

BEST PRACTICES IN ACTION:

**GUIDELINES AND CRITERIA FOR WOMEN'S
SUBSTANCE ABUSE TREATMENT SERVICES.**

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Executive Summary

Important gender differences have not always been well understood or well addressed in the substance abuse treatment system in Ontario; however, over the last 30 years, considerable research about the needs of women has been conducted. This has led to a solid base of new knowledge and an understanding of best practices that can form the foundation for improved substance abuse treatment for women.

The development of research-based best practices for women's substance abuse treatment has progressed considerably. Best practices literature and clinical practice have identified better ways to meet the needs of women who currently access the treatment system. Furthermore, new approaches have been identified to address barriers and better support the needs of women who find existing services difficult to access.

Many women's substance abuse treatment services have become more sensitive to gender differences and some services have made efforts to implement best practices; however, much work remains to be done. Wide variations exist in the implementation of best practices among services for women. Standards for women's services are needed to promote consistency and to ensure that best practices are implemented.

The need to continue to transform the substance abuse treatment system was acknowledged by the Ministry of Health and Long Term Care (MOHLTC) in its document ***Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario*** (Ontario Substance Abuse Bureau, 1999). In an effort to build upon the policy direction articulated in ***Setting the Course***, the Addiction Program, Mental Health and Addictions Branch of the MOHLTC convened a Women's Service Strategy Work Group to address the on-going development of appropriate, accessible services for women.

The Work Group's mandate was to develop protocols, tools, and strategies to support best practices at all levels (including program, system, and government levels) and to operationalize the best practices direction provided by Health Canada's Best Practices documents for women's substance abuse treatment. The goal of the initiative was to support accessible and appropriate services for women through ensuring the use of best practices in women's substance abuse treatment programs.

The efforts of the Work Group resulted in the development of ***Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services***. This document evolved from an attempt to merge existing approaches used within the substance abuse treatment system with established and emerging best practices approaches to support continued improvement of services for women. Although many sources of best practices information were examined and incorporated, ***Best Practices in Action*** is based primarily on Health Canada's Best Practices documents and represents an

attempt to operationalize this information for practical use within Ontario's substance abuse treatment system.

Best Practices in Action is intended, not solely for services restricted to women, but for use by **all** programs that serve women and can be used to evaluate current practices, inform planning and ongoing evaluation, and demonstrate use of best practices to the ministry and the community. **Best Practices in Action** also addresses operational and clinical practice issues specific to services for women. Guidelines have been identified in relation to a wide range of issues, based on an analysis of best practices documents. Criteria have been identified in relation to each guideline.

Some guidelines may seem out of reach due to training and resource issues. Some service staff may need time to learn or require additional training in order to meet some guidelines. Other guidelines will be a challenge for some programs to reach without additional resources. In such cases, programs will need to aim for partial achievement and to document difficulties in achieving guidelines. **Best Practices in Action** represents an ideal standard to which programs can aspire; programs can use it to document the steps taken to achieve best practices for women and to set strategic plans with best practices for women in mind.

Background to Best Practices in Action

Introduction

In matters of health, gender makes a difference. Gender differences are important in many respects and include impacts on physiology, physical and psychological development, socialization, economic and legal status, social conditions and family roles, as well as in patterns and impacts of substance use. The substance abuse treatment needs of women similarly reflect gender differences and a treatment system should be designed that is responsive to the context and realities of women's lives.

Important gender differences have not always been well understood or well addressed by the substance abuse treatment system in Ontario; however, over the last 30 years, considerable research has been conducted about the needs of women. This has led to a solid base of new knowledge and an understanding of best practices that can form the foundation for improved substance abuse treatment for women. As service providers in treatment settings become more aware of best practices, services for women are slowly becoming more appropriate and accessible. While considerable progress is being made toward improving treatment services for women, there is still room to integrate best practices into the day-to-day work of substance abuse service provision in the province.

The need to continue to transform the substance abuse treatment system was acknowledged by the MOHLTC in its 1999 document *Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario*. This document supports the continued and ongoing development of women's services as an integral part of the ministry's policy direction for service system development and reform. *Setting the Course* notes that system development is encouraged and will be reformed through the ministry's initiatives to:

- **develop** a broad vision for the substance abuse treatment system;
- **promote** the use of best practices;
- **establish** provincial priorities, protocols, and benchmarks;
- **develop** standards for services targeted to specific populations; and
- **lead** provincial initiatives to meet both the needs of general substance abuse services and the needs of specific client populations.

Policy and Philosophical Background

Setting the Course was released in 1999. Upon its release, the Addiction Programs (formerly the Ontario Substance Abuse Bureau) initiated a system-wide planning process designed to improve the planning, delivery, and evaluation of substance abuse treatment services across the province. Improved accessibility, appropriateness, and responsiveness

of services for under-served populations, including women, are integral parts of the system change process initiated by **Setting the Course**.

Health Canada's **Women's Health Strategy** calls upon health systems to gain an understanding of the distinct nature of women's health issues and address system biases and insensitivities to women and their issues:

"Our health system has been slow to recognize that sex and gender are other significant determinants of health. For many years, a burgeoning women's health movement called attention to biases in the health system. At first, the sense that the system was failing women was intuitive and personal. Over time, awareness grew that shortfalls in the system were more pervasive and required a comprehensive response – including changes in attitude and practice." (Health Canada, 1999)

The **Interim Report of the Special Committee on Non-Medical Use of Drugs** recognizes the need for comprehensive, gender relevant approaches to treatment and rehabilitation:

"The harmful use of substances and dependence are complex health problems that can not be isolated from the social and economic environment in which they evolve. In many cases, individuals who develop a pattern of harmful use of substances also have a history of victimization, sexual and physical abuse, family violence, mental health issues, learning disabilities, school failure, and criminality....The Committee believes that a holistic, gender relevant, comprehensive approach, which recognizes the importance of integrated services and partnerships, is an essential component of the delivery of treatment and rehabilitation services." (Health Canada, 2002)

The **Ontario Addiction Treatment Services Rationalization Project: Guidelines for Restructuring Services** emphasizes the importance of recognizing gender differences in planning services for women:

"Women's experiences differ from men's, in substance use as in the wider social context. These differences have implications for treatment planning if women are to access services on an equitable basis and have an equal chance for positive outcome." (Ontario Substance Abuse Bureau, 1996)

Setting the Course also supports the need for specialized services for women:

"Effective treatment must take into account women's broader health and social needs and break down any barriers that could scare them away or keep them from participating fully in their recovery." (Ontario Substance Abuse Bureau, 1999)

Health Canada's Best Practices Guidelines

In an effort to address the wide range of issues that impact on women's use of substances, and the treatment needs of women related to these issues, Health Canada developed a

series of Best Practices documents for use by the field. The preparation of **Best Practices in Action** was based on three Health Canada's Best Practices documents:

- **Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems (2001)**
- **Best Practices: Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy (2000)**
- **Best Practices: Concurrent Mental Health and Substance Use Disorders (2001)**

Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems was developed as part of a three year research agenda approved by the Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues, published in 2001. The authors conducted interviews with 40 key informants and reviewed post-1990 research literature related to several dimensions of services for women. The document provides an overview of women's substance use patterns and impacts, identifies barriers to treatment and retention, and identifies principles, strategies, and approaches that have been found to be effective with women. **Best Practices: Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy** and **Best Practices: Concurrent Mental Health and Substance Use Disorders** are similar in content and structure, but specific to issues of pregnancy or concurrent problems.

Best Practices in Action was, in particular, informed by **Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems** which identified best practices principles as needing to:

- provide a menu of options;
- provide a menu of approaches;
- be holistic and address practical needs;
- be gender specific or provide gender specific elements in the context of co-educational services;
- support connectedness among women;
- employ supportive, collaborative, non-hierarchical approaches;
- provide treatment based on the empowerment model;
- address issues of primary concern to women, including childcare;
- be respectful and client driven;
- support client education and awareness;
- provide treatment that is based on client strengths, not deficits;
- provide a continuum of services to meet client needs; and
- work with women on realistic objectives and accept that relapse is a learning experience not a defining point in treatment.

Development of the Women's Services Strategy

In an effort to further the goals outlined in **Setting the Course**, the ministry convened a Women's Service Strategy Work Group to address the continuing development of

appropriate, accessible services for women. The Work Group's mandate was to develop protocols, tools, and strategies to support best practices at all levels, including program, system, and government levels. The Work Group's membership reflected knowledge of women's treatment issues, best practices, regional issues, and substance abuse services. Regional ministry representation was provided through the ex-officio participation of Regional Consultants from the Central West and East Regions.

The efforts of the Work Group resulted in the development of ***Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services***. This document evolved from an attempt to merge existing approaches used within the substance abuse treatment system with established and emerging best practices approaches to support continued improvement of services for women. The development of the document included:

- a systematic review of information from best practices sources;
- an analysis of the efficacy and practicality of these approaches; and
- the formulation of guidelines and criteria for programs to use in both planning and evaluating their services for women.

Best Practices in Action is based on:

- Health Canada's Best Practices documents;
- other research literature that provided insight into key topics including trauma, pregnant and parenting women and their children, and mental health services for women; and
- advice from key informants.

Best Practices in Action is intended, not solely for services restricted to women, but for use by ***all*** programs that serve women and should be used to:

- **evaluate** current practices;
- **inform** planning and ongoing evaluation; and
- **demonstrate** use of best practices to the ministry and the community.

Best Practices in Action will provide agencies with the means to:

- **understand and implement** best practices;
- **plan** more responsive services;
- **demonstrate** competencies, gaps, and needs; and
- **enhance accountability** to their clients, the community, the treatment system, and the ministry.

At a system level, *Best Practices in Action* will:

- **establish** common system guidelines;
- **improve** clarity and communication; and
- **support** system planning.

In addition, a number of recommendations have been developed for government and system planning groups to improve the capacity of the system to support best practices.

Context for Women's Use of Substances

Patterns of Use

As in the wider social context, women differ from men in their patterns of, and reasons for, substance use. These differences have implications for treatment services: that is, if women are to access services on an equitable basis and have an equal chance for positive outcomes, then substance abuse services need to address women's unique experiences (Covington, 2000).

Within the general population, alcohol is the drug most commonly used by women, although women drink less frequently than men, consume smaller amounts, and are less likely to be current drinkers. However, because of physiological differences, the effect of alcohol on women's bodies is much greater than for men. Women achieve higher blood alcohol levels and become more impaired after drinking equivalent amounts of alcohol. As a result they develop alcohol related health problems such as heart disease, cirrhosis and brain damage with lower levels of alcohol consumption and sometimes over a shorter period of time than men (Lynch et al., 2002; United Nations Office on Drugs and Crime, 2004). Alcohol use also puts women at risk for other consequences such as breast cancer, effects on the reproductive system, sexual dysfunction, and effects on the fetus (Health Canada 2001a, Lynch et al., 2002; Reynolds & Bada, 2003; United Nations Office on Drugs and Crime, 2004). Alcohol consumption, in particular binge drinking, can also make women more vulnerable to victimization (Lawrence, Chau, & Lennon, 2004).

Tobacco has taken a particular toll on women's lives. In Canada in 2003, 16% of women are still current smokers (versus 19% of men), although most of these women report "high smoking dependence" (Canadian Community Health Survey, 2004). Rates of smoking among women may be somewhat higher in Ontario, at 21.5% (Centre for Addiction & Mental Health, 2002). Women who smoke are more likely than men who smoke to develop lung problems; in addition, lung cancer has overtaken breast cancer as the leading cause of cancer death among women.

Women are more likely to use and become dependent on psychoactive medications such as sleeping pills and tranquillizers (Currie, 2003). In Canada's Alcohol and Other Drugs Survey: 1994, 24% of women reported using at least one of five psychoactive medications (pain pills, sleeping pills, tranquilizers, anti-depressants, diet pills) versus 17% of men (Health Canada, 1997). Older women are particularly vulnerable to the effects of these drugs through increased risks of falls or cognitive problems such as confusion. The Canadian Addiction Survey (Adlaf, Begin, and Sawka, 2005), a more recent national survey of Canadians' use of alcohol and other drugs, does not include psychoactive medications in its report; however, other research literature indicates that the rates of use and gender discrepancies with respect to psychoactive medications remain much higher among women than among men (Currie, 2003).

The research literature also indicates that women of any age are vulnerable to a medical system bias for prescribing psychoactive medication in response to seeking help for social problems, such as isolation and violence. Societal stereotypes of women less able than men to cope with life stresses are the foundation for increased rates of prescription drug use; for example, women coping with issues such as grief and loss may be prescribed benzodiazepines or antidepressants, instead of being offered psychosocial solutions. These prescribing practices increase exponentially in older age groups of women (Currie, 2003).

