidden. Those who use illicit drugs may face legal charges if their use is reported (Kearney, 1998).

2.3.6 Decreased Hope

Hopelessness is a potential barrier to treatment seeking and engagement (Health Canada, 2001c). Kearney (1998) noted that women continue to abuse substances if they see "no compelling reason not to do so, no convincing evidence that another life is possible and every reason to numb the pain and continue in sad but familiar circumstances" (Kearney, 1998, p. 499). Pregnant women who have not been able to stop using substances also report feelings of hopelessness (Ehrmin, 2001).

2.4 Specific Client-related Considerations and Needs

For related results from Key Informant Interviews, see section 3.3

For related results from Focus Groups, see sections 4.3 and 4.4

KEY POINTS

- Addressing basic needs related to housing and health care services can be critical in early intervention and outreach efforts or in engaging women in ongoing treatment.
- Pregnancy may provide a window of opportunity for reaching many women with problem substance use because of their desire to have healthy children.
- Family responsibilities and care for children are crucial considerations for women when making decisions about pursuing treatment. The care of their children can either be a factor that inhibits women from seeking treatment or it can be a motivating force for them to seek treatment.
- It is challenging for women to maintain recovery if the community or environment they return to has easy access to drugs and alcohol, or encourages substance use.

Women with problematic substance use have diverse life experiences and circumstances that extend beyond the problematic use. Assisting these women requires an understanding of, and sensitivity to, their current life circumstances. The following descriptions reflect important considerations relevant to sub-populations of women and need to be considered when designing early intervention, outreach and community linkage strategies. There may be overlap among the groups.

2.4.1 Pregnant Women

Women who are pregnant have needs that extend beyond their current substance use. They may require, for example, medical care, educational services related to child care, or education about fetal alcohol spectrum disorder (FASD) (Health Canada, 2001c). Research suggests that early intervention is an important determinant in reducing the physiological effects for both the mother and child (B.C. Ministry for Children and Families, 1998). Zilberman et al. (2002) indicated that pregnancy can provide a window of opportunity for reaching women because of their desire to have healthy children. Tait (2000) cautioned that for some pregnant women, addressing issues related to substance use may heighten feelings of guilt and result in further withdrawal from support.

2.4.2 Women with Children

Family responsibilities and care for children are crucial considerations for women when making decisions about pursuing treatment (Health Canada, 1999, 2001c). Treatment may be postponed because they are the primary caregivers for their children. Their reluctance to access services may be heightened by a fear of losing their children to spouses they do not trust, or to social service agencies (Health Canada, 2001c; Poole & Isaac, 2001; Powis et al., 2000). Many services do not provide the

supports needed to accommodate children during the treatment period (Health Canada, 1999, 2001c; Poole & Isaac).

Women may also defer their decision to engage in services due to the absence of necessary supports or the financial means to arrange for child care (Health Canada, 2001c; Marsh, D'Aunno, & Smith, 2000; Powis et al., 2000). Although treatment often does not require payment for services, other indirect expenses, such as transportation or wage loss, may impede access (Health Canada, 2001c).

As well as being a factor that inhibits women from seeking treatment, the care of their children can also act as a motivating force for them to seek treatment (Poole & Isaac, 2001; Powis et al., 2000). Mothers, whether addicted or not, hold similar beliefs and attitudes about the maternal role and its depth of meaning and value to them (Ehrmin, 2001).

2.4.3 Women with Concurrent Mental Health Problems

Estimates of concurrent disorders are higher for women than for men, and clients admitted to substance use treatment programs often exhibit other mental health issues (Sacks, 2000). Women with alcohol use problems are more likely than men (65% vs. 46%) to have a diagnosed comorbid mental health condition and to have a history of abuse, neglect and trauma (Brown, Melchior and Huba, 1999).

In Zilberman et al.'s literature summary, a range of comorbid conditions were associated with problem substance use in women, including depression, anxiety and eating disorders. The comorbid psychiatric condition most often precedes problems with substance use in women, whereas the problems with substance use usually occur first in men (Zilberman et al., 2002).

The long-standing behavioural and emotional features associated with clients who have concurrent mental health conditions require a comprehensive and integrated approach to treatment planning and service delivery (Health Canada, 2001a; Sacks). This population may be easily overwhelmed by the behavioural changes required in the treatment process, such as interacting in groups or complying with unfamiliar program structures and routines. A key strategy to address this is to emphasize the importance of preparation for treatment. This can be done through outreach services, or by having pre-visits to the program and individualized treatment protocols (Brown et al., 1999). It is advantageous for service providers to receive specialized training on the major aspects of concurrent mental health problems and strategies for engaging clients in treatment (Maslin et al., 2001).

2.4.4 Homeless and Transient Women

High rates of substance use problems among the homeless have been well documented in the literature (Wenzel et al., 2001). Common issues for both homelessness and problem substance use can include loss of significant relationships and family attachments, experiences of abuse and mental health concerns (Neale, 2001).

Homeless women have added challenges in accessing treatment services. For example, community service providers may be hesitant to offer services to those who do not have a fixed address. As well, homeless women may be reluctant to pursue treatment because of a lack of trust, or a fear of being labelled by others (Neal, 2004). It is important that gender-specific treatment and aftercare for homeless women be offered, as they are more likely than men to have experienced abuse and violence, issues difficult to discuss in mixed-gender groups (Brunette & Drake, 1998; Coughey, Feighan, Cheney, & Klein, 1998). Homeless women are in particular need of empowering approaches that offer tangible resources for addressing homelessness (Galaif, Nyamathi & Stein, 1999).

Flexible services provided through drop-in or outreach programs can increase access for women who are homeless. Services such as mobile treatment sites or street contacts may be needed to support clients in accessing and engaging community service or treatment programs (Health Canada, 2001c). Homeless women with children are likely to be poorer than homeless women without children, and will require diverse services (Roll, Toro, & Ortola, 1999).

2.4.5 Rural Women

Women in rural areas may not be able to access services due to pre-existing barriers such as travel costs (Poole & Isaac, 2001). For some, a perceived lack of confidentiality in smaller, socially interconnected communities may also impede them from seeking services (Health Canada, 1996b, 1996c, 2001c; Poole & Isaac).

2.4.6 Injection Drug Use

Injection drug users are at high risk for blood-borne pathogens such as HIV and hepatitis B and C viruses. Women are less likely to use illicit substances or inject drugs, however they are more vulnerable physiologically to the transmission of HIV and other diseases than men, and can pass on blood-borne pathogens to the fetus. Social isolation, poverty and poor access to health or pre-natal care contribute to poor outcomes. Researchers have recommended that outreach to female injection drug users include education on cleaning equipment and the dangers of even indirect sharing of paraphernalia (e.g. cotton filters or rinse water) (Wechsberg & Cavanaugh, 1998). Women are less likely than men to inject alone and more likely to be pressured by their partners to share equipment (Whynot, 1998). In light of the power dynamics between men and women who share equipment, interventions should help women negotiate risk reductions without making them more vulnerable (Wechsberg & Cavanaugh).

2.4.7 Aboriginal Women

Aboriginal people are culturally diverse and vary in languages of origin, traditions, customs, and in historical and political backgrounds. As a group, they face the barrier of lack of cultural sensitivity within present treatment programs (Jacobs & Gill, 2002; NNADAP, 1998). For example, there is a lack of services available in the language of the client and a lack of emphasis on cultural beliefs and practices in the treatment process (Health Canada, 1996a, 2002b). Some researchers have suggested that access to services can be enhanced through the use of Aboriginal elders and by giving increased attention to spiritual values and traditions (Poonwassie & Charter, 2001; Stevens, Estrada, Glider, & McGrath, 1998).

Aboriginal women indicate that a challenge they face in maintaining recovery is returning to a community or environment where drugs and alcohol are easily accessible, and where use is acceptable or encouraged (Peterson et al., 2002). Alcohol is usually the dominant problem substance. In one sample, approximately 10% of Aboriginal women indicated that inhalants were often used as a second drug of choice (Peterson et al.).

There is some evidence that alcohol-related problems among Aboriginal women have similar characteristics to those of African Americans and European Americans, with respect to age of onset, psychological features and physical problems. As with other subgroups of women with substance use problems, they often report high incidences of conflict

with the law and experiences of abuse, violence and neglect (Stevens et al., 1998), and share similar barriers, such as the need for child care and transportation, and resistance from partners. Aboriginal women are more likely to identify denial as a barrier than non-Aboriginal women (Poole & Isaac, 2001).

Aboriginal women are less likely to feel judged by their families than women in non-Aboriginal communities (Poole & Isaac, 2001). Confrontational styles, especially as part of dynamic group discussions, tend to be inappropriate for this population, as there is a cultural tendency is to be soft-spoken, unassertive, with little eye contact and minimal self-disclosure (Stevens et al., 1998). In one study examining the experiences of Aboriginal women in several treatment centres, they expressed appreciation for culture-specific programs that were staffed by Aboriginal women and incorporated traditional attitudes, beliefs and spiritual activities (Peterson et al., 2002). As education levels will vary, there is a need to design programs that are adjusted to literacy levels and encourage advancement (Stevens et al., 1998).

2.4.8 Ethnic Minority Women

Ethnicity has been described as a “complex construct” that defines groups based on cultural perspectives and a sense of shared identity. Ethnicity may also contribute to religious beliefs and traditions that place different values on substance use for women than for men (Collins & McNair, 2002). Karuntzos, Dunlap, Zarkin and French (1998) found that, in many

ethnic groups, substance use, in particular the consumption of alcohol, is not acceptable for women, creating a significant barrier to seeking support or treatment. Karuntzos et al. suggest using pictorial aids that present relevant life themes as a means for reaching out to women from diverse ethnic groups. The use of this approach requires cultural sensitivity, and potentially, specialized training.

Research related to ethnicity and its influence on problem substance use among women is limited. Additional research is needed to gain an increased understanding of best practice approaches for structuring prevention and intervention efforts (Collins & McNair, 2002).

2.4.9 Senior Women

Most of the substance use problems observed in seniors are with alcohol, including its interactions with over-the-counter and prescription medication. Older women are prescribed more medication than older men, especially benzodiazepines (Health Canada, 2002b). Senior women have an increased sensitivity to alcohol and to medications compared with younger women and older men (Blow & Barry, 2002). Alcohol use can hasten the physiological aging process and place seniors at high risk for decline in other areas of life functioning (Blow, 1998).

The Centre for Substance Abuse Treatment (SAT) recommends that everyone age 60 or over be screened for alcohol and medication misuse in health care settings (Blow, 1998). Screening of seniors is often overlooked in their visits to primary care physicians (Blow, 1998; Millar, 1998). Discussion of alcohol use problems may be given lower priority than other health problems. Symptoms can be attributed to other medical and behavioural problems observed in this population (e.g. depression, grief, diabetes, injuries from falls and dementia) (Blow, 1998; Health Canada, 2002b). Brief interventions have been shown to be useful with senior adults, although there is little research on gender-specific effects (Blow & Barry, 2002).

Ageism can present an additional barrier for senior women, as their problems are dismissed as a function of age. Seniors may be ascribed a different standard in that substance use problems are not perceived with the same urgency as they would be in younger adults, and treatment would not be a good use of resources (Blow, 1998).

Few senior women seek help in established substance use treatment settings (Blow & Barry, 2002). Family members or significant others may be ashamed of acknowledging the problem and avoid addressing it (Blow, 1998). Senior women face a greater stigma than senior men and may make more attempts to conceal their substance use (Blow).

2.4.10 Sex Trade Workers

Female sex workers are at high risk for problem substance use, victimization and disease.

Although some research supports the use of outreach services to link them with treatment and health services, they have been largely under-represented in community or justice-based treatment systems (Koss, 2000).

Outreach for this population is seen as more effective when trust has been established and maintained over multiple brief sessions.

Addressing basic needs related to housing and health care services may be critical in outreach efforts to engage these workers in ongoing substance use treatment (Yahne et al., 2002).

2.4.11 Women in Conflict with the Law

Covington (1998) stated that the needs of women within the justice system are often “forgotten” or are “the most invisible.”

Many female prisoners tend to have minimal education, a lack of employment skills, the added responsibility of care of children or other dependants, and experiences of trauma or abuse (Byrne & Howells, 2002; Koss, 2000). In addition, there is a significant relationship between incarceration and problem substance use (Covington; van Wormer, 2002). Covington indicates that substance use programs for women should use an integrated model that incorporates

addiction theories, theories of trauma and women’s developmental theory. With such approaches, four key areas need to be addressed: relationships with self, relationships with others, sexuality and spirituality. van Wormer (2002) suggests other components, including learning assertiveness skills, understanding the interplay between problem substance use and continued emotional and physical vulnerability, and acquiring coping skills to replace problem substance use.

In addition to programs within secure custodial settings, services are required to address challenges during transitions, such as from prison to the community. Halfway houses need to provide assistance, especially for women with children. If such supports are not in place, the pattern of problem substance use and conflict with the law will likely continue (van Wormer, 2002).

2.5 Early Intervention

For related results from Key Informant Interviews, see section 3.4

For related results from Focus Groups, see section 4.5

KEY POINTS

- Early intervention involves both the initial identification of individuals with substance use problems and provision of specific intervention activities aimed at removing barriers to services.
- Settings for early intervention are often found outside established addiction treatment facilities or programs. Recognition of problem substance use often becomes evident as women access support from health care or community service providers.
- Having a health professional initiate discussion about substance use behaviours provides an important opportunity for positive change.
- Brief interviewing techniques are useful for enhancing readiness to change by collaborating with clients and engaging their capacity to change.
- Motivational interviewing is often used in brief intervention approaches. The goal of motivational interviewing is to help clients explore their ambivalence about their substance use.
- Eliciting the collaboration of family members and significant others may play a key role in encouraging clients to initiate and remain involved with services.

Early intervention is applied at the early stages of an “addiction career” (Tait, 2000) and involves the initial identification of individuals with substance use problems and the provision of activities aimed at removing barriers to essential services (Department of National Health and Welfare, 1992; van der Walde et al., 2002). Whereas preventive efforts are designed to prevent the onset of risk behaviours, early intervention aims to identify and target those who are at risk but do not demonstrate dependency problems (D’Onofrio et al., 1998b). These strategies can decrease substance use and associated risk behaviours before there is significant impairment to key areas of life functioning (D’Onofrio et al.; Tait), by addressing the substance use issues and other health conditions or co-morbid psycho social areas of concern (Tait; Brown, Parker, & Godding, 2002). Some evidence suggests that early intervention may be more effective for those who do not have an extensive history of treatment experiences, as it addresses the substance use problems before they become chronic or severe (Friedmann, Lemon, Stein, & D’Aunno, 2003).

Designing early intervention strategies requires an understanding of the unique circumstances of each client and the adaptation of services to facilitate timely access to treatment. In light of the range of circumstances facing at-risk women, there is a need to adequately focus on the strength or potential of women, and to undertake strength-based interventions that are solution focussed and empower the client to pursue positive change. Brief interviewing techniques are useful for enhancing readiness to change by collaborating with clients, engaging their capacity to change, and empowering them to adopt harm reduction strategies (van den Bergh, 2000; van Wormer, 2002).

In many instances, recognition of problem substance use becomes evident as women access support from other community service providers in health or social service agencies (D’Onofrio et al., 1998a, 1998b; Tait, 2000). It is often community-based professionals, rather than addiction specialists, who initially identify women experiencing or at risk for problem substance use. Community-based professionals are therefore a critical resource for facilitating women’s access to needed services, and play an important role by providing a variety of early intervention activities, including:

- screening for and identifying problem substance use;
- disseminating educational and referral information;
- providing supportive counselling services and interventions; and

- ensuring the coordination of referrals to appropriate substance use treatment programs. (D’Onofrio et al.; Tait).

2.5.1 Screening for Substance Use

Problem substance use patterns are often not easily detected. Women may not fully grasp the severity of their present substance use behaviours or be aware of the associated consequences and risks, and may require prompting before they will provide information about their current situation. As Haver and Franck (1997) noted: “Drinking alcohol becomes a way of self-medication. Since they continue to conceal their drinking problem – and their physicians usually do not ask, these women may receive inadequate treatment or no treatment at all” (p. 31).

A health professional who initiates discussion about substance use is providing an opportunity to invite contemplation or change in behaviour (Royal New Zealand College of General Practitioners, 1999). A wide range of health care professionals may conduct screening services, including family physicians, nurse practitioners, obstetricians, pediatricians, midwives, public health nurses, mental health personnel, and other service providers who counsel women on health or self-care (B.C. Ministry for Children and Families, 1998; D’Onofrio et al., 1998a; Royal New Zealand College of General Practitioners). Correctional and social welfare settings are also appropriate locations for screening (Zilberman et al., 2002).

Benefits of Screening

Screening programs are an important aspect of effective early intervention. They are often the primary method for identifying key factors associated with problem substance use.

Screening processes are helpful for:

- providing education related to health and problem substance use issues;
- advising individuals of the dangers associated with their consumption levels;
- assisting women to identify potential problem substance use;
- facilitating discussions about the need to pursue positive change; and
- making referrals to treatment services (B.C. Ministry for Children and Families, 1998).

Screening Processes

Substance use screening procedures may be included in regular intake processes or be done in conjunction with initial admission interviews. Screening questions can also be incorporated into routine assessment interviews intended to provide information about medical history or life-style patterns (e.g. diet and exercise) (Heirich & Sieck, 2000; Royal New Zealand College of General Practitioners, 1999). It is imperative that the screening questions be completed collaboratively with clients in a manner that is comfortable and safe (SAMHSA, 2003).

Women should be provided with a reason for why questions are being asked and be informed of the limits of confidentiality. Service providers should approach such tasks with a non-judgmental attitude and the intent of encouraging and empowering women to pursue positive life changes (B.C. Ministry for Children and Families, 1998). Service providers should be careful not to phrase questions to convey a moral evaluation of clients' behaviour or choices. Questions should be structured to convey respect and be open-ended to encourage discussion of health issues and concerns related to problem substance use (Royal New Zealand College of General Practitioners, 1999).

