HERS Intensive Outpatient Program for Substance Use

Implementation Guide

A program of the UCSF Women's HIV Program

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This manual was produced by the Health, Empowerment, and Recovery Services (HERS) Intensive Outpatient Program (IOP) team at the University of California, San Francisco (UCSF) Women's HIV Program (WHP) Clinic: Yvette Cuca, Katy Davis, Joy Walker-Jones. We thank the leadership, providers, staff, and partners of the Women's HIV Program for their commitment to serving the needs of our clients. We also acknowledge our partners Lisa Jaycox and Nipher Malika at The RAND Corporation.

Finally, we are grateful to all of our patients who allow us to be part of their lives and who remind us every day about the importance of compassion in our work.

For More Information

We are very open to sharing our experiences and our resources with others who are implementing the HERS IOP in their own clinic. Please contact Katy Davis (katy.davis@ucsf.edu, 415-514-8327or Joy Walker-Jones (mitcheline.walker-jones@ucsf.edu, 415-413-7230)

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Introduction

Alcohol and drug use conditions have been shown to be associated with trauma and Adverse Childhood Experiences (Felitti et al., 1998; Forster et al., 2019, 2020; Shin et al., 2018). Substance use, however, is commonly not adequately addressed in most adult primary care settings.

The UCSF Women's HIV Program (WHP) provides primary care services to women with HIV who have experienced high levels of trauma and commonly misuse substances as a consequence of trauma and other factors. Situated in San Francisco, CA, WHP mainly serves low-income women from a variety of racial and ethnic backgrounds. In an effort to address substance use and trauma in our own patient population, we adapted and implemented an intensive outpatient program (IOP) called the Health, Empowerment, and Recovery Services (HERS) IOP, and have been implementing it since 2021.

HERS IOP utilizes components of the structure and curriculum of the Matrix model of intensive outpatient substance use treatment (Obert et al., 2000). The Matrix IOP is a structured approach for treating adults who use or are dependent on substances. This model provides at least 16 weeks of intensive support followed by at least 6 months of continued care support. Through our years of experience, we have made adaptations to the Matrix to best serve the needs of our own patient population and we evaluated the adapted approach (Malika et al., 2025).

The purpose of this manual is to document our approach so that other primary care clinics or other organizations can implement HERS IOP in their own settings, for their own patient populations. In the manual, we provide an overview of the program, describe recruitment and clinical flow, and provide resources that may be useful for other organizations.

The Matrix IOP Model

The Matrix IOP, developed by the Matrix Institute in Los Angeles, California, was adapted and manualized by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). It is built on evidence-based practices. The Matrix model incorporates elements of multiple treatment methods—relapse prevention, cognitive-behavioral therapy, psychoeducation, and family therapy. It consists of 5 different modalities:

1. Individual/ Conjoint family sessions (3 sessions)
2. Early Recovery Skills group sessions (8 sessions)
3. Relapse Prevention group sessions (32 sessions)
4. Family Education group sessions (12 sessions)
5. Social Support group sessions (36 sessions)

The model also emphasizes connecting patients to 12-step and other mutual self-help groups outside of the program.

Matrix is a manualized approach that includes a Counselor's Treatment Manual (Center for Substance Abuse Treatment, 2006b) as well as a Client Handbook (Center for Substance Abuse Treatment, 2006a) with worksheets and handouts (Appendix 1).

What is the HERS Intensive Outpatient Program?

As part of our clinic-wide Health, Empowerment, and Recovery Services (HERS) program, we have adapted Matrix IOP to best serve our patient population. The result is a 9-month program (4 months of program content plus 5 months of continued social support and substance use counseling). There are several main differences between Matrix IOP and HERS IOP:

First, Matrix IOP was designed to serve individuals with stimulant use disorders. Because most of our clients have experienced lifetime trauma and use a wide variety of substances to cope with that trauma, HERS IOP addresses all substance use, including alcohol, cannabis, stimulants, opioids, etc.

Second, HERS IOP was adapted specifically to integrate a trauma-informed approach (Machtinger et al., 2015, 2019). As such, we utilize the TRIADS (Trauma and Resilience-informed Inquiry for Adversity, Distress, and Strengths) Framework in our work (University of California, San Francisco, n.d.). This includes assessing for trauma (Adverse Childhood Experiences), Resilience (Benevolent Childhood Experiences), Adversity (Social Determinants of Health), Distress (depression, anxiety, PTSD, substance use), and Strengths (Brief COPE), and using this information to tailor both group and individual services to participants' needs.

Third, HERS IOP utilizes a harm-reduction approach. Rather than requiring complete abstinence, HERS IOP supports participants at almost all stages of their recovery. Participants do not need to be fully abstinent to participate. We have found that this compassionate approach allows participants to share their struggles and their relapses and recover from them without fear of having to leave the program. It also provides an opportunity for other participants and group facilitators to provided needed support.

Fourth, while HERS IOP structure and content is based on Matrix IOP, we utilized feedback from participants to identify elements that did not work or were not appropriate for our population (e.g., Family Education). We have also integrated curriculum elements from Seeking Safety and Treatment for Individual who Use Stimulants (TRUST) to fill gaps and address the specific needs of our population.

Finally, HERS IOP was adapted and implemented in the midst of the COVID-19 worldwide pandemic and provided much-needed social support to people who would otherwise have experienced substantial social isolation. As such, we conduct almost all elements of the program virtually. Participants who do not have devices are loaned Chromebooks and provided with tech support to attend virtually. At the end of the program, we hold an in-person graduation ceremony.

The purpose of this Implementation Guide is to describe how WHP implements HERS IOP and to provide guidance for how other organizations (e.g., primary care clinics) can adapt the program to their own settings.

Staffing

We recommend the following staffing model to implement the HERS IOP program:

100% Behavioral Health Clinician/IOP Coordinator. This person has two main roles. The first is as the Lead Coordinator for implementing HERS IOP overall. The second is as an interventionist, facilitating IOP groups and supporting and consulting with other facilitators. (See Appendix 2).

100% Substance Use Counselor / Social Worker. This effort could be split across more than one person. This person/ team co-facilitates IOP groups and provides individual substance use counseling and social work support as needed. In addition, this role assesses a person's readiness to participate in IOP before the program starts.

10% Project Logistical Assistant. This person coordinates day-to-day support activities around the IOP program. Work may include making and distributing copies of workbooks to participants, loaning and tracking devices for virtual attendance (e.g., Chromebooks or tablets), tracking attendance and waitlists, and distributing participation incentives.

It is important that all IOP facilitators have training in substance use treatment and conditions because having a working knowledge of substance use and recovery is essential to the program. The exact level of effort needed to conduct HERS IOP will vary based on a number of factors including, for example, access to potential participants and the level of effort required for recruitment, the number of participants and their individual needs, number of times per year that the program will be conducted.

Not all primary care clinics will be able to support the level of effort described above. If this is the case, we recommend at least one person with significant working knowledge of substance use and recovery. In addition:

- 20 hours to organize the program, and for general implementation
- 3-5 hours per participant for coordinating participation and assessing readiness to participate before starting groups
- 30 minutes of prep-time needed for each hour of programming
- 16-48 hours of individual substance use counseling per participant
- Some project administrative support.

Members of the team implementing HERS IOP should plan to meet regularly to communicate about program progress, any issues that have come up in group sessions (e.g., interpersonal issues, triggers, people arriving late). This communication will help the overall program run smoothly.