While women are less likely than men to use illicit drugs, many treatment programs report a high incidence of illicit drug use among women who access the treatment system. This is consistent with American research indicating that women entering treatment are more likely than men to be heavy or more frequent users of their drugs of choice and to have more serious health and other problems (Acharyya & Zhang, 2003; Arfken et al., 2001). Though less is known about the effect of illicit drugs on women, studies indicate that the phases of women's menstrual cycles are both affected by, and have an affect on the pharmacokinetics of, illicit drugs. Women also develop a dependence on drugs such as heroin and cocaine more quickly than men (Lynch et al., 2003; National Institute on Drug Abuse, 2002).

As well, women who inject drugs have higher mortality rates than men and are more vulnerable to HIV infection (Barnard, 1993; Latkin, et al., 1998; Perucci, Davoli, Rapiti et al, 1991; Frischer, Bloor, Goldbert et al, 1993). Since 1995, almost half of all new HIV test reports among women were attributed to injection drug use, while rates for men were substantially lower (deBruyn, 2004).

Use of substances during pregnancy can affect the growth and development of the fetus and newborns. Effects can include miscarriage, low birth weight, early delivery and postnatal growth, and development problems, such as Fetal Alcohol Spectrum Disorders (FASD). Comprehensive and coordinated treatment can both positively affect the health of the mother and lead to more positive outcomes for the newborn (Poole & Isaac, 2001).

Women may be introduced to problem substance use by their partners or use substances with their partners. Women who drink heavily often have heavy drinking partners; women who inject drugs are more likely to be influenced by others to inject, to share needles, and to engage in unsafe sexual practices (Health Canada, 2000).

Many women use or are prescribed substances to cope with experiences of abuse and violence. For example, women who had been sexually abused were two to four times more likely to be using psychoactive medication than women who had not experienced such abuse (Lawrence, Chau, & Lennon, 2004). Given this correlation, it is not surprising that women in substance abuse treatment also report very high rates of physical and sexual abuse.

Among women, mental health disorders are commonly associated with, and exacerbated by, heavy substance use. Women have higher rates of post traumatic stress response, eating disorders, anxiety, and depression than men (Lawrence, Chau, & Lennon, 2004; Moses, Huntington, & D'Ambrosio, 2004; Najavits, 2002; SAMHSA, 2004). Women with substance use problems are also at high risk for suicidal ideation and completion (Sinha, 2004).

Unique patterns of drinking, drug use, and smoking have also been reported in young women and girls (ages 8 to 22 years). Puberty is a time of high risk for girls. Girls are more likely than boys to be depressed, have eating disorders, or be sexually or physically abused. Girls and young women are also more likely than boys and young men to experience more adverse health consequences, attempt suicide, and abuse prescription painkillers, stimulants, and tranquilizers (Finkelstein et al, 1997; SAMHSA, 2004).

Substance Use and Women: An Overview of the Issues

The reasons for women's use of substances are multifaceted and interconnected. Substance use may help many women to contend with difficult life circumstances, such as: a history of trauma (violence, sexual abuse, or prolonged childhood stress); current domestic violence; poverty; or feelings of guilt, shame, and inadequacy. Historically, the substance abuse treatment system was designed based on male norms and needs. For example, Covington (2000) examined the development of the history of women's addiction treatment needs in the United States and concludes that "both of the cornerstone treatment approaches in the U.S. [which are A.A. and the work of E.M. Jellinek] have been based exclusively on the experiences of men."

The development of a treatment system based on male norms has resulted in numerous barriers to services for substance involved women. Effective services for women must be informed by gender specific approaches that recognize and address the underlying issues of women's substance use and abuse. Key contextual issues have been identified and the following elements need to be considered in the development of standards.

Substance Use Patterns

Women differ from men in their patterns of, and reasons for, substance use. Women are generally less likely to use alcohol, tobacco, and illicit drugs, but more likely to use psychoactive medications, such as tranquilizers and sleeping pills (Adlaf, Begin, & Sawka, 2004; Centre for Addiction and Mental Health, 2003). When women do smoke, drink, or use illicit drugs, they usually use smaller amounts less frequently, but may become dependent in a shorter period of time (United Nations Office on Drugs and Crime, 2004).

Women's substance use is most often connected to their relationships. For example, women, more often than men, are introduced to substance use by their partners; and women who inject drugs frequently share injecting equipment with their partners (Finkelstein et al., 1997). Many women in treatment have experienced violence or abuse in their lives, usually in the context of family or partners, and use substances to cope (Miller, 2004).

Physiological Effects of Substance Use

There are numerous gender differences in the physiological effects of substance use and in the progression of effects on women's bodies. Women experience more physical harm from intensive substance use in a shorter period of time than do men, in particular from the effects of alcohol and tobacco. Less is known about the physiological consequences of illicit drugs, though they often affect or are affected by the phases of women's menstrual cycles (Lynch et al., 2002; Reynolds & Bada, 2003; United Nations Office on Drugs and Crime, 2004). All psychoactive substances cross the placenta and may affect the growth and development of the fetus.

Identification

Women experience barriers in respect to identification, information, and referral issues. Women's substance use is typically not well identified by society's gatekeepers; societal denial of women's substance use can keep physicians, hospitals, police, health care workers, and employers from asking the appropriate questions (United Nations Office on Drugs and Crime, 2004). Women are often not well supported by partners, family, and others in their recovery efforts, compared with men. Inadequate referral systems and lack of appropriate services present additional barriers for those women who do seek assistance (Wilsnack & Wilsnack, 2003).

Stigma

Women experience a great deal of stigma, shame, and guilt in relation to substance use; this may be especially true for pregnant and parenting women (Greaves et al, 2002). Stigma and fear of ostracism keep women from seeking information to address substance use concerns (Becker & Duffy, 2002). Many pregnant and parenting women also fear their children may be apprehended by child protection services if they seek help for substance use concerns (Poole & Isaac, 2001). Societal stigma has created an historic lack of funding for women's substance abuse treatment programs (Covington, 2000).

Marginalization

Women are marginalized by a wide range of intersecting circumstances related to the social, economic, and legal contexts of their lives. Isolation, age, lack of mobility, language and cultural issues, poverty, violence and abuse, homelessness, mental and

physical disability, and lack of basic living supports are some issues that factor into women's substance use and typically constitute obstacles to engagement and recovery (Becker & Duffy, 2002; Poole & Isaac, 2001; United Nations Office on Drugs and Crime, 2004).

Economic and Social Context

Women are widely disadvantaged by economic and social factors. Women in the paid workforce consistently earn 20% less than men. Women's work in the home and childrearing remains unpaid and unprotected by the social safety net. Numerous concerns about systemic economic and social discrimination experienced by Canadian women have been stated. Poverty, wage disparities, and social program reductions, as well as lack of childcare, lack of social housing, and ongoing violence against women are some of the factors that continue to negatively affect Canadian women (Raphael & Bryant, 2004).

Social Determinants of Health

Government policy now recognizes that health not only is related to access to traditional health care, but also is determined by the social determinants of health. These factors include: income and social status; social support networks; education, employment and working conditions; physical environments; biology and genetic make-up; personal health practices and coping skills; healthy child development; health services; gender; and culture. Higher economic and social status is associated with better health, while poverty is associated with poorer health outcomes. The many pathways through which poverty can influence health, including poor nutrition, substandard housing, living in dangerous or polluted environments, stressful or dangerous jobs, unhealthy behaviours, lack of access to benefits and services, lack of hope, and diminished life expectations have been identified (Raphael & Bryant, 2004).

Pregnancy and Parenting

Women are more likely to have primary responsibility for children. This means that basic services such as prenatal care, childcare, child programming, and parenting programming are particularly important for women's treatment (Boyd, 2004; Poole & Isaac, 2001). The treatment system has historically lacked the capacity to offer these basic services. For example, the research literature has consistently shown the effectiveness of residential treatment services that women can access with their children (Becker & Duffy, 2002; United Nations Office on Drugs and Crime, 2004); however, such services are in their infancy in Ontario.

Services for substance involved pregnant women have been similarly lacking. Urgent timelines are in play to reduce potential fetal harm when women use alcohol and other drugs during pregnancy (Roberts & Dunn, 2003). Research indicates that withdrawal

from some substances can result in harm to the fetus; this knowledge reinforces the importance of harm reduction approaches and substitution therapies (Greaves et al, 2002; Jones, 2004; Lester et al, 2004). Interventions based on best practices such as priority access and harm reduction approaches are gaining ground in substance abuse services for pregnant women (Poole & Isaac, 2001; Roberts & Dunn, 2003).

Another considerable barrier for pregnant and parenting women is the risk of children being apprehended by child protection authorities (Poole & Isaac, 2001). There has been movement within the system to address this barrier; the funding provided for the Early Childhood Development Addictions Projects has meant that some treatment services have begun to form strong working relationships with child protection agencies. These cooperative approaches will help to inform and mediate child protection interventions with substance involved pregnant and parenting women.

Relational Issues

It is now recognized that a primary motivation in women's psychological development is the need to build connectedness with others (Covington & Surrey, 1997). Therefore, relationships or loss of relationships can play a central role in women's substance use (Finkelstein et al, 1997). Women may use substances to maintain relationships, to deal with abusive relationships, or to fill the void left by failed relationships. However, traditional treatment approaches often focus on the individual and have failed to understand and address relational issues in women's lives.

Mental Health and Trauma Issues

A significant number of women in substance abuse treatment have experienced childhood or adult trauma including physical, emotional and sexual abuse, rape, and victimization (Lawrence, Chau, & Lennon, 2004; Moses, Huntington, & D'Ambrosio, 2004). Rates of post traumatic stress response, depression, anxiety, and eating disorders are higher among women than among men. (Lawrence, Chau, & Lennon, 2004; Najavits, 2002). Connections between substance use, co-occurring mental health problems, and experiences of trauma have been widely identified in the literature (Lawrence, Chau, & Lennon, 2004; Moses, Huntington, & D'Ambrosio, 2004; Najavits, 2002; SAMHSA, 2004; Sinha, 2004).

System Profile

Development of Women's Treatment Services

Substance abuse treatment services in Ontario have developed over the last 30 years as communities have tried to respond to people's health needs. Substance abuse treatment services, like much of the health care system, have been slow to recognize the importance of gender specific approaches. Men have historically comprised the majority of clients in treatment within the formal substance abuse treatment system. The greater numbers of male clients resulted in services that have been designed to respond to men's patterns of substance use and life experiences.

Health Canada's discussion of best practices for women notes that "the emphasis on male substance use patterns and treatment for men has resulted in a male-as-norm bias" which has judged women who required treatment more harshly, and has "limited the exploration of gender specific treatment approaches" (Health Canada, 2001a).

Toward the end of the 1970s and during the 1980s, advances were made in research and a base of knowledge about best practices approaches for diverse populations began to be collected. The growing women's movement in Canada, supported by research and expert opinion, indicated that treatment needed to be adjusted for women, leading to the diversification of treatment resources. As a result, women-only programs were established in a number of large urban centres and provincial jurisdictions; simultaneously, the research literature, along with women working in the substance abuse field, began to reflect the growing interest and concern about providing treatment for and by women.

Configuration of the Treatment System

The substance abuse treatment system in Ontario is comprised of a continuum of services that are offered in gender specific or co-ed services. Practice standards and treatment environments vary considerably across service categories and among gender specific and co-ed services.

Provincial Service Categories

The ministry has designated a number of service categories that constitute the continuum of care provided by substance abuse treatment services (Admission and Discharge Criteria 2000) that include:

- Prevention Awareness Services (problem gambling only);
- Entry (inquiry contact, intake, screening);
- Initial assessment/treatment planning;

- Case management services;
- Community treatment services;
- Community day/evening treatment services;
- Community medical/psychiatric treatment services;
- Residential treatment services;
- Residential supportive treatment services (levels 1 and 2);
- Residential medical/psychiatric services;
- Community withdrawal management services (levels 1,2 and 3); and
- Residential withdrawal management (levels 1,2 and 3).

Services for women may be provided in each of the above service categories and may be offered either in women-only (restricted) settings or in co-ed (mixed gender) settings, as defined by:

- **restricted services** offering gender specific programs in dedicated, women-only residential or non-residential settings;
- **generic services** offering services to mixed populations of men and women in co-ed residential or non-residential settings; and
- **specialized services** for women providing dedicated, gender specific programming in women-only groups or individual counselling that may be offered within residential or non-residential settings where services for male clients are also offered

System Capacities for Women's Services

1. Number and configuration of residential services restricted for women

Even though advances have been made in the provision of women specific services, the availability of restricted services for women has remained relatively small as a percentage of total residential services. The availability of women's withdrawal management services is particularly limited as outlined below.

