# Substance Abuse and Mental Health Services for Pregnant Women and Women with Dependent Children in Arizona:

## A Preliminary Needs Assessment Report

September 2015

LeCroy & Milligan
ASSOCIATES, INC.

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**About LeCroy & Milligan Associates:**
Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LeCroy & Milligan Associates has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs.

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**Behavioral Health Services Vision**

*All Arizona residents touched by the public behavioral health system are easily able to access high quality prevention, support, rehabilitation and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities.*

- Arizona Department of Health Services, 2015

# Executive Summary

Substance Abuse Block Grant (SABG) funds are provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Substance Abuse Treatment and Prevention, to provide services for alcohol and drug abuse treatment and prevention services in Arizona.

Block grant funds support a variety of covered substance abuse services in both specialized addiction treatment and more generalized behavioral health settings. Special target groups mandated by the grant include: 1) priority access to treatment for pregnant women using substances and individuals who use drugs by injection; 2) family-centered programs for women with young children, including funds specifically prioritized for parents of children with Department of Child Safety (DCS) involvement; and 3) primary prevention services for children and families who do not require treatment.

The purpose of this report is to provide updated information on the status of the Arizona Department of Health Services, Division of Behavioral Health Services' (ADHS/DBHS), Substance Abuse Block Grant (SABG) funded substance abuse mental health services available to pregnant women and women with dependent children in Arizona within the ages of 18-54. The report offers contextual demographic information regarding the specific mental health and substance abuse service needs of women in this target group. This information is provided in conjunction with a literature review as a means to offer the Arizona Department of Health Services, Division of Behavioral Health Services a framework of best practices and guidelines on how existing and future service providers targeting these populations can become as gender-responsive, effective and inclusive as possible.

Finally, the report offers several recommendations for ADHS/DBHS to consider as it moves forward to further support pregnant women and women with dependent children in Arizona in addressing their mental health and substance abuse service needs in a comprehensive manner. The recommendations are as follows

- Conduct a needs assessment using primary data collection methods such as a stakeholder survey, key informant interviews, and focus groups to identify and address gender-specific service gaps;
- Expand the quantity and range of comprehensive, evidence-based services to pregnant women and women with dependent children;
- Expand gender-specific questions on DBHS surveys;
- Incorporate in-depth gender-specific questions on Behavioral Risk Factor Surveillance System surveys; and,
- Collect updated information from Tribal and Regional Behavioral Health Authorities annually regarding gender-specific services and providers in order to maintain the Women's Directory.

As an addition to this report, a supplemental resource guide was developed, *Women's Directory: A Guide to Substance Abuse and Mental Health Services for Women*, which provides the following information. See Appendix A for more details.

- Contact information for service providers;
- Contact information for associated Tribal and Regional Behavioral Health Authority (T/RBHAs), Veteran's Administrations, and Indian Health Services;
- Indication of child care availability as part of the provider's service;
- Indication of program capacity, or the number of participants that can be served at any given time; and,
- Type(s) of service or treatments offered, i.e., hospitalization/detoxification services, residential services, opioid replacement services, intensive outpatient services, and/or outpatient services.

# Data Collection Methods and Limitations

Data compiled for the report is comprised of a variety of secondary data sources including current research and literature publications such as data from the Office of Injury Prevention of the Arizona Department of Health Services, 2015, Arizona Division of Behavioral Health Services Consumer Survey, 2013, U.S. Census Bureau, 2012-2014, American Community Survey, 2011, and the SAMHSA National Survey on Drug Use and Health (2014), among others. In addition, carefully selected toolkits and guidelines produced by various offices within the Substance Abuse and Mental Health Services Administration (SAMHSA) were reviewed. These include:

- Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series (2014);
- Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals (2011);
- 2013 Quick Guide for Administrators – Based on TIP 51 - Substance Abuse Treatment: Addressing the Specific Needs of Women (2013);
- Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer (BHB): United States, 2014. HHS Publication No. SMA–15–4895. Rockville, MD: Substance Abuse and Mental Health Services Administration (2015); and,
- Center for Substance Abuse Treatment (CSAT), Comprehensive Substance Abuse Treatment Model for Women and their Children (1994 with a series of ongoing updates to the original model).

Additional de-identified secondary data was contributed in aggregate by ADHS/DBHS including:

- 2014 Substance Abuse Prevention and Treatment Case Review Findings;
- 2014 Women, Infant, and Children (WIC) Alcohol and Smoking Data;
- 2008-2014 Neonatal Abstinence Syndrome and Newborn Drug Exposure Data;
- 2014 Research Brief: Neonatal Abstinence Syndrome: 2008-2013 Overview;
- 2013 Poisonings Among Arizona Residents Research;
- 2014 Substance Abuse Reports Among Supplemental Nutrition Assistance Plan Recipients Data; and,
- 2015 Behavioral Risk Factor Surveillance System Data.

Please refer to the References for a complete listing of publications, toolkits, and guidelines analyzed for the review.

To develop the supplemental resource guide, the research team gathered data from ADHS/DBHS sources as well as contacts within the T/RBHAs in the State. DBHS provided service information from prior years as a baseline for further investigation. This information included facility names and contact information, RBHA contact information, funding sources, childcare availability, program capacity for both women and their dependent children, and treatment modalities or types of services offered. The research team then initiated contact with the T/RBHAs through both phone calls and emails, requesting updates to the baseline information and additional details on gender-specific services provided to pregnant women and women with dependent children. The data collected from each agency was reviewed, refined, and compiled into a resource guide. The guide was designed to be accessible and pertinent to the general public. Additional information pertaining to the resource guide is listed in the report under the State Service Profile section.

In terms of limitations, the report does not include the gathering of primary data from service providers or the women served by the providers. The collection and analysis of primary data would be essential to have a more accurate description of the current needs and service options available to women in Arizona. A full scale needs assessment would include interviews with pregnant women and women with children being served (beneficiaries), as well as consultations with SABG funded service providers and other stakeholders (via focus group discussions, surveys and/or other data collection methods). A needs assessment would allow for the identification of service gaps, and the development of practical programming solutions, in a manner that would validate (or "speak to") the unique needs and real-life circumstances of pregnant women and women with children in Arizona who are struggling with mental health and/or substance abuse issues.

The development of the gender-specific treatment guide for Arizona also encountered several key limitations. Primary among these limitations was the lack of full input from all stakeholders. In gathering data for the resource guide, several T/RHBA agencies either did not respond or provided limited information regarding services provided within their service area. Furthermore, changes to the RBHA system effective October 1st, 2015 may render some of the collected data out of date if RBHAs such as Cenpatico elect to create new contracts or discontinue contracts for services specific to this population. Information regarding RBHA intentions in this matter was not provided to the research team at the time of this report.

Additionally, it should be noted that information provided in the resource guide represents only those services that could be defined as gender-specific or gender-exclusive in nature. While this provides a clear review of the availability of such services in Arizona, the resource guide should not be considered an exhaustive list of services available to pregnant women and women with dependent children. Many agencies provide non-gender specific treatment that this population could access if needed.

# Background

## Substance Abuse Block Grant Statewide System

The Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Substance Abuse Treatment and Prevention provided Substance Abuse Block Grants (SABG) to states to provide alcohol and drug abuse treatment and prevention services. Grant funds were acquired by the State of Arizona through an annual application process. Throughout the State, funds were allocated on a per capita basis to ensure equity in the utilization of tax dollars for local communities. Funds are distributed through the Tribal and Regional Behavioral Health Authorities (T/RBHAs).

Funds are used to support a variety of covered substance abuse services in both specialized addiction treatment and more generalized behavioral health settings. Supports offered through funded services are designed to meet the needs of specific populations, such that services give priority access to the treatment of pregnant women using substances and individuals who used drugs by injection; family-centered programs for women with young children; services for parents of children with Department of Child Safety (DCS) involvement; and primary prevention services to children and families who do not require treatment (ADHS/DBHS, 2015).

There are six Regional Behavioral Health Authorities (RBHAs) and four Tribal Regional Behavioral Health Authorities (TRBHAs). Arizona Department of Health Services allocates resources like the SABG funds to the T/RBHAs to manage service delivery on behalf of the State of Arizona. Each T/RBHA enters into contractual agreement with a network of service providers within their region to deliver a range of behavioral health care services and treatment programs (ADHS/DBHS, 2015).