Outreach, Recruitment, Referrals, and Waitlist

An organization conducting HERS IOP may recruit participants from a variety of locations. For example, participants could be patients of the organization/medical clinic itself, referrals from community organizations, word-of-mouth referrals, or mandated by the courts.

Organizations should create flyers and other recruitment materials that provide information about the HERS IOP program (Appendix 3). These materials can be distributed not only to individuals, but also to community agencies with which the clinic works regularly. Recruitment materials should include contact information and may specify the type of population to be served.

Within medical clinics, the IOP facilitators can attend team meetings to promote the program with staff. Medical and mental health providers may be good sources of referrals since they understand their patients' needs. IOP facilitators may also want to be present in the waiting room during some clinic hours to talk with patients about the program, answer questions, and potentially enroll participants.

The program may receive referrals from community collaborators. For example, a detox center or residential substance use treatment program may contact the IOP because they want to ensure that a patient has immediate support upon leaving inpatient treatment. Intensive case management programs, maternal and child health organizations, and family support programs are just a few of the types of agencies that might refer people to HERS IOP. If the clinic already has relationships with these organizations, it can send flyers to be distributed and may want to do a site visit to meet with the agency's staff to promote the program. IOP facilitators may also reach out to Family and Drug courts to provide them with information about the availability of the program.

Clinical Implementation and Workflow

For the Entry Process, see Appendix 4. For overall HERS IOP program scheduling / structure, please see Appendix 5.

Intake Process

Individuals who are interested in HERS IOP start off with three visits with a substance use counselor. During these visits, they complete the enrollment process, an intake assessment, and are oriented to the program. The remainder of the time/visits are an opportunity for the counselor to assess the person's readiness to participate.

Enrollment and Intake Assessment

Potential participants meet with a substance use counselor to learn about the overall HERS IOP program, the schedule of sessions, and the attendance requirements. If they remain interested, they then complete an intake assessment (Appendix 6). The assessment is based within the TRIADS framework and includes demographics, potential areas of stress and distress, trauma history, current use of a range of substances, and coping mechanisms. The assessment is completed in the first Pre-IOP Counseling visit (see below), and the information gathered is used to guide the following two sessions. A similar assessment can be used after the final session as part of program evaluation, and to gather information about client satisfaction and suggestions for improvement. The assessments can be an opportunity for open discussion about a range of issues relevant to a person's substance use situation.

The assessment includes:

- Demographic information that is determined by the coordinator to be relevant to the program
- Reason for participation (e.g., wanting to get/stay sober, mandated)
- Adverse Childhood Experiences (ACEs Aware, n.d.). We recommend using the de-identified version in which the respondent only provides the total number of ACEs experienced, rather than identifying which specific experiences they have had.
- Benevolent Childhood Experiences (Narayan et al., 2018).
- Social Determinants of Health (North Carolina Department of Health and Human Services, 2018). This provides information related to food insecurity, transportation needs, housing instability, interpersonal safety, and immediate needs.
- Measures of Distress. We recommend brief measures to assess participant anxiety (Kroenke et al., 2010), depression (L√∂we et al., 2005), post-traumatic stress disorder (Prins et al., 2016), and substance use (Dyson et al., 1998).

- NIDA Quick Screen for Substance Use or Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) screener (National Institute on Drug Abuse, 2023). We recommend adding one item about frequency of cannabis use, and one item about the impact of cannabis use in the participant's life.
- Brief COPE (Carver, 1997). Based on experience, we recommend a shortened version of this instrument. Responses give the substance use counselor an idea of positive and negative coping strategies that the participant is currently using.

The assessment can be re-administered at the end of the IOP and can serve as the basis of a discussion with the participant about their ongoing needs.

Pre-IOP Counseling

Pre-IOP counseling consists of 3+ individual sessions with a substance use counselor during which the counselor assesses the participant for readiness and starts to build trusting rapport with the potential participant. This serves two purposes. First, it ensures that everyone who attends group is truly engaged and committed to being there and doing the work. This helps create a therapeutic environment in which participants speak up/participate and support one another. Second, pre-IOP sessions also keep potential participants engaged when they are on the waitlist for a new session of IOP to begin. People who decide to address their substance use issues may be ready only at that moment, and if they cannot begin a program when they are ready, we may lose the opportunity to engage them. Meeting with a substance use counselor individually can tide them over until group sessions begin. Additionally, meeting with the substance use counselor helps the potential participant put a face to the program and helps them start to feel connected to it. The substance use counselor exemplifies a trauma-informed, compassionate, and non-judgmental attitude that orients participants to the program and its culture. The substance use counselor remains the point person for each participant and periodically checks in with them individually throughout IOP.

Main Program Content

Matrix IOP was initially designed such that Early Recovery Skills and Relapse Prevention would be conducted back-to-back on the same day. We recommend that clinics implementing HERS IOP conduct these sessions concurrently on different days. This means that participants will have sessions 4 times each week (preferably at the same time each day) – see Sample Weekly Schedule. This level of intensity increases engagement and commitment and ensures that participants are supported by the facilitators and other group members as they face day-to-day stresses and triggers. This format is also helpful for facilitators who are social workers and substance use counselors and likely have other duties within the clinic.

TRIADS Education Session

Early in each new round of IOP, we dedicate one of the Early Recovery Skills sessions to educating participants on the connection between ACEs and substance use. The material taught is designed to help patients develop more understanding of how and why people use substances to manage trauma symptoms. The goal of the session is two-fold: 1) to set the frame of the IOP as a trauma-informed intervention in which the association between substance use and trauma are acknowledged and openly discussed, and 2) to reduce the shame and stigma associate with substance use and develop a more compassionate view of substance use as an attempt to self-medicate and survive. The concepts in this session continue to be referred to throughout the rest of the program. (Appendix 7)

Early Recovery Skills

The goal of Early Recovery Skills (ERS) sessions is to engage a participant who acknowledges using substances but does not feel that their use negatively affects their lives or does not know what to do about it.

ERS helps participants identify triggers and focuses on early access to treatment, ways to stay safe, and how to contact someone if they are at risk for relapse. ERS begins the moment that someone steps away from detox and serves to hold the participant and keep them safe. In some cases, participants will be referred to HERS IOP when they are still in-patient, so it is important to have this structure for them to move into.

The Matrix IOP Early Recovery Skills curriculum consists of 8 sessions over 4 weeks, but we recommend that clinics implementing HERS IOP conduct ERS-type sessions twice weekly for the entire 16 weeks of the program. It is not recommended that the ERS curriculum content be continually repeated as patients tend to get bored with the same material. Instead, clinics can integrate elements of other programs/modalities. For example, Seeking Safety (Empson et al., 2017; Najavits, 2006; Treatment Innovations, n.d.) focuses on the connection between a person's trauma history and their substance use and skill building on how to manage symptoms of both, elevating the concepts of ERS. TRUST is a newer, engaging curriculum that contains content about the impact of substances on the body and particularly on the brain (Addiction Technology Transfer Center Network, n.d.). Utilizing videos and other engaging visuals, TRUST focuses on the impact of substance use on the brain. Clinics may identify other useful program and modalities to address the interests and needs of their specific program populations. Elements from various programs such as Wellness Recovery Action Plan (WRAP) can be used to supplement the Early Recovery Skills sessions (*Wellness Recovery Action Plan*, n.d.). Clinics may also want to look at SAMHSA's Evidence-Based Practices Resource Center to identify appropriate tools (Substance Abuse and Mental Health Services Administration, n.d.)