Residential withdrawal management services

- 30 residential services comprise the Withdrawal Management Service system
- 3 Withdrawal Management Services (10%) serve women only

Residential treatment and supportive programs

- 109 residential programs comprise the provincial treatment system
- 30 programs (27%) serve women only

Configuration and capacity of women specific beds

Residential treatment and supportive program beds:

- 1802 beds comprise the provincial residential system
- 273 beds (15%) are restricted for women
- 67 beds (3.7%) are reserved for women

Residential withdrawal management beds:

- 521 withdrawal management beds comprise the provincial system
- 41 withdrawal management beds (7.8%) are restricted for women
- 86 withdrawal management beds (16%) are reserved for women

Capacity in mixed gender residential services

- Beds for women are also available within mixed gender residential programs; however, it is not possible to determine capacity in these programs since beds may be used for either men or women.

Capacity in non-residential services

- Non-residential services as a rule are mixed gender in structure and setting.

2. Trends in service capacity

Overall reductions in services have been reported across the service system, due to unchanged levels of base funding from 1992 until 2003. The numbers of services and the numbers of beds within the residential system decreased substantially as a result of the subsequent financial pressures during this time.

The number of residential beds for women has remained unchanged between 1996 and 2003. However, the number of restricted women's withdrawal management services decreased from four to three, due to the merger of the men and women's Withdrawal Management Services in Sudbury.

3. Gaps in information

There are numerous gaps in information about women who access the treatment system. Current data collection does not include basic data such as:

- number of parenting women, including single parents and same-sex parenting women;
- number and ages of children;
- number of women whose children have been taken into care;
- other caregiving responsibilities assumed by women (e.g., for elder parents), including caregiving responsibilities related to ethnic origin (e.g., for other extended family or home schooling expectations);
- incidence of violence;

- incidence of sexual assault;
- number of women with concurrent problems; and
- number of women living with a partner who uses substances.

Additionally, data is lacking about the number and characteristics of women with substance use concerns that do not access the existing substance abuse treatment system. Population surveys tend not to generate data about women's substance use. Health care services where women are most likely to present (e.g., primary care physicians, hospitals) are often ill equipped to identify substance use issues. The lack of data about women who are not clients of the system complicates efforts to identify barriers, improve access, and develop relevant programming.

Best Practices in Action

Introduction to the Best Practices Program Evaluation Tool

The Guidelines and Criteria contained in this document have been constructed to comprise a **Best Practices Program Evaluation Tool**, which is recommended for use by all programs that provide services for women, including: women-only services (restricted), women-specific services (specialized), and co-ed services (core or generic). Four levels of benefits are anticipated from its use, including:

Client Level

- expand choices in, and increase accessibility to, services for women;
- improve clarity and consistency of information about services;
- improve quality of services; and
- experience effective and empowering treatment.

Program Level

- support continued improvement in services for women;
- promote learning and make best practices documents more accessible;
- support program planning at clinical and operational levels;
- demonstrate expertise and provide evidence of competencies;
- demonstrate and support legitimacy of differential services for women; and
- communicate clearly about what is offered to clients, referral sources, DART, DATIS, and the Ministry of Health and Long-Term Care.

System Level

- promote common language and understanding;
- improve communication among services;
- facilitate clarity and accountability;
- make gaps more visible and defined;
- support minimum system standards; and
- increase acceptable practices and standards.

Government Level

- enhance accountability;
- inform ministry direction in policy and funding;
- promote better understanding and support of best practices, current strengths, needs, and gaps in women's services; and
- support gender analysis of policy impacts.

Structure and Limitations of the Tool

The **Best Practices Program Evaluation Tool** addresses operational and clinical practice issues specific to services for women. Guidelines have been identified in relation to a wide range of issues, based on an analysis of best practices documents. Criteria have been identified in relation to each guideline.

*The **Best Practices Program Evaluation Tool** has been developed within the framework of a work in progress. It has been formulated as a starting point in an ongoing process in the pursuit of excellence within women's treatment.*

While a range of issues have been identified, much more information is contained within Health Canada's Best Practices documents and these should be consulted by those service providers who wish to pursue program excellence to its fullest extent. Program staff is encouraged to read Health Canada's Best Practices documents and to stay current with new and emerging information regarding best practices approaches in women's substance use treatment.

Additionally, the range of subpopulations of women and their diversity has not been fully explored or addressed within the tool. Further work should be done to identify best practices to address the diverse and varying needs of women. Women are not a homogeneous group; there are varying and intersecting influences on women's health and their interactions with the health system, including (but not limited to):

- physical abilities
- race and/or language
- cultural background
- religion
- sexual orientation

Different populations of women (such as First Nations women, seniors, and adolescents to name a few) also have varying life experiences and consequent treatment needs.

*The **Best Practices Program Evaluation Tool** has been developed to provide a basis for others, who are encouraged to adapt it to the needs of specific groups of women.*

Some guidelines may seem out of reach due to training and resource issues. Some service staff may need time to learn or require additional training in order to meet some

guidelines. Other guidelines will be a challenge for some programs to reach without additional resources. In such cases, programs will need to aim for partial achievement and/or to document difficulties in achieving guidelines.

*The **Best Practices Program Evaluation Tool** has been developed to allow programs to establish and incorporate guidelines to identify either the work that needs to be accomplished or the resources required to do so in relation to best practices and to document the factors that prevent the program from reaching the guideline.*

Best practices standards are the cornerstone of accessible and appropriate services for women. The Guidelines are not intended to place unrealistic pressures on programs; rather, they represent a goal and direction for women's services and setting these guidelines will provide a tangible roadmap for this journey.

*The **Best Practices Program Evaluation Tool** has been developed to allow programs to demonstrate their competencies as well as their needs for support.*

Recommended Application for Implementation

The **Best Practices Program Evaluation Tool** should be completed by all substance abuse treatment agencies that provide services for women. It serves several functions and successful implementation will be demonstrated across several dimensions. It should be used to:

- **provide program evaluation data** to the ministry to demonstrate best practices status and service competencies as part of program reviews and through the annual operating plan process;
- **gather a system-wide set of data** about services for women;
- **collect initial or baseline data** about service provision to women;
- **measure the progress of best practices implementation** through the completion of the Tool on an annual basis;
- **plan at both the program and system levels** to identify strengths and gaps;

- **share information at planning tables** (regional/district implementation committees, substance abuse service groups/networks and women's services planning groups) to create a system-wide picture of competencies and challenges.

Instructions for Use

Implementing the **Best Practices Program Evaluation Tool** requires each Agency to rate the extent to which programming for women currently meets the criteria in relation to each guideline using the following scale:

1. Fully achieved (FA)
2. Partially achieved – in progress (PA)
3. Not achieved (NAC)
4. Not applicable (NA)
5. Not reviewed (NR)

Use of this scale should be complemented by evidence of how the criteria are met. Programs are encouraged to individualize the **Best Practices Program Evaluation Tool** by adding other criteria as applicable to their sites: however, all existing criteria should be used for program evaluation purposes.

Best Practices Program Evaluation Tool

1. Operational Practices

Key Concepts

Best practices are reflected in: Board membership, agency policies, and program services; ongoing staff training and development; hiring and staffing practices; and in physical facilities, in particular those for pregnant and parenting women.

Best Practices Principles

- Empowerment and collaboration are reflected throughout the agency.
- Current, clinically relevant skills and knowledge are based on effective therapeutic approaches (such as motivational interviewing techniques, cognitive behavioural therapy, and harm reduction approaches).
- Gender specific services and female staff for women clients are provided by all agencies who serve women.
- Physical facilities are both welcoming and safe.
- Welcoming issues are addressed by attention to inclusivity of women's diversity and to the thoughtful arrangement of physical space.
- Safety issues are addressed by providing separate, or separated, residential facilities for women with all aspects of physical safety and confidentiality taken into account.
- The relational needs of pregnant and parenting women in regard to their children are addressed by the agency, either onsite or through arrangements with allied services.

1.1 Governance

Rationale: A strong commitment to best practices is essential at the Board level to support quality services for women. Boards shape the philosophical and practical approaches of their programs and play a pivotal role in supporting positive changes. The **Ontario Addiction Treatment Services Rationalization Project: Guidelines for Restructuring Services** (OSAB, 1996) calls upon the field to examine the presence and proportion of women in volunteer roles within their organizations (including board members) as a demonstration of commitment to the best practices principle of empowerment and collaboration.

1.1a) Guideline: Boards and Program Advisory Committees evidence strong support for best practices in services, in membership, and in policies.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Board of Directors and/or Program Advisory Committee members demonstrate an interest in, knowledge of, and commitment to best practices in women's programming.		
The mission, goals, and objectives identify the unique needs of women and interventions specific to women.		
<i>Freestanding restricted women's agency:</i> The majority of the Board of Directors is comprised of women.		
<i>Freestanding co-ed agency:</i> A minimum of 50% of the Board of Directors is comprised of women.		
<i>Sponsored restricted women's program with dedicated Program Advisory Committee:</i> The majority of the Program Advisory Committee members are comprised of women 50% plus 1.		
The Board of Directors uses the guidelines in the Best Practices Program Evaluation Tool as a measure of the program's services for women.		
Agency program policies and practices reflect and support Best Practices Principles.		
Agency program policies and practices reflect and promote anti-stigmatizing attitudes.		
Agency program and procedures for sexual harassment are in place for Board of Directors, staff, volunteers, and clients.		
Agency program policies and procedures are in place for women clients who have a complaint, concern, or difficulty with the program or a staff member. These include clear protocols for resolution including procedures for appeal.		

Planned actions for meeting guideline:

1.2 Education and Training

Rationale: Research and clinical experience in the substance abuse treatment and rehabilitation field continue to provide new knowledge on best practices in working with women. Best practices research to date demonstrates that those who work with women require gender specific training and skill acquisition. Agencies need to ensure their programs provide all counselling staff with ongoing education, training opportunities, and clinical support regarding best practices to ensure that the knowledge and skills of staff remain current and clinically relevant.

1.2a) Guideline: The Agency has mechanisms to ensure that all counselling staff receives specialized training and clinical support to deliver services that address the complex range of issues presented by women.

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency has mechanisms to ensure all counselling staff who work with women receive education and training in effective therapeutic approaches identified by best practices in working with women (such as motivational interviewing techniques, cognitive behavioural therapy, and harm reduction approaches) and that such training is supported and updated on a consistent basis.		
The Agency has mechanisms to ensure all counselling staff who work with women receive education and training in core issues identified by best practices in working with women (such as concurrent problems, trauma informed counselling, relapse prevention, substance use and its effects, and parenting) and that such training is supported and updated on a consistent basis.		
Clinical supervision is provided to staff consistent with best practices in treatment and rehabilitation for women with substance use problems, including supervision and support with respect to vicarious traumatization of staff.		
The Agency initiates opportunities for cross-training with other substance abuse agencies and/or with other systems/sectors that have expertise in women's issues (e.g., violence against women, children's services, trauma services, eating disorder programs, women's mental health services, women's shelters, and outreach services).		
The Agency has mechanisms in place (such as clinical supervision, staff education, and training) to identify and change stigmatizing attitudes and practices.		

Planned actions for meeting guideline:

1.3 Hiring and Staffing

Rationale: Best practices guidelines provide strong support for gender specific hiring and staffing practices when providing services to women. **Setting the Course** also supports the provision of female workers to work with women: “programs must assess and actively support women’s needs for gender specific services women also benefit from working with counsellors and facilitators who are able to empathize with them and validate their preference for gender specific services and who are knowledgeable and skilled in effective interventions and core issues for women’s treatment. In most cases, this means they do better with female workers.” (Ontario Substance Abuse Bureau, 1999, page 29).

1.3a) Guideline: The Agency ensures that it hires staff with relevant knowledge, skills, and experience to provide effective services to women clients.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Recruitment policies and procedures ensure that counselling staff members are hired who have knowledge and skills in effective therapeutic approaches and core issues affecting women (as outlined in the Clinical Practice Issues section) commensurate with their counselling role.		

Planned actions for meeting guideline:

1.3b) Guideline: Female staff fulfills all direct service roles in gender specific services (including clinical, program delivery, and residential support roles).

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency's policies and procedures require female staff for all clinical, program delivery, and residential support positions in gender specific services.		

Planned actions for meeting guideline:

1.3c) Guideline: In co-ed services, women clients receive the counselling and program components related to core issues from female staff and female staff fulfills monitoring and support roles in residential services.

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency's policies and procedures ensure that female staff is available to work with women in clinical, program delivery, and residential support positions, in both daytime and night time functions.		
Only female staff conduct bed checks.		
Female clinical staff is available for individual counselling work.		
Female clinical staff facilitates women-only groups or women-focussed sessions.		
Female clinical staff facilitates or co-facilitates mixed groups.		

