About NADA

The Network of Alcohol and other Drug Agencies (NADA) is the peak organisation for the non-government drug and alcohol sector in NSW, and is primarily funded through NSW Health. NADA has approximately 100 members providing drug and alcohol health promotion, early intervention, treatment, and after-care programs. These organisations are diverse in their philosophy and approach to drug and alcohol service delivery and structure.

NADA’s goal is ‘to advance and support non government drug and alcohol organisations in NSW to reduce alcohol and drug related harm to individuals, families and the community’.

The NADA program consists of sector representation and advocacy, workforce development, information and data management, governance and management support and a range of capacity development initiatives. NADA is governed by a Board of Directors primarily elected from the NADA membership and holds accreditation with the Australian Council on HealthCare Standards (ACHS) until 2014.

Further information about NADA and its programs is available on the NADA website at www.nada.org.au.

About LeeJenn Health Consultants

LeeJenn Health Consultants is a specialist health consultancy focused on health service development through research and evaluation, training and workforce development, and translation of research to practice. Directors, A/Prof Nicole Lee and Linda Jenner, have worked in the mental health and drug treatment fields in clinical practice, research, training and management, and have a combination of skills that enables a balance of academic research knowledge, an understanding of the realities of frontline practice and an ability to make complex concepts accessible to a range of audiences.

Email: info@leejenn.com.au
Phone: 1300 988 184
Web: www.leejenn.com.au
Post: PO Box 359 Elwood VIC 3184

Acknowledgements

NADA and LeeJenn acknowledge the strong commitment of the Women’s Alcohol and Other Drug Services Network to improve outcomes for women and women with children, and for the vision that both inspired and guided this important work.

NADA is also very grateful to each and every one of the 51 women from six services across NSW who generously shared their views and experiences of seeking and receiving treatment for their substance use issues.

NADA and LeeJenn would also like to thank the following 28 member services for their considered and important contributions to the consultations:

- A Woman’s Place, Mission Australia
- Canberra Recovery Service, Salvation Army
- Centre for Youth Well Being: Junaa Buwa, Mission Australia
- Detour House
- Dianella Cottage, Blue Mountains Drug and Alcohol Recovery Services Inc.
- Drug and Alcohol Multicultural Education Centre Freeman House, St Vincent de Paul Society
- GROW Community, NSW
- Guthrie House
- Jarrah House, Women’s Alcohol and Drug Advisory Centre
- Kamira
- Karralika Programs, Karralika Programs Inc.
- Kathleen York House, Alcohol and Drug Foundation NSW
- Leichhardt Women’s Community Health Centre Alcohol, Tobacco and Drugs Service
- Lou’s Place, Marmalade Foundation
- The Lyndon Community
- Maryfields Day Recovery Centre, St Vincent de Paul Society
- McAuley Outreach Service, Mercy Community Services
- New Beginnings, We Help Ourselves
- Odyssey House, Odyssey House McGrath Foundation
- The Peppers, Alcohol and Drug Service, Calvary Health Care Riverina
- Phoebe House
- Sydney Medically Supervised Injecting Centre, Uniting Care
- Sydney Women’s Counselling Centre
- Triple Care Farm, Mission Australia
- Upper Hunter Drug and Alcohol Service
- Weigelli Centre, Weigelli Centre Aboriginal Corporation
- Women and Girls Emergency Centre

The authors are also grateful to members of the Expert Advisory Group for their valuable assistance:

- Dr Lucy Burns, National Drug and Alcohol Research Centre (NDARC), University of NSW
- Dr Courtney Breen, National Drug and Alcohol Research Centre (NDARC), University of NSW
- Sunara Fernando, Mental Health and Drug and Alcohol Office, NSW Ministry of Health (MHDAO)
- Jane Fischer, National Centre for Education and Training on Addiction (NCETA), Flinders University
- Alice Hanna, Jarrah House, Women’s Alcohol and Drug Advisory Centre
- Kristi Hawkins, Australian Government Department of Health (DOH)
- Catherine Hewett, Kamira
- Latha Nithyanandam, Kathleen York House, Alcohol and Drug Foundation NSW
- Juanita Sherwood, Faculty of Arts and Social Sciences, University of Technology Sydney
Contents

About this report ......................................................................................................................... 4
Executive summary ..................................................................................................................... 5
  Background ............................................................................................................................... 5
  Method ....................................................................................................................................... 5
Key findings from the literature .................................................................................................. 5
Key findings from consultations with NADA member services ................................................ 6
Key findings from consultations with women clients ............................................................... 7
Snapshot of the drug and alcohol non government service system for women in NSW .......... 7
Policy and practice context for delivering drug and alcohol services to women in NSW .......... 8
Recommendations ....................................................................................................................... 9
Background ............................................................................................................................... 12
  The Women’s Alcohol and Other Drug Services Development Program ................................ 12
  The Needs Analysis .................................................................................................................. 13
  Practice guidelines .................................................................................................................. 13
Information collection methods for the needs analysis .............................................................. 14
  Literature review ...................................................................................................................... 14
  Policy and practice context ...................................................................................................... 14
  Snapshot of the non government drug and alcohol sector in NSW ..................................... 14
  Consultation with NADA member services ........................................................................... 14
  Consultation with women clients ............................................................................................ 15
What the evidence tells us about women’s drug and alcohol treatment .................................... 16
  Barriers and enablers of drug and alcohol treatment seeking, access and retention for women 16
  Risk factors for women ............................................................................................................. 17
  Best practice in women’s drug and alcohol treatment ............................................................... 18
  Considerations for specific groups of women ........................................................................... 18
What the consultations tell us about women’s drug and alcohol treatment ............................... 28
  About the participants ............................................................................................................. 28
  Key issues in women’s drug and alcohol treatment ................................................................. 29
  Service gaps and barriers to providing services to women in NSW who use drugs and alcohol 36
  What were the access barriers to drug and alcohol treatment for women in NSW? ............ 40
  What were the enablers of drug and alcohol treatment-seeking by women in NSW? .......... 41
  What were the recommendations for improving service delivery? ....................................... 42
  What are the skills and abilities necessary for drug and alcohol workers to enable them to work effectively with women? ................................................................. 45
  What topics should be covered by the practice guidelines? .................................................... 45

2 | P a g e
The non government drug and alcohol service system for women in NSW ................................................. 47
Women-only drug and alcohol services ........................................................................................................ 47
NADA member services that provided care to both female and male clients ........................................... 50
The policy and practice context for delivering drug and alcohol services to women in NSW ................. 53
Specialist services for women that use drugs and alcohol during pregnancy ........................................... 53
Drug and alcohol specific guidelines ............................................................................................................. 54
Other guidelines and action plans that influence drug and alcohol service provision to women in NSW ........................................................................................................................................ 55
Future legislation and treatment models that may influence drug and alcohol service provision to women in NSW ........................................................................................................................................ 55
Summary and recommendations .................................................................................................................... 57
References ......................................................................................................................................................... 68

Table of figures

Figure 1. Overview of information collection methods for the needs analysis ........................................... 15
Figure 2. Location of non government drug and alcohol services available to women in NSW by Local Health District ........................................................................................................................................ 47
About this report

The report summarises the national and international literature on what is known to be good and best practice in responding to the needs of women who seek, and receive, treatment from drug and alcohol services. It also highlights the important issues that emerged during the face to face and telephone consultations conducted in October 2013 with the Women’s Alcohol and Other Drug Services Network and other NADA member services, and those raised by NADA members through an online survey.

The perspectives of women engaged with drug and alcohol treatment services in NSW are also reported, including where these overlap with the views of service providers. The report provides a snapshot of the NSW non government drug and alcohol sector for women that were current members of NADA, and the policy and practice context for service delivery in NSW. The report identifies barriers to treatment seeking by women, barriers to treatment access, gaps in services for women, and finally offers recommendations for enhancing the service system.

The recommendations are intended to assist NADA in identifying the areas of greatest need that may be addressed by the one-off service delivery grants that are available to specialist women’s services through the Women’s Alcohol and Other Drug Services Development Program.
Executive summary

Background

In 2012, NADA received funding from the Australian Government Department of Health\(^1\) to improve the capacity of non-government drug and alcohol services to identify and respond to clients with drug and alcohol, mental health and other complex health and social issues. An area of focus was drug and alcohol services for women. NADA subsequently gained additional funding for the Women’s Alcohol and Other Drug Services Development Program, which aims to build the capacity of specialist women’s non-government drug and alcohol services to meet the needs of substance using women and their children in NSW. The program incorporates the following four capacity building strategies:

1. A needs analysis of women seeking drug and alcohol treatment
2. The development of practice guidelines
3. One-off service delivery grants to specialist women’s drug and alcohol services
4. Support to services through partnership, organisational and workforce development activities.

This report describes the findings from an analysis of the needs of women seeking and receiving drug and alcohol treatment and the services that provide such care in NSW, and offers recommendations for consideration by NADA and specialist women’s drug and alcohol treatment services in the context of the Women’s Alcohol and Other Drug Services Development Program.

Method

The needs analysis was informed by the following five data sources:

1. A review of the best practice literature for women’s drug and alcohol treatment
2. A review of the policy and practice context for delivering services to women by the non-government drug and alcohol sector in NSW
3. An analysis of data collected by NADA through an organisational survey of members (n=27)
4. Consultations with specialist women’s services and other relevant NADA members\(^2\) (n=28).

The sub-groups were:

- a. Specialist women’s drug and alcohol treatment services (n=8)
- b. Specialist women’s services that incorporate drug and alcohol treatment (n=5)
- c. Drug and alcohol services that offer services to women as well as men (n=15)
5. Consultations with women clients of NADA member services (n=51)

Key findings from the literature

- Women access treatment at lower rates than men and are under-represented in the drug and alcohol treatment system.

---

\(^1\) Formerly the Australian Government Department of Health and Ageing (DoHA)

\(^2\) 47 members were invited to participate in the consultations and 28 did so, representing 59.5% of eligible members
A range of issues create barriers for women’s access to drug and alcohol services including social stigma, childcare and custody concerns, financial issues and models of care.

Women have a number of specific risk factors including: higher rates of mental health issues; more severe clinical profile and complex presentations; greater risk taking; pregnancy and childcare issues; and greater social and economic disadvantage.

Evidence-based interventions for drug and alcohol treatment in general such as behaviour therapies (e.g. contingency management, community reinforcement approach) cognitive behaviour therapies (e.g. coping skills and relapse prevention), motivational interviewing and 12-step-facilitation (TSF) are suitable for women.

Access to childcare, prenatal care, women-only programs, psychoeducation sessions focused on women-specific topics, mental health and comprehensive services that offer multiple components have been associated with improved outcomes for women.

In addition to treatments that are effective for women in general, specific groups of women have specific needs that should be addressed by drug and alcohol treatment services through individualised assessment and treatment planning.