A clinic that conducts more than one round of HERS IOP can integrate peer facilitation into the Early Recovery Skills sessions (see below).

Relapse Prevention

The Matrix IOP Relapse Prevention curriculum includes 32 sessions over 16 weeks. It is designed for individuals who have identified that they have a substance use issue and that it is negatively impacting their life in some way, such as their health or their socioeconomic situation; and those who are actively working on their sobriety by gathering support tools, and utilizing skills and resources to manage their recovery by, for example, attending groups (e.g., IOP, Alcoholics Anonymous, Narcotics Anonymous). In Relapse Prevention, participants add skills and resources to their arsenal and utilize them to progress in their recovery.

As with ERS, clinics may choose to employ elements of other programs (e.g., Seeking Safety, TRUST) in Relapse Prevention sessions, and may choose to remove sessions that are not relevant to their patient population. For example, Matrix IOP is abstinence-based; programs that are based in harm reduction approaches can opt to remove sessions on abstinence only. These decisions can be made in collaboration with participants.

Social Support

Participation in the 16 weeks of the HERS IOP is an intense time during which participants build relationships with facilitators and each other. Transitioning from four weekly sessions to none can be challenging, potentially hindering continued recovery. To address this, establishing a social support group that meets once or twice a week is recommended. This is a facilitated group that follows the Matrix model curriculum, offering both structure and flexibility by providing topics and open-ended questions for discussion.

Designed as a resource for those who have participated in or graduated from the IOP, this serves as a step-down option for people who have completed the intensive portion of the program but can benefit from ongoing support. The Matrix Counselor's manual includes a section with various topics such as mental health, guilt, and shame, each accompanied by five questions for discussion. For example, participants can explore how their work-life affects their recovery and how to balance work with recovery.

The support group is part of the Matrix Curriculum; it is structured yet free-form to encourage conversations. With 36 topics covered over 4-5 months, the group sessions can catalyze discussions on various issues relevant to participants' recovery. Even those who participated but not attend frequently enough to officially graduate from IOP can still join the social support group, maintaining contact with peers and the content.

Some graduates have repeated the IOP, either due to relapse or need for significant ongoing support to prevent relapse. The decision to re-engage in IOP depends on the organization's capacity and the patient's needs, which might include detox and reassessment.

Ongoing Substance Use Counseling

During the three early pre-IOP counseling visits, the participant and substance use counselor discuss how the participant can start and sustain their recovery, and resources needed (e.g., an Alcoholics Anonymous sponsor). Counselors provide an opportunity for open discussion of the participant's needs and goals for the program and their lives. Through shared decision-making, the participant and counselor agree upon frequency of future substance use counseling meetings concurrent with participation in IOP. Counseling sessions should occur at a minimum once per month.

During the intake process, the substance use counselor can assess whether the participant would benefit from individual therapy that addresses mental health, trauma, and substance use concerns and on more general coping tools and skills that will support recovery. Organizations that have therapists on staff can provide this service in-house. If not, they should refer participants to other services in the community.

Peer Leader

Peer leaders can play an important role in the IOP's Early Recovery Skills sessions, enhancing the recovery experience by fostering a sense of community and shared understanding. These individuals are selected based on their engagement with the material, willingness to review it, and openness to sharing personal experiences with their peers. The role may rotate if there is a high level of interest.

Peer leaders should come from the IOP population group to ensure relatability and trust within the group. They receive the same incentives as other participants and should meet with one of the staff facilitators to orient them to the role. It also helps prepare them so that they are not triggered by the conversations being had in group.

While it remains the staff facilitator's responsibility to introduce each session's topic of conversation, the peer facilitator can provide valuable support by sharing first-person experiences, which helps normalize recovery challenges, reduce stigma, and build a safe space. They might say, for example, "This is how I overcame that" or "I'm still struggling with that". This involvement reinforces their own recovery, builds skills, and maintains accountability to their peers.

Being a peer facilitator can significantly reinforce an individual's recovery journey and build essential skills through sharing experiences. It helps to create a trusting environment, as participants often feel more comfortable with someone who has been through similar experiences. Peer facilitators must be prepared to face challenging situations without being triggered themselves, which is why careful vetting and preparation are essential.

Prospective peer facilitators must be informed about the commitment required, including attending the all Early Recovery Skills sessions. Clear communication about the role and its responsibilities is essential. Some individuals use this experience as a steppingstone for further training and education, highlighting the role's potential for personal and professional growth.

Incorporating peer facilitators into any recovery program is highly recommended due to their ability to foster trust and relatability among participants. Proper selection, preparation, and clear communication about the role ensure that peer facilitators can effectively support their peers while reinforcing their own recovery journey.

Implementation Hints and Other Considerations

Building Your Team

If HERS IOP is being implemented by more than one facilitator, it is important to build good working relationships among the members of the team. The coordinator / team leader needs to trust their team and know that facilitator styles may be very different.

The team of facilitators should meet regularly (usually weekly) to check in and discuss any updates or concerns. For example, if a participant shows up to group under the influence and the facilitator had to address this, the rest of the team needs to know how it was addressed in order to create consistency for the participants. This is a form of support for the facilitators so that the next facilitator knows what the situation is before going into the next group session. Between meetings, facilitators can check-in via email or text to keep current.

Facilitators themselves should be able to embrace the population and not be critical. They need to be aware of countertransference around people who use substances. Examples include a facilitator who consciously or unconsciously is frustrated by participants who relapse. Or a facilitator who is critical of a participant's recovery process because they are involved in the criminal justice system or were mandated to attend IOP by Child Protective Services. Facilitators would benefit from weekly consultation to address any countertransference that may be impacting the care they provide.

The team will also have to work out who will document attendance in the electronic health record (EHR) for each participant, and how frequently this will be done.

Tailoring the Program

We encourage organizations to tailor the program to the needs of their patient populations. When making modifications or adaptations, we recommend the following:

Know your population

A clinic may want to conduct a needs assessment or more informal conversations with potential HERS IOP participants to gain insight into their specific needs and interests. Clinicians, social workers, and medical providers may also have important insight in how to create a program that is engaging and responsive to needs.

The clinic may want to conduct rounds of HERS IOP that are specific to particular populations. This can improve the group dynamic and ultimately achieve greater success than more heterogenous groups. For example, women who are mothers of young children may have very different needs and interests than older men with heart disease. While there may be economies of scale and other benefits to conducting integrated groups, program planners should consider whether substantial differences between participants will hinder group cohesion and deter recovery.

Attend to group dynamics

During sessions, pay attention to the conversation, what is said, how people respond, and when there is no response. This provides group facilitators with insight into whether content is engaging participants or not. It is also important to pay attention to individuals who may be dominating the conversation and others who do not participate at all, and whether there is conflict among participants. It is recommended that at the start of each IOP session, that group agreements are created with input and buy in from participants and facilitators. This serves as the guide of appropriate and respectful behavior for all attending the group. It also gives participants a sense of knowing and trust that facilitators will address these issues when they come up in the group.

Keep open lines of communication

Group facilitators can check-in with participants at the end of sessions to get open and honest feedback about content, delivery, and group dynamics. Facilitators might also give participants the option of texting, emailing, calling, or otherwise checking in after sessions to get feedback in a more private way. The responses that facilitators get will depend to some extent on the level of trust between them. This is one reason why establishing trust and rapport is so important. This informal feedback can inform program modifications.