Standardized Screening Measures

Several brief standardized screening tests have been found useful for determining current and/or past substance use. They are less time consuming than those in more comprehensive assessment programs (D'Onofrio 1998a), and include:

- CAGE: A mnemonic for four key questions containing the words "cut down, annoyed, guilty, eye-opener." The test is designed to assess for problem alcohol use. The CAGE-AID is specific to drug use.
- Brief MAST – Michigan Alcohol Screening Test: Composed of 10 questions that provide an indication of alcohol abuse or dependency.

- AUDIT– Alcohol Use Disorders Identification Test: A 10-item questionnaire designed to screen for “hazardous or harmful alcohol consumption.”
- TWEAK: A mnemonic for five key questions containing the words “tolerance, worried, eye-opener, amnesia, ‘kut’ down.”

Zilberman et al. (2002) indicates that the AUDIT, the TWEAK, the T-ACE (mnemonic for tolerance, annoyed, cut-down, eye-opener) are more sensitive tools for women, especially when the lower cut-off scores are used. The TWEAK is particularly sensitive for screening women in their perinatal period and was developed initially as an evaluation measure to identify “at-risk pregnant drinkers” (D’Onofrio, 1998a; Zilberman et al.). The CAGE lacks validity with senior adults, especially senior women (Adams, Barry, & Fleming, 1996, cited in Blow & Barry, 2002).

In a systematic review of instruments for screening and brief assessments, Wild, Hodgins, Curtis and Thygesen (2003) recommend that community screening instruments include TWEAK, AUDIT items related to quantity and frequency if this information is desired, CAGE-AID, and specific questions from the Canadian Tobacco Use Monitoring Survey (CTUMS).

The Fagerstrom Tolerance Questionnaire can also be used to assess nicotine dependence (Grigsby & Cheever, 2004).

Structuring Screening Approaches

D’Onofrio et al. (1998a) suggests that an “ideal” screening measure for problem substance use does not exist. Screening practices should incorporate measures that are sensitive enough to identify as many people as possible who would benefit from brief or more intensive interventions. The development of screening approaches must take into account gender differences and demonstrate sensitivity to cultural or racial groups. Service providers should be sensitive as well to varying literacy levels of clients. Additional time and accommodations may be required to support some clients during evaluation processes (Royal New Zealand College of General Practitioners, 1999).

Screening approaches must include information related to current problem substance use. Areas of inquiry that should be addressed during intake or assessment interviews are:

- type of substance(s) used;
- amount and frequency of use;
- possibility of dependence; and
- problems resulting from substance use (Royal New Zealand College of General Practitioners, 1999).

Other guidelines related to the use of screening questions highlight the importance of incorporating questions in practical ways when talking with clients. Table 1 provides a list of informal questions that may be used to obtain information about problem substance use.

Table 1: Practical Questions About Alcohol and Other Drug Use

In addition to screening tools, the following are some sample questions that illustrate a practical approach to asking about the use of alcohol and other drugs.

- How often do you have a drink containing alcohol? How many drinks containing alcohol do you have on a typical day when you are drinking?
- Are there days or times of the week when you drink more than usual? Have you ever driven after drinking?
- Have you ever used illegal drugs?
- How often have you taken illegal drugs during the past year?
- Do you plan to use illegal drugs again?
- Have you ever used inhalants?
- How often have you used inhalants during the past year?
- Do you plan to use inhalants again?
- Are you currently taking any medication to help you sleep, for anxiety or depression, or for pain? How long have you been taking these medications? How often do you take them? Do you usually take the prescribed amount of medication or do you sometimes take less than, or more than, the amount prescribed?
- Do you ever take medication that has been prescribed for someone else? Do you ever share your medication with someone else?
- Have you ever obtained a prescription for the same drug from more than one doctor, without the other doctor knowing? Does one doctor know about all the medications you are taking, even if you are prescribed medications by several doctors?
- Do you ever drink alcohol while you are also taking medication without checking with a doctor?
- Do you have any questions or concerns about your use of substances?
- Do you find that you use alcohol or other drugs to cope with issues in your life (stress, negative feelings, relationships)?
- Have you experienced any problems or negative consequences (e.g. in your relationships, family, work, health or energy level) because of your substance use?
- Has anyone expressed concern to you about your use of substances?
- Have you ever tried cutting down or quitting? What was it like for you?
- Would you like to make changes in your use of alcohol or other drugs?

* Adapted from Addiction Research Foundation (1996)

Screening for Pregnant Women

Tait (2000) stressed the importance of ensuring specific problem substance use screening strategies for women who are pregnant. Early intervention is critical for reducing or preventing the physiological effects associated with problem substance use for both mother and child. Pregnancy provides a unique opportunity to reach women, given their desire to support the healthy development of their children (Zilberman et al., 2002). There is evidence that even brief interventions are effective in reducing substance use in pregnant women (Manwell, Fleming, Mundt et al., 2000, cited in Zilberman et al.).

Screening processes for women are often most effective when undertaken in conjunction with community programs that offer health and social support services (B.C. Ministry for Children and Families, 1998; Royal New Zealand College of General Practitioners, 1999). The Canadian Task Force on Preventive Health Care recommends that screening services be incorporated into regular health examinations for pregnant women or for those who are planning pregnancies (Canadian Task Force on Preventive Health Care, 2004). According to the Joint Statement on Prevention of FAS/FAE in Canada, community-based professionals have a responsibility to screen and educate women and their partners about the potential consequences of alcohol use during pregnancy (B.C. Ministry for Children and Families, 1998).

2.5.2 Screening for Readiness to Change

The screening process in health-related agencies gives service providers an opportunity to discuss current substance use and its impact on various aspects of life functioning with clients. Haver and Franck (1997) noted that women with problem alcohol use often seek support for conditions related to their addiction, such as sleep and eating disorders, and mood and psychosomatic disorders. Women who are identified through health screening interviews may not expect or want support for their substance use. They may also demonstrate minimal desire to explore issues related to their substance use or to view it as problematic. However, some may demonstrate some awareness or concern related to their substance use patterns.

During screening processes, information should be gathered about the nature and prevalence of substance use and the client's readiness to change (D'Onofrio 1998b; Royal New Zealand College of General Practitioners, 1999). Readiness to change is useful for structuring interventions for problem substance use (D'Onofrio et al.). A widely used model for understanding and assessing treatment readiness, The Stages of Change, was developed by Prochaska and DiClemente in 1986 (D'Onofrio et al.). They conceptualized a sequence of stages through which clients move to address areas of problem substance use.

Pre-contemplation Stage: During the pre-contemplation stage, people may not be aware that their substance use is problematic or that change is needed. Community service providers or family members may also notice or become aware of the negative effects resulting from current substance use patterns. For clients to initiate steps toward meaningful change, additional feedback and increased awareness may be required to help them recognize the consequences associated with continued substance use (B.C. Ministry for Children and Families, 1998; D’Onofrio et al., 1998b; SAMHSA, 2003).

Contemplation Stage: The contemplation stage involves a period of ambivalence when people grapple with potential reasons for and against reducing or stopping substance use. It is at this point in the readiness-to-change process that brief intervention and motivational interviewing techniques are used to strengthen the client’s commitment and subsequent move toward positive change (B.C. Ministry for Children and Families, 1998; D’Onofrio et al., 1998b; SAMHSA, 2003).

Preparation Stage: During the preparation stage, community service providers or health professionals assist clients identify specific strategies for pursuing positive change. Such approaches may involve referral to key community services and the identification of evidence-based approaches that address their specific treatment needs (B.C. Ministry for Children and Families; 1998; D’Onofrio et al., 1998b; SAMHSA, 2003).

Action Stage: During the action stage, clients undertake specific steps to initiate change and modify substance use patterns. Although the activities associated with this stage involve a commitment to move toward positive change, such efforts do not ensure that they will be maintained for long periods of time (B.C. Ministry for Children and Families, 1998; D’Onofrio, et al., 1998b; SAMHSA, 2003).

Maintenance Stage: During the maintenance stage, specific actions are initiated to support and sustain the positive efforts undertaken during the action stage. It is during this period that strategies for relapse prevention are developed (B.C. Ministry for Children and Families, 1998; D’Onofrio et al., 1998b, SAMHSA, 2003).

The stages of change model provides a framework for collaborating with clients who are either receptive to or not yet open to pursuing change. Although the initiation of action is outlined only in one phase, implications for enhancing motivation for positive change are evident in each stage. Babor and Higgins-Biddle (2001) emphasize matching client motivation with corresponding intervention strategies to facilitate their commitment and subsequent action toward change. D’Onofrio et al. (1998b) recommend the use of the “Readiness Ruler,” which involves asking the client to rate, on a scale of “1” to “10” how important it is for them to change their present substance use. For this scale, “1” refers to not important and “10” implies very important. Individuals who score between “1” and “3” are

identified as “pre-contemplators” while those who indicate a rating of “4” to “6” are viewed as “contemplators.” Those with scores above “6” are considered as ready to initiate change. Other theorists have cited the use of multiple questions in a questionnaire format designed for specific areas of problem substance use (Royal New Zealand College of General Practitioners, 1999). Having assessed the level of readiness to change and degree of problem substance use, an intervention strategy may be formulated and applied (D’Onofrio et al., 1998b; Miller, 1999).

2.5.3 Brief Interventions

Brief interventions are used strategically to match the client’s current level of motivation. Such interventions have been defined as an “influencing force that comes between” clients and their problem substance use. The intent of brief interventions is to “stand between individuals and their addiction” by assisting them to recognize and evaluate the negative effects of continued substance use. In contrast to traditional treatment approaches in which clients must self-refer and indicate their need for treatment, brief intervention approaches include processes that involve identifying problem substance use and exploring its consequences in a variety of health-related community settings (D’Onofrio et al., 1998b).

Brief interventions may range from 5 to 15 minutes. Typically, they provide a brief assessment of clients’ level of use, feedback on how their current use compares to others, and simple advice or discussion about the consequences of continued use and potential strategies for harm reduction. The application of brief interventions is generally adapted to match the varying levels of clients’ readiness to change. The benefits of this method have been recognized because it can be used without requiring a high level of commitment to pursue change (B.C. Ministry for Children and Families, 1998; D’Onofrio, et al., 1998b; Royal New Zealand College of General Practitioners, 1999).

Controlled studies supporting the effectiveness of brief interventions have been documented in North America and internationally. Many have focussed on the usefulness of brief interventions for reducing problem alcohol use in a variety of health and community settings (Babor & Higgins-Biddle, 2001). Table 2 provides a summary of numerous studies supporting the effectiveness of brief interventions.

Table 2: The Evidence for Brief Intervention

The Evidence for Brief Intervention

During the past 20 years, there have been numerous randomized clinical trials of brief interventions in a variety of health care settings. Studies have been conducted in Australia, Bulgaria, Mexico, the United Kingdom, Norway, Sweden, the United States and many other countries. Evidence for the effectiveness of brief interventions has been summarized in several review articles, including the following:

In one of the earliest review articles, Bien et al. (1993) considered 32 controlled studies involving over 6,000 patients, finding that brief interventions were often as effective as more extensive treatments. "There is encouraging evidence that the course of harmful alcohol use can be effectively altered by well-designed intervention strategies which are feasible within relatively brief-contact contexts such as primary health care settings and employee assistance programs."

Kahan et al. (1995) reviewed 11 trials of brief interventions and concluded that, while further research on specific issues is required, the public health impact of brief interventions is potentially enormous. "Given the evidence for the effectiveness of brief interventions and the minimal amount of time and effort they require, physicians are advised to implement these strategies in their practice."

Twelve randomized controlled trials were reviewed by Wilk et al. (1997), who concluded that drinkers receiving brief intervention were twice as likely to reduce their drinking over 6 to 12 months than those who received no intervention. "Brief intervention is a low-cost, effective preventive measure for heavy drinkers in outpatient settings."

Moyer et al. (2002) reviewed studies comparing brief intervention both to untreated control groups and to more extended treatments. They found "further positive evidence" for the effectiveness of brief intervention, especially among patients with less severe problems. Cautioning that brief intervention should not substitute for specialist treatment, they suggested that they might well serve as an initial treatment for severely dependent patients seeking extended treatment.

* From Babor & Higgins-Biddle, 2001.

2.5.4 Motivational Interviewing

Motivational interviewing is an effective method for enhancing brief intervention approaches (Miller & Rollnick, 1991). It has been designed to incorporate the levels of motivation outlined in Prochaska and DiClemente's (1986) stages-of-change model. The acronym FRAMES has been used to conceptualize the approach:

- **F** – Feedback is given to the client with respect to current health status and problem substance use.
- **R** – Responsibility for change on the part of the client is emphasized.
- **A** – Advice is given regarding harm reduction or referral for treatment from specialized services.
- **M** – Menu refers to the provision of alternatives from which clients may exercise personal choice and commitment in pursuing change.
- **E** – Empathy is used to create a climate conducive to empowering clients to undertake positive changes.
- **S** – Self-efficacy involves service providers' belief in the potential of the client to make positive treatment gains.

The goal of motivational interviewing is to help clients explore their ambivalence about their substance use. In applying this approach, service providers use empathic statements that reflect discrepancies in the client's experience of current substance use patterns and associated consequences. Service providers help clients examine the costs and benefits of substance use, and come to their own conclusions about its effects and consequences. In contrast to heavy "confrontation," concern is communicated, and clients self-evaluate current circumstances and make choices. Service providers then help the client examine the behavioural steps necessary to make changes, what supports are needed, the anticipated challenges and the measures of success (Miller & Rollnick, 1991; Royal New Zealand College of General Practitioners, 1999; Yahne et al., 2002). Table 3 provides examples of motivational interviewing questions that correspond to the various stages of readiness to change (Burge & Schneider, 1999; Rollnick, Heather & Bell, 1992).

Table 3: A Menu of Interviewing Strategies

Interviewing Strategies for Patients with Substance Use Problems		
Strategies	Stage of Change	Description
Lifestyle, stresses and substance use	Precontemplation and all others	Discuss lifestyle and life stresses “Where does your use of drug/alcohol fit in?”
Health and alcohol/substance use	Precontemplation and all others	Ask about health in general “What part does your drinking/substance use play in your health?”
A typical day	Precontemplation and all others	“Describe a typical day, from beginning to end. How does drug/alcohol fit in?”
“Good” things and “less good” things	Contemplation, Preparation and Action	“What are some good things about your use of drug/alcohol? What are some less good things?”
Providing information	Contemplation, Preparation and Action	Ask permission to provide information. Deliver information in a non-personal manner. “What do you make of all this?”
The future and the present	Contemplation, Preparation and Action	“How would you like things to be different in the future?”
Exploring concerns	Preparation and Action	Elicit the patient’s reasons for concern about drug/alcohol use. List concerns about changing behaviour.
Helping with decision-making	Preparation and Action	“Given your concerns about drinking/drug use, where does this leave you now?”

* Adapted from Burge and Schneider (1999) and Rollnick, Heather and Bell (1992).

2.5.5 Brief Negotiation Interview

D’Onofrio et al. (1998b) identified the brief negotiation interview as “an extension” of the motivational interview. This strategy focusses on assisting clients to recognize and modify substance use behaviours that pose significant health risks. This interview involves a joint evaluation of the client’s motivation to change. The term “negotiation” reflects the deliberations undertaken between clients and service providers to determine the client’s level of readiness to pursue treatment options.

Similarly, treatment options are elaborated on and generated in collaboration with the client. The process of negotiation is used to tailor treatment alternatives to the needs of the individual. A key concept is the notion that it is the client who possesses the necessary capacity and knowledge from their own experience to set the stage for change. The client’s participation in pursuing lifestyle changes is as important as the experience and expertise that the service provider brings to the interview (D’Onofrio et al., 1998b).

The process of negotiation is described as a “meeting between experts” comprising five key steps:

- establish rapport;
- ask for permission to discuss the pros and cons of continued substance use;
- be open to allowing clients to self-identify potential evidence of problematic substance use;

- invite clients to assess their readiness for change; and
- negotiate a potential strategy for change, taking into account clients’ perception of their readiness to change (D’Onofrio et al., 1998b).

D’Onofrio, Bernstein and Rollnick (1996, cited in D’Onofrio et al., 1998b) described a range of key principles for effective use of negotiation strategies. These guidelines underscore the importance of service providers respecting and promoting the autonomy of clients and their choices. Clients are viewed as the expert in identifying their need areas and in formulating decisions, while service providers are active in providing information and verbal support for actions undertaken by clients.

2.5.6 Family Participation in Early Intervention Approaches

The concern of family members is an important factor that can motivate clients to seek treatment. Eliciting the collaboration of family members and significant others can play a key role in encouraging clients to initiate and remain involved with intervention services or programs (Copello & Orford, 2002).

The Community Reinforcement and Family Training Approach (CRAFT) emphasizes establishing working relationships with family members of those experiencing problem substance use (Meyers, Miller, Hill, & Tonigan, 1999; Meyers, Miller, & Smith, 2001; Miller, Meyers, & Tonigan, 1999).

This family-oriented approach has three key objectives: to enhance the health, safety and well-being of the family; to engage the family member who is experiencing problem substance use in treatment services; and to reduce the harm associated with continuing substance use. In a 6 month evaluation by Meyers et al. (1999) of 62 significant others, 87% completed their treatment and 74% successfully involved their unmotivated family member in treatment. Improvements were also noted in family members receiving CRAFT whether or not the person with the substance use problem engaged in treatment, with noted reductions in internalizing clinical features (e.g. anxiety and depression). Drug abstinence days also increased. Similar outcomes have been replicated in other randomized clinical studies (Miller, Meyers, & Tonigan, 1999).

In a study by Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999, 32 concerned family members and significant others were recruited through newspaper advertisements offering free treatment to families of drug users. The families were randomly assigned to either the CRAFT or a 12-step support group intervention. The families receiving the CRAFT approach made treatment gains equal to the families assigned to the 12-step support group intervention. The CRAFT model, however, was significantly more effective in sustaining family members' involvement in treatment (85.7% compared to 38.8% for the 12-step) and in facilitating client entry into rehabilitation programs (64% compared to 17% for the 12-step) (Kirby et al., 1999).

Miller (2003) emphasized including family members in early intervention and treatment processes, and when clients do not have such support, reconnecting them with their family or building positive social support systems may be critical for engagement in treatment.