Key findings from consultations with NADA member services

The key issues in women’s drug and alcohol treatment that were identified by the Women’s Alcohol and Other Drug Services Network and other NADa member services were:

- pharmacotherapy, including lack of places for women on pharmacotherapy and inconsistent collaborative care planning with prescribers and pharmacotherapy case managers
- relationships with children, including lack of treatment places for women with children in their care; increasing numbers of women presenting for treatment with children in out-of-home care (OOHC); inconsistent collaborative care planning with case workers from Family and Community Services (FaCS)
- increasingly complex needs of women:
  - Trauma and its enduring effects on drug and alcohol treatment and women’s quality of life
  - Mental health problems co-existing with substance use issues
  - Cognitive impairment that complicates drug and alcohol treatment
  - Physical health issues particular to women
- housing and other support services, particularly the lack of affordable and appropriate housing available to women
- changing cohorts of women seeking treatment, such as greater numbers of first-time treatment seekers and well-resourced older women.

Identified gaps in the service system included:

- overall lack of treatment places specifically for women and women with children, a gap which is even more evident in regional and rural NSW resulting in waiting lists for the places that are available
- limited access to childcare
- the variable capacity of services to meet the needs of Aboriginal women
- the variable capacity of services to meet the needs of women from culturally and linguistically diverse (CALD) backgrounds.
Key findings from consultations with women clients

Women were generally well engaged with the services they were attending. More than half had self-referred, and many were receiving treatment for the first time. Waiting for a treatment place was by far the most frequently identified barrier to gaining access to drug and alcohol treatment. Other barriers to receiving treatment included:

- cost of treatment
- not fitting criteria for service entry
- lack of services where women resided
- transport issues
- services did not accommodate children
- unsuitable appointment times
- unsatisfactory experience with mixed-gender residential rehabilitation
- short duration of programs
- lack of access to aftercare

Enablers of treatment for women were:

- absence of, or short, waiting lists for entry
- low or free cost of treatment
- location suitable for women clients (e.g. close to home, close to public transport)
- access to childcare
- access to transport
- women’s only service

Snapshot of the drug and alcohol non government service system for women in NSW

Data from 28 NADA member services were available for analysis. Seven were providers of women-only services, all of which were located in metropolitan Local Health Districts, and 21 were mixed-gender services.

Women-only specialist services

Seven women-only services catered primarily to women aged 18 years and over. Six of the seven women-only programs had a residential component. Residential withdrawal was offered by only one specialist women’s service, and no women’s only outpatient withdrawal services were available at the time of writing. This was identified by some respondents as a substantial gap in services for women.

All of the six residential services reported a client waiting list for access. Of the seven services, only two reported that women had no difficulties with accessing their programs and the most common barrier to treatment access for clients was considered to be a lengthy waiting list.

---

3 These data were accurate at the time of reporting in February 2014, however are subject to change following future funding rounds
Respondents to the survey described increasing complexity of client presentations including complex mental health problems and involvement with FaCS.

**Mixed-gender services**

Of the 21 mixed-gender services, sixteen provided services primarily to adult women and men. The remainder catered for young people or young people and their families. Of the nine services located outside metropolitan Local Health Districts, two were in Western NSW, three were in Hunter New England, one was in Murrumbidgee, and three were located in the Illawarra Shoalhaven area. Nine services provided residential rehabilitation, most commonly as a thirteen-week stay. Most services were funded to provide either psychosocial counselling and/or case management. The majority of organisations provided a psychosocial aftercare or continuing care program, and more than half provided services through outreach.

Like the women-only services, 19 of the 21 mixed-gender services (90.5%) reported having a waiting list for treatment. Also consistent with women-only services, most respondents reported increased complexity in client presentations coupled with an increase in demand for services generally.

**Policy and practice context for delivering drug and alcohol services to women in NSW**

**Pregnant women**

At the time of writing, there were a number of specialist services for pregnant women who use drugs and alcohol in NSW, including pregnant women enrolled in an opioid pharmacotherapy program. Specialist services included:

- Drugs in Pregnancy Services (DIPS) located in the Mid North Coast of NSW and Western Sydney
- Chemical Use in Pregnancy Services (CUPS) located at the Langton Centre in the Royal Hospital for Women in Sydney and also in Sutherland
- Drug Use in Pregnancy Service (DUPS) at Westmead and Blacktown
- Substance Use in Pregnancy and Parenting (SUPPS) in Wollongong
- Perinatal and Family Drug Health (PAFDH) located at the Royal Prince Alfred Hospital.

These services provided secondary consultation to health workers in NSW about clients in their care as required.

**Guidelines and action plans**

Care of women, including pregnant women, in NSW was influenced by several key practice guidelines, including:

- National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn (in press), NSW Department of Health
- Neonatal Abstinence Syndrome Guidelines (2013), NSW Ministry of Health

---

4 NSW Health (2009) Substance Use in Pregnancy Services and Linkages Review

Also of relevance to women’s drug and alcohol treatment were the following action plans and guidelines:

- Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants (2009)
- *Keep Them Safe*: A shared approach to child wellbeing, the NSW Government’s a five year (2009-2014) action plan for improving the protection of children
- Child Wellbeing and Child Protection: NSW Interagency Guidelines (2006), produced by FaCS to support collaborative efforts to improve child wellbeing and child protection in NSW
- NSW Mandatory Reporter Guide (2012) that assists workers to navigate the ‘grey areas’ and make confident decisions when considering making a child protection report to FaCS.

**Legislation**

Future legislation and treatment models that may influence drug and alcohol service provision to women in NSW include:

- potential amendments to legislation governing the ‘Parent Responsibility Contract’, which may have implications for how drug and alcohol non government services deliver care to pregnant women under such orders
- Drug and Alcohol Clinical Care and Prevention (DA-CCP) Planning Project, which is the first national population-based model for drug and alcohol service planning that will estimate the need and demand for services and calculate the resources needed to provide such services.

**Recommendations**

1. Increase the number of women-specific drug and alcohol treatment places in NSW.
   - Increase the number of women-only treatment places available in all areas of NSW, including residential and non-residential places.
   - Increase the number of specialist places that offer withdrawal services to women and women with children.
   - Examine models of care for Aboriginal women and establish the number, type and location of treatment places to meet the identified needs of Aboriginal women.
   - Examine models of care for CALD women and establish the number, type and location of treatment places to meet the identified needs of women from CALD backgrounds.

   - Create a voluntary ‘women-capable’ drug and alcohol endorsement system for service development.
   - Establish a yearly or biannual symposium on women’s drug and alcohol treatment.
   - Create a new position for a senior nurse (e.g. Clinical Nurse Consultant for Women’s Drug and Alcohol Treatment) in one of the women-only specialist services with a state-wide capacity building role.
• Build an online presence for women’s drug and alcohol treatment in NSW (e.g., by adding an area to the existing NADA website) that acts as a portal for information sharing.
• The senior nurse and endorsed ‘women-capable’ services to support drug and alcohol non government services in regional/rural NSW by offering secondary consultation and advice regarding women in their care.

3. Improve collaboration between drug and alcohol services and FaCS for women who are subject to care and protection orders.
   • Establish a Child Protection Coordinator position to promote collaboration between the non government drug and alcohol sector and FaCS.
   • Trial a program of staff outreach from a women’s drug and alcohol service into a FaCS office in the Metropolitan Local Health District.
   • Work with FaCS to identify satisfactory arrangements for women on a waiting list for a place in a specialist women’s service and who also have children that are subject to care and protection orders.

4. Improve coordination of care with pharmacotherapy prescribers for women whose care is shared by non government drug and alcohol services and pharmacotherapy programs.
   • Trial a program of outreach by staff from a specialist women’s drug and alcohol service into a pharmacotherapy clinic in a metropolitan Local Health District.
   • Encourage opportunities for joint case conferencing.

5. Put into place a range of strategies to maintain engagement of women on a waiting list for treatment.
   • Support services to establish or strengthen waiting list management strategies such as examining opportunities to link waiting list support to aftercare services.

6. Improve access to information about drug and alcohol and other support services available to women in NSW.
   • Establish an internet based information portal for women and service providers.

7. Improve access to childcare for women receiving drug and alcohol treatment.
   • Fund a trial of a voucher system for childcare or other initiatives that are likely to meet the needs of women and services in particular geographical locations.

8. Support workforce development initiatives to enhance the capacity of the drug and alcohol non government sector to respond effectively to women with complex mental health issues and experiences of trauma.
   • Offer training for workers in the practice guidelines to be developed by NADA in 2014.
   • Establish a ‘community of practice’ with membership drawn from services across NSW.
• Identify a small team of specialists from within the sector who are willing to act as mentors for other workers.
• Include high priority women’s topics, such as mental health and trauma, in the annual Women’s Drug and Alcohol Treatment Symposium.
• Fund workers to attend specialised training in these topic areas.
Background

The Women’s Alcohol and Other Drug Services Development Program

In 2012, NADA was funded by the Australian Government Department of Health\(^5\) (DoH) under the Substance Misuse Services Delivery Grant Fund to improve the capacity of non government drug and alcohol services to identify and respond to clients with drug and alcohol, mental health and other complex health and social issues. One area of focus under this initiative was drug and alcohol services for women.

A number of organisations provide specialist services to substance using women in NSW, including services to their children. Service delivery is often complex in comparison to ‘conventional’ drug and alcohol treatment services. Information from NADA members indicated that women report having difficulty accessing other necessary services in the community such as pre-natal classes and housing due to stigma and discrimination, and fear of scrutiny by child protection services.

With support from NADA’s Sector Capacity Building Program, the Women’s Alcohol and Other Drug Services Network was established in January 2013. The Network comprises representatives of organisations that provide specialist services to women who use substances, including those that also provide services to their children. The Network is intended to facilitate sustainable collaboration, knowledge and information sharing with the view to strengthening women’s non government drug and alcohol organisations and to further the common strategic interests of member services. Following several meetings, the Network agreed that an analysis of existing services available to substance using women and their children in NSW was required, as was the development of guidelines to assist these services to provide best practice interventions and ensure consistency of care for substance using women, women who are pregnant and women with children.

NADA subsequently secured a one-off service capacity grant from DoH in July 2013 for the Women’s Alcohol and Other Drug Services Development Program, which aims to build the capacity of specialist women’s non government drug and alcohol services to meet the needs of women and their children in NSW. The program incorporates the following four capacity building strategies:

1. A needs analysis
2. The development of practice guidelines
3. One-off service delivery grants to specialist women’s drug and alcohol services
4. Support to services through partnership, organisational and workforce development activities.

In July 2013, NADA engaged the services of LeeJenn Health Consultants to complete the first and second of these capacity building strategies.

---

\(^5\) Formerly the Australian Government Department of Health and Ageing (DoHA)
**Needs analysis**

This report relates to the first of the four capacity building strategies of the Women’s Alcohol and Other Drug Services Development Program; an analysis of the needs of women seeking and receiving drug and alcohol treatment including women who are pregnant, women with or without children and women receiving pharmacotherapy treatment. The needs analysis was conducted between August and December 2013.