Fill in the gaps, but focus on recovery

Although we have identified Seeking Safety and Trust as programs that may supplement the Matrix IOP content, program planners should feel free to draw upon other treatments, therapies, or modalities that may be appropriate. It is important, however, not to lose focus on recovery as the goal of the program. Do not integrate elements that take away from this discussion. Planners may want to utilize the SAMHSA Evidence-Based Practices Resource Center to identify useful programs for their focus population.

Weigh costs and benefits

Some modifications may be inherently more resource-intensive than others. For example, hiring additional staff to deliver content costs more than identifying educational videos on YouTube. On the other hand, hiring additional staff may allow for more individual substance use counseling sessions or being able to provide individual therapy, which may lead to greater success. Each clinic will have to assess their resources and needs to make these decisions.

Deciding on Virtual vs. In-person

When deciding between virtual, in-person, or hybrid models, it is crucial to understand the needs of the population served. HERS IOP organizers should ask participants directly about their preferences for in-person, hybrid, or virtual sessions, and why they prefer that. Understanding the reasons behind their choices, can guide the development of a program that best suits their needs.

There are pros and cons of each option. Virtual sessions eliminate the need for transportation, which is a significant convenience. This preference is particularly strong among mothers with small children, as it reduces the stress of bringing kids along or finding childcare. In contrast, in-person sessions help patients who tend to isolate by getting them out of the house, fostering connections with others, giving them a purpose outside their home, and improving mobility. In-person sessions also provide an opportunity to coordinate appointments with their healthcare providers. Providing hybrid options may address all of these issues but can be challenging if some patients are in-person and others are on video. It may be useful to have an occasion designated in-person sessions, while the others are provided virtually.

Ensuring Technological Access

If IOP is being conducted virtually, organizers need to ensure that each participant is able to connect, both in terms of having the right technology as well as understanding of how to use it.

Technology requirements include: the Zoom or other videoconferencing software, audio and video capabilities, and internet access. Most participants use their own phones or tablets, but some may not have devices. If the clinic has the funds, it could consider loaning out tablets as needed, but will need to have an administrative structure around this. It could also give out earphones/ earbuds, which can be very useful if participants are joining from locations that are not completely quiet.

When a participant comes in-person to pick up their curriculum materials or during home visits, program organizers should take the opportunity to help the participant get set up on Zoom or to make sure they know how to do it.

Distributing Materials

Participants receive two separate booklets: one for Early Recovery Skills and one for Relapse Prevention. These booklets can be picked up during visits with facilitators / substance use counselors, and it is important that participants receive before IOP starts to ensure they are prepared for the sessions.

Establishing Group Guidelines

During the first IOP group session, facilitators and participants should work together to establish group guidelines around behavioral norms (See sample in Appendix 8). While group guidelines are always useful,

this is particularly true among people who have experienced trauma and who are/were using substances. Some of the guidelines may be standard (e.g., giving everyone an opportunity to speak, maintaining confidentiality), while others may be specific to the particular group (e.g., not being under the influence of drugs or alcohol during group).

Managing Interpersonal Aspects

One of the most important roles of the facilitator is managing interpersonal relationships between participants. For example, if someone comes into group with challenging behavior around their own recovery (being critical of others, being passive-aggressive with others), the facilitator should address the behavior while not putting the person on the spot. IOP is much like therapy since participants speak about such personal matters, but many participants have loose boundaries. The facilitator / therapist serves as the container, working to contain the group, maintain boundaries, and model healthy behaviors and working relationship.

It is also crucial for facilitators to balance personal sharing to avoid shifting the focus from the participants to themselves. At the same time, facilitators should not pretend to relate to experiences they have not had, and instead can say “I can’t relate to this” so that they are not pretending to understand. If someone asks the facilitator a direct question, they should answer in the most fitting way, balancing how much they share about themselves.

Tracking Attendance and Graduation

Facilitators should work closely with the program coordinator to track participant attendance, and progress in the program. Clinics should establish a threshold of sessions that a participant needs to attend in order to “graduate” from the program (we have used 70%). Although people who do not graduate are not excluded from the follow-up social support sessions or from enrolling in the future, graduation may be relevant for participants who are mandated by courts to attend the program. They may also require some form of certificate or signature on a form.

We recommend that HERS IOP hold some form of graduation celebration at the end of the program. For many individuals, completing the program is a significant accomplishment, and one that should be recognized and celebrated. We also recommend that participants who are not graduating be invited to the celebration to acknowledge their participation and relationship to the program, the facilitators, and other group members. Despite the fact that they have not completed the 70% of sessions, they have also put in a substantial amount of work and it can help promote their recovery by recognizing their journey. A Certificate of Graduation or a Certificate of Participation can be printed for each person. Snacks and be provided, and family can be invited to share in the celebration.

Managing Incentives

To encourage engagement in the group, participants receive a $10 gift card for each group they attend, with the opportunity to earn up to $40 per week and $160 per month if they attend all sessions. While incentives are an important draw, the sense of community, camaraderie, and safety within the group also attract participants.

Incentives are important because the population served typically has very low to no income, and many experience food insecurity. The gift cards help supplement their income, supporting their home and family needs. Participants often spend the gift cards on their families, children, and grandchildren. Gift cards from stores such as Target are preferred because these stores offer a wide variety of goods, whereas grocery stores may be too limited. However, it's worth noting that Target does sell alcohol.

Participants receive the gift cards at the halfway point and at the end of the program. It is important to inform them of the incentive schedule in advance and ensure that correct addresses and phone numbers are on file, as many participants move during IOP due to changes in their treatment plans, such as moving into their own homes or other treatment programs.

Tracking Client Progress and Conducting Case Management

The substance use counselors track the progress of all participants (Appendix 9). Once the person is referred, the substance use counselors can speak with the person to determine their interest in the program, assess whether the program is a good fit, and ensure it meets their level of care needs. If IOP seems to be a good fit, the substance use counselors can schedule the first three sessions.

If an IOP participant is not a patient of the clinic, they may have case management and/or social worker from community agencies, but likely will not be able to access the wrap-around support of the clinic itself. If this is the case, it is important to coordinate with these professionals, but also to set clear boundaries around what the clinic can and cannot provide.