2.5.7 Self-help Resources

Self-help resources can be of benefit in addressing problem substance use. These resources should be tailored to reflect individual or gender-related issues. Written resources identified as helpful employ cognitive behavioural and harm-reduction methodologies. Self-help materials provide a range of relevant information and strategies on setting self-limits, using self-monitoring and recognizing and preparing for high risk problem substance use situations (CAMH, n.d).

Internet recovery services (IRS) can be used as a communication tool for early intervention, and components may include:

- individual e-mails or instant messaging systems;
- bulletin boards or interactive Web pages;
- chat rooms; and
- video conferencing (Hall, Wendell & Tidwell, 2003).

An Internet survey of 1000 users with a usable data analysis sample of 928, focussed on the demographic profile of clients with problem substance use who accessed IRS. This study found that, for the 70 different recovery programs being used, twice as many females as males accessed Internet services and most women users (76%) were under the age of 51. As well, it indicated the diversity of people using the Internet, including all ethnic groups and age levels. Internet options may be viable for those who have access to the Internet, and who are uncomfortable discussing their problems face-to-face with a health professional. Additional research is needed to assess the effectiveness of IRS for early intervention strategies or treatment (Hall, Wendell & Tidwell, 2003).

2.5.8 Settings for Early Intervention

Settings for early intervention are often found outside established addiction treatment facilities or programs. Haver and Franck (1997) indicate that women experiencing substance use problems often seek assistance for other conditions related to their addiction. Support may be sought in a variety of community-based settings, including primary health care centres and workplace programs (Samet, Friedmann, & Saitz, 2001). Previous research suggests that between 2% and 18% of women who seek assistance from medical services or health settings show hazardous levels of alcohol consumption (Haver & Franck). In addition, women who develop substance use problems often have co-morbid features, such as anxiety and depression, which prompts them to seek support from other counselling or mental

health facilities. In many instances, women may conceal their problem substance use at health appointments or when they meet community service providers. If health professionals do not include questions in their screening practices related to problem substance use, many women may not receive adequate treatment or any treatment at all (Haver & Franck).

In a Swedish program, the Karolinska project for Early treatment of Women with Alcohol Addiction (EWA), women without prior treatment were encouraged to seek assistance for their problem substance use. Participants were contacted through health-related organizations and services in the community. The treatment intervention involved a short inpatient stay followed by frequent outpatient appointments for a minimum of 6 months, maintaining a stable client–therapist relationship over the course of the program. These appointments included medical evaluations, counselling and therapeutic services, and the development of a “total life situation” treatment contract addressing social support, vocational concerns and a range of physical and mental health issues. There is a research program attached to the EWA and a 2 year outcome study, involving 84 of the first 100 women treated, showed that two thirds of the participants experienced positive outcomes, including drinking within recommended guidelines, and improved occupational functioning and social relationships (Haver & Franck, 1997).

Health appointments with primary care physicians are an opportunity for both screening and brief interventions for problem substance use (Welte, Perry, Longabaugh & Clifford, 1998). To determine the effectiveness

of the Health Care Intervention Service (HIS), 673 hospital patients experiencing or at risk for alcohol dependence were recruited for an attempt at follow-up. Two intervention groups and one control group were formed. Six months post intervention, with a follow-up rate of 75%, the full intervention group showed a reduction in problematic substance use and were more likely to accept a referral for additional assistance; the risk-reduction group also showed a reduction in substance use compared to the control group. Brief intervention focussing on risk reduction was found to render positive effects in reducing alcohol consumption and associated consequences. The results support the notion that “less intensive interventions” may be effective in modifying substance use behaviours and even people who exhibit features of dependence may benefit from such interventions (Welte et al.).

Screening patients who access emergency hospital services can be of benefit (D’Onofrio et al., 1998a). D’Onofrio et al. report that some studies of emergency departments have found that as many as 38% of patients are legally intoxicated when they seek assistance. Given this high prevalence, effective screening and referral services in emergency departments may reduce further morbidity and mortality from substance use. The authors suggest that screening and early intervention services are often not available in emergency departments because of insufficient time and resources, and a lack of education and training for personnel.

Evidence supports the effectiveness of workplace programs in improving health (Lapham,

Gregory & McMillan, 2003). Messages received in workplace settings about problematic substance use can be linked with general health, diet and exercise themes. Successful workplace health programs use general screening and intervention approaches for all employees, with special attention given to those at-risk (Pelletier, 1999, cited in Lapham et al., 2003). Positive outcomes have included reduced rates of absenteeism (Stein, Shakour, & Zuidema, 2000), decreased medical costs, and increases in healthy behaviours by employees (Goetzel et al., 1998).

Lapham et al. (2003) undertook a controlled 3 year study of a worksite early intervention program for health care professionals addressing binge drinking and the intent to reduce alcohol use. The program, entitled Project WISE (Workplace Initiative in Substance Education), involved substance misuse awareness training for managers and application of various health risk appraisals with employees. These measures were supported by showing educational health videos on issues related to problem substance use. The study compared 3442 participants receiving Project WISE at one site to 2032 participants at satellite sites who did not receive the intervention. After three years, outcome analysis indicated that binge drinking rates did not change substantially in either group. Changes were reported, however, in motivation to reduce alcohol consumption, with binge drinkers who received Project WISE being more than twice as likely as those in control sites to indicate a desire to reduce their alcohol intake.

Cardiovascular risk prevention programs implemented in the worksite are often well attended by employees, and may offer a unique opportunity to address alcohol consumption in the context of overall health. Heirich and Sieck (2000) conducted a controlled trial of a worksite alcohol abuse prevention program, comparing 2000 employees randomly assigned to either the individual outreach and personal counselling group or to the control group where clients received group health education classes. Re-screening after three years indicated that reductions in various cardiovascular risk behaviours, including alcohol use, were noted for both groups, however, more clients improved in the group receiving individualized counselling than those participating in the education classes, and 43% of those who had been assessed as at-risk drinkers were abstinent or had reduced their consumption to safe levels.

Richmond, Kehoe, Heather and Wodak (2000) evaluated a workplace brief intervention program for excessive alcohol consumption, where 1206 self-selected employees were randomly assigned to either the brief intervention or comparison group. The intervention was delivered in the context of a broader health and wellness program. After 10 months, significant reductions in alcohol consumption were reported among women who received the intervention, but not among men. Richmond et al. indicated that in many studies, brief interventions yield positive results for men but not for women. In this study, women showed reductions in alcohol consumption at follow-up regardless of whether they were in the intervention or comparison groups. The authors speculated that the process of conducting screening and

assessment processes with women might have facilitated self-reflection about their substance use behaviours, which in turn may have resulted in the decision to reduce their consumption of alcohol or other substances.

2.5.9 Specialized Consultation and Training for Health Care Providers

It is important to have addiction specialists inform health professionals about the wide range of features associated with problem substance use (Haver & Franck, 1997). Specialized addiction counsellors can act as consultants to educate a wide range of service providers responsible for health care services for women in areas related to:

- pregnancy and early childhood development;
- general medical practice;
- psychiatry;
- gynaecology; and
- workplace health services.

Welte et al. (1998) noted that to ensure successful implementation of early intervention programs in health care and medical settings, a commitment by health organizations and senior personnel to provide in-service training for their health staff is required. Health professionals who receive specialized training will be more effective at detecting problem substance use and providing clients with focussed interventions.

Considerable research is still required to enhance the effectiveness of screening and early intervention programs for women with problem substance use in health care or other related

settings. As well, research is needed to examine the impact of health care facilities detecting and referring women to treatment services (Haver & Franck, 1997).

2.6 Outreach

For related results from Key Informant Interviews, see section 3.4

For related results from Focus Groups, see section 4.6

KEY POINTS

- Outreach involves meeting clients in their own environments to engage them in treatment or assist them in accessing other needed services.
- Outreach services are most effective when they are in accessible locations.
- Outreach functions involve building trust and engaging persons gradually over brief encounters.
- Workers must be committed to engaging women in an assessment of risk behaviours and in realistically discussing what resources may be available to enable and support sustainable change.
- The provision of outreach, transportation and child care can lead to greater use of community-based services, which can contribute to decreases in substance use.

Outreach services are a critical part of the continuum of care. Outreach involves meeting clients in their own environments to engage them in treatment or assist them in accessing other needed services (van der Walde et al., 2002). Outreach activities are beneficial for

establishing links with women who are known to have, or be at risk for substance use problems. These efforts may address problem substance use issues that are recent or long-standing (Department of National Health and Welfare, 1992). Many of the early intervention strategies outlined in the previous section can be applied in outreach programs. For example, motivational interviewing and brief interventions are important techniques that can be employed during outreach interventions.

Clients who require outreach services to facilitate access to treatment tend to be further disengaged from formal, informal and family support systems (Tommasello, Myers, Gillis, Treherne, & Plumhoff, 1999). Marsh et al. (2000) noted that women who require outreach were among the heaviest substance users and exhibit a range of other co-morbid health conditions and psychosocial challenges. Community-based outreach services may be particularly effective in engaging clients with challenges or conditions such as homelessness, injection drug use, HIV and other blood-borne infections, concurrent mental health disorders,

unemployment, history of abuse and conflict with the law (Melchior, Huba, Brown, & Slaughter, 1999; Rowe, Fisk, Frey, & Davidson, 2002; Tinsman, Bullman, Chen, Burgdorf, & Herrell, 2001; Tommasello et al.; Yahne et al., 2002).

Outreach programs can be designed within larger treatment programs that offer an array of services or within independent programs associated with other community service providers. They can also be linked to a wide range of community-based health settings that screen for problem substance use and provide referrals to appropriate treatment (NIDA, 2000).

2.6.1 Location of Outreach Services

Outreach services are often most effective when they are accessible in a variety of locations. Given that women with problem substance use are found throughout the community, outreach programs need to take into account the natural living environments of those who could benefit from treatment. Traditional office-based settings, where clients must arrange transportation and attend scheduled appointments, can be difficult for some. Clients who lose faith in the existing system of care may require individualized outreach services to engage them (Tinsman et al., 2001; Tommasello et al., 1999). Community-based or more natural settings can provide increased accessibility and convenience for connecting with clients.

The NIDA (2000) Community-based Outreach Model underscores the importance of face-to-face outreach contacts with clients in a variety of potential settings, including:

- store fronts;
- soup kitchens and food banks;
- homeless shelters;
- temporary locations in hotels or motel rooms;
- hospital emergency departments; and
- accessible offices in buildings with community-based health services.

Other locations can include sites where substances are purchased and used on a regular basis. Appropriate outreach locations can be determined by consulting with community service providers (e.g. police and health agencies) and local agencies that are aware of where and when people at risk spend time (NIDA, 2000; Rowe et al., 2002; Witbeck, Hornfeld, & Dalack, 2000).

2.6.2 Structuring Outreach Interventions

Outreach programs and intervention efforts should respond to the unique needs and circumstances of those requiring treatment services. Workers must be committed to engaging clients in personally assessing their own risk behaviours and having them take part in realistic discussions of resources available to support changes (NIDA, 2000; Yahne et al., 2002).

There is some variety in how outreach services can be structured to address both operational concerns and the needs of clients. They may be delivered through street-based contacts, or be operated through drop-in centres that provide easy access to clients for meeting with workers and other health professionals. Mobile units that combine delivery of health-based programs can also assist in reaching people who would not seek out more structured services (Rowe et al., 2002; Tinsman et al., 2001).

The hours of operation should reflect when clients are easily contacted. On-call protocols for supervisor support should be organized to provide assistance to outreach workers while they are in the field. It can be beneficial for outreach personnel to work in teams of two. As changes in staff take place, teams can provide continuity and ensure stability in relationships with clients (NIDA, 2000).

Outreach programs should obtain information that will facilitate making subsequent contact with clients. For new clients, attempts should be made to obtain personal information, including the participant's name, street name, home address, mailing address, telephone number, alternate contact information (friends or family) and locations in the community where the client regularly spends time (NIDA, 2000; Yahne et al., 2002).

2.6.3 Outreach Personnel

Outreach workers play a key role in client engagement and retention. They support clients by encouraging contemplation about behaviour, consulting on treatment planning and acting as a liaison with other service providers (Rowe et al., 2002).

Providing services by outreach workers who live in the area may be beneficial. They are acquainted with the local community and may be aware of existing drug use subcultures (NIDA, 2000). They may have increased opportunity to be credible role models, educators and advocates. They may also be in a better position to monitor community activities related to local drug use settings and sensitize other program staff to emerging issues that impact clients or the delivery of outreach services. They may be in a unique position to:

- recognize situational barriers that may limit progress toward risk reduction measures;
- understand the values and norms of specific client groups;
- build trust with identified client groups;
- identify and gain access to high-risk sites; and
- enhance community acceptance of outreach programs and organized intervention efforts (NIDA, 2000).

It is beneficial for outreach workers to reflect the “ethnic, gender or cultural” profiles of the identified client groups to help reduce language barriers and ensure that outreach services are responsive to the unique needs of individual clients and groups (Health Canada, 1996a).

A range of skills and attitudes are associated with effective outreach, including:

- communicate unconditional caring and respect for clients;
- apply knowledge of local resources to the needs of problem substance users;
- network within groups of individuals at risk;
- organize and maintain accurate records;
- work in both structured and unstructured service settings; and
- obtain and provide referrals to a comprehensive range of services and facilities (NIDA, 2000).

NIDA (2000) indicates that some outreach programs have found it advantageous to employ outreach workers who have personal substance use experience. They can credibly share their experiences about the key actions required to initiate and sustain change. These outreach workers are often able to communicate in terms familiar to the client target group. The examples they provide of their own experiences can be a model for clients. If staff members have been former drug users, it is recommended that they demonstrate at least two

years of abstinence. The use of support groups assists staff who consider themselves to be in recovery from problem substance use (NIDA, 2000).

Staff should receive specialized on-the-job training and mentoring to support the independence that is needed to be an outreach worker. Many programs use a two-phase training approach, including office- or class-room-based instructional sessions followed by supervised training in the field. The content for in-service training programs should include instruction on how to:

- recognize and make contact with target group members;
- explain the intent of the outreach program and establish trust;
- identify locations for follow-up contact and meetings with clients;
- work and collaborate with other community service providers;
- address personal safety and security concerns; and
- structure brief interventions and help clients access services (NIDA, 2000; Rowe et al., 2002).

2.6.4 Key Outreach Activities

Interactions between outreach workers and at-risk women may be brief or involve longer periods of time. The content involved in these meetings can include:

- exploring risk behaviours;
- identifying realistic strategies for reducing harm;
- providing educational information to support risk reduction efforts; and
- facilitating referrals to needed services (NIDA, 2000).

During informal sessions, outreach workers can use a range of strategies or approaches to engage clients, including:

- using active listening skills to encourage clients' exploration of areas of concern;
- exploring pros and cons of continued substance use;
- formulating plans to address potential barriers to accessing needed services;
- identifying potential social support networks; and
- affirming the clients' ability and commitment to undertake change.

Outreach usually involves building trust and engaging clients gradually over brief encounters. Many of the preceding strategies reflect the use of brief intervention modalities, including motivational interviewing and applied negotiation processes (NIDA, 2000; Rowe et al., 2002).

In addition to providing support for reducing substance use, outreach workers are in a unique position to help clients access services for immediate needs, such as lodging, food, income support, referral for medical attention, and linking with supportive formal or informal social networks. Outreach personnel have been referred to as the “glue” that links the service system together for people with problem substance use (Rowe et al., 2002; Tinsman et al., 2001).

2.6.5 Research Related to Outreach to Women

Melchior et al.(1999), studied 665 women participating in an enhanced outreach and treatment readiness preparation program to determine patterns of treatment entry. They found that, after 4 years, 82.9% of the women had received referrals to substance abuse treatment programs, and of these 51.4% enrolled. As well, the frequency of outreach was inversely related to the likelihood that women with substance use problems would be referred for services. Women who received and accepted referrals were less likely to remain on the streets to receive contact by outreach workers. Continued contact is essential for engaging

women who are not yet ready to accept treatment. The authors stress the importance of enhancing client motivation to change through the application of brief intervention and motivational interviewing techniques. Tinsman et al. (2001) noted that women who received a pre-treatment intervention through outreach were more likely to enter treatment at women-focussed centres.

Women living in circumstances involving domestic violence or in high-risk behaviours are less likely to carry through on outreach referrals for treatment (Melchior et al., 1999). For these women, problem substance use may not be the most immediate concern or challenge they are facing. They may be more concerned with their own personal safety or that of their children. Women with multiple vulnerabilities have a greater range of concerns and challenges, which can reinforce the belief that meaningful change is not possible. Outreach services must work in the context of the immediate situation and provide additional support for the problem substance use and the other areas of concern. Comprehensive support approaches can be critical for enhancing women's willingness and commitment to address their problems.

A study of an outreach program for female street sex workers employed a brief intervention approach using motivational interviewing (Yahne et al., 2002). Twenty-seven women were interviewed about their substance use, health risks and plans for change. This interview technique focussed on conveying genuine concern, asking direct questions and eliciting self-motivational statements. Outreach workers asked clients about their readiness to reduce their substance use and prompted them to

consider the supports required for them to make positive changes. Four months after the initial contact, participants were re-interviewed. At the close of the study, the women reported an increase in the drug abstinent days, from 15% to 51%. They also reported reductions in sex trade work during the same time period. The authors of the study also reviewed the priorities set by women at the outset of the investigation. It is significant that without reliable housing, few of these women would have had the resources necessary to escape the cycle of prostitution and drug use (Yahne et al.).

Marsh et al. (2000) compared an enhanced substance use treatment program with a regular rehabilitation program in a quasi-experimental study that focussed on women with children. Of the total sample of 468 selected clients, 148 agreed to participate in the study: 73 clients were randomly assigned to the enhanced program that provided the "access services" of outreach, transportation, on-site child care and at-home child care and 75 clients were randomly assigned to the regular rehabilitation program. The results, measured 14 months after entering treatment, showed that involvement in the enhanced program was significantly negatively correlated with problem substance use and the provision of access services led significantly to greater use of community-based social services, which was in turn also related to decreased substance use. This study supports the notion that providing access services for health- and social-related services can be effective for women with children.