Planned actions for meeting guideline:

1.4 Physical Facility

Rationale: Best practices guidelines for women demonstrate the need for physical facilities that provide a safe, welcoming atmosphere. Elements that have been identified in both residential and non-residential services to address these issues include:

- separation of residential facilities (or sections of facilities) for women.
- safety mechanisms and security systems (such as attention to lighting and location).
- facilities that are welcoming and inclusive of women (taking into consideration furniture, art/posters, brochures, resources, and colour schemes).

The importance of separate residential facilities for women (or separated sections in co-ed services) has been widely identified in MOHLTC documents such as **Setting the Course, Residential Strategy Phase II Report**, and **Ontario Addiction Treatment Services Rationalization Project: Guidelines for Restructuring Services**.

1.4a) Guideline: Programs that serve women ensure an environment that is safe and comfortable for women.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Mechanisms are in place to ensure physical safety and confidentiality, such as security systems, lighting inside and outside, and screening of visitors.		
The Agency provides a comfortable woman-friendly environment in which furnishings, colour schemes, posters, art, brochures, program resources, and any other visual or written materials demonstrate sensitivity to women of different ethnicity, race, sexual orientation, spiritual persuasion, language (where appropriate), disability, age, life circumstance, etc.		
In co-ed residential settings, separate women-only spaces exist, including sleeping area, lounge/eating area, and program/counselling spaces.		
Residential women-only services are located in a separate and dedicated women's facility.		

Planned actions for meeting guideline:

1.5 Physical Facilities for Pregnant and Parenting Women

Rationale: The ability to maintain an active relationship with their children during substance abuse treatment has been shown to be a strong motivator to change for women. Fear of losing their children is the primary barrier to initiating contact with the substance abuse treatment system reported by women. To support the relationships of mothers and their children, treatment environments must be welcoming of pregnant women and women with children. Dedicated spaces for visits with children, childcare, children's assessments, children's programming, and mother-child programming are needed in both residential and non-residential services. Numerous research studies have established the effectiveness of services that provide residential programming for mothers and children together. There is a critical need for spaces in women-only residential programs to serve mothers and their children.

1.5a) Guideline: Programs that serve women provide a dedicated physical space to facilitate accessibility and delivery of services for pregnant and parenting women and their children.

Criteria Specific to Agency	Status	Evidence of meeting guideline
In all residential services (women-only and co-ed), a dedicated private and comfortable space is provided for mothers to visit with their children.		
In residential (women-only and co-ed) and non-residential services, dedicated space for children's programming, childcare, and mother-child programming is available; or where space cannot be made available onsite, links with allied services are in place to fill this gap.		
In residential women-only services, a dedicated physical space is provided for both mothers and children to reside within the treatment facility.		

Planned actions for meeting guideline:

2. Addressing Barriers

Key Concepts

Barriers to access, admission, and treatment for women include: stigma; complex and multiple needs; lack of accessible services; and inflexible admission criteria. These barriers are magnified for pregnant and parenting women.

Best Practices Principles

- Guilt, shame, and fear are minimized in providing treatment to women, in particular pregnant and parenting women.
- Outreach to substance involved women, who may not feel comfortable approaching substance abuse service providers, is necessary to support early intervention and attract women to substance abuse services.
- Outreach to allied service providers is also necessary to reduce stigma and support women who might require services from the substance abuse treatment system.
- Women's health is complex and rooted in social conditions which requires services that are multi-disciplinary, comprehensive, and coordinated, often requiring an ongoing case management component.
- Services are offered in accessible and non-traditional settings to maximize ease of access and coordination with allied service providers.
- The individual needs of women, especially those who are most marginalized, require substance abuse service providers to be flexible in intake, admission, and programming components.

2.1 Stigma

Rationale: Stigma is one of the powerful barriers that prevent women from seeking help or even seeking information about substance use issues. Substance use by women is more stigmatized than substance use by men. Women who have substance use problems and are marginalized by other factors (such as poverty, disability, culture, language, and age) carry a double burden of stigma. For pregnant women or women with children, stigma is usually accompanied by guilt, shame, and fear that children will be apprehended by child protection services.

Because of the stigma attached to women's substance use, women are likely to seek help and information in settings outside of the specialized substance abuse treatment system (for example, from a family doctor or other health and social service providers). In order to reach women who do not feel comfortable approaching substance abuse treatment services directly, effective strategies are needed to: convey accurate information to the

community at large and to allied service providers; support early identification; and provide outreach services. In addition, close working relationships with the primary health care system should be encouraged.

While stigma prevents women from making inquiries about substance use issues, it may similarly prevent service providers (health care, social services, women’s services, and police) from making inquiries about substance use concerns. **Setting the Course** notes that clients who have not been well served by the traditional substance abuse treatment system, such as women, tend to be diagnosed late in their substance abuse. Their substance abuse problems are often misdiagnosed as signs of aging, depression, mental illness, or other physical or emotional problems. To expedite early identification and timely referral to treatment, **Setting the Course** suggests that substance abuse agencies should work with other health and social service agencies who already serve these populations. This cooperation will help allied service providers develop the knowledge and skills to detect the early signs of substance abuse and make appropriate referrals. Education to ensure early identification of substance use issues and anti-stigma work with allied service providers is a key element of improved access for women.

2.1a) Guideline: The Agency supports and participates in activities to reduce stigma and to affirm and empower substance involved women who are affected by stigma.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Information about both the Agency’s services and about women and substance use (for the public and for clients) is accurate, non-judgmental, and conveys a sense of hope.		
The Agency works with its community partners on initiatives to de-stigmatize substance use problems among women through participation in activities such as public awareness, health fairs, and education/training of allied professionals (e.g., mental health, child welfare, criminal justice, police, women’s services, health care providers).		
The Agency actively engages in advocacy on behalf of its clients to facilitate access to needed services and assist them in situations where stigmatization is likely to occur.		

Planned actions for meeting guideline:

2.1b) Guideline: The Agency’s policies and procedures ensure that information about services is made known to women and to other services for women.

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency ensures that there is a process in place to continuously keep the community, other service providers, and DART informed about its services, using a range of formats and distribution locations to reach women.		

Planned actions for meeting guideline:

2.2 Complex and Multiple Needs

Rationale: Many women have multiple, complex health and social needs that cannot be met by the substance abuse treatment system alone. All aspects of women's lives, including their social, economic, legal and health status, interact and influence their well-being. Social researchers, including Raphael & Bryant (2004), note multiple concerns about the status of women in Canada, including:

- a high percentage of women live in poverty;
- women's poverty has persisted or deepened following social program reductions;
- there is a lack of de facto equality for women in the labour market, among other employment issues;
- women have inadequate social benefits and unequal access to benefits;
- there is a lack of affordable childcare;
- there is inadequate social housing for low income women and female single parents;
- women continue to experience violence and lack sufficient resources to deal with violence; and
- programs and measures are directed toward children, rather than toward women (for example, the notion of "child poverty" minimizes the reality that there are women living in poverty).

Some women are marginalized by intersecting factors including poverty, homelessness, isolation, lack of mobility, age, sexual orientation, race, culture, language, disability, violence, and physical and mental health issues. To increase access and engagement with treatment services, the needs of marginalized women should be addressed in an integrated manner. Coordinated connections with adjunctive services and supports are important in offering effective services to any woman – these linkages are essential to work with marginalized populations of women.

The literature strongly endorses the importance of a multi-component set of services to remove barriers, improve client retention, and provide continuing care and support. Service approaches should be multi-disciplinary, comprehensive, coordinated, and work toward achieving a collaborative model.

A case management approach is recommended to ensure ongoing assessment of client needs for health and social services and coordination of services. Linkages to appropriate services and resources should be facilitated in all phases of treatment.

2.2a) Guideline: Proactive outreach services are in place to overcome barriers experienced by substance involved women, in particular those who are marginalized.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Case finding linkages are established with first contact services, such as physicians, public health units, shelters, and mental health services or other locations where women seek services.		
Information, outreach, and service linkages are established with community services for women of different cultures, languages, abilities, ages, sexual orientation, living situations, legal status, physical and mental health status, geographic locations, as well as services for women who inject drugs or are street- or sex trade-involved to promote the availability of information about services and to develop partnerships for co-service delivery.		

Planned actions for meeting guideline:

2.2b) Guideline: Coordinated access to a comprehensive range of adjunctive services is provided by linkages with allied service providers.

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency works with each woman, other agencies, and adjunctive services to plan and coordinate services in accordance with the woman's identified goals and priorities.		
The Agency's policies and procedures ensure that women's health and social service needs are assessed on an ongoing basis and facilitate access to needed services.		
Policies and procedures ensure that women are provided with case management support, including advocacy for other needed services, either by the Agency or by a partner service.		
Support and advocacy is provided to women leaving violent or abusive situations and to other marginalized women who require assistance in meeting basic needs (e.g. shelter, food, and transportation arrangements through either internal mechanisms or advocacy with other sectors).		
The Agency establishes linkages through service agreements or other mechanisms with health care professionals (mental health providers, General Practitioners, hospital staff, alternative health practices, couples and family counselling, sexuality and sexual/reproductive health, nutritional counselling, and other health care providers).		
The Agency establishes linkages through service agreements or other mechanisms with legal services, social housing, social services and employment/training services.		
The Agency establishes linkages through service agreements or other mechanisms with trauma services, Violence Against Women services, and victim support services.		

The Agency establishes links/partnerships with resources for stabilization and/or residential support in the local system, including substance abuse-specific resources and other sectors (e.g. shelters).		
Linkages are established with harm reduction services (such as Methadone Maintenance Therapy).		
Linkages are established with services for HIV/AIDS, STD clinics, and services for other infectious diseases.		
The Agency establishes linkages through service agreements or other mechanisms to support a range of needs identified for pregnant and parenting women.		
The Agency has partnerships/service agreements with prenatal services and other services for pregnant and parenting women including Methadone Maintenance Therapy for women using opioids.		
Where transportation is a barrier to treatment, assistance is provided for transportation arrangements through either internal mechanisms or advocacy with other sectors.		

Planned actions for meeting guideline:

2.3 Accessible Service Locations

Rationale: In order to increase accessibility, services should be offered in easy-to-reach locations and in non-traditional settings. Outreach services offered in partnership with women’s programs in other sectors (for example, at women’s centres or in partnership with shelters) will broaden the availability of information to the community and facilitate coordinated connections between services.

2.3a) Guideline: Services are offered in locations easily accessible to women.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Service delivery sites are located centrally, with proximity to public transportation whenever possible.		
Outreach and assessment/referral are provided in a variety of locations (i.e. through satellite offices, off-site program offerings, and mobile services).		
To enhance accessibility to women who are involved with other women’s services, services are offered through co-locations and partnerships.		
Service locations are accessible to women with disabilities and mobility challenges.		

Planned actions for meeting guideline:

2.4 Flexible Admission Criteria

Rationale: Best practices support providing women with a range of options and choices. Traditional service structures and agency-specific intake and admission criteria can present obstacles to women, especially those women who are more marginalized and require flexible strategies for engagement and building trust. The challenge to traditional service structures is to increase flexibility, so that options can be offered to meet women's individual needs and goals.

2.4a) Guideline: Services demonstrate respect and support for each woman's ability to identify her needs, choose goals, and select appropriate options for herself.

Criteria Specific to Agency	Status	Evidence of meeting the guideline
Agency policies and protocols ensure that women are clearly informed about their treatment choices, rights, and options at all phases of treatment, starting with early engagement.		
In the context of the use of standardized admission and discharge criteria and assessment, information about the full range of treatment options is made available to women during treatment planning.		
Women are made aware of agency policies and procedures, prior to admission or during orientation.		

Planned actions for meeting guideline:

2.4b) Guideline: Admission criteria and structures reduce barriers and promote equitable access to substance abuse services.

Criteria Specific to Agency	Status	Evidence of meeting the guideline
The Agency's policies and procedures ensure that all requests for service are considered.		
Policies and procedures are in place to ensure that agency-specific admission criteria do not discriminate based on factors such as race, sexual orientation, language or ethnicity, HIV/HCV status, legal status, drug use, or other factors that differentiate clients.		
The Agency's policies and procedures facilitate admission through flexible intake and admission procedures (e.g., allowing women to bring a support person, accepting children during the process, and providing flexible hours of service).		
The Agency demonstrates a flexible approach and makes individual appraisals of a woman's stabilization and ability to participate in the program.		
Strong linkages are established between treatment services and residential and/or community withdrawal management services to facilitate supported detoxification and supported transitions between withdrawal management and treatment.		