Appendices

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Appendix 2	Job Descriptions
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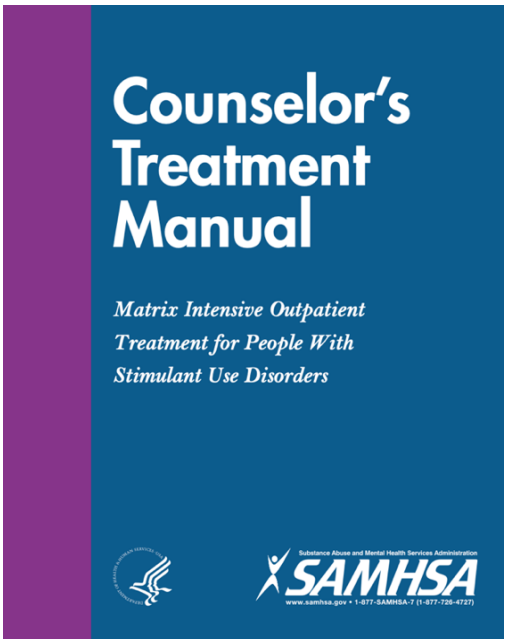
Appendix 1: Matrix IOP Materials



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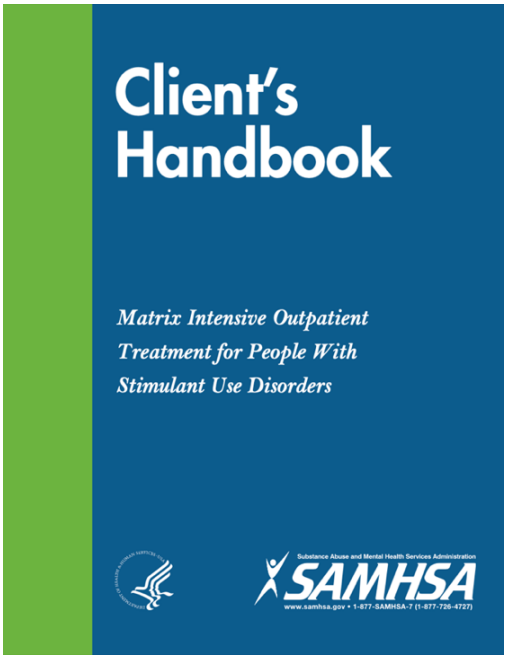

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Appendix 2: Job Descriptions

Therapist

The therapist will have at least an LCSW degree and 5 years of experience working with Black women. The therapist will be responsible for providing clinically and culturally responsive, trauma-informed outpatient mental health and substance use disorder (SUD) services to clinic patients, including: crisis intervention, evaluation and diagnosis, psychosocial assessments, individual psychotherapy, group psychotherapy, SUD Treatment specifically stimulant use disorder, and appropriate internal/external referrals. The therapist will maintain a high level of professional competence and maintain ethical standards as they work collaboratively as part of an integrated healthcare team. The therapist will be required to maintain accurate and timely records of services provided.

Education and Knowledge, Skills and Abilities

Graduation from an accredited school within applicants' professional discipline; Registered with CA Board of Behavioral Sciences; Possession of a valid CA license as an LCSW or LMFT; Familiarity and comfort working with issues related to interpersonal violence, history of trauma, substance use, and mental health diagnosis; Experience providing trauma-informed treatment/care: Understands and practices cultural humility and able to work with a diverse population, specifically women of color; Desire to work in a non-judgmental, culturally responsive, and trauma-informed environment with a diverse patient population; Must be able to work collaboratively with social workers, case managers, and medical team to coordinate patient care. Experience in the following areas: psychosocial assessment; individual, group, and family therapy; 12-step program; cognitive behavior therapy (CBT); motivational interviewing (MI); stimulant use disorder treatment; medication assisted treatment (MAT).

Substance Use Counselor (SUC)

The Substance Use Counselor At least 10 years of experience providing substance use counseling services, and some experience working with women living with HIV. The substance use counselor will provide direct, trauma-informed substance use treatment services that are closely coordinated and integrated with the WHP clinics existing medical, mental health, and supportive programs. Specific responsibilities include:

- Achieves certification in all evidence-based treatment practices to be used by the HERS project, including Motivational Interviewing, Seeking Safety, STAIR, and Matrix IOP
- In collaboration with the PD and PC, maintains master calendar of outpatient treatment interventions throughout the project period

- Recruits, consents, and enrolls clients into the HERS program, and collects NOMS/GPRA data at baseline, discharge, and on an ongoing basis
- Directly facilitates outpatient substance use treatment groups following pre-determined schedules while ensuring fidelity to evidence-based practices
- Tracks client participation and involvement in the programs and links clients to navigation, peer, and mental health services as needed to promote program retention
- Co-facilitates clinic-based drop-in groups and provides informal one-on-one treatment counseling and support to WHP clients
- Provides culturally congruent Complex Care Management and substance use counseling to monolingual Spanish-speaking clients.
- Participates in staff meetings and gives continual input into program design based on experiences providing treatment
- Maintains client confidentiality in all circumstances as required by professional ethics and legal requirements
- Ensures that all attendance and case documentations are completed as required
- Assesses clients for readiness for Medication Assisted Treatment, collaborates with the PMHNP on MAT induction, and provides ongoing support to clients during the process.

Education and Knowledge, Skills and Abilities

Ideal candidate will be a Registered Addiction Specialist, Medication Assisted Treatment Counselor, Co-occurring Disorders Specialist, and have a master's degree in Counseling. The SUC will also be a Substance Use Disorder Certified Counselor 2, approved to bill through the MediCal system, and will have excellent interpersonal and communication skills.

Appendix 3: Sample HERS IOP Flyer

HEALTH EMPOWERMENT RECOVERY SERVICES

Intensive Outpatient Program

UCSF WOMEN'S SPECIALTY PROGRAM

WHAT IS IT?
A structured 12-week outpatient program to address drug and alcohol use to support your **personal** recovery goals (harm reduction or abstinence-based)

Weeks 1-12: 4 groups per week
Every Monday, Tuesday, Thursday and Friday from 11:00am - 12:00pm

Aftercare: Weekly support group

WHO IS IT FOR?
Cis/Trans Women and Non-Binary people in recovery or seeking recovery from substance use

WHERE?
Zoom video conferencing

IS THERE AN INCENTIVE?
$10 gift card for each group attended
*Additional gift cards for completed assessments

FOR MORE INFORMATION CONTACT:

JENNIFER SAMPLE
JENNIFER.SAMPLE@UCSF.EDU
415-353-XXXX

SAMHSA

UCLA | UCSF
ACEs Aware Family Resilience Network

Appendix 4: Entry Process into HERS IOP

1. Referrals go to/through the substance use counselors (SUCs). If anyone receives a telephone referral, they will email the SUCs with the person's name, contact info, date of call and will specifically ask **one** of them to respond to prevent duplication of calls.
2. One of the SUCs will reach out to the person and put them on the waitlist if the current IOP group is full and will let the person and their referring agent know the likely length of the wait. Each participant will be offered individual substance use counseling support on a weekly or biweekly basis while they wait for the next round of IOP to begin. This is optional. For participants who want to engage in individual counseling, the assessment is completed right away,
3. For those who are not engaging in individual substance use counseling before the start of IOP, the SUC will meet with the person to do the enrollment and intake assessment session plus two individual sessions close to the time that the person will enter the group. Ideally, the assessment plus the two sessions will take place over a 2-week period of time to give time to assess for readiness and also get people in while they are motivated.
4. The SUCs will gather the needed information for the clinic Patient Care Coordinator to open them as a specialty care patient if they are not already a primary-care patient at our clinic. The patient's chart needs to be set up in the Electronic Medical Record (EMR) before they start in the IOP groups. Information needed:
    - Name
    - DOB
    - Social Security Number
    - Address (unless homeless)
    - Telephone number, and email if available
    - IOP individual substance use counselor
5. **Pre-Session 1:** Enrollment and Intake Assessment will include:
    - Face sheet with patient's contact information, referral sources, and emergency contacts
    - Consent form for behavioral health services
    - Releases of information for referring provider and other agencies
    - Assessment
    - Review the format of IOP
    - Make sure the participant knows that they will have occasional individual sessions/check-ins to discuss their progress and goals in the program.
    - Schedule follow-up meeting
    - Provide $25 gift card

- Scan all documents and save in the patient's file in the EMR or other secure location including ROIs and consents.