2.7 Community Linkages

For related results from Key Informant Interviews, see section 3.5

For related results from Focus Groups, see section 4.7

KEY POINTS

- Community linkages need to be considered at both the client and systemic levels.
- Linking with community-based services addresses the needs of women with multiple risk factors by coordinating access to a range of medical, social, housing, legal and other programs.
- Liaison personnel, case managers, treatment advocates and case consultation processes can establish and maintain linkages to address the unique needs and circumstances of the client.
- Interagency collaborations maximize the use of limited resources and ensure that multidisciplinary service provision is responsive to the needs of women and their families.
- Enhancing community linkages has specific benefits, including early identification of problem substance use and the opportunity to take proactive steps to prevent relapse for clients already involved in treatment.
- Linkages with primary health care professionals provide opportunities to prevent or treat medical complications caused by substance abuse and deliver early interventions and relapse prevention services.

Community linkages need to be considered at both the client and systemic levels. At the client level, this involves ensuring referral to services that address problem substance use and other related health or basic needs. Liaison personnel, case managers, treatment advocates and case consultation processes help to establish and maintain linkages (Grant, Ernst, & Streissguth, 1999). The process is enhanced when case planning is coordinated and addresses the unique needs and circumstances of the client.

At the systemic level, community linkages refer to cross-sectoral services that work together to provide integrated service delivery systems for clients with a wide range of psychosocial needs. Within such community-based social support models, the continuum of care addresses primary, secondary and tertiary levels of intervention and applies these to individual, family and community needs. Facilitating community linkages requires collaboration and coordination among service providers to maximize the use of limited resources and ensure that multidisciplinary service provision is responsive to the needs of women and their families (Friedmann et al., 2003; Samet et al., 2001). Memoranda of understanding are helpful for introducing new programs into communities and clarifying the roles of agencies (Grant et al., 1999).

Women with substance use problems can experience a range of barriers that prevent or limit their access to services. For example, lack of transportation, inadequate outreach services, absence of social networks to assist with child care and family responsibilities can impede women from making contact with treatment programs, even when they are available in the community. As women initiate contact with treatment programs, other issues may need to be addressed as part of a comprehensive care plan, such as unsafe living conditions, inadequate financial resources, health or mental health conditions. Recent literature underscores the importance of incorporating a wider range of service options to address the complex array of needs experienced by many women. Developing and maintaining strong community linkages among service providers is important to increase support for women (Marsh et al., 2000).

2.7.1 Relevant Community-based Linkages for Women

Linkages with community-based services help to address the needs of women with multiple vulnerabilities by coordinating access to a range of medical, social, housing, legal and other programs (Brown et al., 2000; Vines & Mandell, 1999). Zilberman et al. (2002) recommends that treatment facilities that serve women develop strong referral and collaborative linkages with community shelters for women and counselling services for domestic violence. Establishing working relationships with prenatal care and other related gynecological services are also suggested.

Fostering relevant community linkages involves taking into account women's present life circumstances, and in conjunction with addiction treatment services, ensuring access to a range of other support services necessary for women to initiate and sustain participation in treatment, including:

- gender-specific support networks;
- child care services;
- partner or family therapy;
- parenting programs;
- education and employment preparation; and
- counselling for mental health concerns.

Gender-specific Support Networks

Research has emphasized the importance of gender-specific support networks (Swift & Copeland, 1998; van der Walde et al., 2002), where women have the opportunity to share their experiences and express their feelings in an emotionally safe environment. Gender-specific approaches provide the potential for interactions with positive role models and building support networks (Coughey et al., 1998; Health Canada, 2001c; Sterk, Elifson, & Theall, 2000; Swift & Copeland; van der Walde et al.). Some researchers caution that women-only approaches may not expose women to positive male role models (Swift & Copeland).

Provision of Child Care Services

There is converging evidence that child care is essential to enable women to enter and remain in treatment (Trepper, McCollum, Dankoski, Davis, & LaFazia, 2000; van der Walde et al., 2002). Access to child care services contributes to effective treatment as well as enhancing access to other services and program activities that respond to women's needs (Marsh et al., 2000).

Partner or Family Therapy

Intimate relationships have an influence on treatment outcomes for women (Riehm et al., 2000). Family therapy is beneficial for supporting the family members of women with problem substance use. With therapeutic support, family members can learn responses that help in the treatment process (Meyers et al., 2001; van der Walde et al., 2002).

Trepper et al. (2000) reviewed family therapy studies for drug treatment programs in which both partners were involved. They found higher retention rates and longer periods of sustained treatment progress for family therapy clients than for those who attended individually focussed programs. Trepper et al. also conducted a pilot study that, of a sample of 38 women in residential treatment, compared those receiving both couple focussed and individually focussed treatment to those receiving only individually focussed treatment. Only 21% of the women were available for assessment post treatment, however the results showed that women who experienced the

additional couple focussed treatment were abstinent for significantly more days and had greater improvements on measures of couple commitment, couple happiness, general family functioning and family communication. Engagement of significant partners may provide a supportive environment where treatment gains can be sustained.

Parenting Programs

Parenting classes are regarded as positive additions for women receiving treatment for substance use problems. They can enhance parenting skills, increase feelings of competency in child rearing, address feelings of shame and guilt, and strengthen parent-child attachments (van der Walde et al., 2002).

Education and Employment Preparation

Problems in accessing services for substance use treatment are further exacerbated by poverty, poor educational status and low incomes (van der Walde et al., 2002; Zilberman et al., 2002). The inclusion of education and employment training as components of the treatment plan have been shown to improve outcomes related to psychological and economic security (Vines & Mandell, 1999). In addition to acquiring essential work skills, women feel an increased sense of purpose, greater autonomy and involvement in activities in the community (Woolis, 1998). Vocational programs also have a positive impact by focussing on strengths over deficits, and fostering a sense of empowerment (van der Walde et al.).

Counselling for Mental Health Concerns

Counselling for women with substance use problems should address mental health concerns such as depression, anxiety, feelings of powerlessness or difficulties in establishing trust, and explore how these issues relate to personal histories of substance use, trauma or loss (Health Canada, 1999; Thompson et al., 1998).

2.7.2 Benefits Associated with Developing Community Linkages

Developing community linkages has advantages for clients, service providers and the community at large. For the client, linking community systems or services is critical for enhancing overall care and treatment. Ideally, coordinated and enhanced service delivery will result in reduction of problem substance use and the health and social consequences related to addiction (Samet et al., 2001; Thompson et al., 1998). For community service providers, benefits include the possibility of early identification of problem substance use and the opportunity to take proactive steps to prevent relapse for those in treatment. Some theorists also note that the development of community linkages may reduce the stigma associated with problem substance use. From the community perspective, costs are decreased as expenditures associated with health risks and judicial measures are minimized. See Table 4 for a summary of potential benefits associated with community linkages. Additional research is warranted, however, to provide further evidence for these benefits and cost savings (Samet et al.).

2.7.3 Service Linkage Models

Two models for linking services in the community have been conceptualized: centralized and distributive models. The centralized approach involves linking two primary care services in a single site. This may include bringing mental health and problem substance use together to streamline services. In centralized models, health professionals need training in problem substance use for effective service delivery (Samet et al., 2001, 2003).

The centralized approach has been described as a “one-stop shopping model” and addresses the barriers evident in complex service delivery systems that require clients to negotiate multiple points of entry (Samet et al., 2001). Friedmann, D’Aunno, Jin and Alexander (2000) emphasize providing on-site access and direct health delivery services to clients. They found that utilization of health services was greater for clients who had on-site access compared with those who were referred to formally arranged services between service providers.

Willenbring and Olson (1999) reported positive results for this model when integrating alcohol treatment for men in a primary health care setting. This model included:

- minimum monthly appointments at the clinic;
- outreach for clients who missed appointments;
- completion of clinical notes that prompted primary care physicians to monitor the alcohol intake of clients;

Table 4 : Potential Benefits of Linking Primary Care and Substance Abuse Care Services*

<p>Patient perspective</p> <ul style="list-style-type: none"> Benefits overall care Facilitates access to substance abuse treatment for patients in medical care settings Enhances access to primary medical care for clients receiving substance abuse treatment Improves patient well-being in terms of substance abuse severity and medical problems Provides care that is more convenient Increases patient satisfaction with health care <p>Primary care provider and mental health care provider perspective</p> <ul style="list-style-type: none"> Promotes screening for alcoholism in patients Facilitates inclusion of alcoholism and drug abuse when considering a differential diagnosis Broadens access to the overall substance abuse treatment system Improves prevention of relapse to alcoholism and drug abuse Encourages mental health services for primary care patients Improves adherence to appointments and medical regimens Provides substance abuse training for staff <p>Substance abuse provider perspective</p> <ul style="list-style-type: none"> Improves substance abuse treatment outcomes Reduces medical providers' perceived stigma associated with substance abuse Provides training in substance abuse-related medical conditions Promotes overall healthier behaviour (i.e. improves smoking and sexual habits) Improves medical providers' appreciation of substance abuse treatment Creates support for reimbursement parity for substance abuse services Develops ongoing quality improvement in substance abuse programs <p>Societal perspective</p> <ul style="list-style-type: none"> Reduces health care costs and overall long-term costs Diminishes duplication of services and administrative costs Improves health outcomes in specific populations
--

* From Samet et al., 2001

- advice for health practitioners on the consequences associated with problem substance use and approaches for harm reduction; and
- available on-site mental health counselling services.

One of the key challenges associated with centralized models is unifying the treatment modalities, service delivery frameworks and resource allocations from existing services to create a single, integrated service. A lack of commitment and resources will impede the development of a comprehensive and centralized service.

Distributive models depend on developing effective collaboration and consultation practices among individual providers and service sectors. Strong referral protocols between agencies and effective case management practices are viewed as key components of this model. The distributive model represents a commitment to work toward creating an integrated service delivery system (Samet et al., 2001; 2003; Tinsman et al., 2001). One of the strengths of the distributive model is that it builds on the existing service delivery capacity of communities. Cooperation among service providers, however, must be fostered.

Additional research is needed to investigate the impact of these types of service delivery models. Studies should evaluate the therapeutic benefits and the actual costs of these systems over time (Samet et al., 2001).

2.7.4 Establishing Links with Health Care Providers

It is a significant challenge for women who exhibit health and mental health conditions, in addition to addiction issues, to access health care. They may lack transportation, require child care to attend scheduled appointments or be unaware of the specific steps needed to initiate health referrals (Anderson et al.; Friedmann, Lemon, Stein, Etheridge, & D'Aunno, 2001). Anderson et al. (2003) describe an integrated health and substance use treatment model for women that uses a case management approach to organize and integrate services for women. This approach involves:

- providing outreach;
- establishing links between health care providers and clients;
- encouraging integration of care services among community service providers; and
- implementing strategies that promote client retention in health care.

This personalized care model emphasizes establishing collaborative relationships with clients in which they are active participants defining their own areas of concern and designing their own action plans. Linkages with relevant services are facilitated by providing support activities, such as:

- transportation to health appointments;
- child care during health appointments; and

- accompanying women to preliminary appointments to facilitate their understanding of treatment recommendations (Anderson et al., 2003).

This program has noted significant improvements in scheduling outpatient medical services for clients. In addition, drug use decreased, declines in psychological distress were noted and women reported an improvement in their sense of well-being (Andersen et al., 2003).

In another study assessing the effectiveness of linking health care services and problem substance use treatment, Samet et al. (2003) reported the outcomes of a controlled trial involving clients with alcohol, heroin or cocaine problems in a detoxification unit who had no primary care physician. Of the 470 subjects enrolled, 235 were randomized to the health evaluation and linkage to primary care physician (HELP) clinic intervention and the other 235 to the standard detoxification control group. Staff members of the HELP clinic intervention were trained to focus on clients' indifference to engagement in medical care and to use motivational interviewing techniques to heighten their willingness to participate in the treatment process. Follow-up at 12 months showed that clients who received the treatment were significantly more likely to be successfully linked to medical care than control participants who did not receive the HELP intervention (69% vs. 53%).

Linkages with primary health care present opportunities to prevent or treat medical complications due to substance abuse and deliver early interventions and relapse prevention services (Friedmann, Saitz, & Samet, 1998; Samet et al., 2003). When linkages exist between health care providers and addiction treatment specialists, practitioners are able to be more effective when screening for problem substance use and linking clients to needed services (Friedmann et al., 2000; Samet et al., 2001).

2.7.5 Establishing Links with Other Community Services

Marsh et al. (2000)(see section 2.6.5) found that the use of special access services (outreach, transportation and child care), the receipt of community-based social supports and health services is negatively related to substance use among women with children. The social supports they examined included parenting classes, family counselling, domestic violence counselling, education and employment training, legal services, assistance with housing and obtaining public benefits.

In another investigation, paraprofessional advocates were employed to link pregnant and new mothers with substance use problems to community services. Of the 103 women asked to participate, 65 were enrolled as clients, 31 as controls and 7 refused enrollment. The follow-up rate at 36 months was 92% for clients and 83% for controls. Compared with control participants, those who received the advocacy

intervention made greater progress in family planning, and participating in community-based services, and 14 of the clients entered and completed treatment during the 3 year intervention, while none of the controls did. The overall results provide evidence for the use of longer term advocacy services to facilitate community linkages for women with problem substance use (Ernst, Grant, Streissguth, & Sampson, 1999).

McLellan et al. (1998) compared an enhanced outpatient treatment program offering clinical case management services to standard outpatient treatment programs. Case managers were responsible for evaluating the health and social needs of clients and for linking clients to community services such as education, employment, housing, recreation and parenting resources. After six months, clients who received case management services showed significant improvements compared with control participants in their drug and alcohol use, personal health and social functioning. The researchers recognized that people with substance use problems often come with multiple problems and addiction-focused efforts need to be coupled with social support services to achieve improvements in health, substance use and social functioning.

2.7.6 Key Challenges in the Development of Community Linkages

When seeking creative ways to link with other services, community service providers are often faced with the challenge of working within the constraints of their respective departmental mandates. Although close working relationships among service providers, in rural or urban settings, support the development of integrated service delivery efforts, inconsistent policies can pose challenges for remaining client-focused. Some service delivery systems have included cross-departmental mechanisms or committees of senior-level managers or provincial representatives responsible for investigating areas of policy ineffectiveness and identifying solutions. It has been suggested that policy review strategies are effective only if they have the resources and support necessary to bring about meaningful change in both policy and its application (Loeber, Farrington, & Petechuk, 2003).

Interviews with Key Experts

3.1 Selection of Key Experts

Key experts were identified in consultation with the members of the Health Canada ADTR Working Group. The list of experts included those who had expertise in providing outreach and early intervention services or facilitating

community linkages for women with problem substance use. Tables 5, 6 and 7, respectively, provide the location, the professional role and the academic background of the interviewed experts.

Table 5: Geographical Distribution of Key Experts

Geographic Location (number)	Number of Key Experts
North Northwest Territories (1) Yukon (1)	2
East Nova Scotia (2) New Brunswick (2)	4
Central Quebec (2) Ontario (5)	7
West Saskatchewan (3) Alberta (2) British Columbia (1)	6

Table 6: Professional Roles of Key Experts

Professional Roles	Number of Key Experts
Program manager, service coordinator	9
Front-line worker involved in outreach, counselling, treatment delivery	5
Agency Director	4
Government Policy Advisor	2
Researcher	1

Table 7: Academic Background of Key Experts

Academic Background	Number of Key Experts*
Addictions counselling	6
Social work	6
Nursing	4
Medicine	1
Psychology, Mental health	4
Education	2
Administration	1

* Some key experts had a background in more than one field.

3.2 Key Expert Interview Process

The key experts, representing each province and territory in Canada, were contacted in the summer and fall of 2004. Nineteen interviews were carried out across the country, and two interviews were conducted with more than one key informant. The major areas of focus included:

- circumstances and needs of women with substance use problems;
- service delivery considerations for specific groups of women;
- theoretical or applied orientations for early intervention and outreach;
- early intervention and outreach approaches;
- potential roles for family members, service providers and addiction specialists;
- evaluation of early intervention and outreach strategies;
- essential community-based services and supports;
- barriers to linking community-based programs and treatment services;
- working toward coordinated service delivery;
- strategies for promoting effective consultation and development of community linkages;
- approaches for addressing gaps or inconsistencies in services or policies; and
- challenges and strengths of integrative approaches.

The data gathered from the key experts were recorded to produce 19 written interview protocols. These were then merged to provide a unified data set. Content analysis was used to identify emergent theme categories. The findings for each area of inquiry are presented in the following sections.

3.3 Key Client Considerations

For related results from Literature Review, see sections 2.3 and 2.4

For related results from Focus Groups, see sections 4.3 and 4.4

3.3.1 Circumstances and Needs of Women with Substance Use Problems

Participants were asked to describe the main circumstances that women with problem substance use often face. Respondents outlined a range of key challenges related to the current life situations of many women. These included:

- *History of trauma, violence, and victimization:* Women with problem substance use often have histories of trauma and abuse. In many instances, they are currently victims of domestic violence or sexual assault and have experienced significant stress related to personal and family safety.
- *Stigma and risks associated with seeking treatment:* Many women avoid seeking treatment as a result of potential repercussions resulting from their disclosure of problem substance use. Perceived consequences linked with accessing treatment support can include loss of custody of children, estrangement from family members and social relationships, and risk of increased domestic violence.
- *Multiple family and caregiver responsibilities:* Women often have additional responsibilities including care for children, aging parents or other family members. In many instances, they may be the primary or sole caregivers within the current family system.

- *Poverty and inadequate housing:* In addition to problem substance use issues, women may have concerns related to financial stressors and provision of basic needs for themselves or family members. As a result, they may be reluctant to engage treatment services if other need areas cannot be addressed.
- *Fewer social supports, isolation:* Many key informants indicated that women with substance use problems often have limited social support networks or positive links within their communities. Lack of child care services and transportation further impedes efforts to access support or engage in treatment activities.
- *Emotional and personal distress:* Women often experience feelings of guilt and shame related to their continued problem substance use. Such personal distress contributes to lower levels of self-esteem, feelings of sadness and decreased hope.

3.3.2 Service Delivery Considerations for Specific Groups of Women

Key informants were asked to identify the main issues that should be taken into account for specific groups of women when providing early intervention and outreach services in the community setting and enhancing community linkages.