<p>The Agency accepts and supports women on adjunctive pharmacotherapies (including Methadone Maintenance Therapy, other opioids substitution therapies, Antabuse, Zyban, and Naltrexone) whose need for adjunctive pharmacotherapies has been established through a medical assessment.</p>		
<p>The Agency accepts and supports women who are taking prescribed medications such as anti-psychotics, anti-depressants or anti-anxiety medications and whose need for medications has been established through a medical assessment.</p>		
<p>The Agency's policies and protocols ensure that women who cannot be admitted due to unavoidable program limitations are connected with alternative resources within the community.</p>		
<p>Agency admission decisions are informed by the principles set out by the standard assessment and admission/discharge criteria, in conjunction with women's needs, goals, and preferences.</p>		

Planned actions for meeting guideline:

3. Treatment Planning Issues

Key Concepts

Best practices are reflected in: contextualized information gathering during the assessment process; a treatment plan that addresses the range of women's issues; and flexibility in length of treatment.

Best Practices Principles

- Comprehensive assessment includes a wide range of core issues that impact on women.
- Women's treatment readiness and treatment success are improved when identified core issues are addressed.
- Women who are not treatment ready, or are in an early stage of change with respect to substance use, benefit from an examination of their core issues to identify immediate needs, supports, and linkages required.
- Length of stay and structure of treatment needs to be flexible and based on women's individual needs and goals.

3.1 Assessment and Referral

Rationale: In order to address barriers to treatment entry and to develop a holistic treatment plan, comprehensive assessment of women is essential. Assessment should look beyond substance use patterns to incorporate an understanding of core issues that inform each woman's life.

Assessment is an ongoing process that occurs over time. Layers of information will be added to an understanding of each woman's situation as the treatment relationship develops, trust and self-knowledge increases, and a fuller picture of the woman's needs emerges. Assessment information follows the woman through the treatment system, as intended by the standardized assessment procedure.

Initial assessment is a process that occurs early in the treatment relationship and that provides sufficient information for appropriate referrals. Initial assessment should gather sufficient information about a woman's life situation in order to make good referral recommendations.

The standard assessment provides a set of tools that assists in the process of assessment and treatment planning by gathering information about the strengths and needs that will inform women's treatment. The standard assessment is not gender specific. In order to

ensure adequate initial assessment of women, information about a range of core issues should be gathered. Core issues include:

- **Physical health issues** so that timely referrals can be made to address health problems (including sexual health) and provide information about the physiological effects of substance use on women.
- **Mental health issues** so that integrated assessment, treatment planning, interventions, and treatment can occur.
- **Safety issues** so that an assessment of immediate level of risk of violence (using the Routine Universal Client Screening or RUCS) can be made and safety plans developed as needed.
- **Family, care-giving, and childcare responsibilities** to ensure that women can make, and feel comfortable with, care arrangements.
- **Parenting issues** to ensure that linkages with appropriate resources can be planned.
- **Relationships and support** so that treatment planning can consider relational needs.
- **Pregnancy** so that priority for admission can be given to pregnant women and they can be supported in receiving appropriate prenatal care or other needed services.
- **Sexual orientation** so that treatment planning will be mindful of impacts on substance use and respectful of difference.
- **Culture and language issues** to ensure that a range of cultural impacts on women's use of substances are considered.
- **Vocational/workplace/education** to link women with education, training, or employment resources and/or supports.
- **Housing and/or support in their living situation**, including attention to homelessness risk factors, so that a safety plan can be put in place and women can be linked with housing resources.
- **Recent or past traumatic events** such as physical or sexual abuse so that trauma informed interventions are ensured.
- **Financial and/or poverty issues** so that treatment planning can include referrals and advocacy for basic needs (including food, transportation, housing, clothing, personal hygiene, medication, childcare, and dental).
- **Legal involvement** so that support and scheduling needs regarding outstanding legal issues (probation/parole, custody/child protection issues) can be identified.
- **High risk behaviours** (including injection drug use and high risk sexual behaviours) so that women are provided with education, testing, and referrals as needed.

When clinically appropriate, information about core issues should also be gathered from women who may not be ready to engage in the standardized assessment process. While the standard assessment may not be an appropriate intervention with a woman who is in

an early stage of change, information about core issues will help to identify immediate needs for support and linkages. Women who are physically or cognitively too unstable to complete a standard assessment, or whose lives are too chaotic to consider moving into treatment services, may especially benefit from referrals to adjunctive services identified through assessment of core issues.

3.1a) Guideline: Basic information about core issues is gathered from every woman, either as part of the standardized assessment process or as part of a core issues identification process.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Through its policies, procedures, and partnerships with other substance abuse services, the Agency ensures a client centred and flexible approach to administering provincial assessment tools and admission criteria, including service strategies such as off-site assessments and pacing of assessment completion.		
Initial assessment includes information about core issues and is respectful of and consistent with each woman's stage of change.		
Information about core issues is obtained from women who do not receive a standard assessment to identify immediate needs for support and linkages, using adjunctive screening instruments (such as the RUCS) as required.		
Information about core issues is used to inform referrals to substance abuse treatment agencies and/or adjunctive services, in line with women's needs and goals.		
Information about core issues is used to inform treatment planning.		
A specified set of data from core information is reported to DATIS.		

Planned actions for meeting guideline:

3.2 Duration of Treatment

Rationale: Flexibility and responsiveness are fundamental to planning treatment length. Some key experts support a standard length of stay in residential treatment of at least five weeks with three to six months required for outpatient treatment, but also note that length and structure of treatment should be determined through individualized planning based on a woman's assessed needs and goals.

Non-residential services are well positioned to individualize the duration and structure of their services for women. Programs that operate on fixed length cycles should seek opportunities to individualize services for women. **Setting the Course** encourages fixed length residential programs to become more flexible and supports varying lengths of stay

in accordance with client needs. **Setting the Course** notes that, in fixed length (21 day) services, clients may spend less or more time, according to their assessed needs.

3.2a) Guideline: Duration of treatment is planned in response to women’s identified needs and preferences.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Planned treatment duration is based on both the assessed needs of each woman and recommended best practices, within the context of the Agency’s ability to offer flexible treatment duration.		

Planned actions for meeting guideline:

4. Clinical Practice Issues

Key Concepts

Substance involved women respond best when treatment services: are gender relevant (that is, have gender specific programming and gender sensitive approaches); incorporate stages of change, motivational counselling, and harm reduction approaches; reflect gender balance with both clients and staffing in co-ed settings; and adopt gender specific approaches to health, well-being, and other treatment strategies, including relapse prevention.

Best Practices Principles

- A wide range of core issues that impact on women must be incorporated into treatment programming, with emphasis on trauma and relational issues.
- Gender sensitive, women-only treatment settings are preferred.
- Treatment approaches are based on a woman’s stage of change and incorporate motivational counselling strategies and harm reduction approaches, in particular with women during early stages of change or with pregnant and parenting women.
- When women-only treatment groups cannot be implemented in co-ed settings, a gender balance is necessary (for both clients and staff); if this cannot be met, individual counselling is preferable to women attending gender imbalanced treatment groups.
- A focus on physical health and well-being (including supports for women who smoke and appropriate interventions for tobacco consumption) is incorporated into core programming.
- Relapse is viewed as an opportunity to revisit client goals and treatment plans.

4.1 Gender Relevant Services

Rationale: The importance of providing gender specific treatment approaches has been widely recognized in policy, best practices, and key expert opinion. According to Health Canada's Best Practices research, gender relevant, effective services for women need to:

- be gender specific;
- consider women's life experiences; and
- incorporate both a holistic theory of substance abuse and a theory of trauma.

Gender specific programming: Best practices guidelines identify a wide range of issues to be addressed within the programming content of women's services. A basic set of core issues have been established as a guide for inclusion in gender specific programming, including:

- trauma
- safety
- relationships
- guilt, shame, and stigma
- body image and eating issues
- self-esteem
- parenting
- physical and mental health

This list is by no means exhaustive and Health Canada's Best Practices documents expand upon it; in particular, it should also be noted that additional core issues should be identified in relation to diverse populations of women.

Gender sensitive approaches: Best practices guidelines identify approaches that are effective for use with women, including approaches that are:

- based on empowerment, holistic, relational, and feminist models
- focussed on strengths-based, skills building, and experiential learning
- collaborative and non-hierarchical
- cognitive behavioural and motivational
- based on harm reduction beliefs
- culturally appropriate
- trauma informed

Health Canada's Best Practices guidelines expand upon and provide descriptive information about these, as do other sources of information about women's treatment approaches. (See the **References** section to aid in the identification of helpful sources.)

Key experts emphasize the importance of women-only treatment settings for delivery of gender specific programming and gender sensitive approaches. Concerns have been raised regarding treatment for women in co-ed settings, as it could:

- lack a focus on women’s experiences, issues, and learning styles;
- lack opportunities for women to connect with other women; and
- expose women to an unsafe treatment environment, particularly in residential settings.

At a minimum, mixed gender treatment services should provide gender specific components to cover core issues and provide opportunities for women to connect with each other.

4.1a) Guideline: Gender specific programming that addresses identified core issues, outlined by best practices, is provided to women in specialized and co-ed services.

Criteria Specific to Agency	Status	Evidence of meeting the guideline
Programming in women-only services is gender specific in its content and delivery, and addresses core issues.		
Programming in co-ed services provides women-only, gender specific specialized sessions on core issues.		
Programming in co-ed services provides women-only, gender specific program streams or groups as well as gender specific individual counselling with a female therapist.		

Planned actions for meeting guideline:

4.1b) Guideline: Programming is gender sensitive and incorporates best practices approaches.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Program/services components incorporate educational, skill building, and experiential learning approaches.		
Program/service includes cognitive behavioural components (problem solving, change strategies) and affective components (feelings, emotions).		
Program/service content includes approaches such as the relational model, empowerment and strengths-based models, and feminist models.		
Program/service content is informed by motivational and harm reduction approaches.		
Program/service content incorporates trauma informed approaches.		
Program/service approach is collaborative and non-hierarchical.		

Program/service approach demonstrates a commitment to holistic approaches.		
Program/service incorporates culturally appropriate approaches.		
Program/service approach promotes connections between women.		

Planned actions for meeting guideline:

4.2 Stages of Change, Motivational Counselling, and Harm Reduction Approaches

Rationale: Best practices strongly support strategies based on the stages of change model. Women should receive support, assessment, referral, and treatment services according to their stage or readiness to change and choices. Lack of appropriate service responses to women at early stages of change is also a major barrier to access and retention for some women.

Motivational counselling has been shown to be an effective approach, in particular when working with women at early stages of change and with substance involved pregnant and parenting women. Furthermore, the approach is thought to be especially effective when working with women because of its emphasis on empathy, self-efficacy, and the relational basis of the counsellor-client interaction. Within the motivational counselling framework, both abstinence and reduced consumption are legitimate options. Motivational strategies should be applied uniquely to each stage of change (Center for Substance Abuse Treatment, 1999).

Within the motivational counselling framework, motivation is not seen as a behaviour trait or personality characteristic of the individual. Instead, motivation is seen as a product of the relationship between client and service provider. The technique places the onus for developing the motivation for change equally upon the service provider and the client herself. There are three primary concepts in motivational counselling:

- empathy (rather than guilt or shame based approaches) will create an atmosphere in which change will occur;
- self efficacy is the foundation for change; and
- resistance to change can be decreased by an empathic relationship between counsellor and client.

During early stages of change, reducing harm and building trust may be the most realistic goals of treatment. In addition, harm reduction strategies can be used during any stage of change to encourage incremental changes that will eventually produce lasting change.

4.2a) Guideline: Service approaches and structures are responsive to women at all stages of change and are based on motivational counselling and harm reduction approaches.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Agency policy supports motivational counselling and stages of change training for staff.		
Motivational counselling and interventions appropriate to different stages of change are used to engage women in seeking support towards identified goals.		
All phases of programming use motivational counselling techniques.		
Residential services work with clients at stages of change appropriate to the program's assessed capabilities.		
Services that cannot work with women in a manner appropriate to the woman's stage of change connect these women to other resources in the community.		
Agency services actively avoid shame based interventions including use of labels (such as "alcoholic" or "addict") that can limit progress.		
Harm reduction approaches are integrated into the treatment approach of the Agency.		
Both abstinence and reduced consumption are accepted goals of treatment, depending upon the woman's stage of change and her preferences.		
Adjunctive pharmacotherapies (in particular, Methadone Maintenance Therapy) are available or linkages for substitution therapies are made with allied services/doctors in the community.		
Agency policies and procedures support working with women using harm reduction approaches to address the needs of women who choose non-abstinence based treatment goals or require adjunctive pharmacotherapy such as Methadone Maintenance Therapy, as appropriate to the service type.		
Program policies and procedures support links with services for Injection Drug Users.		

Planned actions for meeting guideline:

4.3 Gender Balance in Mixed Gender Services

Rationale: Mixed gender services face specific challenges with respect to maintaining appropriate gender balance in mixed gender environments and treatment groups. Research shows that women in treatment tend to act differently in co-ed treatment settings and minimize their focus on treatment issues. Mixed gender groups do not provide an appropriate environment for empowering and connecting women to each other or for discussing issues such as relationships or sexuality.