Exhibit 1. Tribal and Regional Behavioral Health Authorities in Arizona

| Geographic Service Area (GSA) | Regional Behavioral Health Authority | Area(s) Served |
|---|---|---|
| GSA 1 | Northern Arizona Regional Behavioral Health Authority | Apache, Coconino, Mohave, Navajo, and Yavapai Counties |
| GSA 2 | Cenpatico | La Paz and Yuma Counties |
| GSA 3 | Cenpatico | Cochise, Graham, Greenlee, and Santa Cruz Counties |
| GSA 4 | Cenpatico | Gila and Pinal Counties |
| GSA 5 | Cenpatico | Pima County |
| GSA 6 | Mercy Maricopa Integrated Care | Maricopa County |
| Tribal Region | Gila River | Gila River Indian Community |
| Tribal Region | Navajo Nation | Navajo Nation |
| Tribal Region | Pascua-Yaqui | Pascua-Yaqui Tribe |
| Tribal Region | White Mountain Apache | White Mountain Apache Nation |

## National Women's Health

According to the Substance Abuse and Mental Health Services Administration (SAMHSA's) National Survey on Drug Use and Health (NSDUH), 6.2% of females in the U.S. (ages 12 and older) were classified with substance dependence or abuse, with only 0.9% of females receiving treatment (SAMHSA TIP, 2014).

The National Survey on Drug Use and Health identified several reasons/barriers for not receiving substance use treatment among surveyed women (aged 18-49) who needed treatment. The three most cited barriers were: not being ready to stop using (36.1%), cost or insurance barriers (34.4%), and social stigma barriers (28.9%). Exhibit 2 shows these and other less-frequently identified barriers.

Exhibit 2. Barriers to Substance Abuse Treatment Identified by U.S. Women Surveyed

| Barrier | Response Rate |
|---|---|
| Not ready to stop using | 36.1% |
| Identified cost/insurance barriers | 34.4% |
| Reported social stigma as a barrier | 28.9% |
| Identified other access barrier | 15.7% |
| Did not feel need for treatment/could handle problem without treatment | 15.5% |

| Barrier | Response Rate |
|---|---|
| Did not know where to go for treatment | 13.2% |
| Did not have time to go for treatment | 4.7% |
| Reported treatment would not help | 2.7% |

## Women's Mental Health in Arizona

The Behavioral Health Barometer (BHB): Arizona, 2014 Report presents a set of substance use and mental health indicators based on data collected through various national surveys from 2009-2013. It was found that approximately 230,000 adults (4.8% of all adults) in Arizona were classified as having a Serious Mental Illness (SMI). This rate is similar to the national percentage of 4.7% in 2012-2013. Further, an estimated 359,000 adults with Any Mental Illness (AMI) (40.1% of all adults with AMI) in Arizona received mental health treatment or counseling.

However, the data indicate that 59.9% did not receive treatment during this time period. Given that extensive research (SAMHSA 2011; 2014) indicates that substance misuse often occurs alongside other mental health concerns, this large proportion of individuals in Arizona who are not receiving treatment puts many individuals and families – including women, men and their children -- at greater risk of experiencing a multiplicity of physical, social, emotional and financial consequences impacting their overall well-being and quality of life.

The target population for this assessment includes pregnant women and women with dependent children (ages 18-54) in Arizona with substance abuse and/or mental health service needs (including prevention, treatment and/or other relevant services). As such, key health indicators/statistics related to this target population are provided below.

Data from the 2015 Arizona Behavioral Risk Factor Surveillance Survey (BRFSS) indicate that in 2013, 14.4% of Arizona women age 18 and older reported frequent mental distress (defined as 14 or more mentally unhealthy days in the past 30 days) compared to 13.2% of US women. The percentage of Arizona women age 18 and older who reported frequent mental distress was also higher than the national percentage of such women in 2011 (see Exhibit 3).

Exhibit 3. Percent of Women 18 Years and Older Reporting Frequent Mental Distress: Arizona & U.S.

| Year | Arizona | United States |
|---|---|---|
| 2011 | 14.1% | 13.6% |
| 2012 | 13.4 % | 13.7% |
| 2013 | 14.4 % | 13.2% |

### *Geographical Variations*

The data indicate some variations between rural and urban counties, with 15.8% of women reporting frequent mental distress in rural areas, versus 13.6% in urban areas, such as Maricopa, Pima, Pinal and Yuma Counties. Variations were also evidence between national border (Cochise, Pima, Santa Cruz and Yuma) and non-border counties. In 2013, 11.9% of women reporting frequent mental distress lived in border counties, versus 14.6% that lived in non-border counties (BRFSS Survey, 2015).

### *Variations by Ethnicity*

With respect to variations by ethnicity, 2015 Arizona Behavioral Risk Factor Surveillance Survey data indicated that in 2013, 10.5% of Non-Hispanic White women reported frequent mental distress, as compared to 20.2% of Hispanic or Latino women. An interesting finding was that while the percentage of women reporting frequent mental distress decreased from 13.9% in 2011 to 10.5% in 2013 for Non-Hispanic White women, the percentage increased for Hispanic or Latino women during that same time period from 13.2% to 20.2%. Non-Hispanic Black, Non-Hispanic American Indian and Other Non-Hispanic women were also surveyed, but estimates for those groups were based on sample sizes that were determined to be too small to meet standards for reliability or precision.

### *Variations by Education & Income*

The most notable findings from the 2015 Arizona BRFFS survey, however, involved variations by education and income. These two factors help to determine socioeconomic status, which has long been linked to health (Adler, et al, 1994). As illustrated in Exhibit 6, the percentage of women reporting frequent mental distress who had graduated from college or a technical school was 7.6% in 2013, compared to 14.9% of those who had only graduated from high school. The rates for women who did not have a high school degree were much higher, reaching 20.5% in 2012 (see Exhibit 4).

Exhibit 4. Percentage of Women 18 Years and Older Reporting Frequent Mental Distress by Education

| Year | Not high school graduate | High school graduate | Attended college or technical school | College or technical school graduate |
|---|---|---|---|---|
| 2011 | 20.0% | 13.5% | 16.2% | 6.8% |
| 2012 | 20.5% | 15.1% | 13.6% | 6.3% |
| 2013 | 25.9% | 14.9% | 13.5% | 7.6% |

Along with guidelines relating to their specific behavioral health condition, Arizona residents and members of Native American tribes located within Arizona can qualify for public behavioral health services depending on their income level (www.azdhs.gov/bhs/aboutbhs.htm). Variations by income within the 2015 Arizona BRFSS survey were also found to be significant every year between 2011 and 2013 (see Exhibit 5). In 2013, the percentage of women reporting frequent mental distress was much higher (22.4%) among lower income women making less than $20,000 per year as compared the percentages reported by women making $50,000 or more (8.5%)(BRFSS Survey, 2015). To offer context, of the 306,077 households in Arizona that are headed by women, 101,924 (33%) have incomes that fall below the poverty level (U.S. Census Bureau, 2012; American Community Survey, 2011).

Exhibit 5. Percentage of Women 18 Years and Older Reporting Frequent Mental Distress by Income

| Year | Less than $20,000 | $20,000 – $49,999 | $50,000 or more |
|---|---|---|---|
| 2011 | 22.5% | 14.3% | 9.6% |
| 2012 | 26.0% | 13.4% | 6.6% |
| 2013 | 22.4% | 16.1% | 8.5% |

## Substance Abuse among Women and Pregnant Women in Arizona

The latest figures from the Arizona Department of Health Services' Division of Behavioral Health Services, provide aggregated counts of women and pregnant women, ages 18-54, identified as having been diagnosed with a substance abuse condition during the calendar year 2014 (January 1, 2014 – December 31, 2014).

This data (provided in Exhibit 6 below) indicates that a total of 23,255 women in Arizona, including 1,249 pregnant women, who were enrolled and serviced by the State in 2014 were diagnosed with a substance abuse condition (ADHS/DBHS, 2015). These figures do not include women with tobacco-related conditions, and thus, the actual figures are higher than what is presented in this analysis.