6. **Pre-Session 2** will cover:
   - More in-depth substance use assessment—client history of substance use, triggers, and access to support system; history of treatment programs (residential and outpatient); recovery/sobriety tools; and resources and supports.
   - Establish patient's short-term and long-term goals (e.g., harm-reduction, abstinence, fulfilling requirement to get kids back, etc.).
   - Schedule follow-up meeting.
   - It is helpful to do session 2 or 3 in-person to establish connection and give IOP materials.

7. **Pre-Session 3** will cover:
   - Go over short-term goals that were created in previous session.
   - Go over guidelines again and structure of IOP groups and individual sessions to make sure patient understands what they are getting into.
   - Review IOP group guidelines and having patient sign guidelines (including how many groups patients can miss in a row).
   - Set up follow-up individual meeting to check on experience of IOP

8. SUC will talk to referring agent about patient regarding recommendation for IOP. If patient is not ready, a recommendation is made to the referring agent about other options (e.g., residential treatment, individual substance use sessions, etc.). If patient is ready, SUC will discuss patient with HERS IOP team. If team agrees, a summary report or link to the assessment is sent and a start date is established in consultation with the team.

A progress note for each encounter for all patients who are receiving IOP and substance use counseling services should be documented in the EMR.

Appendix 5: HERS IOP Structure

Referrals go to/through the substance use counselors (SUCs). If anyone receives a telephone referral, they will email the SUCs with the person's name, contact info, date of call and will specifically ask **one** of them to respond to prevent duplication of calls.

Intensive Treatment — Weeks 1-16

Weeks 1-16:

- Early Recovery Skills Group (2x/week)
  - TRUST
  - Matrix Early Recovery Skills
  - Seeking Safety
- Relapse Prevention (2x/week)
  - TRUST
  - Matrix Relapse Prevention Skills
- Total = 4 groups per week
- Participants are encouraged to attend 12-step/mutual self-help groups at least 2x per week
- Individual substance use counseling/treatment check-in with substance use counselor at least 1x/month

Social Support/Aftercare — Weeks 17-33

Weeks 17-33

- Social Support Group (1x/week)
- Total = 1 group per week
- Participants are encouraged to attend 12-step/mutual self-help groups as well as seek out job training, volunteer, or employment opportunities
- Individual substance use counseling/treatment check-in with Esther or Ericka at least 2x during social support phase of treatment

Appendix 6: HERS IOP Participant Assessment Packet

Date: _____

Name: _____

Age: _____

Thank you for participating in the HERS IOP! I am going to complete this assessment with you as part of the program. The assessment starts with some general questions about how you identify. We ask these questions because we want to make sure that we are providing the most culturally relevant and responsive care possible and don't want to make assumptions about participants' race, culture, gender identity, etc. You do not have to answer question that you are not comfortable answering. You will receive a gift card for your participation in this assessment.

Which gender identity do you identify with?

- ☐ Woman
- ☐ Genderqueer or non-binary
- ☐ Gender identity not listed → please describe: _____

Do you think of yourself as... [YOU MAY INDICATE MORE THAN ONE]

- ☐ Straight Or Heterosexual
- ☐ Homosexual (Gay Or Lesbian)
- ☐ Bisexual
- ☐ Queer, Pansexual, Asexual, and/or Questioning
- ☐ Other (SPECIFY) _____

Are you of Hispanic, Latino/a, or Spanish origin?

- ☐ Yes
- ☐ No

What race do you consider yourself? [Check all that apply]

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander Alaska Native
- ☐ White
- ☐ American Indian
- ☐ Other, please specify: _____

What are your sources of income? (check all that apply)

- ☐ Formal work for pay → How many hours per week do you work, on average? _____
- ☐ Informal work for pay → How many hours per week do you work, on average? _____
- ☐ SSI / SSDI
- ☐ CalFresh/SNAP, TANF (Temporary Assistance for Needy Families)
- ☐ Help from family or friends, or other person in your household
- ☐ Spousal support or child support
- ☐ Other → please describe: _____

Are you currently in an intimate relationship with someone (spouse, partner, boyfriend/girlfriend)?

- ☐ No
- ☐ Yes

Do you have children living in your home?

- ☐ No
- ☐ Yes → If yes, how many are under the age of 18? _____

In the past 30 days, have you been a caregiver for another adult. Meaning, have you helped care for ill or disabled adult family members, neighbors, or friends?

- ☐ No
- ☐ Yes

Do you have a physical or mental impairment that substantially limits one or more major life activities? Meaning, do you have an impairment with walking or standing, hearing or seeing, taking care of yourself, participating in work or social activities.

- ☐ No
- ☐ Yes

What brought you to this program? (check all that apply)

- ☐ Wanted to get/stay sober
- ☐ Required / Court-mandated →
  - For CPS
  - For drug court or diversion
- ☐ Staying sober after leaving an in-patient program
- ☐ Monetary incentive
- ☐ Other → _____
  _____
  _____

Notes / Comments:

Domain	Questionnaire	Score/Total	Notes
Experiences	Adverse Childhood Experiences (ACEs) Benevolent Childhood Experiences (BCEs) Social Determinants of Health (SDOH) ☐ Food ☐ Finances ☐ Housing/Utilities ☐ Transportation ☐ Interpersonal Safety ☐ Immediate Need	____/10 ____/10 ____/2 ____/1 ____/3 ____/1 ____/3 ____/2	
Distress	Anxiety (GAD-2) Depression (PHQ-2) PTSD (PC-PTSD) Substance Use (CAGE-AID) NIDA: Alcohol Tobacco Illegal/Non-prescription drugs Cannabis	____/6 ____/6 ____/5 ____/4 At risk? Y / N Y / N Y / N Y / N	
Coping	Brief COPE		

ACEs:	0: Low risk for toxic stress 1-3: Intermediate risk for toxic stress (problematic if high level of distress) >4: High risk for toxic stress
BCEs:	No clinical score cutoff. More benevolent childhood experiences help mitigate negative impact of ACEs.
SDOH:	No score cutoff; should be used as a checklist of needs.
GAD-2:	Score ≥ 3 further diagnostic evaluation for generalized anxiety disorder may be warranted.
PHQ-2:	Score ≥ 3 further diagnostic evaluation for depression may be warranted.
PC-PTSD:	Score ≥ 3 further diagnostic evaluation for PTSD may be warranted.
CAGE-AID:	Score ≥ 1 further diagnostic evaluation for substance use disorder may be warranted.
NIDA:	“No” for all drugs → reinforce abstinence. “Yes” to one or more days of heavy drinking → patient is an at-risk drinker. “Yes” to use of tobacco → any current tobacco use places a patient at risk. “Yes” to use of illegal drugs or prescription drugs for non-medical reasons → further discussion/assessment.
Cannabis:	Anything other than “Never” to failing to do what was normally expected from you → patient is at-risk.
Coping:	Discussion with patient about types of coping.

The next section of this assessment is focused on understanding the impact of past experiences on your current health and wellbeing. I will ask you about your experiences, behavioral health symptoms, and your coping and strengths.

It is very common for childhood traumas and challenges to impact our health and be associated with specific health concerns like substance use conditions. My hope is that completing this assessment with you will help you have a better understanding of your health and help you see your strength and resilience in the face of the challenges you've faced.

When we are done with the assessment, I will provide you with some information about the connection between trauma and substance use. I hope that the information will help you have some compassion for yourself and motivate you to keep up the great work you're doing in IOP.