Mixed gender groups may not provide safety for women, in particular women who have experienced violence or abuse. Research shows that certain groups of women, especially women with histories of trauma, are more likely to complete treatment when involved in women-only, gender sensitive treatment services.

In co-ed treatment groups, an appropriate gender balance should be maintained to facilitate the safety and active participation of women; that is, the ratio of women to men should be as close as possible to equal. When this condition cannot be met, Health Canada's Best Practices recommend that a woman is never a lone participant in a group of male clients.

4.3a) Guideline: In co-ed groups, an appropriate balance of women and men is achieved.

Criteria Specific to Agency	Status	Evidence of meeting guideline
At a minimum, co-ed treatment groups are comprised of at least one third women.		
When gender balance in co-ed groups cannot be achieved, women are provided with individual counselling onsite or referral/linkages are made to women's services in the community.		

Planned actions for meeting guideline:

4.3b) Guideline: An appropriate gender balance is supported by staffing of co-ed groups.

Criteria Specific to Agency	Status	Evidence of meeting guideline
A female therapist facilitates (or co-facilitates) co-ed treatment groups.		

Planned actions for meeting guideline:

4.4 Gender Specific Approaches to Physical Health and Well-Being

Rationale: There are substantial differences in the physical effects, consequences, and risks of substance use for women, compared to men including:

- faster intoxication on smaller quantities of psychoactive substances;

- earlier onset of related illness and negative health effects;
- longer length of effect of some substances;
- reproductive effects and consequences;
- issues related to sexuality and sexual health; and
- high risk behaviours and consequences.

Women may express more concern about the physiological effects of substance use. Services should provide clear, accurate information and discussions about physical aspects of substance use and recovery. Alternative therapies and wellness techniques can be very helpful to some clients, especially for pain management, relaxation, and reduction of anxiety. Connections to public health or physicians for counselling or testing in regard to specific health concerns may be necessary. It is recommended that services for women explore strategies to restore health and promote well-being through lifestyle changes (improved nutrition, stress management, exercise). Furthermore, information and discussion opportunities about sexuality should be included.

Women with substance use problems are often regular smokers and (as with other substances) are more vulnerable than men to the health consequences of tobacco use. Women also smoke for different reasons than men and may also have a more difficult time than men when they attempt to quit smoking. Tobacco use may also increase the risk of relapse to other substance use. At the same time, there is evidence that smoking cessation policies and programming can be effectively included with treatment for other substances. Programs should include information and education about tobacco use and provide an environment that supports women in their efforts to quit smoking.

4.4a) Guideline: Programs provide information, education, and/or opportunities for experiential learning on issues related to physical health.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Information and discussion about the effects of substance use on women’s bodies and physical health issues is: <ul style="list-style-type: none"> • integrated into programming as a core issue in women-only services • delivered in specialized women-only sessions by a female counsellor in co-ed services. 		
Information and discussion about gynecological and reproductive issues and care are incorporated into programs (delivered by program staff or through partnerships with allied services): <ul style="list-style-type: none"> • as part of core programming in women-only services • in specialized women-only sessions by a female counsellor in co-ed services. 		
Programming components include education and dialogue about eating patterns and nutrition in recovery, including discussions of healthy eating, healthy weight, eating disorders, and body image: <ul style="list-style-type: none"> • as part of core programming in women-only services • in specialized women-only sessions by a female counsellor in co-ed service. 		

Programming components include education and discussion about the effects of physical health issues on mood, recovery, relapse triggers, and sense of well-being (for example, effects on mood and possible relapse triggers of a medical problem, such as diabetes).		
Information about the effects of substance use on sexual functioning (including discussion about the drawbacks and benefits of substance use on sexuality) is incorporated into programming: <ul style="list-style-type: none"> • as part of core programming in women-only services • in specialized women-only sessions by a female counsellor in co-ed services. 		
Discussion about sexual orientation is available in accordance with client needs and preferences.		
Information about the ages and stages of women's lives and the physical aspects of women's life cycles is incorporated into programming: <ul style="list-style-type: none"> • as part of core programming in women-only services • in specialized women-only sessions by a female counsellor in co-ed services. 		
Programming components integrate information and discussion about strategies to improve self-care (e.g. stress management and high-risk behaviours and/or consequences).		
Opportunities to introduce clients to information sources about alternative, therapeutically legitimate options are incorporated into programming (e.g. yoga, acupuncture).		

Planned actions for meeting guideline:

4.4b) Guideline: Program components include information and education about tobacco and provide an environment that supports women to quit smoking.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Agencies provide a smoke-free environment for their clients, staff, and visitors.		
Program components include information and education about the effects of tobacco on women's health.		
Programs assess women's readiness to quit smoking and, for women in the action stage, provide and/or link them with smoking cessation resources and support.		
Programs assess women's readiness to quit smoking and, for women in the precontemplation or contemplation stage, provide them with and/or link them to appropriate resources and support.		

Planned actions for meeting guideline:

4.5 Gender Sensitive Relapse Prevention Approaches

Rationale: Relapse is a part of the experience of recovery for many women and can be a positive impetus for exploring client growth and change. Research shows that when women relapse, it is often associated with specific relapse triggers such as unpleasant emotions or interpersonal issues. For example, women who have experienced trauma may experience relapse triggers rooted in flashbacks or trauma-related feelings. Gender sensitive relapse prevention reflects and responds to the context of women's lives and incorporates principles such as empowerment and strengths-based approaches.

When relapse occurs, interventions should focus on assisting women to maintain safety, achieve stabilization, and remain engaged with helping resources. Relapse may signal a need to reassess a client's treatment goals and revise her treatment plan (using the provincial standardized assessment tools, if appropriate). Programs should continue to work with clients who have relapsed, to the degree that it is clinically appropriate to do so. Residential programs should make individual determinations of their capacity to work with clients who have relapsed.

4.5a) Guideline: Gender relevant relapse prevention and appropriate supports for women who relapse are available at all phases of treatment.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Program materials incorporate relapse prevention strategies as a component of the services delivered to women at all phases of treatment.		
Relapse prevention education and strategies are women-specific and focus on situations of particular risk for women (e.g. interpersonal relationships, emotional triggers).		
Policies and procedures ensure that relapse is seen as a learning opportunity and that women are supported in remaining engaged with helping resources and renegotiating their treatment plans.		
In settings where discharge occurs on relapse, linkages and referrals are put in place to support the woman's continuing engagement with the substance abuse treatment system at her appropriate stage of change.		

Planned actions for meeting guideline:

5. Specialized Issues

Key Concepts

Co-occurring mental health problems (in particular, depression and anxiety) are common among substance involved women as are high rates of trauma experiences and Post Traumatic Stress Disorder.

Best Practices Principles

- Mental health issues are connected to the context of women's lives and the treatment of co-occurring mental health and substance abuse issues is similarly interconnected and integrated.
- Substance abuse treatment services collaborate with mental health services to provide effective assessment, referral, treatment planning, and case management for women with co-occurring mental health and substance abuse issues.
- Substance use and PTSD are treated concurrently within the context of an integrated approach to assessment, treatment planning, and intervention if service providers have specific training and skills, along with adequate time to undertake this.
- All substance abuse service providers are trauma informed.

5.1 Co-Occurring Substance Use and Mental Health Issues

Rationale: Co-occurring mental health problems are common among substance involved women with depression, anxiety, and Post Traumatic Stress Disorder (PTSD) being the most frequent co-occurring mental health issues among women (Najavits, 2002; Health Canada 2001b). Women with a co-occurring mental health problem may have poorer treatment outcomes; therefore, it is critical to screen for, and provide women with, assistance for concurrent problems.

The mental health concerns of women are intimately related to social structures and the context of their lives. The onset of women's substance use is often tied to traumatic losses and critical life events. Depression and anxiety can be rational responses to environmental and life situations but may be pathologized within the medical model. Limiting treatment to pharmaceutical intervention is likely to discount the context of women's lives. As a result, underlying issues such as loss and grief or the effects of trauma may be dismissed or remain unaddressed.

Gender sensitive responses to women's co-occurring mental health and substance abuse issues are fundamental to adequate services. Gender-neutral models of service are likely

to discount or miss the vital context of power differentials, violence, trauma and oppression that pervade the experience of many women. The needs of women requiring mental health services may not be recognized as differential in nature by mental health service providers (for example, in mixed gender inpatient units). Specialized programs for clients with concurrent problems should have settings that can be gender restricted and should offer gender specific approaches to treatment.

Women who experience mental health problems may use substances to self-medicate; ongoing self-medication is a typical response. The substance abuse treatment system needs to recognize the role substance use plays in mitigating some mental health problems and be prepared to work with mental health issues that emerge as substance use is reduced or ended.

Women with concurrent problems are often marginalized and isolated. Effective outreach services are especially important to engage women who lack social supports and basic supports. As with other marginalized populations, harm reduction approaches have proven helpful to client engagement and adequate client services. Health Canada's Best Practices provides recommendations for screening, assessment, and treatment. Overall, the report recommends an integrated approach to treatment, which may occur either at the program or at the system level.

Integrated approaches can be delivered at various service points in either the substance abuse or the mental health system of services, provided that integrated treatment planning, communication, and a commitment to work together are in place. For example, clients who are currently involved with mental health programs may receive substance abuse treatment services onsite at the mental health facility. Substance abuse treatment services can partner with community mental health agencies that have access to the services of a psychiatrist through the MOHLTC sessional fee program.

Given the wide range of mental health problems in both intensity and severity, it is clear that not all substance abuse treatment agencies can work with all women. Integrated treatment, however, means that effective assessment, referral, collaboration, partnership, and case management are available for all women. This should be accomplished through a range of strategies including: onsite expertise, consulting relationships with mental health services, referrals to mental health services and the co-delivery/coordination of mental health and substance abuse treatment services.

5.1a) Guideline: Services for women with co-occurring substance use and mental health problems are gender sensitive and are planned/delivered in an integrated manner.

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency establishes strong linkages through partnerships and service agreements with local mental health services and psychiatrists who can provide gender sensitive and substance abuse informed treatment.		

Policies and procedures are in place for integrated assessment, treatment planning, and intervention when a mental health issue is identified through screening.		
Agency specific admission criteria reflect client centred and individualized decisions for admission of women with serious mental health issues and/or taking prescribed medication for mental health problems.		
The Agency works with its partners in the substance abuse and mental health systems to reach out to women with substance use and mental health issues who are homeless or in unstable housing or in other ways marginalized or underserved.		
The Agency collaborates with other substance abuse services to obtain appropriate clinical consultation from the mental health system for complex mental health problems and gain access to psychiatrist services through the MOHLTC sessional fee program.		

Planned actions for meeting guideline:

5.2 Trauma and Post Traumatic Stress Disorder

Rationale: There are high rates of trauma experiences and Post Traumatic Stress Disorder (PTSD) among women in substance abuse treatment services. Much of the research literature suggests that significant numbers of women in substance abuse treatment have experienced trauma including physical and sexual abuse (Finkelstein et al, 1997; Health Canada, 2001; Najavits, 2002).

According to recent research literature, treating clients with trauma histories in early recovery require special attention. For example, Najavits (2002) stresses that clients learn to reduce their self harming behaviours in first stage treatment by learning safe coping skills. She defines early or first stage treatment as at least the first 25 weeks of recovery or until clients have their substance use under control and are stabilized. Exposure therapy is not recommended in the early or safety phase.

Health Canada’s Best Practices recommendations indicate that substance use problems and PTSD should be treated concurrently within the context of an integrated approach to assessment, treatment planning, and intervention. It is crucial that all substance abuse treatment services that work with women should be trauma informed; services that are not trauma informed may unintentionally re-traumatize clients. However, a caveat is also emphasized; that is, ***substance abuse treatment service providers should not attempt in-depth trauma counselling unless they have specific training and skills, along with adequate time to undertake this.***

When a woman client has self-disclosed a history of trauma that is also currently a therapeutic issue for her, the ideal service venue is a restricted (women-only) service that

offers gender specific, trauma informed programming and has the capacity to work concurrently on intersections of trauma and substance use. However, the implications of mixed gender versus restricted or specialized women’s services should also be discussed with these women, so that they can make informed choices about the kind of treatment they feel would best suit their needs.

5.2a) Guideline: Services for women are trauma informed and take an integrated approach to the treatment of substance abuse and trauma related issues.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Treatment planning addresses both trauma and substance abuse issues in an integrated approach through onsite trauma work and/or referrals to trauma services.		
Written program materials demonstrate that programming is trauma informed and, at a minimum, all services include program components that incorporate techniques for establishing safety as part of Stage 1 trauma work, such as grounding techniques.		
Policies and procedures address actions to be taken, including the development of a safety plan for women (including dependents) living in an unsafe environment, and/or for supporting women in finding safe housing.		
All program staff is trauma informed and can respond appropriately to women experiencing the consequences of trauma.		