Pregnant Women

- Early intervention and outreach initiatives need to make concerted efforts to establish positive helping relationships with women who are pregnant. This is particularly important for preserving the health of both the child and mother and reducing the risks associated with FASD.
- Support activities should include disseminating relevant health information on prenatal care and ensuring basic medical services.
- Several respondents also indicated the need to provide advocacy for this client group to connect them with key services and using non-judgmental approaches in developing a strong therapeutic alliance.

Women with Children

- Women's fears regarding the potential for losing custody of their children are a significant barrier to pursuing treatment. Efforts should be undertaken to address this when providing early intervention and outreach.
- Basic needs, including adequate resources for food, clothing or housing, need to be addressed in conjunction with outreach and treatment efforts.
- Provision of child care and transportation services are important considerations to facilitate women's initial involvement in programs.

- Outreach to clients can be undertaken in collaboration with community-based education programs that address life skills instruction on such topics as self-care, parenting or budgeting.

Women with Concurrent Mental Health Problems

- It is important for mental health and addiction specialists to work collaboratively when providing comprehensive service plans for this client group. Such efforts should address treatment issues while also developing positive community linkages that will provide ongoing post-treatment supports.
- Various respondents indicated the need for health care providers and addiction workers to receive specialized training on specific strategies for working with concurrent clients.

Homeless and Transient Women

- Addressing basic needs such as food, shelter and clothing are critical considerations for reaching out to homeless women experiencing problem substance use.
- Outreach services should provide flexible meeting times for clients in accessible locations.

Rural Residents

- There are often limited accessible services available for women with problem substance use in rural communities. Lack of transportation can be a significant barrier for women to attend services or programs in other locations.
- In smaller communities, the importance of maintaining confidentiality was viewed as critical for facilitating clients' willingness to seek assistance for problem substance use.
- Local support groups or help lines can provide a means for connecting with women in rural areas and linking them with early intervention services.

Injection Drug-using Women

- Women who use injection drugs should be provided with safe environments in which they can disclose their problems and openly discuss their concerns without fear of judgment or repercussions from others.
- Increasing awareness and understanding among employers, community members and service providers may reduce the stigma associated with injection drug use and reduce the barriers associated with accessing treatment.

Aboriginal Women

- Addiction and health service providers need to be sensitive to the traditions and beliefs associated with Aboriginal communities. Cultural awareness should be taken into account in the development and adaptation of approaches for working with Aboriginal women.

- Aboriginal community members, leaders and professionals may be important sources of support and play valuable roles in the delivery of outreach and early intervention services.

Senior Women

- Outreach services are crucial for providing treatment services for seniors with problem substance use.
- Misuse of prescription medication among seniors is an area of concern that should be targeted for early intervention efforts.

Sex Trade Workers

- Sex trade workers often have long-standing histories of both physical and sexual abuse and have an increased likelihood of experiencing ongoing problem substance use.
- Outreach programs are critical for connecting with sex trade workers. Such services should be provided in accessible locations, and target times when individual contacts can be made with the client.

Women in Conflict with the Law

- Several respondents underscored the importance of problem substance use screening when women first come into conflict with the law. Such efforts may provide a critical opportunity for providing early intervention services.
- Police and other justice professionals should receive training on problem substance use and strategies for linking women with community resources and services.

3.4 Early Intervention and Outreach Approaches

For related results from Literature Review, see sections 2.5 and 2.6

For related results from Focus Groups, see sections 4.5 and 4.6

3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach

Respondents were asked to identify the theoretical orientations or frameworks that provide the basis for organizing or delivering early intervention and outreach services for women. Most employ an eclectic or integrative approach in designing such services. With respect to central theoretical perspectives, many noted the benefits of Prochaska and DiClemente's stages of change model in conjunction with concepts related to motivational interviewing. Others highlighted the importance of gender-specific approaches that focus on empowerment and enhanced autonomy for planning and undertaking steps for positive change.

Several participants emphasized the need for theoretical perspectives that respond to the concurrent life circumstances of women with problem substance use. It is necessary to design community-based programs and supports that address a range of areas, including problem solving, budgeting, child care, housing and nutrition. The provision of such services was deemed as essential.

A harm reduction orientation is useful for conceptualizing and designing early intervention and outreach services. It emphasizes the provision of non-judgmental approaches and

addresses the needs of clients based on their readiness to pursue change.

Other reported but less frequently identified perspectives included reality therapy, communication-based models, solution-focussed treatment, rational-emotive therapy, and Rogerian techniques.

3.4.2 Early Intervention Approaches

Educational Approaches

The most frequently cited early intervention strategy is educational sessions that include the dissemination of prevention-focussed information. This approach should incorporate problem substance use prevention and harm reduction strategies within general educational programs aimed at enhancing personal or family health. Settings for educational sessions can vary widely and include women's group meetings, safe houses, employee assistance programs, health centres, community centres, prisons, mental health facilities, physicians' offices, parenting programs, mall displays and radio interviews. Several respondents also mentioned peer support strategies for early intervention programming.

In contrast to group-oriented interventions, other respondents underscored the importance of individualized approaches that facilitate

meeting women in their respective community settings. These approaches are accessible to clients, involve flexible meeting times and offer such services as education, counselling and referral to appropriate community agencies for needed assistance.

Many respondents indicated that the organization of early intervention strategies requires both ongoing collaboration and consultation among community health and addiction service providers.

Screening Approaches and Measures

Many respondents indicated that screening procedures provide a means for intervening early with clients who are experiencing or who are at risk of ongoing problem substance use. Participants reported that various agencies within their jurisdiction use both standardized and informal approaches for initial screening of clients at the point of referral. With respect to formal approaches, some use standardized regional or agency questionnaires, whereas others use instruments such as the CAGE and the TWEAK. An important strength associated with standardized screening approaches is that most have been field tested and developed based on significant research done out with specific client populations.

Most respondents indicated that informal discussions with clients were often used for screening or baseline assessments. This approach involves adapting questions or areas of inquiry from standardized instruments or questionnaires and asking questions in an informal and unstructured way. Some partici-

pants regard informal approaches as helpful for decreasing clients' anxiety and creating an environment conducive to a collaborative therapeutic relationship.

Key informants also identified various areas of inquiry related to problem substance use that should be included within intake and screening protocols. These included questions on:

- onset, patterns and types of substance use;
- circumstances related to problem substance use;
- clients' awareness of their level of use and readiness to pursue change;
- consequences associated with ongoing problem substance use on personal health, relationships and occupational functioning;
- misuse of prescription medications;
- areas of personal need and potential change; and
- current links with services and other interventions.

Several respondents indicated that screening and baseline assessments were beneficial for gaining background information on clients and their substance use, and for providing an opportunity to discuss options for pursuing change. Such deliberations could lead to clients' examination of the consequences associated with prolonged problem substance use, the benefits of reducing use and potential sources of support or intervention to assist them.

Caution is needed when implementing structured or informal screening approaches. Some areas of inquiry may elicit from women feelings of guilt and shame and consequently result in under-reporting. Women may be reluctant to address certain areas of inquiry given the potential consequences of sharing information (e.g. losing custody of their children). In other instances, the way in which questions are presented to women can trigger unpleasant memories or impart a sense of obligation to respond in a particular manner. Service providers need to be non-judgmental in their approach and to sensitive to the unique needs and circumstances of women in the application of screening protocols and procedures.

Internet Services

Many key informants consider Internet services as a viable self-help and early intervention resource. Clients can use Web-based services to access self-assessment tools or obtain key information related to substance use and treatment options. In many instances, Web sites can be accessed anonymously which may overcome common barriers to accessing services, such as lack of transportation or confidentiality issues.

Various respondents cautioned that the Internet can be a source of misinformation and “bad advice” if clients’ searches or Web activities are not structured or directed to appropriate sites. Concerns include unregulated chat rooms and vulnerability to those who may exploit women’s needs for support.

Employing Web-based options as part of an early intervention strategy requires both access to Internet services and knowledge of how to use the resource effectively. Some women may not have the financial means to access confidential Internet services or may be unfamiliar with how to use computers.

3.4.3 Outreach Approaches

Partnerships

Many respondents reported that effective outreach services for women often depend on collaborative efforts between addiction specialists and community-based agencies. Partnerships are essential because women tend to seek initial support for basic needs and health issues from other services in their community. Addiction treatment specialists have a key role to play in assisting health and community-based providers identify and reach out to women with problem substance use.

Types and Settings

Outreach to clients may take a variety of forms, including individual meetings, in-home visits and small group educational or support programs. Respondents stressed the importance of engaging clients in their own community settings and increasing the opportunity for them to access necessary services. In particular, seniors, pregnant women, women living in poverty or women with children may find it difficult to leave home to access services. It is imperative in such instances that outreach services be extended to these clients.

Key experts also described a variety of settings for outreach services. These included:

- drop-in centres or mobile units for homeless or transient individuals;
- food banks, community kitchens, agencies that give away clothing;
- transition homes, shelters, hostels;
- women's centres, child care centres, parenting programs;
- recreational centres, community centres, Aboriginal centres, Band halls;
- hospitals, health care centres, wellness centres; and
- needle exchange programs, methadone clinics, bus stops.

Several respondents also noted the potential benefits of involving peer support strategies, either individual assistance or the use of community-based self-help groups. Others highlighted the importance of the participation of community elders or leaders in healing circles or other support activities for Aboriginals.

Service Delivery Times

Many participants indicated that outreach-services are often restricted to the hours of 8:00 a.m. to 5:00 p.m., with some service providers working into the early evening. Although key informants stated that weekends were important times for outreach to be available, they also reported that with the exception of crisis lines, few services were

readily accessible during these times. Flexibility of service hours was emphasized as key in defining outreach service hours.

Qualities of Outreach Workers

Key informants indicated that people involved in outreach efforts must possess the ability to convey a caring and non-judgmental respect for women. They should be approachable, comfortable in communicating directly, and skilled in conveying empathy for the circumstances and concerns expressed by clients. They must be creative and resourceful in their efforts to connect with both women and community service providers. Outreach workers should:

- possess personal or family experiences related to addiction or recovery;
- be skilled in self-care;
- demonstrate an ability to set personal boundaries and limits with clients;
- possess individual counselling skills related to motivational interviewing and case planning strategies;
- be knowledgeable about gender-specific approaches and treatment options; and
- have the ability to work collaboratively with community-based service providers.

Activities and Tasks

Most respondents agreed that the main role of outreach workers was to connect with clients and subsequently link them with necessary services. In many instances, preliminary

meetings with clients involve information sharing on available community-based services and programs. As workers and clients talk together, specific steps for accessing services can be identified and acted upon. For example, outreach workers may assist clients in obtaining needed services by arranging transportation and child care services or by accompanying them to preliminary appointments.

In addition, key informants indicated that outreach workers may provide clients with relevant educational information and counselling support to take steps to reduce problem substance use or opt for healthy choices. Such efforts may include support in acquiring and practising basic life skills related to areas like budgeting, parenting, communication and problem solving.

Some respondents emphasized the importance of case planning and service coordination activities of outreach workers. Outreach activities should empower clients to become active collaborators in developing and implementing identified case plan priorities.

3.4.4 Roles for Individuals Supporting Early Intervention and Outreach

Respondents described the potential roles that key individuals could play to support early intervention and outreach efforts. Feedback was given on the potential contribution of family members, community and health service providers, and addiction treatment specialists.

Family Members

Family relationships can be critical sources of sustainable support and encouragement for women. Family members can also provide tangible resources such as transportation and child care for those pursuing treatment. Respondents also recognized that the dynamics of some family situations may not support women's efforts to reduce problem substance use. This may be particularly evident in situations where there has been a shared history of substance use or when the home context has been an ongoing source of trauma or abuse. Some respondents stated that concurrent changes in family relationships may be critical for women to make and sustain positive changes.

Several participants underscored the importance of extending support and counselling services to family members. In particular, children may require assistance to understand their parent's behaviour and deal with possible feelings of guilt and responsibility related to their current family situation. Some key informants also suggested that family members may benefit from counselling and consultation services that help them understand the stages of change and actions they can take to support the recovery of their loved one.

Community and Health Service Providers

Key informants described health care and other service providers as being in a unique position to recognize at-risk behaviours and participate in the provision of early intervention and

outreach services. Screening practices for problem substance use, however, are not used consistently among health care providers or community-based agencies. If adequate screening procedures for problem substance use are in place, health and other service providers can play an important role in connecting women with essential services in the community.

To be an effective referral agent, service providers must be familiar with the range of services and programs available in the community and know how such services are accessed. Health care providers are also an important source of health information for clients. Ideally, they should have basic knowledge about problem substance use and be able to present such information in the context of a wider health scope. Key informants also described the importance of community service providers' roles in facilitating access to multiple services to address a woman's concurrent needs. Such assistance might take the form of providing transportation or helping women access child care.

Various key informants highlighted the need for community health care providers to receive continuing education on strategies for early intervention and outreach. Areas of training should include:

- recognition of risk factors and consequences associated with problem substance use;
- gender differences in problem substance use patterns and prevention;

- current information on prescription drug misuse;
- approaches for working with family members;
- brief intervention and harm reduction strategies;
- motivational interviewing techniques; and
- referral processes and protocols.

Addiction Treatment Specialists

Key informants indicated that addiction specialists play critical roles in terms of consultation and case planning for community and health service providers. Consultation should include disseminating educational information or providing formalized training sessions on problem substance use and harm reduction approaches. Participants emphasized the need for addiction treatment specialists to be knowledgeable about evidence-based practices and literature relevant to early intervention.

Many respondents emphasized the importance of the case planning functions. These activities include promoting awareness of treatment options, providing counselling, and collaborating or consulting with other services. Case consultation and linking women with community resources were viewed as instrumental in helping clients address needs and treatment goals.

3.4.5 Evaluation of Early Intervention and Outreach Strategies

Several respondents highlighted the importance of reviewing the ongoing effectiveness of early intervention and outreach strategies. Evaluation requires both baseline and follow-up data-gathering activities with clients and service providers in a range of areas, including:

- basic need profile and substance use patterns at baseline;
- changes in substance use patterns;
- changes in specific life areas;
- client satisfaction levels;

- early intervention and outreach services that were most beneficial;
- adequacy and relevance of prevention/educational information;
- number, sources and types of completed referrals; and
- challenges and lessons learned.

With respect to ongoing evaluation of community-based services and initiatives, respondents identified several data collection methods that could be used. These include client information systems, questionnaires and self-report measures, phone surveys or interviews, service or program satisfaction measures and focus groups.

3.5 Community Linkages

For related results from Literature Review, see section 2.7

For related results from Focus Groups, see section 4.7

3.5.1 Essential Community-based Services and Supports

Key informants were asked to identify community services or supports that help women pursue healthy choices and behaviours in the early stages of problem substance use. These supports included:

- stable and safe residential options and basic need services (e.g. food banks);
- basic medical and health services;

- personal development opportunities for acquiring effective skills in areas such as communication, stress management, anger control, budgeting and nutrition;
- counselling and mental health services;
- educational or career-readiness programming; and
- community-based leisure activities.

Various respondents stated that involvement in community-based activities and services were important preventive measures for reducing problem substance use. Although many of these services are available in communities, lack of coordination in case planning and fragmented service delivery impedes clients' ability to engage them in a timely manner. A lack of transportation and child care can further complicate accessing community services.

Respondents agreed that greater integration of community-based services should be undertaken, and a greater range of supports should be offered in conjunction with early intervention or treatment programs. In particular, there is a need to strengthen the linkages between addiction specialists and community health care providers in providing early intervention and outreach services.

3.5.2 Barriers to Linking Community-based Programs and Treatment Services

Respondents were asked to highlight the challenges that affect the capacity of community service providers to work together collaboratively. Those most frequently cited were different perspectives on treatment goals and priorities, and limitations imposed by agency and department mandates. Although networking among community agencies is expected, sufficient time is not allotted to develop working alliances. Service providers working in isolation or "in silos" was viewed as

decreasing trust and confidence among professionals, and to potential delays in processing referrals between services. Other respondents identified limited finances, competitiveness between agencies, a lack of mechanisms for information exchange, and demands for paper-work as barriers to effective collaboration and communication.

3.5.3 Working Toward Coordinated Service Delivery

Several respondents indicated that community service providers must first have a mutual understanding of services if they are to work together effectively. Other service providers who have an understanding of problem substance use and treatment options will have increased insight into potential integrative strategies to address the needs of clients.

Ideally, community service providers should work in partnership to enhance the accessibility of community-based services. Steps that could be taken by community agencies or professionals include:

- establishing a single point for referral to community services;
- completing standardized assessment protocols that reduce duplication;
- adopting more flexible service hours;
- ensuring greater flexibility in eligibility requirements for key services; and

- providing essential supports for facilitating easy access to or attendance at community-based programs (e.g. child care, transportation).

Many key informants also emphasized the benefits of having services accessible and in proximity to clients.

3.5.4 Strategies for Promoting Effective Consultation and Community Linkages

Respondents stressed the importance of service providers meeting frequently to consult, case conference and plan integrated responses to address the unique needs of clients. Most participants reported that having enough time for networking and face-to-face dialogue are critical for fostering the development of strong working alliances.

Service agreements between community professionals on information sharing and data collection can be beneficial for promoting effective consultation. In addition, cross-sectoral training or shared professional development are helpful for strengthening relationships among service agencies. As well, interagency meetings should be designed to enhance mutual understanding among community service providers. These meetings could entail discussion of their respective case planning responsibilities, agency mandates and roles.

Several key informants underscored the need for commitment to work together with other community professionals to develop integrated approaches for addressing client needs. Successful interactions depend on mutual respect, an understanding of other service providers' perspectives and the need to remain client-focussed. When commitment to interagency collaboration is not forthcoming, it may be necessary to develop policies and protocols that encourage or direct the creation of positive community linkages among service providers.

3.5.5 Gaps and Inconsistencies in Services or Policies

Many participants spoke of the need to review and revise service guidelines to ensure that they remain client focussed. Several mentioned the importance of developing effective procedures and policies for preserving and strengthening the mother-child family system during treatment periods or times of transition.

To address gaps in services, key informants highlighted the need for collaborative reviews of services by interagency committees, to discuss how current policies are working and examine their impact on service delivery processes. Information for reviews can be gathered efficiently through individual or focus group interviews with service providers and clients. The review efforts should culminate in the formulation of key recommendations that can be acted upon to enhance community and regional service delivery systems.