The objectives of the needs analysis were to:

1. identify what is current best practice for service delivery to women with substance use issues in Australia and internationally
2. identify existing policy, practice guidelines and practices in drug and alcohol service provision for women with a specific focus in NSW
3. identify the gaps and challenges in providing services to women with substance misuse issues including women who are pregnant, women with and without children and women receiving pharmacotherapy treatment from the point of view of NADA member services
4. identify women’s service needs, service gaps and the challenges faced when accessing services from the point of view of women clients of NADA member services
5. make recommendations to address the gaps and challenges identified by the needs analysis.

**Practice guidelines**

The second of the four capacity building strategies – the development of practice guidelines for specialist drug and alcohol services working with women in NSW – will build on the findings of the needs analysis and will be conducted between February and June 2014. The guidelines will be disseminated by NADA to support the non government drug and alcohol sector to provide best practice interventions to women and children in their care.
Information collection methods for the needs analysis

Literature review

A review of the literature regarding best practice for women’s drug and alcohol treatment was conducted at the beginning of the needs analysis project. The review focused on women in general, pregnant women, women with children, and women receiving pharmacotherapies. The review also highlighted issues specifically relevant to Aboriginal women and their children and women from CALD backgrounds, as well as issues relevant to certain sub-groups of women such as those in the criminal justice system; lesbian, bisexual, transgender and intersex women; women working in the sex industry; and homeless women.

Relevant literature was identified through a search of the following electronic databases: Medline, PsycINFO, Scopus, CINAHL and the Cochrane Library. A total of 1,307 citations were located and screened during stage 1. Of these, 870 were excluded and 428 assessed as potentially eligible for inclusion in the review. After screening for duplicates and hand searching seminal papers, 161 papers were reviewed.

Early findings from the review influenced the development of the questions that were asked during the consultations. The comprehensive review will inform the development of practice guidelines, which is phase two of the four capacity building strategies of the Women’s Alcohol and Other Drug Services Development Program. The full literature review was extensive, thus the findings were summarised for inclusion in this report.

Policy and practice context

Specialist services for pregnant women who use drugs and alcohol in NSW, including pregnant women enrolled in an opioid pharmacotherapy program, were identified, as were key guidelines, action plans and policies that influence how non government drug and alcohol services deliver care to women in NSW.

Snapshot of the non government drug and alcohol sector in NSW

NADA completed an organisational survey across a specific cohort of the NADA membership in 2013. These data, in conjunction with the results of the consultations, have been used to identify current practices and potential gaps in service delivery.

Consultation with NADA member services

To identify the gaps and challenges in providing services to women with substance use issues, consultations with NADA member services were conducted throughout October and November 2013. For the purpose of conducting consultations relevant to this needs analysis, member services were divided into three categories:
1. Category 1: specialist women’s (with or without children) drug and alcohol services (n=8).

2. Category 2: specialist women’s services that did not provide a specialist drug and alcohol program, but incorporate drug and alcohol service provision in their specialist women’s service role (n=5).

3. Category 3: specialist drug and alcohol services who, as a part of a larger program, also provided services to women. This category also included youth services that offered programs for young women (n=34).

All Category 1 services were members of the Women’s Alcohol and Other Drug Services Network (the Network). Six were consulted as a group during the Network’s meeting in October; those not present were later consulted by telephone. One of the Category 2 services also had a representative present at the October meeting of the Network, and the remainder of the Category 2 services were consulted via telephone during the consultation period.

Of the Category 3 services, four had a family program and three of these services agreed to participate in a telephone or face to face consultation. The remainder of the Category 3 services were invited to share their views via a personalised link to an online consultation and 10 services agreed to do so.

In all, every Category 1 and Category 2 service participated in the consultations, as did 15 of the 34 Category 3 services. Of the 47 NADA member services invited to participate in the consultations, 59.5% (n=28) did so. The findings for the needs analysis are therefore considered to be representative of the sector as a whole.

**Consultation with women clients**

To identify women’s service needs, service gaps and the challenges women face when accessing services, a sample of women clients of NADA member services were consulted. A semi-structured interview was developed. The six specialist women’s drug and alcohol services involved in the client consultations chose to facilitate the interviews with their clients and provided the responses to NADA. A total of 51 women participated in the consultations.

![Figure 1. Overview of information collection methods for the needs analysis](image-url)
What the evidence tells us about women’s drug and alcohol treatment

**Key points**

- Women access treatment at lower rates than men and are under-represented in the drug and alcohol treatment system.
- A range of issues create specific barriers for women’s access to drug and alcohol services including social stigma, childcare and custody concerns, financial issues and models of care.
- Women have a number of specific risk factors including: higher rates of mental health issues; more severe clinical profile and complex presentations; greater risk taking; pregnancy and childcare issues; and greater social and economic disadvantage.
- Evidence-based interventions for drug and alcohol treatment in general, such as behaviour therapies (e.g. contingency management, community reinforcement approach) cognitive behaviour therapies (e.g. coping skills and relapse prevention), motivational interviewing and 12-step-facilitation (TSF), are suitable for women.
- Access to childcare, prenatal care, women-only programs, psychoeducation sessions focused on women-specific topics, mental health and comprehensive services that offer multiple components have been associated with improved outcomes for women.
- In addition to treatments that are effective for women in general, specific groups of women have specific needs that should be addressed by drug treatment services through individualised assessment and treatment planning.

**Barriers and enablers of drug and alcohol treatment seeking, access and retention for women**

Although the prevalence of 12-month substance use disorders among women is about half that of men (3.3% vs. 7%) [1], less than a third of closed treatment episodes in NSW and nationally were for women (32%) [2], suggesting that women are under-represented in treatment services.

There are a number of barriers to women seeking drug and alcohol treatment, including:

- Social stigma, labelling and community disapproval of substance use and lack of family support [3-6].
- Lack of awareness of the treatment options available, childcare concerns, the economic and time costs of residential treatment, concerns about the confrontational models used by some treatment services, and stereotypical views of clients of treatment services (e.g. ‘religious’ aspects of 12-step groups) [4].
- Pregnancy, lack of services for pregnant women, fear of losing custody when the baby is born, or fear of prosecution, voyeurism, and sexual harassment and lack of available affordable childcare [7].
- Women who use drugs or alcohol have a higher prevalence of co-occurring mental health issues such as mood, anxiety, posttraumatic stress and eating disorders than males and appropriate dual diagnosis treatment may be difficult to access [5].
- Women appear more likely than men to encounter disapproval for their substance use and their participation in treatment [3, 5, 6].
- Women are more likely than men to attribute their substance use to external issues, such as stress, psychological, or physical health conditions and may not perceive their use as a problem [6].
- Women who use drugs or alcohol are more likely to have substance-using partners, which could contribute to defining their use as non-problematic [5, 8].

**Risk factors for women**

Best practice treatment for women takes into account the varied and unique drug and alcohol risk factors that women face. Although treatment retention, outcomes and rates of relapse to substance use among women do not differ from men, compared to men:

- Psychiatric comorbidity and, in particular, experiences of trauma, including childhood sexual abuse and intimate partner violence, is more prevalent among women [3, 5, 7, 9], increasing the risk of neglect and abuse of their own children [10].
- Women generally present with a more severe clinical profile and more problems related to mental health, family and interpersonal relationships, employment, and physical health [11], including involvement with child protective services and partners who are also substance users [3, 12].
- Women who enter treatment generally have fewer years of substance use and have used smaller quantities than men but have an equivalent severity of their substance use problem and symptoms [5, 13].
- Women are more likely than men to inject drugs, use drugs with many partners, share paraphernalia after an injection partner, exchange sex for money or drugs, and have difficulty negotiating condom use with their sex partners [3], resulting in a higher vulnerability to HIV infection.
- Women may be pregnant, presenting unique perinatal risks that are associated with a higher rate of obstetric complications and poor outcomes, including miscarriage, birth defects, decreased birth weight, cognitive deficits, growth restriction, increased neonatal mortality, and maternal health problems [14]; and are more likely to be parenting, increasing risks to their children [15].
- Women more commonly experience lower levels of education and income, as well as financial dependence on partners or others and have lower rates of employment [16, 17].

These specific risk factors suggest that women need integrated programs that, in addition to drug and alcohol treatment, ask about and focus on:

- pre and post natal care of children and family programs
- mental health issues, especially those related to trauma, including treatment for post-traumatic stress disorder (PTSD), personality disorders, eating disorders, depression and anxiety
- vocational training, education and employment
- specific harm reduction strategies for blood borne viruses, sexual risk taking, violence, safer drug use.
While findings are inconsistent, early reviews suggest that women in women-only treatment may have better treatment retention and outcomes than women in mixed-gender treatment programs. Women with substance use disorders are more likely to seek treatment in non-specialty settings [5], suggesting collaboration and colocation of drug and alcohol agencies with other relevant services may act as enablers for women to enter drug and alcohol treatment; outreach case management can also assist women to address issues that prevent them seeking treatment [6].

**Best practice in women’s drug and alcohol treatment**

Evidence-based interventions for drug and alcohol treatment populations include behaviour therapies (e.g. contingency management, community reinforcement approach) cognitive behaviour therapies (CBT) (e.g. coping skills and relapse prevention), motivational interviewing and 12-step facilitation (TSF) [18, 19]. These interventions are aligned with the specific clinical needs of women who use drugs or alcohol, or are capable of being easily adapted to gender-specific treatment environments.

Ashley et al. [3] identified six components of women’s treatment that are associated with positive treatment outcomes such as longer retention in treatment; decreased substance use; decreased mental health symptoms; improved birth outcomes; greater employment; HIV risk reduction; and improved self-reported health status. These components were access to childcare, access to prenatal care, access to women-only programs, psychoeducation sessions focused on women-specific topics, mental health interventions and comprehensive services that offer multiple components [3].

Greenfield et al. [5] identified effective women’s specific interventions including: alcohol interventions for pregnant women; contingency management to increase abstinence in pregnant women; parenting skills for mothers on methadone maintenance; relapse prevention for women with PTSD, relapse prevention for women with marital distress and alcohol dependence; and dialectical behaviour therapy for patients with co-occurring drug dependence and borderline personality disorder. Family inclusive practices that focus on repairing relationships with children and family members; enhancing the quality of the family/domestic environment; addressing trauma; and developing a support system to prevent relapse, were considered vital for women with drug and alcohol issues [5]. In a longitudinal study of recovery and relapse cycles, self-help participation was more strongly associated with moving from substance use to recovery for women than for men in substance use treatment, and women were more likely than men to participate in self-help [11].