Planned actions for meeting guideline:

6. Pregnant and Parenting Women

Key Concepts

Substance involved pregnant and parenting women may fear involvement with the substance abuse treatment system. Timely involvement is critical and strategies are needed to engage and retain pregnant and parenting women. Key strategies (stages of change based approaches, motivational counselling, and harm reduction) are of particular importance, as are attention to relationships with children and with child protection services.

Best Practices Principles

- Treatment focus is on the mutual needs of the pregnant woman and her child.
- Access to childcare is deemed essential by substance abuse services.
- Women feel secure that their entry into the substance abuse treatment system does not automatically result in loss of custody of their children.
- Substance abuse services are flexible, accessible, informed, and responsive to the context of women's lives and provide safe places for children.
- Substance abuse service providers are thoughtful of the continuum of care and the range of substance abuse services provided to pregnant and parenting women, with a preference for geographically accessible, community-based treatment.
- Pregnant women receive priority access to all levels of treatment.
- Supportive, non-stigmatizing interventions are more effective than either shame based, punitive approaches or mandatory treatment.
- Harm reduction strategies for pregnant women enhances protective factors that reduce harm to both mother and child.
- Relational models that promote the mother/child bond and other important relationships improve treatment outcomes for pregnant and parenting women.
- Collaborative working relationships between substance abuse services and child protection services are essential.

6.1 Engagement and Retention

Rationale: The reasons pregnant and parenting women use substances are multifaceted and interconnected. For many women, substance use helps them contend with difficult life circumstances such as a history of trauma, current domestic violence, poverty, or feelings of guilt, shame, and inadequacy. They may also be physically dependent on substances, making abstinence a difficult proposition, especially within the short timeframe of a pregnancy.

Treatment services must be able to address, not only women's use of psychoactive substances, but also the range of issues they experience. The lives of substance involved pregnant and parenting women are complex. "[Their issues] may include lack of a support system, unstable environments, homelessness, poor parenting, mental illness, partner substance abuse, family violence, and poverty as well as, of course, the lack of appropriate services" (Health Canada, 2000, page 45). Failure to address the complexity of the lives of substance involved pregnant and parenting women within the treatment setting will result in treatment dropout and treatment failure.

Substance involved pregnant or parenting women can be caught between policies that punish substance use without adequate, sensitive, non-stigmatizing options for overcoming substance use (Lester et al, 2004). Some strategies that are seemingly intended to support both women and children paradoxically may encourage some women to avoid beneficial medical and social services or to seek abortion (Poole & Isaac, 2001). What is required is a focus on the mutual needs of the woman and her child as opposed to believing that the woman and child have mutually exclusive needs (Finkelstein et al, 1997; Poole, 2003).

With Ontario's Early Childhood Development Investments and Outcomes, formerly known as Early Childhood Development Initiative, women's substance abuse treatment services are slowly overcoming the significant barriers to engage pregnant and parenting women. Best practices guidelines demonstrate the need for pregnant and parenting women to feel secure that their entry into the substance abuse treatment system will not automatically result in loss of custody of their children nor should they have to go to great lengths to find childcare while they access help.

To engage and retain pregnant and parenting women, substance abuse services need to become more flexible, accessible, informed, and responsive to the context of women's lives and must provide safe places for children and families to receive services. Substance abuse service providers need to be thoughtful of the continuum of care and the range of substance abuse services that could be provided to pregnant and parenting women; community-based treatment is often the best option for them. Also, given childcare responsibilities, substance abuse services geographically located closest to their homes may be the option of choice for pregnant and parenting women.

6.1a) Guideline: Service providers understand the range of services required by substance involved pregnant and parenting women and adopt comprehensive approaches to care.

Criteria Specific to Agency	Status	Evidence of meeting guideline
<p>The Agency provides outreach or attempts to work with sites of first contact for pregnant and parenting women, such as Community Action Program for Children or Canada Prenatal Nutrition Programs to engage and involve women in substance use counselling. In order to engage substance involved pregnant and parenting women in substance abuse services, the Agency will offer services off site when possible and appropriate.</p>		
<p>Relationships with relevant community services (including anti-violence, sexual assault, anti-poverty, community mental health, and advocacy services) have been established and cross training protocols are established.</p>		
<p>Referrals to relevant community services are made when the associated needs of pregnant and parenting women are identified.</p>		
<p>Staff of substance abuse services examine their own values and attitudes regarding substance use by pregnant women in order to provide empathic and non-judgemental care.</p>		

Planned actions for meeting guideline:

6.2 Access to Services

Rationale: Timely availability of appropriate services is critical to the ability of programs to assist substance involved pregnant women. Barriers such as waiting lists, lack of appropriate services, and policies that limit admission of pregnant women to programs mean lost opportunities to reduce potential negative birth outcomes.

Fetal Alcohol Spectrum Disorder (FASD) is a leading cause of birth defects and mental and emotional difficulties. Health Canada's Best Practices notes that the effects of alcohol use during pregnancy vary with the timing, amount and duration of consumption, the general health of the mother, and the overall resources available to the mother.

The effects of using other substances during pregnancy are less well understood, but depend on the substance in question. For example, methadone maintenance therapy is the treatment of choice for opioid dependent pregnant women.

6.2a) Guideline: Priority access to appropriate services is provided for pregnant women in all service settings (including assessment, withdrawal management, residential and non-residential, women-only, and co-ed service settings).

Criteria Specific to Agency	Status	Evidence of meeting guideline
Agency policy ensures rapid access to residential and community-based services for pregnant women based on first available bed or service space; pregnant women take precedence over other clients who may be awaiting service.		
It is desirable for pregnant women to complete standard admission tools; however, priority access is not contingent on completion or results of standard admission. The main priority is to engage pregnant women as quickly as possible.		
Methadone Maintenance Therapy as the treatment of choice is offered to opioid dependent pregnant women as quickly as possible.		

Planned actions for meeting guideline:

6.3 Effective Services

Rationale: Pregnant and parenting women who are substance involved experience societal and intrapersonal pressures. Women who have been asked about barriers to seeking support frequently identify shame, guilt, and fear of reprisal from child protection services and the community at large. (Poole & Isaac, 2001). Supportive, non-stigmatizing interventions have been shown to be more effective than either shame based,

punitive approaches or mandatory treatment, since substance involved pregnant and parenting women experience high levels of social stigma.

“Treatment services employing a respectful, flexible, culturally appropriate, and women centred approach that is open to intermediary harm reduction goals, based on client circumstances, are effective in engaging and retaining women in supportive programming and in improving the quality of their lives.” (Health Canada, 2000, page 88)

The key strategies of stages of change based approaches, motivational counselling, and harm reduction (important to working with all women as expressed in the **Clinical Practice Issues** section) are very effective with substance involved pregnant and parenting women. Both service providers and women clients need to balance the pressures often exerted on pregnant and parenting women by external forces (such as child custody) against the need to work through the stages of change in a way that is therapeutically beneficial to the woman.

Harm reduction with pregnant women involves enhancing protective factors that may reduce harm to the fetus as well as to the mother, even when a reduction in actual substance use is not achieved. Safer use strategies are a legitimate and important treatment approach with pregnant women who do not reduce substance use. Even if abstinence is not achieved, strategies that assist women in reducing their use or in using more safely are recommended as any reduction in substance use is a potential benefit both for the woman and for the fetus.

6.3a) Guideline: Approaches and interventions for engaging and treating pregnant and parenting women are appropriate to their identified goals and consistent with improving and optimizing the health of both mother and child.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Agency staff understands the unique needs of pregnant and parenting women with respect to therapeutic interventions such as motivational counselling and stages of change based approaches.		
Supportive strategies to enhance protective factors to the health of the fetus (such as prenatal care, nutritional counselling, basic life supports, health care, safe accommodation) are incorporated to reduce harm.		
Reduced use strategies or safer use strategies are utilized as intermediary harm reduction approaches in appropriate situations.		

Planned actions for meeting guideline:

6.4 Relationships with Children

Rationale: Research indicates that relational models of women’s treatment, including emphasis on promoting the mother/child bond and other important family relationships in a woman’s life, will engage, retain, and improve the outcomes of substance involved pregnant and parenting women within the treatment process. Women who have lost custody of children should be supported to address grief and loss issues, either through onsite services or referrals to community-based services and supports.

6.4a) Guideline: Services facilitate women’s contact with children and family.

Criteria Specific to Agency	Status	Evidence of meeting guideline
The Agency provides children’s programming and child development assessments or ensures these are provided by relevant community services.		
The Agency advocates on behalf of pregnant and parenting women with Ontario Works and other social services in an endeavour to remove barriers such as childcare to participation in substance abuse or other necessary treatment.		
The Agency facilitates a barrier free service through outreach, one stop service, and an integrated systems approach among substance abuse services and other sector services that provide childcare, food, and transportation when needed.		
The Agency supports women to learn and practice parenting skills through onsite programs or through linkages with community services.		
The Agency supports women to gain a better understanding of the consequences of fetal exposure to substances through contact with on or off site child development workers.		
The Agency supports women who have lost custody of children to find appropriate supports for loss and grief issues.		

Planned actions for meeting guideline:

6.5 Child Protection Issues

Rationale: With respect to child protection issues, there are legal and moral obligations for agencies in “duty to report”. It is understood that children are a powerful motivator for change (Poole & Isaac, 2001) and involvement with child protection services can be used constructively when service providers are supportive and sensitive. Similar to potential job loss for men, women are likely to engage in treatment in order to regain or maintain custody of children. However, loss and grief are likely to be significant issues for women whose children have been apprehended by child protection services. Further, unresolved loss of children can lead to replacement pregnancies. Researchers have also found that women who have custody of their children stay in treatment longer than

women who do not have custody (Nishimoto & Roberts, 2001). It is significant to note that the most widely represented family group within child protection services is single mothers who live in poverty: therefore, the context of the lives of women in this situation needs to be very well understood by service providers.

6.5a) Guideline: Services understand child protection reporting responsibilities and fulfill these responsibilities in a woman-sensitive way.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Agency policy requires the establishment of a positive and ongoing relationship with local child protection services.		
Agency policy requires updated education and training to keep current with child protection services requirements.		
Agency policy requires interaction and cross training with service providers in the child protection system about issues related to substance involved women.		
Policy and procedures address child protection issues in accord with mandatory reporting guidelines. Formal protocols with child protection services have been established to ensure that appropriate reporting and supportive linkages are made at program and system levels.		
Policies and procedures to address child protection issues ensure that mothers and children are fully and respectfully informed of options and reporting obligations, and supported to facilitate positive relationships with child protection authorities.		

Planned actions for meeting guideline:

7. Monitoring and Evaluation

Key Concepts

Monitoring and evaluation ensures the ongoing relevance of substance abuse programs for women. The monitoring and evaluation process occurs at the client, program, and system levels.

Best Practices Principles

- Outcome measures for women include measurement of psychosocial issues in addition to substance use status.
- Agency adherence to best practices is reflected in all of the program's formal monitoring and evaluation mechanisms.
- The system is monitored for indicators of improvement in overall service delivery to women.

7.1 Monitoring and Evaluation

Rationale: Program monitoring and evaluation is critical to ensuring that services remain relevant to clients and to the larger community. Many services rely on client satisfaction surveys for process evaluation. While the direct input of clients is invaluable, the afterglow that often follows program completion may inflate positive responses to satisfaction surveys. To gather valid information about clients' experiences of services, satisfaction surveys must be carefully constructed to elicit thoughtful and detailed input.

When constructing outcome measures for women, consideration must be given not only to substance use status but also to psychosocial issues. Health Canada's Best Practices guidelines identify a number of indicators for measuring client outcomes, including:

- reduction in substance use
- improvement in physical health status and appropriate use of medical services
- improvement in educational status
- improved employment functioning/vocational skills
- decrease in involvement in criminal activities
- improvement in family relationships
- improved self esteem
- improvement in mental health status and use of mental health services
- reduction in risk behaviours
- improved lifestyle (housing, recreation, leisure, handling of stress, etc.)

System-wide evaluation ensures standardization of guidelines among services and promotes implementation and maintenance of substance abuse treatment services for women that are based on best practices principles.