3.5.6 Challenges and Strengths of Integrative Approaches

Most respondents indicated the benefits of integrative service delivery approaches. For clients, strengthening community linkages among health and community services can result in:

- increased awareness about the range of community-based supports;
- enhanced access to essential treatment and supports; and
- provision of early intervention services.

Strengthening working alliances supports joint case planning and problem-solving approaches, as well as training and sharing expertise with other community professionals. However, a few respondents stated that, while strengthening community linkages can extend overall service capacity, it still may be insufficient to overcome the problems of limited financial resources and availability of direct support programs.

Focus Groups

4.1 Introduction

The purpose of the focus groups was to obtain the perspectives of women who had been in need of early intervention and outreach services to address problem substance use. Data collection activities included eight focus group sessions across four Canadian regions. The jurisdictions represented in the sample included Northern, Western, Central and Eastern Canada.

Initial contact with participants was done in collaboration with local and regionally based treatment service providers. The purpose of the research and the nature of their possible involvement in the study were explained to participants. They were also advised that the session would take about two hours and there would be opportunities to debrief following the focus group exercise.

A semi-structured format was used to facilitate discussion in each focus group. Participants were given an opportunity at the close of each session to review their responses and highlight the themes they viewed as most crucial. Four key areas of inquiry were addressed:

- What services or supports might make a difference for women *early on* in their problem substance use?
 - How can services in your community effectively reach out and connect with women experiencing problem substance use?
 - What kinds of community services are most needed or helpful?
- Flip charts, descriptive notes and session summaries provided the basis for a written protocol for each focus group. At the end of the eight focus groups, individual protocols were merged to provide a unified data set. Content analysis was used to identify key themes and trends. Clustering of key themes subsequently provided the basis for development of meaningful categories to illuminate the various areas of inquiry.
- What are the key challenges facing women with problem substance use?

4.2 Participant Demographics

Sixty women, over the age of 18, participated in the eight focus group sessions that lasted approximately 2 hours. The number of women in each group ranged from five to eleven, with an average attendance of eight. Demographic information was gathered from participants before each focus group session began.

The following table provides a profile of the women who attended the sessions taking into account residence, ethnicity, marital status, number of children, educational level, employment status and the degree of perceived family support.

Table 8: Focus Group Participant Demographics

Participant Variable	Percentage of Sample (%)
Residence	
Urban	75
Rural	25
Ethnicity	
Caucasian	82
First Nation	15
Other	3
Marital Status	
Married or Common Law	27
Single	73
Number of Children	
No Children	31
One Child	20
Two Children	27
Three Children	19
More Than Three Children	3
Education	
Less Than Grade 10	15
Grade 10 to 12	22
High School Graduate	17
Some University/Technical School	27
University/Technical School Graduate	18
No Response	1

Table 8: Focus Group Participant Demographics (cont'd)

Participant Variable	Percentage of Sample (%)
Employment Status	
Employed Full-time	25
Employed Part-time or Seasonal	14
Receiving Employment Insurance or Pension	12
Receiving Income Assistance	42
Student	7
Perceived Family Support	
Significant	38
Moderate	18
Some	32
None	12

4.3 Key Challenges: Priority Concerns

For related results from Literature Review, see sections 2.3 and 2.4

For related results from Key Informant Interviews, see section 3.3

"I had started working on a treatment plan. But my worker changed and they took my children from me. I became suicidal. My kids are all I have got."

"Safety is an issue. Our substance use puts us in some very volatile situations sometimes."

"We worry that our husbands will leave us if we admit that we have a problem."

"It is a downward spiral. As we use more, our physical health deteriorates. As our appearance gets worse, so does our self-esteem."

Participants were initially asked to describe the key challenges faced by women experiencing problem substance use. They were also asked to identify which issues were of greatest concern for them. The following prioritizes the challenges and indicates the number of focus groups that endorsed the given theme:

- Accessing Treatment Services (7);
- Recognizing Substance Use Problems (7);
- Securing Personal Supports (7);
- Coping with Negative Emotions (6);

- Obtaining Essential Treatment Information and Support (6);
- Maintaining Treatment Gains (6);
- Experiencing the Fear of Losing Children (5); and
- Ensuring Confidentiality (3).

4.3.1 Accessing Treatment Services

Participants mentioned several barriers related to accessing treatment services. In particular, wait times were often lengthy, leading some to relapse as they wait for their initial treatment appointments. As well, they were not always aware of the treatment options available in their community, and service providers could not always provide suggestions for obtaining assistance.

Even when programs were accessed, services were often insufficient to address their needs. Specific program challenges included inadequate treatment slots, filled detoxification facilities and rationing of resources to address only those in crisis. Other barriers included lack of transportation, the need for child care and inadequate resources available in rural or remote areas.

4.3.2 Recognizing Problem Substance Use

A key challenge was the initial recognition that they had a problem with substance use. They spoke of denying the problem to themselves and to those around them. Some also reported that their continued problem use was endorsed as normal behaviour by substance-using peers.

4.3.3 Securing Personal Supports

Securing personal support was identified as a key challenge. Many spoke of their fears of rejection by people they valued and of their need to keep family and employment relationships intact. Participants also underscored the potential benefits of having peer support available throughout the treatment process and that such interactions are important sources of encouragement for women.

4.3.4 Coping with Difficult Emotions

Many participants reported that their continued substance use was a means of coping with or avoiding overwhelming feelings associated with their past or current life situation. Participants described emotions related to their present and previous circumstances, including depression, low self-esteem, loneliness, loss and hopelessness. Shame and guilt were often identified as contributing to ongoing problem substance use. Generational cycles of abusive relationships, both physical and emotional, were also paired with prolonged problem use.

4.3.5 Obtaining Essential Treatment Information and Support

Many participants expressed concern about the difficulty of accessing essential information on issues related to addiction and substance use. They underscored the importance of providing accurate information to their family, friends and agencies that assist women. The need to provide education on problem substance use to community service providers, government agencies, employers and schools was emphasized.

In several focus group sessions, women also expressed the need for increased support from staff in community health and social service agencies. They perceived that their struggles with substance use were often not well understood by community service providers. Family physicians were viewed as critical for supporting women by providing information, screening for problem substance use, and making referrals to core treatment services. It was also stressed that health care providers should recognize the vulnerability of women to prescription drug misuse, and that approaches for managing stress and anxiety without medication should be offered more often.

4.3.6 Maintaining Treatment Gains

Women discussed the difficulties associated with maintaining positive changes and personal gains when returning to community and family settings following treatment. Relationships that remain unchanged can be a trigger for re-using. The presence and social acceptance of drug or

alcohol use in their environment increases vulnerability to relapse. Supportive aftercare services accompanied by involvement in daily living activities and work routines were viewed as essential for maintaining treatment gains.

4.3.7 Experiencing the Fear of Losing Children

Women described fears of repercussions, especially the loss of custody of their children, if they acknowledge their problem substance use or seek treatment. Fulfilling parenting obligations, both while using and in recovery, was viewed as a significant challenge.

4.3.8 Ensuring Confidentiality

Ensuring confidentiality was viewed as critical for participants when first accessing services. In rural or remote areas, participants indicated that it is often difficult to access services or support groups without their attendance being noticed by others or discussed in the community.

4.4 Additional Challenges

For related results from Literature Review, see sections 2.3 and 2.4

For related results from Key Informant Interviews, see section 3.3

Other key challenges were cited by participants. The following outlines the areas of concern and the number of focus group sessions in which each of these themes emerged:

- Addressing Negative Stereotypes (8);
- Coping with Employment Issues and Financial Challenges (5);
- Experiencing Disrespect (5); and
- Living with Health and Safety Concerns (3).

4.4.1 Addressing Negative Stereotypes

In their communities and in broader society, women reported perceiving negative stereotypes from others associated with their gender, problem substance use and participation in treatment-related activities. Stigma and the associated fears of encountering judgmental attitudes were considered a deterrent for many women to acknowledge their problem substance use and seek treatment.

4.4.2 Coping with Employment Issues and Financial Challenges

Focus group participants expressed concern about their employment status and income. For some, residential or inpatient programs are inaccessible without incurring job loss or without accessing adequate financial support. Employers were identified as requiring education on substance use, addiction and recovery.

4.4.3 Experiencing Disrespect

Various participants reported being treated disrespectfully by some service providers. As a result, they have diminished trust in some agencies and greater difficulty establishing positive working alliances, in particular with child protection services and justice officials.

4.4.4 Living with Health and Safety Concerns

Participants discussed the interplay between addiction and relationships that are physically or emotionally abusive. Substance use increases in reaction to ongoing abuse and violence in domestic relationships, and the consequences of prolonged problem substance use negatively impact both the long-term physical and emotional health of women.

4.5 Early Intervention

For related results from Literature Review, see section 2.5

For related results from Key Informant Interviews, see section 3.4

“I would have told my doctor everything. I was ready to be honest.”

“If I had the courage to be able to share ... with my parents when I was young, I don’t think I would have ended up here.”

“You need to be in crisis to get any attention.”

Participants were asked to identify key services, supports or events that might have made a positive difference for them early on in their experience with problem substance use. The following summarizes the key themes and the number of focus groups that endorsed each major response:

- Intervene Early with Adolescents (7);
- Enhance Community Awareness and Knowledge (7);
- Foster and Maintain Sources of Support (6);
- Provide Individual Counselling Services (5);
- Implement Community-based Early Intervention Programs (4);
- Maintain Parental Bonds (3);
- Provide Toll-free Help Lines (3); and
- Ask Screening Questions (2).

4.5.1 Intervene Early with Adolescents

Participants underscored the importance of reaching out to young women through education and prevention programs that employ approaches that enhance self-esteem and inner strength. Involvement of youth in structured activities was viewed as a potential protective factor for preventing the development of problem substance use behaviours.

Teachers should be aware of problem substance use issues and have knowledge of community services where students can be referred for assistance. Youth should have access to confidential contacts within the system when they have concerns or substance use issues. In general, participants perceived that treatment and support services are not readily available to young women. Many felt that early detection and intervention during their adolescence by either teachers or family members may have prevented their use from escalating.

4.5.2 Enhance Community Awareness and Knowledge

Many participants suggested that information sessions on problem substance use issues should be offered to family members, employers and service providers in the health care, social services, education and justice sectors.

As well, physicians play a critical role in women's awareness about prescription drug misuse and alternatives for dealing with pain management. Overall, participants indicated that having a better informed community would reduce the stigma and shame associated with seeking treatment.

4.5.3 Foster and Maintain Sources of Support

Participants emphasized the importance of family support in early intervention efforts. Family members can benefit from counselling to address areas of personal challenge and to help the client reduce problem substance use. Handing out educational information on problem substance use to employers is needed to elicit their understanding and support. Peer-led support groups were also mentioned as potential sources of ongoing support for women throughout the treatment process.

4.5.4 Provide Individual Counselling Services

Participants emphasized the importance of individual counselling services for women. Supports should involve creating a safe environment where life difficulties can be discussed. Counsellors should also work with family members and collaborate with other services providers to develop case plans. Many women asserted that such services should be accessible and not limited by one's capacity to pay. In conjunction with counselling, basic life skills training was also viewed as a beneficial component of early intervention activities.

4.5.5 Implement Community-based Early Intervention Programs

Women emphasized the importance of implementing early intervention community-based programs, in particular workplace programs.

4.5.6 Maintain Parental Bonds

Participants spoke of the benefits of being able to maintain bonds with their children during treatment. In contrast, the removal of children from the home was perceived by many as a penalty for seeking help.

4.5.7 Provide Toll-free Help Lines

Several groups noted the benefits of toll-free help lines to provide a means for addressing concerns and questions related to addiction, and essential information on local resources and programs.

4.5.8 Ask Screening Questions

Many participants stated the importance of providers asking key screening questions. Questions should be asked openly, and in a respectful and caring manner. Physicians play a valuable role providing women with accurate information and facilitating their access to needed treatment services.

4.6 Outreach Services

For related results from Literature Review, see section 2.6

For related results from Key Informant Interviews, see section 3.4

“It is hard to go into town to see my counselor because my chances of relapsing are pretty good. Everyone I know is using.”

“It would have helped most if someone could have not only helped me make that first appointment, but also made sure that I got there for the first time.”

Participants were asked to describe specific actions that communities could undertake to reach out effectively to women with problem substance use. The following summarizes the key responses that emerged and the number of focus groups that endorsed each major theme:

- Enhance Community Provider Capacity to Reach Out (7);
- Increase Awareness of Community Resources and Referral Processes (7);
- Enhance Accessibility of Services (6);
- Foster Collaborative Actions (6); and
- Strengthen Advocacy for Gender-specific Approaches (6).

4.6.1 Enhance Community Service Provider Capacity to Reach Out

Participants reported that women with problem substance use often have preliminary involvement with community-based providers long before their initial contact with specialized treatment programs. They indicated that service agencies are in a unique position to reach out to these women. Various participants stressed the importance of providing information sessions on addictions to a wide range of service providers, including medical professionals, mental health clinicians, law enforcement officials, social workers, teachers and clergy. With increased understanding of the issues, these community members and professionals could play a critical advocacy role in linking women with needed services.

4.6.2 Increase Awareness of Community Resources and Referral Processes

Participants indicated that health care and community providers need to possess adequate knowledge about local resources and referral processes. Health care professionals, police and staff in shelters are in optimal positions to use this knowledge when working with women.

4.6.3 Enhance Accessibility of Services

Many women noted the lack of timely access to needed services. Specific barriers affecting access include long wait times for detoxification programs, inadequate outreach and lack of available treatment services. Walk-in clinics or drop-in centres can provide an effective means for connecting with women. Such approaches have the advantage of offering immediate contact with service providers and minimizing the difficulties associated with scheduling appointments and wait time periods.

4.6.4 Foster Collaborative Actions

Participants highlighted the importance of community service providers working together to address the needs of women with problem substance use. Increased collaboration should be undertaken by key stakeholders in addiction treatment centres, shelters, mental health agencies and law enforcement. Community-based planning should include strategies or procedures to help women access treatment without fear of losing their children.

4.6.5 Strengthen Advocacy for Gender-specific Approaches

Respondents stated that there is a need for stronger advocacy for activities and services designed to meet the unique needs of women. They strongly voiced the view that child welfare agencies could do more to help mothers retain custody of their children during the recovery process. Respondents also pointed to a need for more detoxification and residential facilities specifically for women. Many expressed appreciation for the relationships with addiction counsellors who were knowledgeable and understanding of women's issues. They also recognized the benefits of having designated advocates to speak out on behalf of women with substance use problems.

4.7 Community Services and Linkages

For related results from Literature Review, see section 2.7

For related results from Key Informant Interviews, see section 3.5

“There are a lot of programs that are helpful. But they do not go far enough. They need to offer to help us get connected with services...”

Participants were asked to identify the kinds of community services that are most needed by or helpful to women with problem substance use. The following outlines the key responses and the number of focus group sessions in which the given themes emerged:

- Support Groups (6);
- Child Care Services (5);
- Service Descriptions (4);
- Crisis Intervention Services (4);
- Housing and Shelter (4);
- Community-based Educational Programs (4);
- Transition Supports and Aftercare Programs (4).

4.7.1 Support Groups

Respondents identified support groups such as Marijuana Anonymous and Narcotics Anonymous as helpful. Several also noted the benefits of treatment-oriented support groups facilitated by addiction specialists.

4.7.2 Child Care Services

Participants highlighted the importance of providing quality child care services for women attending treatment, and the benefits associated with having access to their children during the treatment process.

4.7.3 Service Descriptions

Some focus group members indicated the need to develop written resource documents detailing key programs and support services available for women within local jurisdictions. Ideally, such resources should be easily accessed and well promoted. The creation of service descriptions for given regions would also be helpful for enhancing community service providers' mutual understanding of programs and services.

4.7.4 Crisis Intervention Services

Participants emphasized the importance of providing crisis lines and addiction help services for women. They also indicated that women would benefit from having access to crisis intervention services, such as those offered through drop-in centres and agencies that respond to victims of sexual assault and trauma.

4.7.5 Housing and Shelter

Participants reiterated the need for safe shelters and affordable housing for women. They recommended that staff in shelters receive specialized training on problem substance use issues and gender-specific approaches, and be skilful in connecting women with other needed services. Respondents expressed concern that women in rural areas have less access to such services and programs.

4.7.6 Community-based Educational Programs

Along with treatment services, participants stressed the need for community-based educational programs that address a wide range of personal development topics, including self-esteem, grief recovery, budgeting, parenting, healthy choices, nutrition, assertiveness, and anger management.

4.7.7 Transition Supports and Aftercare Programs

Women indicated that during times of treatment transition they often experienced increased stress and were more vulnerable to relapse. Several participants emphasized the importance of providing longer term rehabilitation options for women such as “halfway” support homes and transitional housing programs. In-home services and family programs were also identified as essential supports for women during periods of change. Some also mentioned that prevention information should be provided at the time of discharge from detoxification centres, and that there is a need for offering aftercare services following detoxification and initial treatment programs. Care plans should include activities related to monitoring and supporting clients’ treatment gains over the long term.

Best Practice Statements

5.1 Introduction

The purpose of this section is to present best practices guidelines associated with providing early intervention, outreach and community linkages to women with substance use problems. The best practice statements reflect the convergence of major insights gleaned from the research and the key expert interviews with service providers, and/or focus group sessions with women who had experienced problem substance use. A range of client needs and service delivery issues are addressed in the guidelines. These evidence-based strategies should facilitate access for women in need of addiction-related services. As research continues, these statements will need to be reviewed and modified to reflect new and additional insights. The following summarizes the major categories of best practice statements for this section:

- General Considerations;
- Screening Processes;
- Early Intervention Strategies;
- Outreach Services;
- Relevant Community-based Support Programs; and
- Community Linkages and Integrative Approaches.

5.2 General Considerations

Client Circumstances

Early intervention and outreach strategies require an understanding of the circumstances and needs of each client and/or client groups in order to adapt services and include relevant supports. The goal is to reduce problem substance use as well as enhance overall health and social functioning.