**Considerations for specific groups of women**

**Pregnant women**

Pregnant women who use drugs or alcohol are more likely to be disadvantaged and are at higher risk of a range of issues. Pregnant women who use drugs or alcohol are more likely than non-users to be smokers, to have a psychiatric condition, to be single, Aboriginal, experience greater social and economic disadvantage, to be living in a metropolitan area, younger, unemployed, Australian-born, and to have previously given birth [20, 21]. Access to a comprehensive range of well-connected
services, such as social support, case management, and mental health services is therefore crucial. Pregnant women with drug and alcohol issues require services that can support them throughout their pregnancy and provide post-natal support for themselves and their baby. Among pregnant women who use drugs or alcohol, opiate use remains most prevalent; however use of other drugs, such as methamphetamine, are of increasing concern due to the impact on women’s mental and physical health and the heightened risk for obstetric complications [22].

Gold standard treatments for pregnant substance users include extended hospitalisation if required, additional support during birth and post-delivery, and the option of assertive follow-up of the mother and child through the child’s formative years to assist the woman in the areas of healthcare, navigating social services, accessing housing, and positive parenting [23]. Women-only and gender-specific treatment programs are best suited to respond to the specific health and medical needs of pregnant women with substance use issues [5].

Evidence supports a range of psychosocial interventions for pregnant women, including:

- programs that incorporate standard evidence-based practice treatment modalities
- treatment approaches that begin during pregnancy
- treatment engagement strategies
- home-based interventions
- comprehensive treatment that includes perinatal care, mental health services, child-care and other supports
- service integration approaches, where addiction services are provided with onsite services related to pregnancy, parenting, or other child-related services.

**Women with children**

Women who have children and experience issues with their drug or alcohol use are more likely to have a range of material and personal support needs; a higher prevalence of psychiatric symptoms; early childhood and lifetime trauma experiences; and lack of social support. These issues present significant clinical challenges, and many of these factors may also inhibit the mother’s attachment to her infant, their advancement of parenting skills and their capacity to maintain child custody. In addition, mothers may face difficulties maintaining engagement with, or completing drug and alcohol treatment [5].

Significant maternal drug or alcohol use is associated with a variety of caregiving, child and family functioning problems, including a greater likelihood of neglect or abuse of children, reduced emotional involvement and attachment, increased punitive behaviour toward children, insensitive and interfering behaviour, ambivalent feelings about retaining custody, feelings of guilt and increased parenting stress [24-27]. The continuing presence of drugs or alcohol significantly reduces an individual’s dopaminergic response to stress, leaving the mother highly vulnerable to negative emotions and potentially lacking feelings of pleasure or reward ordinarily associated with caring for young children [27].

The need to enhance capacity for care giving, and interventions focusing on the relationship between mother and infant, is a developing area of research. Best practice treatment services for women with children include:
• Women-centred treatment that involves children such as women specific outpatient clinics and day programs; women-only residential treatment including residential services that allow children to stay with their mothers.
• Specialised health and mental health services, particularly pre and post-natal health interventions and specialist mental health interventions such as individual or group therapies.
• Home visits, typically by a nurse, focusing on providing maternal support, promoting healthy parent-child interactions, and providing information and linkages to material resources.
• Concrete assistance, such as transportation, childcare, and worker assistance to link with treatment services.
• Short-term targeted interventions, including psycho-educational groups, counselling or support groups and contingency management approaches.
• Comprehensive and holistic interventions, including programs that integrate several of these components.

Women in pharmacotherapy treatment

Women in pharmacotherapy treatment have the same needs as women in drug and alcohol treatment more generally, including access to childcare and greater focus on engagement and retention in treatment.

Regular benzodiazepine use during pregnancy is associated with a neonatal abstinence syndrome as are opioids. However, benzodiazepines may be administered for symptomatic relief during inpatient alcohol withdrawal if required with appropriate supervision and neonatal care [23, 28]. For pregnant women who are dependent on benzodiazepines, best treatment approaches aim for tapering of dose and subsequent discontinued use when and if this is safely achievable. Benzodiazepines are generally unsafe for use while breastfeeding and cause significant withdrawal symptoms for the newborns of dependent mothers [14].

For opioid-dependent pregnant women, induction to methadone maintenance as part of comprehensive treatment programs is considered best practice [14, 29]. Commencement of methadone should ideally take place in an inpatient setting, with maternal and obstetric supervision [28]. Continued buprenorphine treatment is safe for women who become pregnant while already in this type of treatment, achieves similar outcomes in reducing maternal drug use and promoting positive neonatal outcomes to methadone, and appears to result in a less severe neonatal abstinence syndrome compared to methadone [28, 30]. However, as buprenorphine induction may place the foetus at risk from precipitated maternal withdrawal and potentially trigger relapse in mothers, methadone is recommended for active opioid users who need to be inducted to pharmacotherapy during pregnancy [28].

Young women

Young people who enter specialist treatment for their drug and alcohol use frequently present with multiple issues, such as mental health problems, involvement with the criminal justice system, social exclusion, and lack of education or employment opportunities. Young women in particular may have lower levels of psychological wellbeing and have been found to be more likely than young men to experience psychological problems prior to treatment entry, with greater prevalence of anxiety and depression [31, 32]. There is also evidence that young women who come into contact with specialist drug and alcohol treatment services and the criminal justice system may have more severe drug and...
alcohol issues and mental health problems than young men, and may be more vulnerable in other ways such as exposure to sexual exploitation [33].

Younger women in drug and alcohol treatment may also need greater support to build their friendships and recovery support networks, with research suggesting that they are less likely than younger men to have social support and support to maintain abstinence, and more likely to have a smaller social network and to have a heavy drinking partner [33, 34]. They may particularly benefit from interventions aimed at helping them to expand their social networks to those that provide support for changing their drinking or substance use and build their friendship skills [33, 34].

Younger age is associated with poorer treatment retention than for older people, suggesting a need to increase motivation for younger women to enter and stay engaged in drug and alcohol treatment. Greater vulnerability and psychiatric comorbidity commonly seen among younger women in treatment highlights the need for enhanced psychological support and thorough but sensitive approach to assessment to identify their specific needs.

There is relatively limited evidence relating to effective drug and alcohol treatment for young women. Recent reviews suggest that for adolescents generally, both CBT and family systems therapy are effective [18], as are motivational interviewing, multidimensional family therapy, and adolescent community reinforcement approach [33]. These interventions are effective in both residential and community outpatient settings [33].

Key approaches for tailoring treatment specifically for young women includes: the establishment of regular outreach or practical support type contact that aims to overcome barriers to accessing and engaging with treatment; the provision of support to help establish supportive relationships and networks; and the prioritising of one-to-one services rather than group work for young women with multiple issues. Age differences among members in group treatment settings may act as a barrier to younger people’s attendance [32].

**Older women**

Coinciding with the ageing of the population in Australia, the proportion of clients entering treatment aged 40 years and older has increased significantly, and the numbers of younger clients entering treatment such as opioid substitution programs is decreasing [35].

The literature on drug and alcohol use among older people is limited, and there is little research examining the impact of gender and age on drug and alcohol treatment outcomes [5]. In general, older adults who use drugs or alcohol may have a range of issues and barriers that differ from those who are younger. Older people in treatment may have specific transport and mobility needs, have reduced social networks and be socially isolated [36, 37]. A language barrier to treatment access is an increased issue with older people in treatment who are migrants and/or whose first language is not English. Stigma can be a more salient issue among older women who use drugs and alcohol.

These issues potentially impede treatment-seeking and can be barriers to ongoing treatment engagement. However, research suggests that being older may be correlated with higher levels of treatment attendance and length of treatment once access barriers are overcome.
Specific clinical issues for older people who use drugs and alcohol include complex interactions with prescribed medicines, decreasing mobility and increasing disability, unintentional injury, and increased risk of falls, car accidents and suicide [38, 39]. They are more likely than younger people to experience complex and severe psychiatric comorbidity, including symptoms of anxiety, dementia, loneliness, memory problems and confusion, and prolonged use of illicit drugs is also associated with depression and cognitive impairment [39]. Due to physiological changes associated with aging, older people can be more sensitive to drugs and alcohol, physically and cognitively [36, 39]. Although the evidence is limited, withdrawal is generally considered medically riskier for an older person [36], indicating a highly supervised and supported detoxification process may be needed for this cohort.

**Women who have experienced trauma**

Women with substance use disorders, and especially those with co-occurring mental health disorders, have a higher likelihood of past experience of traumatic events, including sexual assault and domestic violence. This is a particular barrier to entering or completing treatment in a mixed-gender setting and may make some treatment approaches less desirable for these women [5, 6].

Drug and alcohol use disorders, mental health and trauma are now recognised as critical and interrelated issues, requiring comprehensive treatment responses addressing both trauma and drug and alcohol issues [40]. Factors associated with early attrition among women with co-occurring PTSD and substance use disorders in treatment include experience of partner violence during adolescence [41]. The addition of trauma-focused group behavioural treatments to existing substance abuse treatment has been found to reduce PTSD symptoms in women with co-occurring substance use and post-traumatic stress disorder [10].

Comprehensive services integrating mental health, drug and alcohol and trauma-informed services may provide more effective treatment for women than non-integrated service settings, with provision of more integrated counselling (addressing trauma, mental health, and substance use issues) associated with better mental health and substance use related outcomes for women [5].

**Women with mental health problems**

In Australia, between 20-30% of women who have alcohol use issues meet diagnostic criteria for a mental health disorder [42]. Co-occurring mental health problems are common among women who use drugs and alcohol. Affective disorders, such as major depression, are associated with poorer treatment outcomes and higher rates of relapse. In a review of the evidence for women in drug and alcohol treatment, Greenfield et al [5] suggest that higher rates of co-occurring disorders among women, such as depression, anxiety, eating disorders and posttraumatic stress disorder, may make it difficult for women to gain appropriate treatment for both mental health and substance use problems. Additionally, the experience of multiple disorders may increase the chances that women perceive their issues as specific to their mental illness and focus on seeking psychiatric help, rather than drug and alcohol treatment.

Psychiatric status has been associated with recent participation in sex work, elevated risk for infectious diseases, poorer treatment retention and outcomes, and difficulty engaging in treatment [43, 44], indicating a range of additional harm reduction and health supports are required.
Women with co-occurring psychiatric and drug and alcohol disorders may exhibit a more erratic recovery process than those not experiencing mental illness, more commonly moving in and out of treatment programs.

They may require a highly structured treatment environment, at least initially, to allow for a stabilisation period [5, 45].

Due to the high risks and complex needs of women experiencing substance use disorders and co-occurring mental health issues, integrated and holistic treatment approaches are commonly recommended for this group [46-48]. The need for a longer term approach to recovery and sensitive outreach, engagement, and support interventions are also indicated [42, 46].

**Women who work in the sex industry**

The prevalence of women entering treatment who have past year involvement with sex work is high, with rates of 30% to 40% reported [49, 50]. Women who work in the sex industry, particularly street-based sex workers, have high rates of drug and alcohol use and dependence, including intravenous drug use and poly-drug use, as well as increased risk of contracting blood borne viruses [51, 52]. A recent study found that women who work in the illegal sex industry have significantly poorer mental health than those working in brothels or privately [53].