7.1a) Guideline: The Agency reflects its adherence to best practices in the program's formal monitoring and evaluations.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Board Policy Manual reflects reporting standards by Executive Directors for program evaluations.		
The Agency regularly seeks client feedback on its services and ensures that feedback can be provided in a non-threatening and confidential manner.		
The Agency develops and follows a logic model or strategic plan that directs its evaluation and quality management activities.		
The Agency actively participates in system or province wide data collection activities.		
Program evaluation data are readily available to the ministry, service system, clients, and the community.		
The Agency develops a plan to monitor achievement of program objectives.		
The Agency has a monitoring/evaluation program review process in place that includes input from stakeholders (clients, community members, other service providers) and includes best practices guidelines.		

Planned actions for meeting guideline:

7.1b) Guideline: Information is shared at planning tables (regional/district implementation committees, addiction service groups/networks, and women's services planning groups) to create and maintain a system-wide picture of competencies and challenges.

Criteria Specific to Agency	Status	Evidence of meeting guideline
Regional addiction system planning groups discuss Best Practices in Action as a regular item at meetings.		
MOHLTC is encouraged to bring representatives from other systems (such as primary health care, mental health care, and child protection service providers) to planning meetings		
The MOHLTC assesses and reviews implementation of best practices at the program and system levels.		

Planned actions for meeting guideline:

A Final Word and Summary of Best Practices

Best Practices in Action has been developed to operationalize best practices research from a variety of sources, notably Health Canada's Best Practices documents. **Best Practices in Action** represents an ideal standard to which treatment programs within the MOHLTC substance abuse system can aspire; programs can use it to document the steps taken to achieve best practices for women and to set strategic plans with best practices for women in mind.

Best Practices Summary

1. Operational Practices

Key Concepts

Best practices are reflected in: Board membership, agency policies, and program services; ongoing staff training and development; hiring and staffing practices; and in physical facilities, in particular those for pregnant and parenting women.

Best Practices Principles

- Empowerment and collaboration are reflected throughout the agency.
- Current, clinically relevant skills and knowledge are based on effective therapeutic approaches (such as motivational interviewing techniques, cognitive behavioural therapy, and harm reduction approaches).
- Gender specific services and female staff are provided for women by all agencies who serve women.
- Physical facilities are both welcoming and safe.
- Welcoming issues are addressed by attention to inclusivity of women's diversity and to the thoughtful arrangement of physical space.
- Safety issues are addressed by providing separate, or separated, residential facilities for women with all aspects of physical safety and confidentiality taken into account.
- The relational needs of pregnant and parenting women in regard to their children are addressed, either onsite or through arrangements with allied services.

2. Addressing Barriers

Key Concepts

Barriers to access, admission, and treatment for women include: stigma; complex and multiple needs; lack of accessible services; and inflexible admission criteria. These barriers are magnified for pregnant and parenting women.

Best Practices Principles

- Guilt, shame, and fear are minimized in providing treatment to women, in particular pregnant and parenting women.
- Outreach to substance involved women seen by allied service providers, who may not feel comfortable approaching substance abuse service providers, is necessary to support early intervention and attract women to substance abuse services.
- Outreach to allied service providers is also necessary to reduce stigma and support women who might require services from the substance abuse system.
- Women's health is complex and rooted in social conditions which requires services that are multi-disciplinary, comprehensive, and coordinated, often requiring an ongoing case management component.
- Services are offered in accessible and non-traditional settings to maximize ease of access and coordination with allied service providers.
- The individual needs of women, especially those who are most marginalized, require substance abuse service providers to be flexible in intake, admission, and programming components.

3. Treatment Planning Issues

Key Concepts

Best practices are reflected in: contextualized information gathering during the assessment process; a treatment plan that addresses the range of women's issues; and flexibility in length of treatment.

Best Practices Principles

- Comprehensive assessment includes a wide range of core issues that impact on women.
- Women's treatment readiness and treatment success are improved when identified core issues are addressed.
- Women who are not treatment ready, or are in an early stage of change with respect to substance use, benefit from an examination of their core issues to identify immediate needs, supports, and linkages required.
- Length of stay and structure of treatment needs to be flexible and based on women's individual needs and goals.

4. Clinical Practice Issues

Key Concepts

Substance involved women respond best when treatment services: are gender relevant (that is, have gender specific programming and gender sensitive approaches); incorporate

stages of change, motivational counselling, and harm reduction approaches; reflect gender balance with both client and staffing ratios in co-ed settings; and adopt gender specific approaches to health, well-being, and other treatment strategies, including relapse prevention.

Best Practices Principles

- A wide range of core issues that impact on women must be incorporated into treatment programming, with emphasis on trauma and relational issues.
- Gender sensitive, women-only treatment settings are preferred.
- Treatment approaches are based on a woman's stage of change and incorporate motivational counselling strategies and harm reduction approaches, in particular with women during early stages of change or with pregnant and parenting women.
- When women-only treatment groups cannot be implemented in co-ed settings, a gender balance is necessary (for both client and staff ratios); if this cannot be met, individual counselling is preferable to women attending gender imbalanced treatment groups.
- A focus on physical health and well-being (including supports for women who smoke and appropriate interventions for tobacco consumption) is incorporated into core programming.
- Relapse is viewed as an opportunity to revisit client goals and treatment plans.

5. Specialized Issues

Key Concepts

Co-occurring mental health problems are common among substance involved women (in particular, depression and anxiety) as are high rates of trauma experiences and Post Traumatic Stress Disorder (PTSD).

Best Practices Principles

- Mental health issues are connected to the context of women's lives and the treatment of co-occurring mental health and substance abuse issues is similarly interconnected and integrated.
- Substance abuse treatment services collaborate with mental health services to provide effective assessment, referral, treatment planning, and case management for women with co-occurring mental health and substance abuse issues.
- Substance use and PTSD are treated concurrently within the context of an integrated approach to assessment, treatment planning, and intervention if service providers have specific training, skills, and adequate time to undertake this.
- All substance abuse service providers are trauma informed.

6. Pregnant and Parenting Women

Key Concepts

Substance involved pregnant and parenting women may fear involvement with the substance abuse treatment system. Timely involvement is critical and strategies needed to engage and retain pregnant and parenting women. Key strategies (stages of change based approaches, motivational counselling, and harm reduction) are of particular importance, as are attention to relationships with children and with child protection services.

Best Practices Principles

- The focus is on the mutual needs of the pregnant woman and her child as opposed to a focus on mutually exclusive needs of the woman and child.
- Access to childcare is deemed essential by substance abuse services.
- Women feel secure that their entry into the substance abuse treatment system does not automatically result in loss of custody of their children.
- Substance abuse services are flexible, accessible, informed, and responsive to the context of women's lives and provide safe places for children.
- Substance abuse workers are thoughtful of the continuum of care and the range of substance abuse services provided to pregnant and parenting women, with a preference for geographically accessible, community-based treatment.
- Pregnant women receive priority access to all levels of treatment.
- Supportive, non-stigmatizing interventions are more effective than either shame based, punitive approaches or mandatory treatment.
- Harm reduction strategies for pregnant women enhances protective factors that reduce harm to both mother and child.
- Relational models that promote the mother/child bond and other important family relationships improve treatment outcomes for pregnant and parenting women.
- Collaborative working relationships between substance abuse services and child protection services are essential.

7. Monitoring and Evaluation

Key Concepts

Monitoring and evaluation ensures the ongoing relevance of substance abuse programs for women. The monitoring and evaluation process occurs at the client, program, and system levels.

Best Practices Principles

- Outcome measures for women include measurement of psychosocial issues, in addition to substance use status.

- Agency adherence to best practices is reflected in all of the program's formal monitoring and evaluation mechanisms.
- The system is monitored for indicators of improvement in overall service delivery to women.

Best Practices Guidelines Summary

1. Operational Practices	
1.1 Guideline for Governance	<ul style="list-style-type: none"> Boards and Program Advisory Committees evidence strong support for best practices in services, in membership, and in policies.
1.2 Guideline for Education and Training	<ul style="list-style-type: none"> The Agency has mechanisms to ensure that all counselling staff receives specialized training and clinical support to deliver services that address the complex range of issues presented by women.
1.3 Guidelines for Hiring and Staffing	<ul style="list-style-type: none"> The Agency ensures it hires staff with relevant knowledge, skills, and experience to provide effective services to women clients. Female staff fulfills all direct service roles in gender specific services (including clinical, program delivery, and residential support roles). In co-ed services, women clients receive counselling and program components related to core issues from female staff and female staff fulfills monitoring and support roles in residential services.
1.4 Guideline for Physical Facility	<ul style="list-style-type: none"> Programs that serve women ensure an environment that is safe and comfortable for women.
1.5 Guideline for Physical Facility for Pregnant and Parenting Women	<ul style="list-style-type: none"> Programs that serve women provide a dedicated physical space to facilitate accessibility and delivery of services for pregnant and parenting women and their children.
2. Addressing Barriers	
2.1 Guidelines for Stigma	<ul style="list-style-type: none"> The Agency supports and participates in activities to reduce stigma and to affirm and empower substance involved women who are affected by stigma. The Agency's policies and procedures ensure that information about services is made known to women and to other services for women.
2.2 Guidelines for addressing women with complex and multiple needs	<ul style="list-style-type: none"> Proactive outreach services are in place to overcome barriers experienced by substance involved women, in particular those who are marginalized. Coordinated access to a comprehensive range of adjunctive services is provided by linkages with allied service providers.
2.3 Guideline for Accessible Service Locations	<ul style="list-style-type: none"> Services are offered in locations easily accessible to women.
2.4 Guidelines for Flexible Admission Criteria	<ul style="list-style-type: none"> Services demonstrate respect and support for each woman's ability to identify her needs, choose goals, and select appropriate options for herself. Admission criteria and structures reduce barriers and promote equitable access to substance abuse services.
3. Treatment Planning Issues	
3.1 Guideline for Assessment and Referral	<ul style="list-style-type: none"> Basic information about core issues is gathered from every woman, either as part of the standardized assessment process or as part of a core issue identification process.
3.2 Guideline for Duration of Treatment	<ul style="list-style-type: none"> Duration of treatment is planned in response to women's identified needs and preferences.

4. Clinical Practice Issues	
4.1 Guidelines for Gender Relevant Services	<ul style="list-style-type: none"> • Gender specific programming that addresses identified core issues is provided to women in specialized and co-ed services. • Programming is gender sensitive and incorporates best practices approaches.
4.2 Guideline for Stage of Change Based Approaches	<ul style="list-style-type: none"> • Service approaches and structures are responsive to women at all stages of change and are based on motivational counselling and harm reduction approaches.
4.3 Guidelines for Gender Balance in Mixed Gender Services	<ul style="list-style-type: none"> • In co-ed groups, an appropriate balance of women and men clients is achieved. • Appropriate gender balance is supported by staffing of co-ed groups.
4.4 Guidelines for Gender Specific Approaches to Physical Health and Well-being	<ul style="list-style-type: none"> • Programs provide information, education, and opportunities for experiential learning on issues related to physical health. • Program components include information and education about tobacco and provide an environment that supports women to quit smoking.
4.5 Guideline for Gender Sensitive Relapse Prevention Approaches	<ul style="list-style-type: none"> • Gender relevant relapse prevention and appropriate supports for women who relapse are available at all phases of treatment.
5. Specialized Issues	
5.1 Guideline for Co-occurring Substance Use and Mental Health Issues	<ul style="list-style-type: none"> • Services for women with co-occurring substance use and mental health problems are gender sensitive and are planned and delivered in an integrated manner.
5.2 Guideline for Trauma and Post Traumatic Stress Disorder	<ul style="list-style-type: none"> • Services for women are trauma informed and take an integrated approach to treatment of substance abuse and trauma issues.
6. Pregnant and Parenting Women	
6.1 Guideline for Engagement and Retention of Pregnant and Parenting Women	<ul style="list-style-type: none"> • Service providers understand the range of services required by substance involved pregnant and parenting women and adopt comprehensive approaches to care.
6.2 Guideline for Access to Services for Pregnant and Parenting Women	<ul style="list-style-type: none"> • Priority access to appropriate services is provided for pregnant women in all service settings (including assessment, withdrawal management, residential and non-residential, women-only, and co-ed service settings).
6.3 Guideline for Effective Services for Pregnant and Parenting Women	<ul style="list-style-type: none"> • Approaches and interventions for engaging and treating pregnant and parenting women are appropriate to their identified goals and consistent with improving and optimizing the health of both mother and child.
6.4 Guideline for Relationships with Children	<ul style="list-style-type: none"> • Services facilitate women's contact with children and family.
6.5 Guideline for Child Protection Issues	<ul style="list-style-type: none"> • Services understand child protection reporting responsibilities and fulfill these responsibilities in a woman-sensitive way.
7. Monitoring and Evaluation	
7.1 Guidelines for Program Monitoring and Evaluation	<ul style="list-style-type: none"> • The Agency reflects its adherence to best practices in the program's formal monitoring and evaluations. • Information is shared at planning tables to create and maintain a system-wide picture of competencies and challenges.

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