Maricopa County had the largest number of women enrolled and experiencing substance abuse problems, accounting for 9,819 women, 774 of whom were pregnant women. Pima County followed with a total of 6,009 women experiencing substance abuse problems enrolled and serviced by the State, of whom 209 were pregnant women.

Exhibit 6. Substance Abuse among Women & Pregnant Women in Arizona by County, 2014

| Arizona County | Women Ages 18-54 with Substance Abuse Condition | Pregnant Women Ages 18-54 with Substance Abuse Condition |
|---|---|---|
| Maricopa | 9,045 | 774 |
| Pima | 5,800 | 209 |
| Yavapai | 1,652 | 58 |
| Mohave | 1,408 | 58 |
| Pinal | 1,027 | 51 |
| Yuma | 616 | 25 |
| Coconino | 605 | 18 |
| Navajo | 551 | 13 |
| Cochise | 467 | 14 |
| Gila | 326 | 13 |
| Apache | 167 | 7 |
| Graham | 150 | 3 |
| La Paz | 76 | 1 |
| Santa Cruz | 75 | 3 |
| Greenlee | 35 | 2 |
| Out of State | 6 | 0 |
| **Total** | **22,006** | **1,249** |

The medical, social, emotional and financial consequences and costs of these disorders (when left untreated) to women, women's families, and society as a whole, are enormous. There are potential impacts on newborns, as well, such as Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorders (FASD). Given the data pertaining to these conditions in Arizona is alarming, a few relevant statistics are provided below.

### *Neonatal Abstinence Syndrome (NAS) and Newborn Drug Exposures in Arizona*

The National Institutes of Health defines Neonatal Abstinence Syndrome (NAS) as a group of problems that occur in a newborn exposed to addictive illegal or prescription drugs while in the mother's womb (in utero-exposure) (Hussaini, 2014). NAS is a withdrawal syndrome in newborns that is caused by the use of opiates and other drugs of abuse during pregnancy. These drugs include: amphetamines, barbiturates, benzodiazepines (diazepam, clonazepam), cocaine, marijuana, and opiates such as heroin, methadone, codeine, hydrocodone (Vicodin), and oxycodone (OxyContin). Other substances, including alcohol, have also been linked to this syndrome. Alcohol exposure during pregnancy and its impact

on the fetus is typically described by the umbrella term Fetal Alcohol Spectrum Disorders (FASD).

Research indicates that infants with NAS are more likely to have diverse neonatal outcomes including low birth weight (LBW), which is a major risk factor for infant mortality. Other characteristics associated with NAS include irritability, respiratory distress, sleep-wake disturbances, tremors, feeding difficulties, gastrointestinal disturbances, vomiting, loose stools, autonomic dysfunction, and failure to thrive (Hussaini, 2014).

According to the Office of Injury Prevention of the Arizona Department of Health Services (ADHS/OIP, 2015), between 2007 and 2014 there were 599,262 newborns with NAS and drug exposures in Arizona (including narcotics, cocaine and alcohol) in Arizona. Yearly totals moved up and down over the period, ranging from a high of 95,420 in 2008 to a low of 81,988 in 2011 (ADHS/OIP, 2015). With respect to NAS specifically, during 2008–2013 there were a total of 1,472 cases in Arizona. Arizona's NAS rate increased by 156% over the period from 1.57 incidents per 1,000 newborns to 4.03 incidents per 1,000 newborns in 2013.

The ADHS/OIP also reported that the rate of newborns in Arizona exposed to narcotics increased more than 218% between 2008 and 2014. Further, the number of newborns with Fetal Alcohol Syndrome increased by 67% between 2013 and 2014. The rate of NAS increased by 235% from 2008 to 2014, and 27% just from 2013 to 2104. The number of newborns exposed to cocaine, on the other hand, decreased by 76% between 2008 and 2014, and by 39% from 2013 to 2014 (ADHS/OIP, 2015). Exhibit 7 shows the increase in NAS and some drug exposures over the last six years.

Exhibit 7. Newborns with NAS and Drug Exposures in Arizona, 2008-2014

| Year | NAS | Narcotics | Alcohol | Cocaine | # of Hospital Births total |
|---|---|---|---|---|---|
| 2008 | 145 | 234 | 22 | 161 | 95,420 |
| 2009 | 154 | 410 | 25 | 99 | 89,115 |
| 2010 | 223 | 414 | 15 | 79 | 84,069 |
| 2011 | 300 | 424 | 30 | 68 | 81,988 |
| 2012 | 304 | 531 | 27 | 59 | 82,905 |
| 2013 | 339 | 646 | 20 | 55 | 82,338 |
| 2014 | 438 | 650 | 33 | 34 | 83,427 |
| **Total** | **1903** | **3309** | **172** | **555** | **599,262** |

In terms of ethnicity, White, non-Hispanics made up more than two-thirds (68%) of the total number of NAS cases between 2008 and 2014. White, non-Hispanics also comprised the majority (52%) of the total number of narcotic exposure cases (n=1,707) from 2008-2014, with Hispanics composing an additional 28% (n=922) of cases (ADHS/OIP, 2015).

Finally, in addition to the direct personal suffering, and emotional, physical, and financial costs of untreated mental health and substance abuse conditions to women and their families, there is also a financial cost to society. A 2014 study indicated that the median cost of a NAS newborn was approximately $31,000 with a median length of stay of 13 days compared to a non-NAS newborn with a median cost of approximately $2,500 with a median length of stay of two days. The study further found that the median cost for total charges of a hospital stay for a newborn exposed to drugs (i.e., substances including narcotics, cocaine, and alcohol) was twice as high as compared to other hospital births in Arizona (Hussaini, 2014). Arizona data indicates that the Arizona Health Care Cost Containment System (AHCCCS) was the payer for 76% of the cases of newborns exposed to narcotics and 79% of the NAS cases for the period 2008-2014 (ADHS/OIP, 2015).

# Literature Review

## Overview

Research on the substance abuse and mental health service needs of pregnant women and women with dependent children consistently indicates that "gender differences influence the prevalence, course and burden of mental illness" and that "women often have different pathways to substance use, have different risk factors of substance use, suffer different consequences of substance use, experience different barriers to treatment, and have different recovery-support needs from those of men. There are also differences in drug of choice, relapse predictors, frequency of use, and mode of use between men and women (SAMHSA, 2011; SAMHSA, 2013; SAMHSA, 2015b)."

There is a growing body of literature that demonstrates there are "both sex and gender differences between men and women that impact mental health and/or substance use conditions and disorders. Sex differences are biological in nature and include differences related to reproductive organs and functioning, as well as physical differences in body size, bone mass, and bone structure determined by DNA. Gender differences are part of a person's self-representation. Roles and expectations are constructed by culture and social norms (SAMHSA, 2011)."

Although research on how sex and gender differences affect mental health and substance abuse and corresponding treatment has made significant strides, "there remains a strong need to improve prevention and treatment programs through the use of [gender-responsive] core competencies (SAMHSA, 2011)."

## A Gender-Responsive Framework

In recognition that providing effective substance abuse and mental health services for women involves addressing their special prevention, intervention and treatment needs, SAMHSA brought together a 16-member Expert Panel on Core Competencies for Women and Girls in Behavioral Heath to develop a set of gender-responsive programming recommendations intended to offer general guidance to service providers. The manual *Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals* was created as a tool to provide a broad programming framework that can be tailored and adapted to meet multiple needs (SAMHSA, 2011).

The literature identifies the *public health approach, trauma-informed care, and recovery-oriented system of care models* as being integral to SAMHSA's response to the needs of service providers and foundational to the core competencies for women and girls with mental

health and/or substance use conditions and/or disorders. "These three approaches combine to create a comprehensive model for services" aimed at positive outcomes for women, girls and their families (SAMHSA, 2011). Each of these three approaches is described below (See SAMHSA Core Competencies report for full definitions).

The **public health model** considers that mental health and substance abuse problems arise (or worsen) when individuals who are at risk for problems interact with agents (such as substances or stressors) in environments that encourage problems. Services may include reducing risk and promoting resiliency factors within the environment. Addressing environmental risk factors can effectively reduce the incidence and severity of substance use, trauma, and mental health problems. Sex/gender and cultural factors lead to differences in socialization, expectations, and lifestyle, as well as differences in the way women and men experience risk and resiliency factors, stress, and access to resources (SAMHSA, 2011).