An investigation into street-based sex work in Sydney found that many workers initiated sex work to obtain money for drugs [51]. Working in the sex industry is associated with higher risk of physical and mental health problems, primarily among those involved in street-based sex work, and is often linked with socio-demographic disadvantage. Sex workers commonly report experiences of childhood trauma and adult sexual assault and violence compared to women generally and women who use drugs and alcohol in particular [49, 51, 52, 54].

Harm reduction approaches are indicated for this group, but there are few controlled studies to guide other interventions. Street outreach services and motivational interviewing techniques for linking female workers in the sex industry into substance use treatment are both effective [51, 52]. While there is some indication that women working in the sex industry do participate and benefit from mainstream drug and alcohol treatment, the available evidence points toward greater benefits from targeted interventions. The provision of additional mental health services such as seeing a psychologist and individual counselling, as well as services such as employment counselling and housing assistance, have been associated with stopping work in the sex industry, which in turn was associated with improved drug and alcohol and mental health outcomes.

**Homeless women**

Homeless women who use drugs and alcohol also have higher risk and rates of mental health issues, experience of trauma and potential involvement in the sex industry [43, 55]; addressing these issues is therefore highly important for this group.

Structured group sessions (CBT, motivational interviewing), community reinforcement approach and advocacy/case management in combination with CBT appear to be effective in reducing
psychological symptoms and improving health service utilisation for homeless women, with some support for targeted therapeutic communities [56, 57]. The introduction of trauma informed care is also important, such as targeted informal day programs and drop-in programs where services integrate components of harm reduction, trauma informed care and social support to homeless and marginally housed women [55, 58]. Studies indicate that low-threshold and tailored environments for care can engage highly vulnerable and intervention-resistant clients into regular service contact, with benefits for health and wellbeing reported.

Evaluation of intensive comprehensive housing support programs, utilising long term case management, trauma informed care and holistic support, have shown positive outcomes for homeless substance users, requiring the establishment of strong partnership across substance use, housing and other relevant services [59, 60].

**Women involved in the criminal justice system**

Women involved in the criminal justice system experience high rates of victimisation and mental health issues [61]. Women leaving prison have significant and complex health care needs, and this time of transition has been identified as an opportunity to offer effective drug and alcohol treatment, support and other health-promoting interventions [62].

Highly structured, manual-based interventions may be less effective among mandated clients, especially pregnant women, and may be counterproductive in terms of retention [63].

Hall et al. [61] recommended that interventions should comprehensively address psychological and social needs of these women, because addressing victimisation, drug and alcohol use and other mental disorders is more effective than criminal justice programs that do not address these factors. The authors suggested that comprehensive intervention models for women in the criminal justice system should include components that aim to address the woman’s immediate needs, such as assistance in accessing safe and affordable housing and providing job training, education and employment assistance [61].

For drug and alcohol treatment among women in residential correctional facilities, therapeutic effects of treatment programs appear to be enhanced when trust-based relationships are established, care is individualised and the treatment facilities are separate from the general prison environment [64]. For women in court-mandated treatment, women-only or gender-specific programs are advocated for [65]. Women themselves favoured individualised, tailored, treatment approaches and indicated individual and group counselling, twelve-step programs, opportunities to develop life skills, vocational training, and job placement interventions, in addition to services that enabled access to family throughout the treatment process [65].

Brief intervention for women offenders may result in short term increases in number of days abstinent from alcohol [66] and there are indications that women-only treatment may result in improved outcomes for female offenders (e.g. [5, 67]). The value of aftercare programs for women offenders post-release is emphasised [52] and is associated with reduced risk of recidivism, especially when combined with treatment that was initiated while women were in prison [68].
Lesbian, bisexual, transgender and intersex women
As with all populations, there is variability in drug and alcohol use patterns among women who identify as lesbian, bisexual, transgender or intersex (LBTI). However in general, sexual minority women report higher rates of drug and alcohol use disorders than heterosexual women [69, 70]. LBTI women are at least as likely as heterosexual women to seek help for their drug and alcohol use issues [70, 71].

A range of specific characteristics and treatment needs have been identified for LBTI substance users. Due to the elevated prevalence of drug and alcohol use, and potentially earlier age of commencing use, sexual minority clients are likely to enter treatment with more severe substance abuse problems than heterosexual clients and have an elevated prevalence of mental health issues [70].

Socialising in the LBTI communities often occurs in settings where drugs or alcohol are available, increasing women’s risk of substance use and relapse after treatment [67, 69]. The additional stress related to being a member of a sexual minority may contribute to increased levels of substance use [69, 70, 72]. Sexual minorities face unique barriers when seeking and staying in substance abuse treatment, including providers who hold stigmatising attitudes about homosexual behaviour or who lack knowledge about sexual minorities and their health needs [69, 71, 72]. Elevated levels of substance use in the LBTI community could lead to unique expectations and perceived normality around drug and alcohol use, increasing the likelihood of individuals choosing to drink heavily or use drugs and consequently affecting treatment goals [70].

There is a paucity of treatment outcome data for sexual minority women. The available evidence has not shown large benefits in the use of LBTI specific treatment protocols, nor demonstrated that unique aspects of sexual minority substance users and patterns of use require specialised treatment protocols [69, 70]. Best practice guidelines to treat LBTI women with drug and alcohol issues (e.g. [73, 74]) also emphasise the need for cultural competence and inclusive approaches, especially in response to the elevated potential of these clients to have histories of trauma and experiences of stigma based on both sexism and homophobia. Services are advised to develop trauma informed treatment and consider sexuality and gender issues in assessment procedures and treatment planning (e.g. issues of ‘coming out’, the role of sexual minority bars, the need for clean and sober social networks for recovery).

Aboriginal women
Aboriginal women entering treatment are likely to present with complex needs. Among Aboriginal Australians, the high prevalence of poor physical health, social disadvantage and co-occurring mental health issues [75] greatly increase their risk for poor treatment outcomes. The complexity of issues faced by many Aboriginal people include high rates of trauma (including intergenerational trauma), histories of family separation or disruption and elevated experiences of grief related to early deaths and high rates of incarceration [76]. Aboriginal women have poorer physical health and higher rates of psychological distress than non-Aboriginal women, and are significantly more likely to have children with lower birth weight, be admitted to hospital for assault, and are up to twice as likely to die as a result of illicit drug use [75].
Of all closed drug and alcohol treatment episodes for women in NSW for the period 2011-2012 (n=112,676), approximately 11% (n=12,858) were provided to Aboriginal and Torres Strait Islander women\(^6\).\(^7\). As Aboriginal women comprised only 2.5% of all women resident in NSW in 2011\(^8\), these data suggest that Aboriginal women use drug and alcohol treatment services at a higher rate than non-Aboriginal women in NSW, potentially reflecting their elevated need for treatment and suggesting that service providers need to offer tailored programs that are culturally as well as gender appropriate.

Guidelines for effectively working with Aboriginal people who use drugs and alcohol have been developed, but there is a lack of well-controlled studies to support their consensus recommendations [77]. Aboriginal-specific treatment programs have tended to focus on men so studies that examine substance use treatment specifically for Aboriginal women and their children are lacking [78].

Recommendations for responding to Aboriginal women are similar to those recommended for non-Aboriginal women, including addressing co-occurring trauma and mental health issues by “holistically and simultaneously, within an Aboriginal worldview, using a strength-based approach” [77, pp. 331], including linking the support of mothers with their children and cultural components [77]. For example, gender mixing in some services may conflict with cultural perspectives [79].

Community Reinforcement Approach (CRA) and Community Reinforcement Approach and Family Training (CRAFT) are interventions consistent with the role that family and community factors play in modifying Aboriginal people’s health risk behaviours [80]. In the Calabria et al study, CRA was considered by the Aboriginal people surveyed (51% of whom were women) as most acceptable for people following alcohol withdrawal, while CRAFT was most acceptable for people who want to help a problem-drinking relative or friend initiate alcohol treatment [80].

Evaluation of a ‘soft entry’ drug and alcohol intervention strategy aimed at Aboriginal Australians in an area of rural NSW, found the approach demonstrated great effect, particularly in regard to increasing the number of Aboriginal women accessing drug and alcohol services in that community [78]. Drug and alcohol counsellors provided access to their services at Aboriginal community events, groups and gatherings. Although no treatment outcomes were measured, the study found the soft entry approach provided services in a way that was acceptable to those receiving them and women were particularly responsive.

**Women from culturally and linguistically diverse backgrounds**
A low level of culturally and linguistically diverse (CALD) communities’ engagement with treatment services is reflected by national data on treatment utilisation. From the 2012 ATOD-NMDS data, in 96% of closed treatment episodes English was recorded as the preferred language [2]. This finding may reflect an under-utilisation of services by CALD communities, even if drug and alcohol problems

---


\(^7\) These data do not include Aboriginal services funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH)

may be lower among women in some CALD communities in Australia than in the general community due to cultural attitudes, religious beliefs and conventional patterns of use.

Women from CALD communities commonly experience two key issues related to potential problematic drug or alcohol use: the stress of migration and mental health problems [81]. In addition, refugees and asylum seekers in Australia are particularly vulnerable to, and affected by, homelessness. Women from CALD backgrounds may experience violence at increased rates and be at greater risk of victimisation than women from non-minority backgrounds [42].

A range of barriers to accessing treatment have been identified, which highlight specific needs and areas relevant for treatment. Some of the barriers for these women include language difficulties and lack of availability of translation services; social stigma; lack of family and/or community support; insecure living conditions; immigration status that impacts on eligibility for many social and health supports; and cultural perceptions including spirituality and beliefs around health and/or drug and alcohol use which may be contradictory to western models of health and harm reduction approaches [42, 82]. More time may be needed to build trust and rapport with clients, and additional services such as longer-term supported English-language learning and one-on-one case worker support are recommended to assist women with engagement in treatment and long-term recovery [42].