Again, you do not have to answer any questions you do not want to answer.

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please add up the number of categories of ACEs you experienced prior to your 18th birthday and put the total number at the bottom. (You do not need to indicate which categories apply to you, only the total number of categories that apply.)	
1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
2. Did you lose a parent through divorce, abandonment, death, or other reason?	
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
6. Did you live with anyone who went to jail or prison?	
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
9. Did you feel that no one in your family loved you or thought you were special?	
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
Your ACE score is the total number of yes responses.	

Do you believe that these experiences have affected your health? ○ **Not Much** ○ **Some** ○ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

Benevolent Childhood Experiences

When you were growing up, during your first 18 years of life:

	No	Yes
1. Did you have at least one caregiver who you felt safe with?	0	1
2. Did you have at least one good friend?	0	1
3. Did you have beliefs that gave you comfort?	0	1
4. Did you like school?	0	1
5. Did you have at least one teacher who cared about you?	0	1
6. Did you have good neighbors?	0	1
7. Was there an adult (non-parent) who could provide you with support or advice?	0	1
8. Did you have opportunities to have a good time?	0	1
9. Did you like yourself or feel comfortable with yourself?	0	1
10. Did you have a predictable home routine, like regular meals and a regular bedtime?	0	1

11. When you were growing up, during your first 18 years of life, who were your primary caregivers/ parental figures? (Check all that apply)

- ❑ Biological mother
- ❑ Biological father
- ❑ Grandmother
- ❑ Grandfather
- ❑ Aunt
- ❑ Uncle
- ❑ Stepmother
- ❑ Stepfather
- ❑ Foster mother
- ❑ Foster father
- ❑ Adoptive mother
- ❑ Adoptive father
- ❑ Sister
- ❑ Brother
- ❑ Other (Specify): _____

Social Determinants of Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	No	Yes
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	0	1
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	0	1
Finances		
3. During the past 6 months, did you / your household have difficulty paying bills because you did not have enough money?	0	1
Housing/ Utilities		
4. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?	0	1
5. Are you worried about losing your housing?	0	1
6. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?	0	1
Transportation		
7. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?	0	1
Interpersonal Safety		
8. Do you feel physically or emotionally unsafe where you currently live?	0	1
9. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?	0	1
10. Within the past 12 months, have you been humiliated or emotionally abused by anyone?	0	1
Optional: Immediate Need		
11. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.	0	1
12. Would you like help with any of the needs that you have identified?	0	1

Distress Screens

Stress and trauma affect our physical and emotional health. We are asking all of our patients about some of the common responses to stress so we can better support you and your health.

GAD-2

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	not at all	several days	more than half the days	nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

Total: _____

PHQ-2

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	not at all	several days	more than half the days	nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Total: _____

PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the **past month**, you:	**No**	**Yes**
1. Have had nightmares about it or thought about it when you did not want to?	0	1
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	0	1
3. Were constantly on guard, watchful, or easily startled?	0	1
4. Felt numb or detached from others, activities, or your surroundings?	0	1
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	0	1

Total: _____

CAGE-AID

In the **last year**….	**No**	**Yes**
1. Have you felt you should cut down or stop drinking or using drugs?	0	1
2. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	0	1
3. Have you felt guilty or bad about how much you drink or use drugs?	0	1
4. Have you been waking up wanting to have an alcoholic drink or use drugs?	0	1

Total: _____

NIDA Quick Screen

Over the **past year**, how often have you used the following?	never	once or twice	monthly	weekly	daily/ almost daily
Alcohol, 4 or more drinks a day					
Tobacco Products					
Cannabis Products, non-prescribed					
Prescription Drugs for non-medical reasons					
Illegal Drugs (i.e. cocaine/crack, heroin, methamphetamine)					

If ever used cannabis in the past year, ask:

How often during the past 6 months did you fail to do what was normally expected from you because of your use of cannabis?

___ Never
___ Once or Twice
___ Monthly
___ Weekly
___ Daily or Almost Daily

Brief COPE (revised)

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. These questions ask you about what you generally do and feel when you experience stressful events.

1 = I don't do this at all
2 = I do this a little bit
3 = I do this a medium amount
4 = I do this a lot

Thinking of stressful situations, how often do you do the following things to cope with them?

	I don't do this at all	I do this a little bit	I do this a medium amount	I do this a lot
1. I turn to work or other activities to take my mind off things.	1	2	3	4
3. I say to myself "this isn't real" or "this isn't happening".	1	2	3	4
4. I use addictive behaviors (for example, substance use, sex, food) to make myself feel better.	1	2	3	4
5. I get emotional support from others.	1	2	3	4
6. I give up trying to deal with things.	1	2	3	4
7. I take action to try to make stressful situations better.	1	2	3	4
10. I get support and/or advice from other people.	1	2	3	4
12. I try to see things in a different light, to make them seem more positive.	1	2	3	4
13. I criticize and blame myself for things that happen.	1	2	3	4
18. I make jokes about things.	1	2	3	4
20. I accept what has happened.	1	2	3	4
21. I express my negative feelings.	1	2	3	4
22. I try to find comfort in my religion or spiritual beliefs.	1	2	3	4
25. I think about what steps to take to make things better.	1	2	3	4

OPTIONAL:

What coping strategies are most helpful to you?

1. _____

2. _____

3. _____

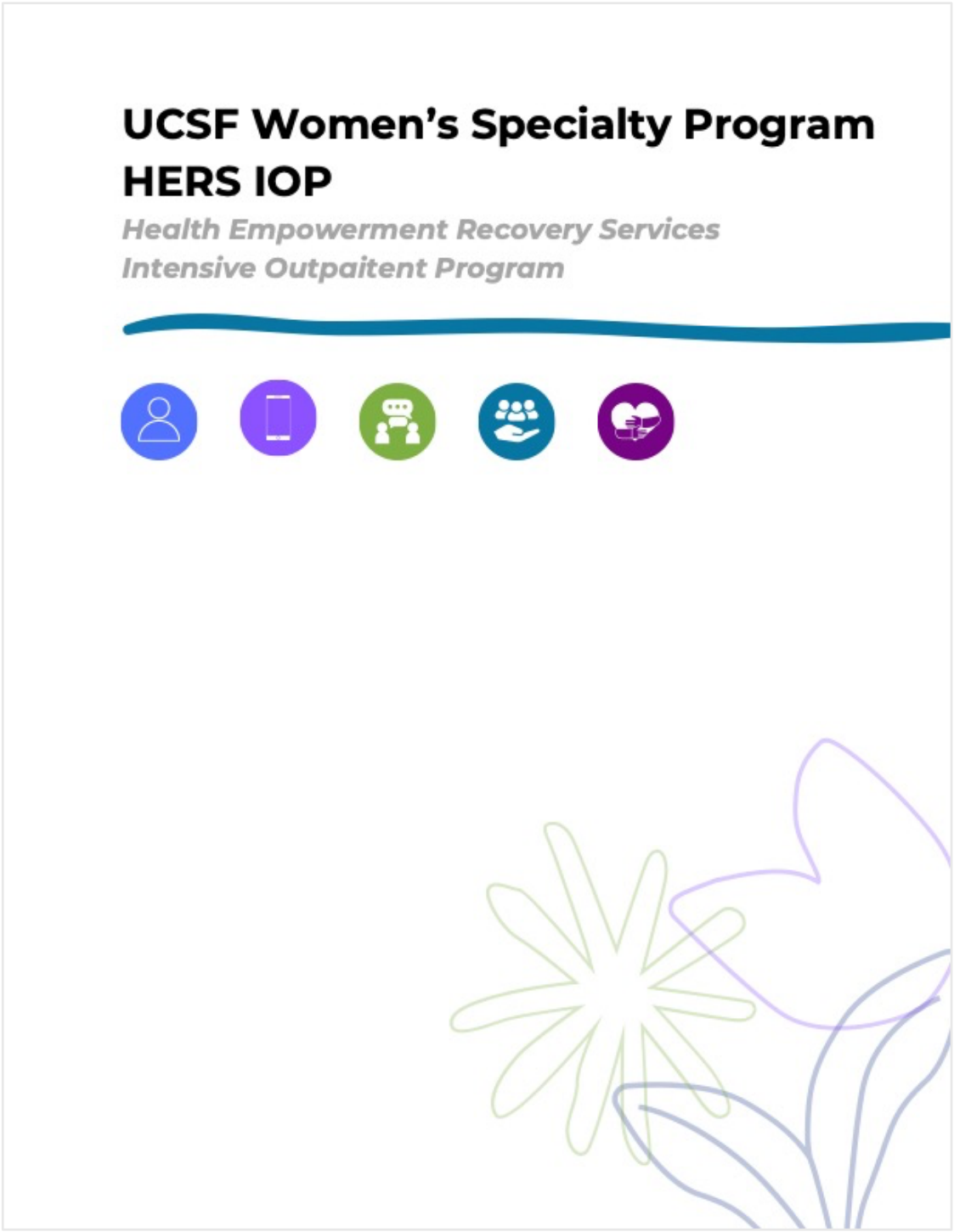
Are there any coping strategies you'd like to start using?