A **trauma-informed care approach** empowers staff to recognize and respond to the significance of trauma when providing care to women and girls with mental health and/or substance use conditions/disorders. The approach recognizes that: the effect of violence and trauma in women's lives is substantial; women are more likely to be victims of interpersonal violence than men are; and there is a close correlation between surviving trauma and experiencing a mental or substance use disorder, and as such, it is critical that providers understand trauma. The approach acknowledges that when staff members possess a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and family, women and girls have better outcomes. A trauma-informed care approach includes a universal trauma assessment, development of crisis/safety plans, staff understanding of the importance of environmental changes toward "reducing triggers," and assisting clients to manage emotions (SAMHSA, 2011).

The **recovery-oriented system of care** calls for a comprehensive service system that integrates individuals with mental health and/or substance use conditions/disorders into the community. The approach recognizes that varying levels and types of services may be needed at different points in time. Recovery services include establishing recovery supports and social networks necessary to live a life in the community, as well as providing treatment services based on the values of self-determination, hope and empowerment. Women often have fewer economic resources, greater vulnerability to violence, and more family responsibilities than men do. Recovery-oriented systems of care designed for women reflect these gender differences and include relevant resources and support (formal and informal) (SAMHSA, 2011).

More specifically, the Expert Panel developed a set of **Guidance Statements**, which provide the basis for the development of the core competencies for gender-responsive behavioral health service provision and programming. A few sample guiding statements are provided below, with a full listing of the SAMHSA Guiding Statements provided in Appendix B:

- Women and girls are more frequently vulnerable to violence and trauma, and this vulnerability must be addressed in prevention efforts as well as other mental health and substance abuse services. Trauma-informed environments based on safety, respect, and dignity are essential for the prevention and treatment of women across their life spans.
- Mental health and substance use conditions/disorders affect the entire family. Parenting and caregiving are key roles and important aspects of identity for many women; they must be taken into account when providing them services.
- Women often have multiple roles, family responsibilities, a higher incidence of poverty as compared to men, and a range of health, mental health, substance abuse, and social service needs. Navigation, access use, and coordination among numerous community resources and systems may be necessary for their success in prevention and treatment programs.

## Knowledge and Skill Competencies for Service Professionals

Beyond these guiding principles, the Expert Panel identified specific knowledge, skills, attitudes and attributes (KSAAs) essential for behavioral health service providers that, when combined, form the core competencies needed to effectively serve women and girls with mental health and/or behavioral support needs (SAMHSA, 2011). These include knowledge and skills pertaining to: sex and gender differences; relational approaches in working with women and girls; understanding trauma in women and girls; family-centered needs of women and girls; special considerations during pregnancy; women's health and health care; and collaboration and interdisciplinary skills (see SAMHSA, 2011, for full descriptions of recommended knowledge and skill competencies for service professionals).

In addition to knowledge and skills, there are accompanying attitudes and attributes that the Expert Panel deemed to be "critical components of the competencies," including: respect and empathy, recovery orientation, service-specific attitudes and attributes, and self-awareness and professional development (see SAMHSA, 2011, for full description of recommended provider attitudes and attributes).

## Gender-Responsive Treatment Principles and Protocols

Recognizing that gender has an impact on the treatment of substance abuse and mental health outcomes, SAMHSA worked with clinicians, researchers and program

administrators to develop a 180+ page *Treatment Improvement Protocol (TIP) 51 focusing on Substance Abuse Treatment: Addressing the Specific Needs of Women* (SAMHSA 2014), as well as a practical *Quick Guide for Administrators based on TIP 51* (SAMHSA, 2013). The primary contributions of both guides are listed below.

The *Treatment Improvement Protocol (TIP) 51* manual:

- Discusses women's patterns of substance use across a continuum from initiation of use through recovery;
- Identifies the physiological effects of alcohol, drugs, and tobacco on women;
- Focuses on specific screening, assessment, and treatment engagement, placement, and planning processes that support the unique constellation of women's issues;
- Highlights women's prevention issues and treatment needs across specific population groups and treatment settings; and
- Synthesizes current knowledge, including science-based and best practices, to address the biopsychosocial factors that influence treatment engagement, retention, and outcomes among women.

The *Quick Guide for Administrators based on TIP 51*, which accompanies the treatment improvement guidelines, summarizes the how-to information pertinent to behavioral health program administrators, focusing on program development, procedures, and policies in addressing substance use disorders among women in behavioral health settings. The guide provides a list of gender-responsive treatment principles, as described in Exhibit 8 (SAMHSA, 2014).

Exhibit 8. Gender Responsive Treatment Principles

| Gender Responsive Treatment Principles |
|---|
| Acknowledge the importance and role of socioeconomic issues and differences among women. |
| Promote cultural competence specific to women. |
| Recognize the role and significance of relationships in women's lives. |
| Recognize that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances. |
| Adopt a trauma-informed perspective. |
| Use a strengths-based model for women's treatment. |
| Incorporate an integrated and multidisciplinary approach to women's treatment. |
| Maintain a gender-responsible treatment environment across setting. |
| Support the development of gender competence specific to women's issues among clinicians, administrators, and other staff. |

## Essential Services for Women's Substance Abuse Treatment

The *Quick Guide* also provides a list of essential services needed in women's substance abuse treatment, including medical services, health promotion, psychoeducation, gender-specific needs, cultural and language needs, life skills, family- and child-related services (including childcare), comprehensive case management, mental health services, disability services, and staff and program development. Studies confirm the need for services to be tailored to women's needs and to address the specific hardships women often encounter in engaging treatment services showing that, "promising practices designed to treat women with substance use disorders include comprehensive and integrated clinical and community services that are ideally delivered at a one-stop location (SAMHSA, 2014)." These services are "recommended by the SAMHSA consensus panel and reinforced by some State standards, and the services may be warranted across the continuum of care, beginning with early intervention and extending to continuing care services (SAMHSA, 2014)." Exhibit 9. Shows the consensus panel recommended core service areas and the specific services they include.

Exhibit 9. Services Needed for Women's Substance Abuse Treatment

| Core Services Needed for Women's Substance Abuse Treatment (SAMHSA, 2014) | |
|---|---|
| Medical Services | • Gynecological care<br>• Family planning<br>• Prenatal care<br>• Pediatric care<br>• HIV/AIDS services<br>• Treatment for infectious disease, including viral hepatitis<br>• Nicotine cessation treatment services |
| Mental Health Services | • Trauma-informed and trauma-specific services<br>• Eating disorder and nutrition services<br>• Services for other co-occurring disorders, including access to psychological and pharmacological treatments for mood and anxiety disorders<br>• Children's mental health services |
| Family- and Child-Related Services | • Childcare services, including homework assistance in conjunction with outpatient services<br>• Children's programming, including nurseries and preschool programs.<br>• Family treatment services, including psychoeducation surrounding addiction and its impact on family functioning.<br>• Couples counseling and relationship enrichment recovery groups |

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|---|---|
| | • Parent/child services, including age-appropriate programs for children and education for mothers about child safety; parenting education; nutrition; children's substance abuse prevention curriculum; and children's mental health needs, including recreational activities, school and other related activities. |
| Cultural and Language Needs | • Culturally appropriate programming<br>• Availability of interpreter services or treatment services in clients' native languages |
| Health Promotion | • Nutrition counseling<br>• Educational services about reproductive health<br>• Wellness programs<br>• Education on sleep and dental hygiene<br>• Education about STDs and other infectious diseases (e.g., viral hepatitis, HIV/AIDS<br>• Preventive healthcare education |
| Gender-Specific Needs | • Women-only programming (e.g., is the client likely to benefit more from a same-sex versus mixed-gender program due to trauma history, pattern of withdrawal among men, etc.)<br>• Specific services to meet the needs of lesbian, bisexual, and transgender women. |
| Disability Services | • Resources for learning disability assessments<br>• Accommodations for specific disabilities<br>• Services to accommodate illiteracy |
| Comprehensive Case Management | • Linkages to welfare system, employment opportunities, and housing<br>• Integration of stipulations from child welfare, Temporary Assistance for Needy Families (TANF), probation and parole, and other systems<br>• Intensive case management, including case management for children<br>• Transportation services<br>• Domestic violence services including referral to safe houses<br>• Legal services<br>• Assistance in establishing financial arrangements of accessing funding for treatment services<br>• Assistance in obtaining a GED or further education, career counseling, and vocational training, |