Many of the strategies and best practice approaches indicated for other groups (e.g. trauma informed services) are also relevant for services aiming to engage and work with women from CALD backgrounds. Treatment programs that build on women’s strengths, use supportive rather than confrontational approaches, and involve women-only groups or mixed-gender programs that incorporate strong policies related to sexual harassment and safety are important [42]. Outcome studies of specific interventions are rare for this group but mindfulness-based relapse prevention (MBRP) provided as part of a residential addiction treatment program for women referred by the criminal justice system (n = 70) was found to be more effective than traditional relapse prevention [83].
What the consultations tell us about women’s drug and alcohol treatment

About the participants

The Women’s Alcohol and Other Drug Services Network
The Women’s Alcohol and Other Drug Services Network (‘the Network’) comprises representatives from thirteen specialist women’s services, all of which were consulted during a focus group in October 2013 or via telephone interviews in the ensuing weeks. Network members consulted for the needs analysis were:

- A Woman’s Place, Mission Australia
- Dianella Cottage, Blue Mountains Drug and Alcohol Recovery Services Inc.
- Detour House
- Guthrie House
- Jarrah House, Women's Alcohol and Drug Advisory Centre
- Kamira
- Kathleen York House, Alcohol and Drug Foundation NSW
- Leichhardt Women's Community Health Centre Alcohol, Tobacco and Other Drugs Service
- Lou's Place, Marmalade Foundation
- New Beginnings, We Help Ourselves (WHOS)
- Phoebe House
- Sydney Women’s Counselling Centre
- Women and Girls Emergency Centre

Other NADA member services
In addition to services represented by the Network, fifteen NADA member services (referred to as ‘other member services’ in this report) participated in the consultations in person or by telephone (five services) or online (ten services). Online surveys were conducted with services that provided drug and alcohol treatment or support services to both men and women.

The other member services reported a range of 20%-70% of women clients in their care or an average of 35%, which is consistent with closed treatment episodes nationally.\(^9\)

Other member services consulted for the needs analysis were:

- Canberra Recovery Service, Salvation Army
- Centre for Youth Well Being: Junaa Buwa, Mission Australia
- Drug and Alcohol Multicultural Education Centre (DAMEC)
- Freeman House, St Vincent de Paul Society
- GROW Community, NSW

\(^9\) Same as 6
Women clients

A total of 51 clients from six NADA member services\(^{10}\) shared their experiences in seeking and receiving treatment for substance use issues. Consultations with the women were facilitated by the services and written responses were provided to NADA.

Basic demographic information was obtained for some, but not all women. For example, of 38 women whose parenting status was known, 20 (53%) were mothers of children that were in the care of others; 11 (29%) had children in their own care; two women (5%) were pregnant at the time of the consultation and five women (13%) had no children. Seven women (14%) were aged 18-25 years, three (6%) were aged 50 years and over, four women (8%) were Aboriginal and three women (6%) came from culturally and linguistically diverse (CALD) backgrounds. At least nine of the women (18%) usually resided in regional or rural NSW.

Many of the women were receiving treatment for the first time, and as a group they were strongly engaged with their current treatment services. Half had approached their current treatment service directly (primarily because they reported that the services suited their needs), while the remainder of the women had been referred from another agency.

Key issues in women’s drug and alcohol treatment

A number of key issues were raised by members of the Network, which were echoed consistently by representatives from other member services. Key issues raised by all services were grouped according to the following five domains:

- pharmacotherapy
- relationships with children
- complex needs of women
  - trauma
  - mental health
  - cognitive impairment
  - physical health
- housing and other support services

\(^{10}\) The six services were: Jarrah House; Kamira; Kathleen York House; Leichhardt Women’s Community Health Centre; Phoebe House; We Help Ourselves (WHOS), New Beginnings.
• changing cohorts of women seeking treatment.

Pharmacotherapy
A number of issues relating to women on pharmacotherapy were highlighted consistently by service providers. The first was limited treatment places, particularly residential places, available to women on pharmacotherapy. Residential services have traditionally been abstinence-based and, while some services are broadening their admission criteria to accommodate women on pharmacotherapy, places are still very limited. Residential services that do accept women on pharmacotherapy tend to have waiting lists, and one network member spoke of the difficulties in obtaining methadone prescriptions for women that cover the full duration of the program, making it difficult for women to renew prescriptions in locations distant from the service (monthly review by prescribers is often required) and to maintain regular dosing at the service’s dispensing pharmacy. In contrast, another specialist women’s service described an excellent working relationship with the local pharmacotherapy clinic where women picked up their doses daily.

Another issue is a lack of coordinated care planning for women on pharmacotherapy with prescribers. Some Network members highlighted the differences in perceptions between their services and specialist pharmacotherapy clinics about what case management entails. Service providers held the view that not enough attention is paid to supporting women to access the help they need to manage other important areas of their lives, and while the pharmacotherapy dose is an important aspect of treatment, it should not be the sole focus.

There’s a perception that pharmacotherapies are just solely the treatment and so it’s quite insular... it’s not that they [the pharmacotherapy providers] are resistant to doing things outside but there’s a lot of barriers... if the woman looks like she might be stepping outside of the pharmacotherapy treatment world to access another service it can actually be really problematic. [Network member]

It’s not that they [prescribers] are not willing to work with other services... it’s that they are so time poor and to then spend more time supporting engagement with other services, looking outside the square...they need more support. [Network member]

Another important issue raised by the Network is the involvement of some case workers from Family and Community Services (FaCS) in pharmacotherapy treatment planning for mothers whose children are under review or subject to a Care and Protection order. Network members reported incidents involving case workers from FaCS who had stipulated a reduction in or cessation of pharmacotherapy as a condition for either retaining a child in the mother’s care or for restoration of the child to her care. Concern was raised over these types of conditions as it is inconsistent with evidence-based practice. Cessation of pharmacotherapy is a common trigger for relapse to illicit drug use, which is inconsistent with the goal of a safe and stable family environment for children and an undesirable outcome for the mother.

DOCS will [sometimes] dictate treatment; they’ll say “mum needs to come off methadone” which makes it really unsafe for her and her children...the methadone or Suboxone is actually a stabilising factor in their lives...[Network member]
Sometimes the client them self doesn’t want to come off and know how unstable they’ll become, but they sometimes get it into their mind… and will actively try and get the prescriber to bring them down in the community which is even more unsafe... all driven to get their child back in their care. [Network member]

We have had a few women who have been on prescribed Valium [in conjunction with pharmacotherapy] for however long...and it’s like “bang, you need to be off it”... and we’ve had a couple of hairy situations where that’s been the expectation and we’ve had to try to explain again the slow process that needs to occur. [Network member]

**Relationships with children**

The increasing number of women with children not in their own care (i.e. children subject to Emergency Care and Protection orders or long term care orders) was consistently raised as a key issue in providing drug and alcohol treatment to women. Services also reported that more children are not being restored to mothers, or there is a lengthy restoration period – in some cases taking up to two years for a review of the care order – resulting in significant feelings of grief and loss, which can reduce women’s motivation to continue drug and alcohol treatment. Services also reported that some women clients become disgruntled with drug and alcohol treatment services when children are not restored, which undermines the therapeutic alliance.

A number of services also described cases in which women were unaware of what FaCS required for child restoration, or indeed if restoration was possible, and women were entering treatment of their own accord in the hope that their children would be restored or access visits would be increased.

*For four years pretty consistently we have had children vacancies... we haven’t been full [with children] because DOCS are removing children... we don’t have a child in residency at the moment. We don’t get children because they are either on permanent guardianship orders or the restoration look very slim and they [women] are coming to us in the hope of [restoration]. [Network member]*

*We are the same. Sometimes we think “we’re a child service and we don’t have children”. [Network member]*

The variable working relationships with FaCS case workers was also raised as an important issue. Some services highlighted a lack of clarity in FaCS case planning for women and their children or a lack of communication to the services about the plan, leaving women and the workers that care for them unsure of the goals set by FaCS and what was required to meet those goals. Some services found it difficult to ensure the presence of FaCS case workers at the service’s care planning meetings, while others had established routines with some FaCS case workers from local offices.

*We have a few mums at the moment who aren’t sure what they need to do to get access visits... what we’ve asked FaCs is to give us from the get go a plan... we have to work with these women... but it’s like “oh, we’re not really sure”. [Network member]*
They [FaCS] used to turn up with a 17-page care plan and now you never see one. Women have the impression if they do a residential program they will get their kids back and it’s not the case today. [Other member service]

Some [FaCS] workers will be engaged, will have a plan with our clients when she leaves us but … this is at an individual level it is not system wide – we don’t have an agreement with FaCS across the state although it’d be great to have that. [Network member]

At the beginning of a woman’s stay we set up an ‘expectation meeting’ between FaCS, our staff and the client. We ask the case worker what they expect... it’s a transparent process and everyone knows the plan. The case worker is called back four weeks before the woman’s discharge and a detailed plan is made then too. [Network member]

The impact of Care and Protection Orders on the children of substance using mothers was also raised as an important area for consideration by services. Children who expect, but fail to be reunited with their mothers; and children in care who must travel long distances to see their mothers for access visits (often solely in the care of designated ‘access drivers’ from non-government family services) were two groups that were highlighted as needing long-term support that is perceived as difficult to get with the recent focus on early intervention resulting from the Wood Special Commission of Inquiry into Child Protection Services in NSW.

The reluctance of women to disclose substance use during pregnancy or to seek treatment out of fear of scrutiny by FaCS was also highlighted as a key issue, particularly when it results in women not receiving adequate antenatal care or late detection of neonates in withdrawal.

We had a woman admitted to us recently and we didn’t know she was pregnant and she was about to deliver in about five weeks and she’s on methadone and then antenatal screening happened very quickly...it is frightening that you can go to a dosing clinic and you can wear baggy clothes and be ready to give birth and not have any antenatal treatment as well because of the barriers and stigma... “if they know what I’m doing .. I’ll have my baby removed”. [Network member]

Complex needs
The increasingly complex needs of women clients emerged as a common theme throughout the consultations. Issues in providing responsive services to women with histories of trauma and or mental health problems co-existing with substance use problems were raised by almost every service. Cognitive impairment was also identified by informants as an additional area of difficulty for many women in treatment, and the physical health needs of women were also identified requiring attention during drug and alcohol treatment.

Trauma
Consistent with the literature, the high prevalence of women that have experienced trauma as a child and/or an adult, including intimate partner violence, was among the key issues identified by
informants in relation to the increasing complexity of women’s needs when entering treatment for substance use problems.

The impact of enduring symptoms of trauma on drug and alcohol treatment and women’s quality of life were also highlighted during the consultations. Some of the issues raised included self-harming behaviours, emotion dysregulation, difficulties with interpersonal relationships, recognising and or maintaining healthy boundaries, and vulnerability to future trauma. As examples, several informants highlighted the difficulties faced by women who begin emotionally-charged romantic relationships during residential treatment, and the negative effect the relationships have on their treatment outcomes when the relationships fail.

The increased risk of trauma among Aboriginal women, including intergenerational trauma, was also noted by some informants. Network members also raised the issue of the trauma experienced by children following separation from their mothers as a result of Care and Protection Orders, and the long-term implications of such trauma on children’s mental health. Network members suggested that opportunities be explored for providing mental health care for children in the context of drug and alcohol treatment for mothers.

A good understanding of trauma and the ongoing effects on women and their children was considered essential for all workers in drug and alcohol treatment settings.