1. _____

2. _____

3. _____

Appendix 7: Educational Materials




What are ACEs?
Adverse childhood experiences (ACEs)include childhood emotional, physical, or sexual abuse and household dysfunction during childhood. These experiences can impact long-term health.
People with 4 or more ACEs are:
12x more at risk for suicide
7x more likely to develop alcoholism
4x more likely to develop depression
2-4x higher risk of using alcohol or other drugs
2-4x more likely to begin substance use at a young age
2x higher rate of heart disease or lung cancer
People with 5 or more ACEs are:
7-10x more likely to use illicit substances
7-10x greater risk of illicit substance use addiction
7-10x more likely to inject illicit substances
3x higher risk for misuse of prescription pain medications

Addictions and Trauma

Addictive behaviors arise not as a pleasure-seeking strategy but as a survival strategy:

- To self-soothe and regulate emotions
- To numb intense emotions, negative/obsessive thoughts, over-reactivity
- To increase alertness and ability to stay awake to reduce feelings of helplessness and to feel more in control
- To increase energy and intensity to feel less depressed, empty, numb
- To wall off bad memories
- To be able to function and feel safe in the world

How Substances "Medicate" PTSD

For hyperarousal symptoms (like anxiety, obsessive or intrusive thoughts, inability to sit still, difficulty sleeping, feeling on edge, feeling angry/defensive):

- Alcohol and marijuana induce relaxation and numbing and help with social engagement and allow for falling asleep
- Cocaine, speed, and crystal meth creates and amped up powerful, alert, awake state that can make people feel like they are in control and can protect themselves
- Heroin calms rage and impulsivity
- Ecstasy combines relaxation with increased energy

For hypoarousal symptoms (like feeling depressed, numb, disconnected, low motivation, avoidant):

- Speed, cocaine, ecstasy, and crystal meth counteract feelings of deadness, numbing, hopelessness, and helplessness
- Marijuana and other downers maintain numbness, low motivation, disconnection
- Alcohol at different doses can induce numbing or counteract it
- Although alcohol is a depressant, it can be stimulating in small doses
- Treatment must address the relationship between trauma and addictive behaviors

Appendix 8: HERS IOP Group Guidelines

1. Confidentiality first. What is said in group, stays in the group please.
2. To receive $10 gift card for each group session, please log on no later than 10 minutes into the group and stay on until the end of the call.
3. Text or call staff if you are unable to make it to group.
4. Make the most out of Zoom and make the group as private as possible.
    - Make sure that you are in a location where other people will not see your screen or they do not appear on screen. We want everyone to feel comfortable sharing in group.
    - If you don't have a private room, try using headphones and turning your screen away from others. (Let us know if we can help with equipment (e.g., earbuds) to make your space more private).
    - Don't call in to the group while you're on the go (e.g., on public transportation). Try to be in one place so you can be present and keep the group private.
    - Keep your camera on as much as possible to create a sense of safety and connection in the group.
5. Share your feelings and experiences, but not advice. Please use "I" statements.
6. Please only share the headlines and not explicit details of traumatic stories, as it can be triggering for other individuals in group.
7. Accept each other without making judgments.
8. Listen to each other and give everyone an opportunity to share. If you notice you have shared a lot already, step back and make space for others to participate.
9. Avoid interrupting or having side conversations.
10. Staff are mandated reporters and will report self-harm or harm to others if shared in group.
11. Please come to group even if you have not abstained from using. You are still welcome. We do ask that you do not come to group under the influence of alcohol or any substances.
12. Smoking and drinking alcoholic beverages while on Zoom is not permitted, as it could be triggering for others.
13. Group members do not form confidential or sexual relationships with one another.
14. Be respectful, supportive and encouraging to others. We want Group to be a safe place to share your feelings!

If you are unable to follow these guidelines we will remove you from group unpaid for one day and if the behavior continues we will remove you from the program.

Appendix 9: HERS IOP Sample Attendance Tracking Sheet

EARLY RECOVERY SKILLS GROUP													
Sessions to Date ------->		10	x	x	x	x	x	x	x	x	x	x	x
Initials	**# Attended**	**% Attended**	MON Nov 11	FRI Nov 15	MON Nov 18	FRI Nov 22	MON Nov25	MON Dec 2	FRI Dec 6	MON Dec 9	FRI Dec 13	MON Dec 16	….
AB	8	80%	x	x			x	x	x	x	x	x	
CD	2	20%	x	x									
EF	9	90%	x	x	x		x	x	x	x	x	x	
GH	5	50%	x					x	x	x	x		
IJ	6	60%	x		x			x	x	x		x	
KL	2	20%	x		x								
MN	1	10%	x										
OP	2	20%	x				x						
QR	7	70%	x	x			x		x	x	x	x	
ST	9	90%	x	x	x		x	x	x	x	x	x	

RELAPSE PREVENTION SKILLS GROUP													
Sessions to Date ------->		8	x	x	x	x	x	x		x		x	x
Initials	**# Attended**	**% Attended**	TUE Nov 12	THU Nov 14	TUE Nov 19	THU Nov 21	TUE Nov 26	TUE Dec 3	THU Dec 5	TUE Dec 10	THU Dec 12	TUE Dec 17	....
AB	8	100%	x	x	x	x	x	x		x		x	
CD	2	25%	x	x									
EF	4	50%		x		x	x					x	
GH	7	88%		x	x	x	x	x		x		x	
IJ	6	75%		x	x	x	x			x		x	
KL	0	0%											
MN	0	0%											
OP	1	13%					x						
QR	7	88%	x	x	x	x	x	x				x	
ST	8	100%	x	x	x	x	x	x		x		x	