| | |
|---|---|
| | • and job readiness training to prepare women to leave the program and support themselves and their families<br>• Assistance in locating appropriate housing in preparation for discharge, including referral to transitional living or supervised housing<br>• Services to accommodate women receiving methadone or buprenorphine treatment |
| Psychoeducation | • Sexuality education<br>• Assertiveness skills training<br>• Education on the effects of alcohol and drugs on prenatal and child development<br>• Prenatal education |
| Life Skills | • Money management and budgeting<br>• Stress reduction and coping skills |
| Staff & Program Development | • Strong female role models in terms of both leadership and personal recovery<br>• peer support<br>• Adequate staffing to meet added program demands<br>• Staff training and gender competence in working with women<br>• Staff training and program development centered on incorporating cultural and ethnic influences on parenting styles, attitudes toward discipline, children's diet, level of parenting supervision, and compliance with medical treatment<br>• Flexible scheduling and staff coordination<br>• Adequate time for parent-child bonding and interactions<br>• Administrative commitment to addressing the unique needs of women in treatment<br>• Staff training and administrative policies to support the integration of treatment services with client on methadone maintenance<br>• Culturally appropriate programming that matches specific socialization and cultural practices for women. |

# Barriers to Substance Abuse Treatment among Women

The literature provides evidence that women face multiple factors that can serve as barriers to entering treatment; to engaging and continuing the utilization of treatment services across the continuum of care; and in maintaining connections with community services and self-help groups that support long-term recovery (SAMHSA, 2014). Barriers may exist on several levels – for which a snapshot of SAMHSA's research findings (quoted directly from the SAMHSA 2014 *Treatment Improvement Protocol (TIP) 51 focusing on Substance Abuse Treatment: Addressing the Specific Needs of Women)* is provided below.

## Intrapersonal Factors/Barriers

Individual factors include health problems, psychological issues, cognitive functioning, motivational status, treatment readiness, etc. Women may have feelings of guilt and shame regarding use and behavior associated with use, and may fear losing custody of their children if the drug or alcohol problem is admitted and treatment is sought.

## Interpersonal Factors/Barriers

Relational issues include significant relationships, family dynamics, and support systems. Because women are usually the primary caregivers of children as well as of other family members, they are often unable or not encouraged to enter and remain in treatment. In addition, women generally fear family or partner reactions or resistance to asking for help outside the family.

## Sociocultural Factors Factors/Barriers

Social factors include cultural differences; the role of stigma, bias, and racism; societal attitudes; disparity in health services; attitudes of healthcare providers toward women, and others. Women are more stigmatized by alcohol and illicit drug use than men, being sometimes characterized as morally lax, sexually promiscuous, and neglectful as mothers. In addition, women who have children often fear that admitting a substance use problem will cause them to lose custody of their children. They worry that they will be perceived as irresponsible or neglectful "bad mothers" if they admit to substance abuse or dependence. These fears and stereotypes compound a woman's shame and guilt about substance use and subsequently, interfere with help-seeking behavior.

## Structural Factors/Barriers

Program characteristics include treatment policies and procedures, program design, and treatment restrictions. According to SAMHSA's 2005 National Survey of Substance Abuse Treatment Services, 87% of these programs accepted women as clients, but only 41% provided special programs or groups for women. Overall, only 17% of treatment facilities offered groups or programs for pregnant or postpartum women (SAMHSA, 2006). Being

responsible for the care of dependent children is one of the biggest barriers to women entering treatment. Women who do not have access to a treatment program that provides childcare or who cannot arrange alternative childcare may have to choose between caring for their children and entering treatment.

Unfortunately, few residential programs across the U.S. have provisions that allow mothers to have their children with them, and outpatient programs often do not provide services for children or childcare. Only 8% of substance abuse treatment facilities provided childcare in 2003, and only 4% provided residential beds for clients' children (SAMHSA, 2004). Even when children are accepted into residential treatment, programs often impose age restrictions and limit the number of children a mother is permitted to bring to treatment (SAMHSA, 2014).

Treatment resources for pregnant women who abuse substances are also scarce. Few programs simultaneously combine the necessary prenatal care with substance abuse treatment and services for older children. Research indicates the major barriers to providing resources for pregnant women are based on administrative concerns about medical issues for mothers, infants, and children; fear of program liability; inability to care for infants and lack of services for other children while mothers are in treatment; lack of financial resources; and limited staff training and knowledge about pregnancy and substance use (SAMHSA, 2014).

Substance abuse treatment providers may not fully understand the needs and the types of interventions most conducive to assisting women in recovery. Studies have found that treatment staff attitudes and unsubstantiated myths about women actually may act as barriers to successful treatment completion among women. In addition, programs may lack cultural competence in addressing treatment issues for women from different cultural or language backgrounds. Thus, women from varied cultural backgrounds may be reluctant to seek treatment if treatment staff or the programs feel foreign, judgmental, hostile, or indifferent (SAMHSA, 2014).

Even women who are highly motivated for treatment face additional program barriers that may produce significant challenges. These barriers include waiting lists, delayed admission, limited service availability, and preadmission requirements (e.g., paperwork requirements, detoxification). Other barriers are related to program structure, policies, and procedures and include program location, lack of case management services, limited funding sources, and lack of transportation. Because women are more likely to be poor, their ability to obtain transportation may make it difficult to receive treatment. Also, women may have to travel with their children and use public transportation to reach treatment agencies, which can be a hindrance for women who live in rural areas or have limited income (SAMHSA, 2014).

## Systemic Factors/Barriers

Larger systems include federal, state, and local agencies that generate public policies and laws, private sector services used by large numbers of people (e.g., health insurance), and environmental factors such as the economy and drug trafficking patterns. Many women in need of treatment are involved in multiple social service systems that have different expectations and purposes. The co-occurrence of substance use disorders and involvement in the child welfare system ranges from 50-80%. Moreover, collaboration among substance abuse treatment, child welfare, and welfare reform systems is challenging and often not integrated because of differences in timetables, definition of clients, complexity of client needs, staff education and training, and funding streams. Services may be fragmented, requiring a woman to negotiate a maze of service agencies to obtain assistance for housing, transportation, childcare, substance abuse treatment, vocational training, education, and medical care. Overall, these simultaneous demands can discourage a woman, particularly when seeking treatment or during early recovery (SAMHSA, 2014).

Women who have substance use disorders often fear legal consequences. In entering treatment, they sometimes risk losing custody of their children as well as public assistance support. Likewise, women who have substance use disorders often fear prosecution and incarceration if they seek treatment during pregnancy. The public debate over privacy and the fetus's right to be born free from harm fuels a legal focus on pregnant women who smoke, drink alcohol, or use illicit drugs. These conflicts have impeded the diagnosis of women with substance abuse problems, the availability of services, and access to appropriate care (SAMHSA, 2014).

In summary, while the identification of barriers is essential to effective case management and treatment planning, it is equally important to develop specific strategies to address each barrier as early as possible. As highlighted in the Center for Substance Abuse Treatment's (CSAT's) *Comprehensive Substance Abuse Treatment Model for Women and Their Children*, strategies to overcome these barriers need to focus on three core areas: clinical treatment services, clinical support services, and community support systems. CSAT's research concludes that "without a proactive plan to address barriers, women will not be as able to engage in or benefit from substance abuse treatment (SAMHSA, 2014)."

# State Service Profile

The section below provides a snapshot of services provided to pregnant women and women with children in Arizona and identifies several gender-specific findings with implications for future service provider programming opportunities.

## Gender-Specific Implications for Future Service Programming

The SABG grant requires the State to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (ADHS/DBHS Case File Review, 2015). The Arizona Department of Health Service successfully fulfilled this requirement by reviewing substance abuse treatment programs, which are contracted through the T/RBHAs. ADHS contracted with Health Care Excel (HCE) as an independent peer review organization to carry out a case file review of behavioral health records. HCE received a predetermined sample size of records to review, which included a total of 150 records. HCE analyzed the findings and prepared the annual external quality review report for State Fiscal Year 2014.