*Child sexual abuse, adult sexual assault, high levels of domestic violence and children being removed... we have significant issues with women relating to others and lacking emotion regulation. [Network member]*

*In my experience [the issue of trauma] has been substantial. I can’t really think of a woman in drug treatment who doesn’t have a complex trauma history. [Other member service]*

*I’d say 90% of the young women we see have a history of some type of abuse, or they’ve witnessed traumatic events. Many of them come to us with self-harming behaviours, personality disorders, PTSD [post traumatic stress disorder]... it can be difficult because we’re a mixed gender service and they’re vulnerable to forming a volatile relationship while they’re with us. [Other member service]*

*We help women focus on what is a healthy relationship... if domestic violence isn’t addressed women will continue to make unhealthy relationship choices. [Other member service]*

**Mental health**

Throughout the consultations, services consistently reported mental health problems of increasing complexity among women clients. For example, services responding to the online consultation were asked to nominate the main mental health issues that affect women clients of their service. All ten services nominated depression, anxiety and trauma; eight nominated personality spectrum disorders; eight nominated psychotic disorders; and four services reported that eating disorders also affected women clients of their services.
Similarly, the Network members reported 80-100% of women in specialist services had mental health problems, particularly anxiety and depression, eating disorders, self-harming behaviours and symptoms of borderline personality disorder.

> All of our women have mental health issues – a lot are on antidepressants – all of them are depressed and anxious. Some have PTSD, and the majority of women have had a major trauma in their lives. Recently we had a woman referred who had just come out of hospital for drug-induced psychosis. [Network member]

> We ask for a mental health report before the client comes in but we sometimes find in the withdrawal period that the alcohol and drug use has been protective of the mental health problem so we will see psychosis emerging. [Network member]

> We have a lot of women on mood stabilisers and we have had a couple of women who’ve come to us on CTOs (Community Treatment Orders)… and went very well actually. We had one young woman who stayed … for five months… but we’ve had other women admitted with psychoses and they struggled to live in that sort of community setting. [Network member]

**Cognitive impairment**

The term cognitive impairment\(^{11}\) is used to describe deficits in cognitive skills or functioning, and includes those both present at birth and acquired later. Deficits related to Foetal Alcohol Spectrum Disorder, traumatic and acquired brain injury, and genetic abnormalities are often grouped under this term. Of the ten services that responded to the online consultation, six highlighted cognitive impairment as a significant issue that affected women clients of their service. Similarly, a member of the Network suggested that cognitive impairment, though common, is often missed in drug and alcohol treatment settings.

> There is a big issue with cognitive impairment in drug treatment settings and people are discharged for non-compliance when in fact they may not be able to understand [what has been asked of them]. [Network member]

**Physical health**

By the time women seek treatment for drug and alcohol issues, many have significant physical health problems. Services that participated in the online consultation reported that women clients are affected by a wide range of problems including blood borne viruses (hepatitis A, B and C); sexual and reproductive health problems; being overweight or underweight; physical trauma (e.g. bone fractures, facial damage, and bleeding, often from intimate partner violence); dental problems; liver problems; infections at injecting sites; and malnutrition. Both Network members and other member services highlighted the importance of addressing physical health as part of a comprehensive treatment plan for women.

---

\(^{11}\) Please see Network of Drug and Alcohol Agencies (NADA) (2013), *Complex Needs Capable: A Practice Resource for Drug and Alcohol Services* for useful information on this topic.
Housing and other support services

Many services also identified inconsistent or poor access to other support services needed by women such as safe and stable housing and/or antenatal care.

Homelessness is also on the top of the list as when women lose their accommodation they end up with someone just to get a roof over their head. They sleep on couches and they trade the need for safety. [Other member service]

Housing is a massive gap. It’s difficult for women with more than one child, single women... if they are on pensions their ability to pay commercial rent is difficult. [Network member]

There is a population of women who want to get out of the criminal justice system and they are stuck and unable to get out. The women have been travelling up to [...] from the city to get away from their old networks but there’s few supports here, there’s no housing. [Network member]

It’s hard to get women into antenatal classes or regular maternal care as they have to go to CUPS [Chemical Use in Pregnancy Services] but that is over an hour away from where our clients live. [Network member]

Changing cohorts of women seeking treatment

In addition to greater numbers of women whose children are in care, and women with more complex mental health issues including trauma, several other emerging cohorts of women seeking treatment were identified, which have implications for how drug and alcohol treatment services respond to meet the needs of a range of women.

The first group identified by Network members are older women who are often high functioning and well-educated professionals that are fairly affluent.

The second group are women who have not accessed treatment services before, and who have been managing their drug and alcohol use for a long period of time, despite high levels of use. Though not as well-resourced as group one, services reported that they have stable accommodation and usually access treatment in response to an event or trigger.

Services outside the specialist women’s treatment sector also reported greater numbers of women with complex mental health issues (including self-harming behaviours) and women with children involved with FaCS. In addition, several services indicated that a greater number of younger women were seeking treatment, many for the first time. Some of these younger women reportedly have problems with

---

12 Another notable group of older women clients identified by the Expert Advisory Group are those that are homeless for the first time due to separation from, or death of, partners

---
alcohol use and some are pregnant. One other member service reported increased referrals of women from CALD backgrounds, including refugees.

[The emerging cohort] does change the way we do business a little bit... now we’re doing business with a highly literate population so the level of cognitive behavioural therapy that you can do with them is a little bit different... and any handouts we give now, we think “well they can do this now...” [Network member]

The drug and alcohol clients tend to be dealing with stuff that has happened - child sexual assault or neglect or both... the system is nipping at their heels and in their 40’s they are dealing with old issues that they have been carrying this whole time. That is our typical client. [Network member]

People are jumping on the internet and seeing pictures... maybe stories about [Hollywood stars] going into rehab may be demystifying fears. [Network member]

Once people used to be referred from agencies but now anyone can go to the internet and work out what they want and where they want to access it. [Network member]

They are coming from the internet – I’ll get email... “I saw your website and I just wanted to know what your program is...”. [Network member]

The views of workers about these emerging cohorts were supported by information gained from women clients during the consultations: a significant proportion of women reported being in drug treatment for the first time, and about half had self-referred, choosing a specific service based on how closely it appeared to meet their particular needs.

Service gaps and barriers to providing services to women in NSW who use drugs and alcohol

Many of the key issues that were identified during the consultations regarding service provision to women and the barriers to providing those services revolve around access to treatment. A number of issues that impacted on access were raised consistently by Network members and other member services during the consultations. These were:

- overall lack of treatment places specifically for women and women with children, a gap which is even more evident in regional and rural NSW
- waiting lists for the places that are available
- access to childcare
- the need to meet criteria for accessing specialist services

One of the hardest things for women is gaining access to treatment – they have issues around children and their relationships and you often find domestic violence and other complicated issues in relation to access. By the time women are seeking treatment they are at the extreme end of the scale - we are not targeting women in the early stages of recovery. [Network member]
• lack of routine aftercare options
• the capacity of services to meet the needs of Aboriginal women and those from culturally and linguistically diverse backgrounds

**Lack of specialist women's treatment places and waiting lists for places**

The Network and many other member services reported that services for women were insufficient to meet demand, and also highlighted the paucity of treatment places outside of metropolitan areas. In particular, residential withdrawal facilities for women and women with children were identified as inadequate.

Due to the limited places in specialist women’s services, there were substantial waiting lists for places in many of the services consulted. One Network member service that offered specialised care and support to substance-using women including the only withdrawal management program available to women with children, reported that **in excess of 220 women were waiting for a treatment place.** Although an extreme example, it provides insight into the often unmet demand for women’s only drug and alcohol treatment in NSW.

Another issue raised by Network members that added to the pressure on specialist places was not always lack of infrastructure but lack of funding for staff. In the case of one specialist residential service, government funding was made available for the addition of six new beds for women and their children, however although the beds are now available an operational grant for the staffing and resources required to increase the services capacity to provide service to the six new beds was not provided and is still not forthcoming five years on.

As several services pointed out, if the service system cannot respond quickly when women ask for help, the window of opportunity for an effective intervention may be missed.

*We get calls from desperate clients who are in danger of having their kids removed by FaCS and we might not have a place. They’ll say “If I can’t get into rehab they are going to take my baby.”* [Network member]

*There is a very small number of treatment places, both residential and day programs, and if you add them and compare the number to men’s programs there is not enough, they are inadequate... they also tend to be closer to metropolitan areas... access to treatment places decreases once you go west in NSW.* [Network member]

*If you’re in the city, life is different – you have options like Jarrah and Phoebe House... they are fabulous and you can have your kids there... out here [rural NSW] there is nothing... We take couples and if the relationship is an issue we try to get them into Relationships Australia but that is 100 kilometres away so we drive them there.* [Other member service]
Access to childcare

Substance-using mothers with children in their care require access to childcare if they are to receive the help that they need. The lack of childcare facilities within services, and poor access to childcare in the community due to high cost or lack of places, were highlighted by many services during the consultations as potential barriers to treatment-seeking by women.

_We have got to have women’s and children’s services, but we also need to be looking at better access to childcare so women can attend a day program if they choose._ [Network member]

Meeting criteria for accessing specialist women’s services

Access to the small number of specialist services was reported to be further complicated by the different entry criteria for each. Mirroring the view of service providers, several women clients referred to the difficulty they had in navigating the drug and alcohol service system.

_The further you get out of the CBD, the less you get... women have to meet specific criteria and as there are not that many services, you need to have more flexible criteria._ [Network member]

_A big issue for us is the number of women who want to come in but don’t have a child. We have to refuse them because we are a parenting program too._ [Network member]

_Pregnant women and young women under the age of 18 are excluded from our organisation by legislation._ [Other member service]

Access to aftercare

Aftercare for women was considered an essential part of drug and alcohol treatment, and some services suggested that they were not adequately resourced to provide effective aftercare. Some services did provide longer aftercare, however, in some cases up to 12 months.

Services also reported that access to aftercare was hindered by inadequate links with reputable and effective therapists to deal with issues that were beyond the scope of drug and alcohol treatment agencies to provide (e.g. childhood trauma, complex family issues). Lack of access to safe and suitable accommodation was also considered a significant barrier to adequate aftercare.

My drug and alcohol counsellor told me I needed to be discharged after I was three weeks clean. I needed ongoing support to stay clean. I didn’t have the skills to express this at the time. But I was under the impression that because I had stopped using he couldn’t see me anymore. [Client]

I have tried many places to get help before but was also turned down due to them saying my problems couldn’t be helped / solved by those services. [Client]

I have got to have women’s and children’s services, but we also need to be looking at better access to childcare so women can attend a day program if they choose. [Network member]
I’ve had several clients who did well over six months [in the program] but they finish and go back to the community, back to their old environments, and there’s not enough support... even for clients who are having counselling it’s only one hour a week – it’s not enough support, and they often relapse. [Other member service]

The biggest problem for aftercare is housing. The Department of Housing policy is to retain the accommodation for three months only and we have a six month program – if a woman has to give up her property she’ll be deterred from coming in – she’ll be homeless... If a woman has lost her baby she is less likely to come into treatment for fear of losing her housing, and if they do come in and lose their accommodation, six months isn’t enough time to find other accommodation for them. [Network member]

Responding to the needs of Aboriginal women

Some services felt that their approach to responding to Aboriginal women was working quite well, while others indicated that they could do better. Members of the Network noted that there were no Aboriginal-specific specialist women’s drug and alcohol treatment services available, which was seen as a considerable gap in services for this cohort of vulnerable women.