Basic Needs

Basic needs, including adequate resources for food, clothing or housing, must be addressed in conjunction with outreach and early intervention efforts.

Child Custody Concerns

Women's fears about losing custody of their children are significant barriers to pursuing needed treatment services. These concerns should be addressed in a gender-sensitive way in early intervention and outreach efforts.

Rural Challenges

Services are often limited for women with problem substance use in rural communities. Local support groups, help lines and Internet services may provide viable means for connecting with women in more remote locations, and subsequently linking them with early intervention services.

Prescription Drug Misuse

Women are prescribed mood-altering drugs, including tranquilizers and painkillers, more often than men and are at higher risk of experiencing problems with prescription medication. Health care providers should take into account women's potential vulnerability to prescription drug misuse. When appropriate, alternative approaches for managing stress and anxiety without medication should be undertaken.

Cultural Awareness

Cultural awareness should be taken into account when developing and adapting outreach and early intervention strategies. For Aboriginal women, community members, leaders and professionals may be important sources of support and play a valuable role in the delivery of services.

5.3 Screening Processes

Client-centred Screening Processes

Screening questions should be completed collaboratively with clients in a manner that is comfortable and safe. Health care and community service providers should approach this with a non-judgmental attitude, conveying respect and an openness to discuss health issues and social concerns related to problem substance use.

Literacy Levels

When completing screening questionnaires, service providers should be sensitive to the varying literacy levels of clients and allow for additional time and accommodations when required.

Areas of Inquiry

Areas of inquiry to be addressed during intake or assessment interviews should include: onset, types of substances and patterns of use; circumstances and consequences related to use; clients' awareness of level of use and readiness to pursue change; and clients' links with community services and intervention programs.

Role of Health and Community-based Service Providers

It is often community-based service providers and health care professionals, rather than addiction specialists, who initially identify women experiencing, or who are at risk for, problem substance use. Family physicians, nurse practitioners, nurses, public health nurses, obstetricians, pediatricians, midwives, mental health personnel and other service providers who counsel women on health or self-care, are in a unique position to provide screening for problem substance use. They are therefore a critical resource for facilitating access to needed services.

5.4 Early Intervention Strategies

Theoretical Models of Treatment Readiness

Prochaska's and DiClemente's stages of change theory is a practical framework for understanding and assessing treatment readiness. This model supports the development of collaborative alliances with clients who are at varying levels of readiness to pursue change and is often applied in conjunction with brief interventions and motivational interviewing strategies.

Brief Interventions

Brief interventions and motivational interviewing techniques are useful methods for enhancing readiness to change. Given the evidence for the potential effectiveness of brief interventions and the minimal amount of time they require to implement, health care and other service providers are in a unique position to apply these strategies. Although brief interventions should not be used to replace more intensive treatment services, they can be effective initial engagement strategies for more severely dependent clients.

Workplace Early Intervention Applications

Recent research supports the use of early intervention strategies in workplace health programs. These may include providing educational messages on problem substance use in conjunction with general information on health, diet and exercise.

5.5 Outreach Services

Settings

It is critical to take into account the natural living environments of clients when planning and implementing outreach programs. Potential locations or settings may include safe houses, employee assistance programs, health centres, community centres, prisons, mental health facilities, physicians' offices and community educational programs. Outreach can also be done in collaboration with community-based education programs, such as personal development, parenting, employment readiness, budgeting, self-esteem, nutrition, stress management, assertiveness and interpersonal relationships.

Accessibility

Outreach services provided through drop-in programs, mobile treatment services and street contacts increase access to services by providing flexible hours of operations in accessible locations. They may be particularly crucial for women who are street workers, homeless or injection drug users.

Developing Trust

Outreach is more effective when trust has been established and maintained over multiple brief sessions or meeting times. This may be a particularly important consideration for high-risk groups such as sex trade workers.

Outreach Activities

Outreach activities should include dissemination of health information, education on strategies for harm reduction, provision of information on community-based resources and programs, identification of strategies for accessing these services, and when needed, accompanying clients to preliminary appointments.

5.6 Relevant Community-based Support Programming

Gender-specific Programming

Recent research has emphasized the importance of making available gender-specific program approaches for women. These programs can offer women the opportunity to share their experiences in emotionally safe environments, interact with positive role models and build support networks.

Counselling Support

Women often experience feelings of guilt and shame related to their problematic substance use, which contributes to lower self-esteem, decreased hope and continued problem substance use. Counselling services should address these feelings when providing early intervention for women.

Child Care Services

The absence of social networks to assist with child care and family responsibilities can impede women from making contact with treatment programs, even when these are available in the community. Research indicates that access to child care services contributes to treatment-engagement and enhanced outcomes.

Family Therapy and Support

Concern from family members can be an important motivating factor for women to seek treatment. Family therapy can be beneficial for educating and supporting family members to learn responses that help women in the treatment process. Family members may also be able to provide tangible resources, such as transportation and child care.

5.7 Community Linkages and Integrative Approaches

Community Awareness

Social perceptions and disapproval of women's substance use may decrease client willingness to pursue rehabilitative services. Increasing awareness and understanding among employers, community members and primary health care providers can reduce the perceived social barriers associated with accessing treatment.

Knowledge of Services

To be effective referral agents, service providers must be familiar with the full range of government and non-government programs and support services available to women, be knowledgeable about how they are accessed, and develop strong referral and collaborative links with them.

Community Service Provider Agreements

Service agreements or memoranda of understanding related to interagency referral and treatment protocols have been identified as helpful for increasing collaboration and coordination among service providers. Such efforts assist in maximizing the use of limited resources and ensuring that service provision remains responsive to the needs of women and their families.

Consultation Role of Addiction Specialists

Addiction specialists play a critical consultation role for community health care and service providers. Consultation can include disseminating educational information or formalized training sessions on problem substance use screening approaches and intervention strategies.

Case Management

Case management strategies assists in organizing and integrating services for women. Approaches should empower clients to become active collaborators in developing and implementing case plan priorities.

Treatment Transitions

During times of treatment transition, women often experience increased stress and are more vulnerable to relapse to former substance use patterns. Support services that may be helpful during periods of change include drop-in centres, outpatient counselling, longer term rehabilitation options, "halfway" support homes, transitional housing programs, in-home services and family programs.

Future Research

This research project pointed to gaps in knowledge and practical applications related to early intervention strategies, outreach services and enhancement of community linkages for women with problem substance use. The following summarizes these areas:

Minority Women

Research related to ethnicity and its influence on problem substance use among women is limited. Additional research is warranted to gain an increased understanding of minority women and the best approaches for structuring prevention and intervention efforts.

Internet Recovery Strategies

Preliminary research indicates that women may access Internet services more often than men to address problem substance use. Although Internet recovery strategies are being used increasingly by clients, research is needed to evaluate the effectiveness for early intervention or treatment strategies.

Evaluation of Integrative Service Delivery

Additional research is needed to investigate the full impact of enhancing linkages among community-based services. It would be advantageous to evaluate not only the therapeutic benefits of such approaches but also the costs over extended time periods.

References

- Addiction Research Foundation. (1996). *Hidden majority: A guidebook on alcohol and other drug issues for counsellors who work with women*. Toronto, ON: Author.
- Adlaf, EM, Begin, P, & Sawka, E. (Eds.). (2005). *Canadian Addiction Survey (CAS): A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed Report*. Ottawa: Canadian Centre on Substance Abuse.
- Alberta Alcohol and Drug Abuse Commission [AADAC]. (2003). *Women and substance use*. Retrieved June 1, 2004 from <http://corp.aadac.com/women/factsheets/wasu-womsubab.asp>
- Andersen M., Smereck, G.A., Hockman, E., Tinsley, J., Milfort, D., Shekoski, C., Connelly, C., Faber-Bermudez, I., Schuman, P., Emrich, K., Paliwoda, J., & Harris C. (2003). Integrating health care for women diagnosed with HIV infection, substance abuse, and mental illness in Detroit, Michigan. *Journal of the Association of Nurses in AIDS Care*, 14(5), 49–58.
- Babor, T.F., & Higgins-Biddle, J.C. (2001). *Brief interventions for hazardous and harmful drinking: A manual for use in primary care*. World Health Organization.
- B.C. Ministry for Children and Families. (1998). *B.C. FAS community action guide*. Retrieved June 13, 2004 from http://www.mcf.gov.bc.ca/spec_needs/fas/guide.pdf
- Blow, F. (1998). *Substance abuse among older adults. Treatment Improvement Protocol (TIP) series no. 26*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
- Blow, F.C., & Barry, K.L. (2002). Use and misuse of alcohol among older women. *Alcohol Research and Health*, 26(4), 308–315.
- Brown, V.B., Melchior, L.A., & Huba, G.J. (1999). Level of burden among women diagnosed with severe mental illness and substance abuse. *Journal of Psychoactive Drugs*, 31(1), 31–40.
- Brown, V.B., Melchior, L.A., Panter, A.T., Slaughter, R., & Huba, G.J. (2000). Women's steps of change and entry into drug abuse treatment: A multidimensional stages of change model. *Journal of Substance Abuse Treatment*, 18, 231–240.
- Brown, S.A., Parker, J.D., & Godding, P.R. (2002). Administrative, clinical, and ethical issues surrounding the use of waiting lists in the delivery of mental health services. *Journal of Behavioural Health Services and Research*, 29(2), 217–228.
- Brunette, M., & Drake, R.E. (1998). Gender differences in homeless persons with schizophrenia and substance abuse. *Community Mental Health Journal*, 34(6), 627–642.
- Burge, S.K., & Schneider, F.D. (1999). *Alcohol-related problems: Recognition and intervention*. American Family Physician. www.aafp.org/afp/990115ap/contents.html

- Bush-Baskette, S. (2000). The war on drugs and the incarceration of mothers. *Journal of Drug Issues*, 30(4), 919–928.
- Byrne, M.K., & Howells, K. (2002). The psychological needs of women prisoners: Implications for rehabilitation and management. *Psychiatry, Psychology and Law*, 9(1), 34–43.
- Canadian Task Force on Preventive Health Care. (2004). *Primary prevention of fetal alcohol syndrome*. Retrieved July 27, 2004 from <http://www.ctfphc.org>
- Centre for Addiction and Mental Health [CAMH]. (n.d). *CAMH Treatment Applications: Drink Wise/Saying When*. Retrieved Dec 8, 2004 from <http://sano.camh.net/resource/drink.htm>
- Collins, R.L., & McNair, L.D. (2002). Minority women and alcohol use. *Alcohol Research and Health*, 26(4), 251–256.
- Copello, A., & Orford, J. (2002). Addiction and the family: Is it time for services to take notice of the evidence? *Addiction*, 97, 1361–1363.
- Coughey, K., Feighan, K., Cheney, R., & Klein, G. (1998). Retention in an aftercare program for recovering women. *Substance Use & Misuse*, 33(4), 917–933.
- Covington, S.S. (1998). Women in prison: Approaches in the treatment of our most invisible population. *Women and Therapy*, 21(1), 141–155.
- Department of National Health and Welfare. (1992). *Addiction Services Guidelines*. Ottawa: Minister of Supply and Services Canada. Cat. No. H39-237/1992E.
- D’Onofrio, G., Bernstein, E., Bernstein, J., Woolard, R.H., Brewer, P.A., Craig, S.A., & Zink, B.J. (1998a). Patients with alcohol problems in the emergency department, part 1: Improving detection. SAEM Substance Abuse Task Force, Society for Academic Emergency Medicine. *Academic Emergency Medicine*, 5(12), 1200–1209.
- D’Onofrio, G., Bernstein, E., Bernstein, J., Woolard, R.H., Brewer, P.A., Craig, S.A., & Zink, B.J. (1998b). Patients with alcohol problems in the emergency department, part 2: intervention and referral. SAEM Substance Abuse Task Force, Society for Academic Emergency Medicine. *Academic Emergency Medicine*, 5(12), 1210–1217.
- Ehrmin, J.T. (2001). Unresolved feelings of guilt and shame in the maternal role with substance-dependent African-American women. *Journal of Nursing Scholarship*, 33(1), 47–52.
- Ernst, C.C., Grant, T.M., Streissguth, A.P., & Sampson, P.D. (1999). Intervention with high-risk alcohol and drug-abusing mothers: II. Three-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 19–38.
- Friedmann, P.D., D’Aunno, T.A., Jin, L., & Alexander, J.A. (2000). Medical and psychosocial services in drug abuse treatment: Do stronger linkages promote client utilization? *Health Services Research*, 35(2), 443–465.
- Friedmann, P.D., Lemon, S.C., Stein, M.D., & D’Aunno, T.A. (2003). Community referral sources and entry of treatment-naïve clients into outpatient addiction treatment. *American Journal of Drug & Alcohol Abuse*, 29(1), 105–115.

- Friedmann, P.D., Lemon, S.C., Stein, M.D., Etheridge, R.M., & D'Aunno, T.A. (2001). Linkage to medical services in the Drug Abuse Treatment Outcome Study. *Alcohol & Alcoholism*, 39(3), 284–295.
- Friedmann, R., Saitz, R., & Samet, J.H. (1998). Management of adults recovering from alcohol or other drug problems: Relapse prevention in primary care. *Journal of the American Medical Association*, 279, 1227–1231.
- Galaif, E.R., Nyamathi, A.M., & Stein, J.A. (1999). Psychosocial predictors of current drug use, drug problems, and physical drug dependence in homeless women. *Addictive Behaviors*, 24(6), 801–814.
- Goetzel, R., Jacobson, B., Aldana, S. et al., (1998). Health care costs of worksite health promotion participants and non-participants. *Journal of Occupational and Environmental Medicine*, 40, 341–346.
- Grant, T.M., Ernst, C.C., & Streissguth, A.P. (1999). Intervention with high-risk alcohol and drug-abusing mothers: I. Administrative strategies of the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 1–18.
- Grigsby, D.G., & Cheever, T.R. (2004). *Substance Abuse: Nicotine*. Retrieved March 15, 2005 from <http://www.emedicine.com/PED/topic2663.htm>
- Hall, M.J., & Tidwell, W.C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, 24(2), 161–167.
- Haver, B., & Franck, J. (1997). Karolinska project for early treatment of women with alcohol addiction. *European Addiction Research*, 3(1), 30–36.
- Health Canada. (1996a). *Immigrant women and substance use: Current issues, programs and recommendations*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H39-336E/1996E.
- Health Canada. (1996b). *Rural women and substance use: Issues and implications for programming*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H39-364/1996E.
- Health Canada. (1996c). *Rural women and substance use: Insights from a national project in three communities*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H39-398/1997E.
- Health Canada. (1999). *Best practices – Substance abuse treatment and rehabilitation*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H39-438/1998.
- Health Canada. (2001a). *Best practices – Concurrent mental health and substance use disorders*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H39-599/2001-2E.
- Health Canada. (2001b). *Best practices – Fetal Alcohol Syndrome/Fetal Alcohol Effects and the effects of other substance use during pregnancy*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H49-156/2001E.
- Health Canada. (2001c). *Best practices – Treatment and rehabilitation for women with substance use problems*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H49-153/2001E.

- Health Canada. (2001d). *Best practices – Treatment and rehabilitation for youth with substance use problems*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H49-154/2001E.
- Health Canada. (2001). *Reducing the Harm Associated with Injection Drug Use in Canada*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H39-589/2001E.
- Health Canada. (2002a). *Best practices – Methadone maintenance treatment*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H49-164/2002E.
- Health Canada. (2002b). *Best practices – Treatment and rehabilitation for seniors with substance use problems*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H46-2/03-295E.
- Heirich, M., & Sieck, C.J. (2000). Worksite cardiovascular wellness programs as a route to substance abuse prevention. *Journal of Occupational & Environmental Medicine*, 42(1), 47–56.
- Hernandez-Avila, C.A., Poling, J., Rounsaville, B.J., & Kranzler, H.R. (2002). Progression of drug and alcohol dependence among women entering substance abuse treatment: Evidence for telescoping. *Drug and Alcohol Dependence*, 66 (Suppl.), S79.
- Jacobs, K., & Gill, K. (2002). Substance abuse in an urban Aboriginal population: Social, legal and psychological consequences. *Journal of Ethnicity in Substance Abuse*, 1(1), 7–25.
- Jarvis, T.J., Copeland, J., & Walton, L. (1998). Exploring the nature of the relationship between child sexual abuse and substance use among women. *Addiction*, 93(6), 865–878.
- Karzuntos, G.T., Dunlap, L.J., Zarkin, G.A., & French, M.T. (1998). Designing an employee assistance program (EAP) intervention for women and minorities: Lessons from the Rockford EAP study. *Employee Assistance Quarterly*, 14(1), 49–67.
- Kearney, M.H. (1998). Truthful self-nurturing: A grounded formal theory of women's addiction recovery. *Qualitative Health Research*, 8(4), 495–513.
- Kirby, K.C., Marlowe, D.B., Festinger, D.S., Garvey, K.A., & LaMonaca, V. (1999). Community reinforcement training for family and significant others of drug users: A unilateral intervention to increase treatment entry of drug users. *Drug & Alcohol Dependence*, 56, 85–96.
- Koss, M. (2000). Blame, shame, and community: Justice responses to violence against women. *American Psychologist*, 55(11), 1332–1343.
- Lapham, S.C., Gregory, C., & McMillan, G. (2003). Impact of an alcohol misuse intervention for health care workers – 1: Frequency of binge drinking and desire to reduce alcohol use. *Alcohol & Alcoholism*, 38(2), 176–182.
- Loeber, R., Farrington, D., & Petechu, D. (2003). *Child delinquency: Early intervention and prevention*. Child Delinquency: Bulletin Series. U.S. Department of Justice. Office of Justice Programs. OJJDP. Washington, D.C.
- Marsh, J.C., D'Aunno, T.A., & Smith, B.D. (2000). Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction*, 95(8), 1237–1247.