In compliance with the State of Arizona's policies and regulations, this FY2014 Annual Report's objective was to determine the extent to which substance abuse treatment programs in the State of Arizona use nationally recognized best practices in the areas of screening, assessment, treatment, engagement, and retention in accordance with the terms of their contracts and state and federal regulations. In addition, the case file review included the collection of data pertaining to National Outcome Measures. Of particular value to this study, the ADHS/DBHS Case File Review 2014 offered several important **gender-specific findings** with implications for future service provider improvements (ADHS/DBHS Case File Review, 2015). These findings include:

- Sixty-one percent (61 %) of sampled service providers reported completing a **safety plan** with female clients with a history of domestic violence;
- Approximately fifty-seven percent (57.1 %) of sampled service providers reported that if the female client was pregnant, **coordination of care** was completed with the primary care physician and/or obstetrician;
- If the female client was pregnant, **education on the effects of substance use** on fetal development occurred with 57.1 % of clients;
- Among females with a child less than one year of age, 30 % of sampled service providers reported completing **screening for postpartum depression/psychosis**;
- Among female clients with dependent children, 36.7 % of sampled service providers reported **addressing child care**; and

- When asked if there was "evidence of **gender-specific treatment services** (e.g., women's only group therapy session)," 22.5 % of service providers responded "yes."

Of notable interest, the case file review found that the top three methods of referrals in Arizona among women are referrals from one's self or a family friend (52%), criminal justice or correctional referrals (i.e., from the Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections) (45.3%); and other behavioral provider (6.0%). This data may be helpful in any future outreach efforts to provide more women with gender-responsive mental health and substance abuse services in Arizona.

These case file review findings indicate that while there are signs of gender-responsive programming occurring within the ADHS/DBHS SABG funded services available to pregnant women and women with dependent children in Arizona, additional and more comprehensive programming on a range of service areas would be beneficial to meet the many needs of this population. Areas of potential improvements include: the provision of more childcare facilities; more residential bed capacity for women and their children; increased coordination of care with health care providers; additional education on the effects of substance use on fetal development; and more consistent, routine screening for postpartum depression among new mothers.

## Services Available to Pregnant Women and Women with Children

The target population for this report includes pregnant women and women with dependent children (ages 18-54) with substance abuse and/or mental health service needs. A supplemental resource guide was developed, *Women's Directory: A Guide to Substance Abuse and Mental Health Services for Women*, which provides the following information (Appendix A).

The guide provides provider-level contact information for those providers that have been identified by the T/RHBAs as providing gender-specific services for the treatment of substance abuse and mental health. Each provider listing includes the agency name, address, phone number, website, indication of child care availability, indication of program capacity (e.g., the number of participants that can be served at any given time), and the types of services provided at that location. Types of services, as described in the guide, include:

### *Hospitalization/Detoxification Services*

Detoxification services are offered in hospital settings when stopping the use of a particular drug may cause severe withdrawal symptoms that may require medical attention.

### *Residential Services*

Residential services typically involve anywhere from a 45-day to a 6-month program in which the individual lives on-site and receives daily counseling, group meetings, and general support. The length of each program varies and depends on individual needs. Many programs offer "after care" programs that involve Intensive Outpatient or Outpatient services.

### *Opioid Replacement Services*

Opioid Replacement services or medication assisted treatment are programs that can prescribe methadone or buprenorphine to individuals with an opioid use disorder. Eligibility for such programs is based on an assessment completed by the agency. These programs generally include case management support and requirements to attend group and/or individual counseling sessions.

### *Intensive Outpatient Services*

Intensive Outpatient Services (IOP) are typically comprised of programs with a clear start and stop date, 8 to 12 weeks is common, in which consistent participation is a requirement. These programs generally include over 9 hours of group and individual services per week, and can be combined with other services (such as support groups addressing other needs).

### *Outpatient Services*

Outpatient services are generally comprised of individual and group counseling that is not part of a larger "program," such as an IOP or residential service. This might include a once-a-week relapse prevention group, individual counseling, or medication services.

As noted in the limitations section, not all T/RBHAs responded to inquiries about gender-responsive services in their regions and some services available to the target population could not be included in the guide because they are not gender-exclusive. For this reason, the guide also includes general contact information for the statewide 24-hour Hotline, the T/RBHAs, Veterans Administration, and Indian Health Services.

# Recommendations

This report should be viewed as a preliminary assessment of the substance use and mental health service needs of pregnant women and women with dependent children in Arizona. It is a vital first step in ensuring that women receive comprehensive, culturally responsive and evidence-based treatment. The recommendations below constitute what the research team suggests are appropriate next steps in ensuring that this population is appropriately served.

### *Conduct a Needs Assessment to Address Gender-Specific Service Gaps*

It is recommended that ADHS/DBHS consider conducting a full-scale needs assessment which includes primary data collection from pregnant women and women with dependent children being served (beneficiaries), as well as SABG funded service providers, via interviews, focus groups, surveys and/or other data collection methods. This type of an assessment would offer the Arizona Department of Health Services an opportunity to clearly identify and address service gaps in way that directly speaks to the particular needs and circumstances of pregnant women and women with dependent children with mental health and substance abuse service needs living in Arizona.

While interviews and focus groups of individuals affected would yield key insights into the unique needs of this population, interviews of providers and other key informants would likely provide much needed information regarding perceived and real obstacles for those providing such services. These points of consideration are likely to highlight gaps in services more readily addressable by ADHS/DBHS. These may include specific regions in which increased or decreased funding is recommended, opportunities for increased collaboration between specific agencies, or the need for increased agency training regarding treatment within this population.

### *Expand the Quantity and Range of Comprehensive, Evidence-Based Programming Services to Pregnant Women and Women with Children*

While there appear to be signs of gender-responsive programming occurring within the ADHS/DBHS SABG funded services available to pregnant women and women with dependent children in Arizona, additional and more comprehensive programming on a range of service areas would be highly beneficial to meet the many needs of this population. Areas of potential improvement include the provision of more childcare facilities; more residential bed capacity for women and their children; increased coordination of care with health care providers; additional education on the effects of substance use on fetal development; and more consistent, routine screening for postpartum depression among new mothers.

### *Expand Gender-Specific Questions on DBHS Surveys*

It is recommended that ADHS consider expanding the gender-specific questions on upcoming Division of Behavioral Health (DBHS) surveys. Currently, surveys include the following valuable gender-specific questions for service providers:

- If there was a history of domestic violence, was a safety plan completed?
- If the female was pregnant, was coordination of care completed with the primary care physician and/or obstetrician?
- If the female was pregnant, did education on the effects of substance use on fetal development occur?
- If the female had a child less than one year of age, was screening completed for postpartum depression/psychosis?
- If the female had dependent children, was childcare addressed?
- Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?

Should a needs assessment be commissioned by ADHS, findings from the assessment would offer invaluable insights into the specific types of gender-specific questions that might be incorporated into the Arizona Behavioral Risk Factor Surveillance System survey.

### *Incorporate In-Depth Gender-Specific Questions into BRFSS Surveys*

The Arizona Behavioral Risk Factor Surveillance System (BRFSS) program is in the process of selecting which of the Arizona BRFSS Optional Modules and proposed state-added questions will be included in the upcoming BRFSS 2016 [telephone] survey. It is recommended that ADHS ensure that in-depth gender-specific questions are fully incorporated throughout the BRFSS survey to reflect the needs of pregnant women and women with dependent children with mental health and/or substance abuse conditions. The survey is an especially valuable programming tool, as it is used to "identify emerging health problems, establish and track health objectives, and to develop and evaluate public health policies and programs [in Arizona] (ADHS, 2015)." As noted above, a needs assessment would allow for the identification of relevant gender-specific questions to include within the BRFSS surveys.

### *Annually Update the Women's Directory*

It is recommended that ADHS collect updated information from Tribal and Regional Behavioral Health Authorities annually regarding gender-specific services and providers in order to maintain the Women's Directory. The Women's Directory not only serves the unique function of listing services just for women, but takes key structural barriers (such as a lack of childcare or residential facilities) into consideration, for instance, by showing

which providers offer childcare and bed capacity for women and children. Findings from a full-scale needs assessment would allow for the development of a complete list of key gender-responsive variables to include within in the annually updated Women's Directory.

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# Appendix A. Information from the Women's Directory

Below is the information gathered for the Women's Directory: A Guide to Substance Abuse and Mental Health Services for Women. A full version of the guide designed for distribution is available upon request from the Arizona Department of Health Services.

ARIZONA DEPARTMENT OF HEALTH SERVICES, DIVISION OF BEHAVIORAL HEALTH

# Women's Directory

## A Guide to Substance Abuse and Mental Health Services for Women

**LeCroy & Milligan Associates, Inc.**

**9/30/2015**

Arizona Department of Health Services

LeCroy & Milligan ASSOCIATES, INC.

## Introduction

Pregnant women and women with dependent children face difficult challenges in their lives every day. Whether it be providing basic needs like food, clothes, and appropriate medical care to their children or ensuring that children have the education and support needed to live happy and healthy lives, even the most skilled of parents need support. For pregnant women and women with dependent children suffering from and fighting addiction in their lives, this need for support is only that much greater.

In cooperation with the Substance Abuse and Mental Health Services Administration (SAMHSA), the State of Arizona is dedicated to ensuring that pregnant women and women with dependent children who struggle with substance misuse receive help and support to live healthy, stable lives free from the grip of addiction. Additionally, the research shows and Arizona recognizes that substance misuse often occurs alongside other mental health concerns that if left untreated, may put both women and their children at greater risk.

The following resource guide is a first step in ensuring that women in Arizona are able to address substance misuse and mental health needs in order to provide a safe and nurturing environment for their children. If you are or know of a pregnant woman or woman with dependent children seeking support with these issues, please use this guide as a starting point in what we hope is a road to recovery, stability, and wellness.

*Note on Eligibility*

Every year, agencies in our state receive funding from the federal Substance Abuse and Mental Health Services Administration and the State of Arizona to provide substance abuse prevention and treatment. Currently, pregnant women and women with dependent children are considered by the state to be a priority population in receiving services through this funding.

**What does this mean for you?**

If you are a pregnant woman or a woman with dependent children (including women attempting to regain custody of their children) and experience substance misuse issues, you are eligible to receive these services ***regardless of your current insurance status***. While these services may be limited in certain circumstances, it means that starting services is often as easy as making a single phone call.

Make that call today and start your road to recovery.

## Women's Services vs. General Substance Abuse Programs

Research shows that gender-specific treatment, that is, counseling and other services designed specifically for women, can be especially helpful for women in recovery. As a result, this guide focuses only on agencies and services in Arizona that offer women-only services. For example, Southwest Behavioral Health Services in Yavapai County offers a substance abuse support group for women-only. ***This does not mean that the services listed below are the only services available to you.*** There may be agencies offering groups for both men and women that are better suited for your needs. If you think this is the case, you should start by calling Arizona's 24-hr Hotline at 1-800-662-HELP for free and confidential information (in English and Spanish). You could also contact your local Regional Behavioral Health Authority (RBHA), Veterans Administration, and/or Indian Health Services.

*Service Location Support - Contact Information*

| RBHA | Area(s) served | Phone | Website |
|---|---|---|---|
| 24-hr Hotline | All of Arizona | 1-800-662-HELP | http://www.azdhs.gov/bhs |
| Cenpatico RBHA | Cochise, Gila, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, andYuma Counties | 1-866-495-6735 | http://www.cenpaticoaz.com |
| Gila River RBHA | Gila River Indian Community | 1-800-259-3449 | http://gilariverrbha.org |
| Mercy Maricopa Integrated Care RBHA | Maricopa County | 1-800-631-1314 | http://www.mercymaricopa.org |
| Navajo Nation RBHA | Navajo Nation | 1-866-841-0277 | http://www.nndoh.org/dbhs.html |
| Northern Arizona RBHA | Apache, Coconino, Mohave, Navajo, and Yavapai Counties | 1-877-756-4090 | http://www.narbha.org |
| Pascua-Yaqui RBHA | Pascua Yaqui Tribe | 1-800-572-7282 | http://www.pascuayaqui-nsn.gov |
| White Mountain Apache RBHA | White Mountain Apache Nation | 1-877-336-4811 | http://www.wmabhs.gov |
| Veterans Administration (Central AZ) | Gila and Maricopa Counties | 602-277-5551 | http://www.phoenix.va.gov |
| Veterans Administration (Northern AZ) | Apache, Coconino, Mojave, Navajo, and Yavapai Counties | 928-445-4860 | http://www.prescott.va.gov |
| Veterans Administration (Southern AZ) | Cochise, Graham, Gila, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma Counties | 520-792-1450 | http://www.tucson.va.gov |
| Indian Health Services (Navajo Nation) | Navajo Nation | 928-871-4811 | http://www.ihs.gov/navajo |
| Indian Health Services (Tucson) | Tohono O'Odham Nation and Pascua Yaqui Tribe | 520-295-2405 | http://www.ihs.gov/phoenix |
| Indian Health Services (Phoenix) | All other Arizona Tribal Nations | 602-364-5159<br>602-364-5039 | http://www.ihs.gov/tucson |

## Types of Services

The directory shows what type of service is available at each agency so that you can find the service best suited for your needs. Determining the best type of service for you should involve a conversation between you and the agency staff and will likely include the completion of an assessment by licensed or certified staff within the agency. Remember, there is no "one-size fits all" substance abuse service out there. They can be tailored to your needs and combined with additional support services (skills training, personal care, counseling, etc.) offered by each agency.

*Hospitalization/Detoxification Services*

Detoxification services are offered in hospital settings when stopping the use of a particular drug may cause severe withdrawal symptoms that may require medical attention.

*Residential Services*

Residential services typically involve anywhere from a 45-day to 6-month program in which you live on site and receive daily counseling, group meetings, and general support. The length of each program varies and depends on individual needs. Many of these programs offer "after care" programs that involve Intensive Outpatient or Outpatient services (see descriptions below).

*Opioid Replacement Services*

Opioid Replacement services or medication assisted treatment are programs that can prescribe methadone or buprenorphine to individuals with an opioid use disorder. Eligibility for such programs is based on an assessment completed by the agency. These programs generally include case management support and requirements to attend group and/or individual counseling sessions.

*Intensive Outpatient Services*

Intensive Outpatient Services (IOP) are typically programs with a clear start and stop date, 8 to 12 weeks is common, in which consistent participation is a requirement. These programs generally include over 9 hours of group and individual services per week and can be combined with other services such as support groups addressing other needs.

*Outpatient Services*

Outpatient services are generally individual and group counseling that is not part of a larger "program" such as an IOP or residential service. This could include a once-a-week relapse prevention group, individual counseling, or medication services as a few examples.

| Facility Name (address and phone number) | Facility address | Phone | Website | Child Care | Program Capacity (amount served) | Services for Women |
|---|---|---|---|---|---|---|
| Cochise County | | | | | | |
| Women's Transition Project: The Renaissance House | 240 Ohara Ave Bisbee, AZ 85603 | (520) 432-1771 | http://www.renaissance-house.org | Available | 9 women, 9 children | Residential Services |
| Corazon Integrated Healthcare Services | 936 F Ave, Ste B Douglas, AZ 85607 | (520) 364-3630 | http://www.chaposcorazon.com | None | No limit | Outpatient Services |
| Coconino County | | | | | | |
| Southwest Behavioral Health Services | 1515 E Cedar Ave, Ste B2 Flagstaff AZ 86004 | (928) 779-4550 | http://www.sbhservices.org | None | No known limit | Outpatient Services |
| The Guidance Center | 2187 N Vickey St Flagstaff, AZ 86004 | (928) 527-1899 | http://tgcaz.org | None | No known limit | Outpatient Services |
| Maricopa County | | | | | | |
| Native American Connections | 4520 N Central Ave Phoenix, AZ 85012 | (602) 254-3247 | http://www.nativeconnections.org | None | 5 women | Residential Services |
| Mohave County | | | | | | |
| Southwest Behavioral Health Services | 1845 McColloch Blvd, Ste B1 Lake Havasu, AZ 86403 | (928) 453-2661 | http://www.sbhservices.org | None | No known limit | Outpatient Services |
| Southwest Behavioral Health Services | 809 Hancock Rd, Ste 1 Bullhead City, AZ 86442 | (928) 763-7111 | http://www.sbhservices.org | None | No known limit | Opioid Replacement Services<br>Outpatient Services |
| Navajo County | | | | | | |
| Community Counseling Centers, Inc. | 2500 Show Low Lake Rd Bldg A & B Showlow, AZ 85901 | (928) 368-4110 | http://www.ccc-az.org | None | No known limit | Intensive Outpatient Services<br>Outpatient Services |
| Pascua Yaqui | | | | | | |
| Pascua Yaqui Health Center Centered Spirit Program | 7490 S Camino De Oeste Tucson, AZ 85757 | (520) 879-6225 | http://www.aachc.org<br>http://www.elrio.org/pascua-yaqui-clinic | Sometimes Available | Inpatient: 5 woman and their children<br><br>Outpatient: 50 women and their children | Intensive Outpatient Services<br>Outpatient Services<br>Residential Services |
| Pima County | | | | | | |
| The Haven | 1107 E Adelaide Dr Tucson, AZ 85719 | (520) 623-4590 | http://www.thehaventucson.org | Available | 54 beds | Residential Services |