- Maslin, J., Graham, H.L., Cawley, M., Copello, A., Birchwood, M., Georgiou, G., et al. (2001). Combined severe mental health and substance use problems: What are the training and support needs of staff working with this client group? *Journal of Mental Health*, 10(2), 131–140.
- McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., et al. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, 93, 1489–1499.
- Melchior, L.A., Huba, G.J., Brown, V.B., & Slaughter, R. (1999). Evaluation of the effects of outreach to women with multiple vulnerabilities on entry into substance abuse treatment. *Evaluation & Program Planning*, 22(3), 269–277.
- Meyers, R.J., Miller, W.R., Hill, D.E., & Tonigan, J.S. (1999). Community reinforcement and family training (CRAFT): Engaging unmotivated drug users in treatment. *Journal of Substance Abuse*, 10, 291–308.
- Meyers, R.J., Miller, W.R., & Smith, J.E. (2001). *Community reinforcement and family training (CRAFT)*. In: R.J. Meyers, & W.R. Miller (Eds). A community reinforcement approach to addiction treatment. Cambridge University Press, Cambridge, U.K. pp 147–160.
- Millar, W.J. (1998). Multiple medication use among seniors. *Health Reports*, 9(4), 11–17.
- Miller, W.R. (1999). *Enhancing motivation for change in substance abuse treatment*. US Department of Health and Human Services, SAMHSA/CSAT, Rockville, MD.
- Miller, W.R. (2003). A collaborative approach to working with families. *Addiction*, 98, 5–6.
- Miller, W.R., Meyers, R.J., & Tonigan, J.S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three intervention strategies. *Journal of Consulting and Clinical Psychology*, 76, 688–697.
- Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, Guilford Press.
- Mumenthaler, M.S., Taylor, J.L., O'Hara, R., & Yesavage, J.A. (1999). Gender differences in moderate drinking effects. *Alcohol Research and Health*, 23(1), 55–64.
- National Institute on Alcohol Abuse and Alcoholism [NIAAA]. (1999). Are women more vulnerable to alcohol's effects? *Alcohol Alerts*, 46.
- National Institute on Drug Abuse [NIDA]. (2000). *The NIDA community-based outreach model: A manual to reduce the risk of HIV and other blood-borne infections in drug users*. Retrieved June 1, 2004 from www.drugabuse.gov/CBOM/Index.html
- National Native Alcohol and Drug Abuse Program. [NNADAP] (1998). *NNADAP review*. Retrieved June 13, 2004 from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/cp/nnadap/publications/literary_review_abuse_prgs.pdf
- Neal, R. (2004). *Voices: Women, poverty and homelessness in Canada*. Ottawa: The National Anti-Poverty Organization.
- Neale, J. (2001). Homelessness amongst drug users: A double jeopardy explored. *International Journal of Drug Policy*, 12, 353–369.
- Nyamathi, A., Leake, B., Keenan, C., & Gelberg, L. (2000). Type of social support among homeless women: Its impact on psycho social resources, health and health behaviors, and use of health services. *Nursing Research*, 49(6), 318–326.

- Ontario Substance Abuse Bureau [OSAB]. (1996). *Ontario Addiction Treatment Services Rationalization Project: Guidelines for restructuring services*. Author. Retrieved December 8, 2004 from <http://sano.camh.net/resource/wom.htm>
- Peterson, S., Berkowitz, G., Cart, C.U., & Brindis, C. (2002). Native American women in alcohol and substance abuse treatment. *Journal of Health Care for the Poor and Underserved*, 13(3), 360–378.
- Poole, N., & Isaac, B. (2001). *Apprehensions: Barriers to treatment for substance-using mothers*. BC Centre of Excellence for Women's Health, Vancouver.
- Poonwassie, A., & Charter, A. (2001). An Aboriginal worldview of helping: Empowering approaches. *Canadian Journal of Counselling*, 35(1), 63–73.
- Powis, B., Gossop, M., Bury, C., Payne, K., & Griffiths, P. (2000). Drug-using mothers: Social, psychological and substance use problems of women opiate users with children. *Drug & Alcohol Review*, 19(2), 171–180.
- Prochaska, J., & DiClemente, C. (1986). *Toward a comprehensive model of change*. In: W.R. Miller, & N. Heather (Eds.). *Treating addictive behaviours: Processes of change*. New York: Plenum.
- Richmond, R., Kehoe, L., Heather, N., & Wodak, A. (2000). Evaluation of a workplace brief intervention for excess alcohol consumption: The workscreen project. *Preventive Medicine*, 30, 51–63.
- Riehmman, K.S., Hser, Y.-I., & Zeller, M. (2000). Gender differences in how intimate partners influence drug treatment motivation. *Journal of Drug Issues*, 30(4), 823–838.
- Roll, C.N., Toro, P.A., & Ortola, G.L. (1999). Characteristics and experiences of homeless adults: A comparison of single men, single women, and women with children. *Journal of Community Psychology*, 27(2), 189–198.
- Rollnick, S., Heather, N., & Bell, A. (1992). Negotiating behaviour change in medical settings: The development of brief motivational interviewing. *Journal of Mental Health*, 1, 25–37.
- Rowe, M., Fisk, D., Frey, J., & Davidson, L. (2002). Engaging persons with substance use disorders: Lessons from homeless outreach. *Administration & Policy in Mental Health*, 29(3), 263–273.
- Royal New Zealand College of General Practitioners. (1999). *Guidelines for recognizing, assessing, and treating alcohol and cannabis abuse in primary care*. Retrieved December 8, 2004 from www.rnzcgp.org.nz/alac/topicInformation.htm
- Sacks, S. (2000). Co-occurring mental and substance use disorders: Promising approaches and research issues. *Substance Use & Misuse*, 35(12–14), 2061–2093.
- Samet, J.H., Friedmann, P., & Saitz R. (2001). Benefits of linking primary medical care and substance abuse services: Patient, provider, and societal perspectives. *Archives of Internal Medicine*, 161(1), 85–91.
- Samet, J.H., Larson, M.J., Horton, N.J., Doyle, K., Winter, M., & Saitz R. (2003). Linking alcohol- and drug-dependent adults to primary medical care: A randomized controlled trial of a multi-disciplinary health intervention in a detoxification unit. *Addiction*, 98(4), 509–516.

- Smith, W.B., & Weisner, C. (2000). Women and alcohol problems: A critical analysis of the literature and unanswered questions. *Alcoholism: Clinical and Experimental Research*, 24(8), 1320–1321.
- Stein, A., Shakour, S., & Zuidema, R. (2000). Financial incentives, participation in employer-sponsored health promotion and changes in employee health and productivity: HealthPlus Health Quotient Program. *Journal of Occupational and Environmental Medicine*, 42, 1148–1155.
- Sterk, C.E., Elifson, K.W., & Theall, K. (2000). Women and drug treatment experiences: A generational comparison of mothers and daughters. *Journal of Drug Issues*, 30(4), 839–862.
- Stevens, S.J., Estrada, A.L., Glider, P.J., & McGrath, R.A. (1998). Ethnic and cultural differences in drug-using women who are in and out of treatment. *Drugs and Society*, 13 (?), 81–95.
- Substance Abuse and Mental Health Services Administration [SAMHSA] (2003). *Silence hurts: Alcohol abuse and violence against women. Center for Substance Abuse Prevention*. Retrieved June 1, 2004 from http://pathwayscourses.samhsa.gov/vawp/vawp_6_pg10.htm
- Swift, W., & Copeland, J. (1998). Treatment needs of women with alcohol and other drug problems: Experiences and views of Australian treatment personnel. *Drug and Alcohol Review*, 17, 59–67.
- Tait, C.L. (2000). *A study of the service needs of pregnant addicted women in Manitoba*. Manitoba Health. www.gov.mb.ca/health/documents/PWHCE_June2000.pdf
- Thompson, A.S., Blankenship, K.M., Selwyn, P.A., Khoshnood, K., Lopez, M., Balacos, K., & Altice, F.L. (1998). Evaluation of an innovative program to address the health and social service needs of drug-using women with or at risk for HIV infection. *Journal of Community Health*, 23(6), 419–440.
- Tinsman, P.D., Bullman, S., Chen, X., Burgdorf, K., & Herrell, J.M. (2001). Factors affecting client response to HIV outreach efforts. *Journal of Substance Abuse*, 13(1–2), 201–214.
- Tommasello, A.C., Myers, C.P., Gillis, L., Treherne, L.L., & Plumhoff, M. (1999). Effectiveness of outreach to homeless substance abusers. *Evaluation & Program Planning*, 22(3), 295–303.
- Trepper, T.S., McCollum, E.E., Dankoski, M.E., Davis, S.K., & LaFazia, M. (2000). Couples therapy for drug abusing women in an inpatient setting: A pilot study. *Contemporary Family Therapy: An International Journal*, 22(2), 201–221.
- van den Bergh, N. (2000). Where have we been?... Where are we going?: Employee assistance practice in the 21st century. *Employee Assistance Quarterly*, 16(1–2), 1–13.
- van der Walde, H., Urgenson, F.T., Weltz, S.H., & Hanna, F.J. (2002). Women and alcoholism: A biopsychosocial perspective and treatment approaches. *Journal of Counselling and Development*, 80 (2), 145–153.
- van Wormer, K. (2002). *Addictions and women in the criminal justice system*. In: S.L. Straussner et al. (Eds.). *The handbook of addiction treatment for women* (pp. 470–486). San Francisco: Jossey-Bass/Pfeiffer.

- Varcoe, C. (1998). *From “better than nothing” to “best practices”: A background paper on “best practices” in health care in relation to violence against women*. British Columbia: Ministry of Health, Ministry Advisory Council on Women’s Health.
- Vines, J.A., & Mandell, C.J. (1999). Characteristics of female alcohol and drug substance users engaged in treatment programs. *Journal of Applied Rehabilitation Counselling*, 30(1), 35–43.
- Wechsberg, W.M., & Cavanaugh, E.R. (1998). Differences between drug using women who are in and out of treatment: Implications for interventions. *Drugs & Society*, 13(1–2), 63–79.
- Welte, J.W., Perry, P., Longabaugh, R., & Clifford, P.R. (1998). An outcome evaluation of a hospital based early intervention program. *Addiction*, 93, 573–581.
- Wenzel, S.L., Burnam M.A., Koegel, P., Morton, S.C., Miu, A., Jinnett, K.J., & Sullivan, J.G. (2001). Access to inpatient or residential substance abuse treatment among homeless adults with alcohol or other drug use disorders. *Medical Care*, 39(11), 1158–1169.
- Whynot, E.M. (1998). Women who use injection drugs: The social context of risk. *Canadian Medical Association Journal*, 159, 355–358.
- Wild, T.C., Hodgins, D., Curtis, M., & Thygesen, K. (2003). *Review of screening and assessment instruments for women: Substance use and co-occurring disorders*. Edmonton, AB: AADAC.
- Willenbring, M.L., & Olson, D.H. (1999). A randomized trial of integrated outpatient treatment for medically ill alcoholic men. *Archives of Internal Medicine*, 159, 1946–1952.
- Witbeck, G., Hornfeld, S., & Dalack, G.W. (2000). Emergency room outreach to chronically addicted individuals: A pilot study. *Journal of Substance Abuse Treatment*, 19(1), 39–43.
- Woolis, D.D. (1998). FamilyWorks: substance abuse treatment and welfare reform. *Public Welfare*, 56(1), 24–34.
- Yahne, C.E., Miller, W.R., Irvin Vitela, L., & Tonigan, J.S. (2002). Magdalena pilot project: Motivational outreach to substance abusing women sex workers. *Journal of Substance Use Treatment*, 23(1), 49–53.
- Zelvin, E. (1999). Applying relational theory to the treatment of women’s addictions. *Affilia: Journal of Women and Social Work*, 14(1), 9–24.
- Zilberman, M.L., Tavares, H., Blume, S.B., & El-Guebaly, N. (2002). Towards best practices in the treatment of women with addictive disorders. *Addictive Disorders*, 1(2), 39–46.

Appendix A:

Document Sections Supporting the Best Practice Statements

This appendix identifies the sections from the document that support each best practice statement.

General Considerations

Client Circumstances

Sources:

- 2.3.4 *Lack of Social Support*
- 2.4.1 *Pregnant Women*
- 2.4.3 *Women with Concurrent Mental Health Problems*
- 2.4.9 *Senior Women*
- 2.5 *Early Intervention*
- 2.5.1 *Screening for Substance Use*
- 2.5.6 *Family Participation in Early Intervention Approaches*
- 2.7.5 *Linkages with other Community Services*
- 3.3.1 *Circumstances and Needs of Women with Substance Use Problems*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*
- 3.4.1 *Theoretical or Applied Orientations for Early Intervention and Outreach*
- 4.5.3 *Foster and Maintain Sources of Support*

Basic Needs

Sources:

- 2.6.4 *Key Outreach Activities*
- 2.7 *Community Linkages*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*
- 3.5.1 *Essential Community-based Services and Supports*
- 4.7.5 *Housing and Shelter*

Child Custody Concerns

Sources:

- 2.2.4 *Social Context and Relationships*
- 2.3.5 *Fear of Repercussions*
- 2.4.2 *Women with Children*
- 3.3.1 *Circumstances and Needs of Women with Substance Use Problems*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*
- 4.3.7 *Experiencing the Fear of Losing Children*

Rural Challenges

Sources:

- 2.4.5 *Rural Women*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*
- 4.3.1 *Accessing Treatment Services*

Prescription Drug Misuse

Sources:

- 2.2.2 *Patterns of Use*
- 3.4.2 *Early Intervention Approaches*
- 4.3.5 *Obtaining Essential Treatment Information and Support*

Cultural Awareness

Sources:

- 2.4.7 *Aboriginal Women*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*

Screening Processes

Client-centred Screening Processes

Sources:

- 2.5.1 *Screening for Substance Use*
- 2.5.5 *Brief Negotiation Interview*
- 3.4.2 *Early Intervention Approaches*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*
- 4.5.8 *Ask Screening Questions*

Literacy Levels

Sources:

- 2.5.1 *Screening for Substance Use*
- 3.5.1 *Essential Community-based Services and Supports*

Areas of Inquiry

Sources:

- 2.5.1 *Screening for Substance Use*
- 2.5.2 *Screening for Readiness to Change*
- 3.4.2 *Early Intervention Approaches*
- 4.5.8 *Ask Screening Questions*

Role of Health and Community-based Service Providers

Sources:

- 2.5 *Early Intervention*
- 2.5.1 *Screening for Substance Use*
- 2.5.2 *Screening for Readiness to Change*
- 2.5.8 *Settings for Early Intervention*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*
- 4.3.1 *Accessing Treatment Services*
- 4.3.5 *Obtaining Essential Treatment Information and Support*

Early Intervention Strategies

Theoretical Models of Treatment

Readiness

Sources:

- 2.5.2 *Screening for Readiness to Change*
- 2.5.4 *Motivational Interviewing*
- 3.4.1 *Theoretical or Applied Orientations for Early Intervention and Outreach*

Brief Interventions and Motivational Interviewing

Sources:

- 2.5.3 *Brief Interventions*
- 2.6.4 *Key Outreach Activities*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*

Workplace Early Intervention Applications

Sources:

- 2.5.8 *Settings for Early Intervention*
- 3.4.2 *Early Intervention Approaches*
- 4.5.5 *Implement Community-based Early Intervention Programs*

Outreach Services

Settings

Sources:

- 2.6 *Outreach*
 - 2.6.1 *Location of Outreach Services*
 - 2.7.2 *Relevant Community-based Linkages for Women*
- 3.4.3 *Outreach Approaches*
- 3.5.1 *Essential Community-based Services and Supports*
- 4.7.6 *Community-based Educational Programs*

Accessibility

Sources:

- 2.4.4 *Homeless and Transient Women*
- 2.6.2 *Structuring Outreach Interventions*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*
- 3.4.3 *Outreach Approaches*
- 4.6.3 *Enhance Accessibility of Services*

Developing Trust

Sources:

- 2.4.10 *Sex Trade Workers*
- 2.6.4 *Key Outreach Activities*
- 3.4.3 *Outreach Approaches*

Outreach Activities

Sources:

- 2.4.6 *Injection Drug-using Women*
- 2.6.4 *Key Outreach Activities*
- 3.4.1 *Theoretical or Applied Orientations for Early Intervention and Outreach*
- 3.4.3 *Outreach Approaches*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*

Relevant Community-based Support Programming

Gender-specific Programming

Sources:

- 2.7.2 *Relevant Community-based Linkages for Women*
- 3.4.1 *Theoretical or Applied Orientations for Early Intervention and Outreach*
- 4.6.5 *Strengthen Advocacy for Gender-specific Approaches*

Counselling Support

Sources:

- 2.7.2 *Relevant Community-based Linkages for Women*
- 4.5.4 *Provide Individual Counselling Services*

Child Care Services

Sources:

- 2.4.2 *Women with Children*
- 2.7.2 *Relevant Community-based Linkages for Women*
- 3.3.1 *Circumstances and Needs of Women with Substance Use Problems*
- 3.3.2 *Service Delivery Considerations for Specific Groups of Women*
- 4.7.2 *Child Care Services*

Family Therapy and Support

Sources:

- 2.5.6 *Family Participation in Early Intervention Approaches*
- 2.7.2 *Relevant Community-based Linkages for Women*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*
- 4.3.3 *Securing Personal Supports*
- 4.7.7 *Transition Supports and Aftercare Programs*

Community Linkages and Integrative Approaches

Community Awareness

Sources:

- 2.3.2 *Stigmatization*
- 4.4.1 *Addressing Negative Stereotypes*

Knowledge of Services

Sources:

- 2.5 *Early Intervention*
- 2.7.2 *Relevant Community-based Linkages for Women*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*
- 4.6.2 *Increase Awareness of Community Resources and Referral Processes*

Community Service Provider Agreements

Sources:

- 2.7 *Community Linkages*
- 3.5.4 *Strategies for Promoting Effective Consultation and Community Linkages*
- 4.6.4 *Foster Collaborative Actions*

Consultation Role of Addiction Specialists

Sources:

- 2.5.9 *Specialized Consultation and Training for Health Care Providers*
- 3.4.4 *Roles for Individuals Supporting Early Intervention and Outreach*

Case Management

Sources:

- 2.7.3 *Service Linkage Models*
- 2.7.4 *Establishing Links with Health Care Providers*
- 3.4.3 *Outreach Approaches*

Treatment Transitions

Sources:

- 2.4.11 *Women in Conflict with the Law*
- 3.5.5 *Gaps and Inconsistencies in Services or Policies*
- 4.7.7 *Transition Supports and Aftercare Programs*