| Facility Name (address and phone number) | Facility address | Phone | Website | Child Care | Program Capacity (amount served) | Services for Women |
|---|---|---|---|---|---|---|
| CODAC Behavioral Health Services: Las Amigas | 1650 E Fort Lowell Rd, Ste 202 Tucson, AZ 85719 | (520) 202-1840 | http://www.codac.org | Available | 18 women, 2 children per parent - must be age 7+ | Residential Services |
| CODAC Behavioral Health Services: Mothers Caring About Health (MCAS) | 1650 E Fort Lowell Rd, Ste 202 Tucson, AZ 85719 | (520) 202-1840 | http://www.codac.org | Available | No limit | Intensive Outpatient Services |
| Pinal County | | | | | | |
| Corazon Integrated Healthcare Services | 900 E Florence Blvd Casa Grande, AZ 85122 | (520) 836-4278 | http://www.chaposcorazon.com | None | No limit | Intensive Outpatient Services |
| Santa Cruz County | | | | | | |
| Corazon Integrated Healthcare Services | 1891 N Mastick Way Nogales, AZ 85621 | (520) 375-5300 | http://www.chaposcorazon.com | None | No limit | Outpatient Services |
| White Mountain Apache Tribe | | | | | | |
| Apache Behavioral Health Services, Inc. | 249 W Ponderosa Whiteriver, AZ 85941 | (928) 338-4811 | http://www.wmabhs.org | None | No known limit | Outpatient Services |
| Yavapai County | | | | | | |
| Southwest Behavioral Health Services | 7600 E Florentine Rd, Ste 101Prescott Valley, AZ 86314 | (928) 775-7088 | http://www.sbhservices.org | None | No known limit | Opioid Replacement ServicesOutpatient Services |
| Spectrum Healthcare | 8 E Cottonwood, Bldg A Cottonwood, AZ 86326 | (928) 634-2236 | http://www.spectrumhealthcare-group.org | None | No known limit | Outpatient Services |
| Spectrum Healthcare | 8 E. Cottonwood, Bldg A Cottonwood, AZ 86326 | (928) 634-2236 | http://www.spectrumhealthcare-group.org | None | 12 women, no children | Residential Services Outpatient Services |
| West Yavapai Guidance Clinic | 505 S Cortez Prescott, AZ 86303 | (928) 445-5211 | http://www.wygc.org | None | No known limit | Intensive Outpatient Services |
| West Yavapai Guidance Clinic | 642 Dameron Dr Prescott Valley, AZ 86301 | (928) 445-5211 | http://www.wygc.org | None | 26 adult, no children | Residential Service Outpatient Services |
| Yuma County | | | | | | |
| Community Intervention Associates, Inc. | 2851 S Ave B, Bldg 4 Yuma, AZ 85264 | 928-376-0026 x 1115 | http://www.ciayuma.com | None | No limit | Outpatient Services |
| Community Intervention Associates, Inc. | 2851 S Ave B, Bldg 4 Yuma, AZ 85264 | 928-376-0026 x 1115 | http://www.ciayuma.com | None | No limit | Outpatient Services |

# Appendix B. SAMHSA Core Competency Guiding Statements for Gender-Responsive Services

The Guiding Statements listed below were developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The are intended to provide a basis for core competencies for gender-responsive behavioral health service provision and programming (CITATION). NOTE: ADJUST FORMATTING OF LIST

1. Women and girls are different from men and boys in physiology, cognition, emotions, social development, communication patterns, roles, socialization, risks, and resiliency. These differences affect the prevention, treatment, and recovery needs of women and girls.
2. Although women and girls may share many biopsychosocial and spiritual characteristics as a gender group, women and girls are heterogeneous. Culture, age, socioeconomic status, religion, disability, and racial and sexual identity all influence women's gender role. It is critical that staff understand how sociocultural identities differ among women and girls and may lead to different health outcomes.
3. Women and girls are more frequently vulnerable to violence and trauma, and this vulnerability must be addressed in prevention efforts as well as other mental health and substance abuse services. Trauma-informed environments based on safety, respect, and dignity are essential for the prevention and treatment of women across their life spans.
4. Women and girls with mental health and/or substance use conditions/disorders are at higher risk for associated physical health and medical problems. Likewise, trauma experiences, including intimate partner violence, rape/sexual abuse, and childhood abuse and/or neglect are risk factors for mental health, substance abuse, and other health problems. Knowledge of the possible risk factors and their consequences is critical in preventing and treating mental health and substance use conditions/disorders among women.
5. Societal expectations and messages regarding women's sexuality can deter healthy sexual development and decision-making. They also may contribute to mental health/substance abuse problems. Therefore, competencies must include awareness of these expectations and messages, and the knowledge, skills and attitudes/attributes required to respond to them.
6. Staff members often have life experiences with mental health problems, substance abuse, and trauma they hold in common with the women they serve. These experiences, when coupled with self-awareness and appropriate boundaries, add depth to their ability to develop and implement appropriate services. Thus, competencies address acceptance and inclusion of women with lived experiences of mental health problems, substance abuse, and trauma in the delivery of comprehensive, gender-responsive services and recovery-oriented care.
7. Relationships are critical to the emotional development of women and girls and also play a significant role in both the development of, and recovery from, mental health and substance use conditions/disorders. Thus, competencies for working with women and girls must address the relational-cultural context of their functioning.
8. Adolescence, pregnancy, perimenopause, and menopause are distinct periods in a woman's life, each accompanied by a range of physiological, psychological, and developmental changes, which changing risks, opportunities, and support needs. Staff serving women and

girls need to be familiar with each of these stages.

9. Mental health and substance use conditions/disorders affect the entire family. Parenting and caregiving are key roles and important aspects of identity for many women; they must be taken into account when providing them services. Effectively addressing the needs of women includes consideration of the needs of children (of all ages) for whom she is responsible. Culturally sensitive, family-centered work with a woman's family – as she defines it – is critical to her wellness and recovery. This includes working with intimate partners as well as other family members.
10. Women often have multiple roles, family responsibilities, a higher incidence of poverty as compared to men, and a range of health, mental health, substance abuse, and social service needs. Navigation, access, use, and coordination among numerous community resources and systems may be necessary for their success in prevention and treatment programs. These systems may include (but are not limited to) welfare programs (e.g., Temporary Assistance for Needy Families [TANF]), child care, schools, child welfare, employment, faith-based organizations, and health care. Women may be responsible for ensuring care not only for themselves, but also for their children and other family members.
11. The number of incarcerated women grows annually. The prevalence of mental health and/or substance use conditions/disorders among these women is high, and their involvement in the criminal justice system further increases their risk. Staff serving women involved in legal systems must consider the special needs of women and girl offenders (e.g., separation from family, employment barriers, institutionalization, and additional trauma).
12. Women with mental health and/or substance use conditions/disorders are more highly stigmatized and stereotyped. This may result in barriers to accessing services, which can prevent or impede recovery. Women in recovery may also be at greater risk of being blamed or judged because of their disorders. They may also face negative sexual stereotypes or criticism of their parenting ability. Thus, these competencies address the impact of stigma and stereotypes on recovery for women and girls, as well as the skills and attitudes required to address these challenges.