Of the ten services that offered their views through the online consultation, all reported having Aboriginal women in their care.

Aboriginal woman need more links to family and community – we need to really look at that now and try to manage that – we refer to Aboriginal specific services if women want that, but we might need to adapt the group program to make it more culturally appropriate by, for example, involving Aboriginal women to co-facilitate groups. [Network member]

Our service has achieved greater engagement with Aboriginal women in our community, by facilitating groups and offering services in a lively non-threatening environment and encouraging consumers to bring another community member to share the learning experience and build community capacity. [Other member service]

Our day program idea is attractive for Aboriginal women. They like the idea that they don’t have to go away...this gives women anonymity and they can be discreet...they’ve told me “No one knows I’m in a treatment program – I’m just not available for a few hours a day.. I say I’m doing a course.” [Network member]
We would love an Aboriginal worker...having an Aboriginal worker would make a big difference in the team...we used to have an Aboriginal admin person that helped to engage women... we would love to have someone that looks at our policies, someone that is more enlightened and can help us discuss how we can improve... [Network member]

Responding to the needs of women from culturally and linguistically diverse backgrounds

Services reported variable success in attracting women from CALD backgrounds. Seven of the ten services that responded to the online consultation indicated that such women were in their care. Another NADA member service identified the physical structure of the treatment services offered to CALD women, a lack of understanding about women’s cultural backgrounds and lack of research into the literacy needs of women from CALD backgrounds as gaps in service provision for these women.

We have good mix of staff with different languages... it does help to have a team with different languages [Network member]

We try to celebrate the different cultural events as we have women for 12 months... [Network member]

We don’t capture as many [women from CALD backgrounds] as we would like to... we don’t recruit well either... [Network member]

What were the access barriers to drug and alcohol treatment for women in NSW?

Of the fifty-one women consulted for this needs analysis, waiting for a treatment place was by far the most frequently identified barrier to gaining access to drug and alcohol treatment. Other barriers to receiving treatment were:

- cost of treatment
- not fitting criteria for service entry
- lack of services where women resided
- transport issues
- services did not accommodate children
- unsuitable appointment times
- unsatisfactory experience with mixed-gender residential rehabilitation
- short duration of programs
- lack of access to aftercare
- lack of personal motivation for treatment

Some women offered brief written examples to NADA of the barriers they had faced in gaining drug and alcohol treatment in the past. These included:
The waiting lists were months long.

A slow process when in crisis or distress.

Not all services allow for newborns to join the program and there was a long waiting list for other programs that accept children.

I was once rejected from a rehab because I had a history of intravenous drug use.

I’m from a country town where there is hardly any practical / decent support. The hospital is the only service and it’s not very helpful.

Previous service offering unsuitable appointment times, especially with public transport and shift hours.

Went to a mixed rehab, women and men. Discrimination issues, men making passes and comments, interrupting each other’s recovery.

Too short (program). Lack of follow up. Lack of structures in place to maintain abstinence.

Short term counselling. Having to change services or worker is an issue – open up then have to wrap it up.

What were the enablers of drug and alcohol treatment-seeking by women in NSW?

It is not surprising that most women indicated that gaining access to treatment without waiting made it easier to receive help. Other treatment enablers were:

- low or free cost of treatment
- suitable location
- access to childcare
- access to transport
- women’s only service

Comments offered by the women included:

When I went to [service] they got me in straight away. There were local aftercare groups, very helpful.

I only waited two weeks it was really easy to get in to and the price is really good, I think a lot cheaper to the last rehab I was at.
I only had to wait a short time to be accepted and the cost of rent is a lot cheaper than the other rehabs and the location was just a train ride away from my home.

Needs met instantly – window of opportunity.

The cost of getting good care is very high in a private facility. But [...] is just as good, even though it’s a public place.

I wanted a long term rehab and a therapeutic community, the advantage of transition and exit houses.

[Service] not far from where [my child] was, low cost and caters for children.

Half of the women chose the particular service they were in for specific reasons. These included:

- women’s only service
- recommended by friends or relatives that had been through the program
- the content of the program was appealing
- children could stay with the mother or were allowed to visit
- ease of access (no waiting list)

I heard [service] has a good reputation it is a long term rehab which I need. I liked the sound of the program and that my son could visit and stay. Also very family orientated and a smaller number of women.

I picked this service because it deals with the issues that I need to deal with, such as parenting issues.

What were the recommendations for improving service delivery?

The Network and other member services

The recommendations made by services for enhancing treatment focused largely on the gaps and barriers that were identified during the consultations and the systems issues in working with other agencies that are important to the care of women who use drugs and alcohol. The duration of the programs on offer, such as the need for flexibility, was also referred to in the recommendations.

Most services identified a need for increasing the capacity of the women’s drug and alcohol service system by establishing new specialist women’s programs or expanding existing services, particularly withdrawal services and those that cater to families.

Recommendations for smaller-scale capacity building initiatives are described here.
Improve linkages and information sharing with FaCS

The Network members made a number of suggestions for improving collaboration between drug and alcohol services and case workers from FaCS. These included the development of a continuum of care model for women in drug and alcohol treatment that are involved with FaCS; education of FaCS workers about best practice in drug and alcohol treatment; increased opportunities for networking and joint training for drug and alcohol workers and FaCS case workers; a dedicated drug and alcohol worker position in FaCS (e.g. seconded from the specialist women’s drug and alcohol service sector) to undertake drug and alcohol assessments and recommend a suitable care plan.

Improve linkages and collaborative care planning with pharmacotherapy prescribers and pharmacotherapy case managers

Network members suggested greater collaboration with prescribers and case managers is required, including involvement of non government drug and alcohol services in treatment planning for shared clients to meet the wide range of women’s needs.

The Network recommended a trial of a model in which a worker from the non government drug and alcohol sector is located in a centralised pharmacotherapy clinic to provide brokerage case management and establish pathways of care for women clients.

More flexible service responses to women in regional and rural NSW

One network member suggested that greater flexibility in service provision was required for women outside metropolitan areas. The establishment of online support for women was suggested as an option.

Enhance the cultural appropriateness of services

Network members and other member services recommended further enquiry into how the needs of Aboriginal women and women from CALD backgrounds could be met. A stand-alone project to look at best practice in these areas with a view to developing a model that could be modified for use throughout NSW was recommended by the Network.

Workforce development

The greater complexity of mental health problems among women who seek treatment from drug and alcohol services, the high prevalence of trauma and the enduring effects of trauma among women in treatment for drug and alcohol problems was a consistent theme of the consultations. Workforce development to increase the capacity of workers to assist clients with complex issues was recommended by many services.
Examination of best-practice for optimum duration of women’s programs

One Network member recommended a review of what is considered the optimum duration of programs for women with a view to modifying programs as required. Although only one member suggested this explicitly, a number of services reported that some programs may be too short and some women clients also linked their length of stay in residential programs to improved treatment outcomes.

Women clients

Clients were asked “What would make drug and alcohol services better for you? (or women in general).”

Many women indicated that they were very happy with the help they had been given, but like service providers, women clients also suggested that more women’s only services and women’s and children’s services should be made available to eliminate waiting lists for treatment places.

Other suggestions made by women were:

- better access to information about programs available (suggested by a number of women)
- better access to aftercare and outreach programs
- longer-term programs
- more opportunities for individual therapy
- more bridging programs (e.g. withdrawal – rehabilitation – aftercare)

Comments offered by the women included:

Easier admission process / shorter waiting list.

More readily available information about the various treatment offerings at each facility.

Accessibility, to have more knowledge about services available for women.

24 hours contact line. One person that you could call on 24 hours.

Better access when needed and not having to go on a waiting list. More information about long term rehabilitation.

Longer programs. Better outreach services.

Intensive aftercare support.
What are the skills and abilities necessary for drug and alcohol workers to enable them to work effectively with women?

Network members and other member services consulted identified a range of skills and abilities that they considered necessary for workers to respond to the increasingly complex needs of women in drug and alcohol treatment settings. These included:

- appropriate qualifications in drug and alcohol treatment or other relevant field (tertiary qualifications in psychology, social work, and nursing were considered highly desirable)
- the ability to provide trauma-informed care
- an understanding of, and responsiveness to, women with mental health issues
- sound conflict resolution skills
- the capacity for self-reflection on professional practice
- non-judgemental practice
- the commitment to client centred practice and capacity for empathy
- an understanding of issues related to gender and gender inequality
- the ability to work with children and families
- recognition of, and commitment to, working within professional boundaries
- an understanding of the issues involved in intimate partner violence and an ability to address those issues with clients.

What topics should be covered by the practice guidelines?

Suggestions for topics for the practice guidelines reflected the treatment setting of the service provider. In addition to establishing the context for specialist women’s drug and alcohol treatment services and the particular needs of women that differ from those of men, the following topics were identified as particularly important:

- responding to complex needs including trauma informed care, mental health and cognitive impairment (including foetal alcohol spectrum disorders)
- working with FaCS
- legal and policy issues (including mandatory reporting, confidentiality, information sharing)
- awareness of, and responses to family violence
- effective management of waiting lists
- providing effective after-care
- providing family-centred care
- holistic client care (beyond basic relapse prevention)
- practicalities of working with clients (content of a session)
- working with pregnant women
- working with women on pharmacotherapy
- fostering attachment between mother and child
- working with other services
- referral pathways between the non government and government sectors
- education resources for drug and alcohol workers
- case studies that illustrate how principles can be put into practice
• descriptions of guidelines available for specific groups such as the National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn
The non government drug and alcohol service system for women in NSW

Another important piece of information required to inform the needs analysis is a snapshot of the non government drug and alcohol service system available to women and women with children in NSW. NADA recently conducted an organisational survey across a specific cohort of the NADA membership, including women-specific services, and relevant data from the 28 participating services are summarised in this section.

A snapshot of the location of women-only services (n=7) and NADA member mixed-gender drug and alcohol services (n=21) surveyed is shown in Figure 1.

Map source: NSW Health Annual Report, 2011-2012 (Service location markers added by authors)

Figure 2. Location of non government drug and alcohol services available to women in NSW by Local Health District

Women-only drug and alcohol services

Seven NADA members reported being providers of women-only services. All were located in Metropolitan Local Health Districts:

- Central Coast (n=1)
- Nepean Blue Mountains (n=1)
- South Eastern Sydney (n=2)
- Sydney (n=3)

13 This is an overview as not all NADA members in scope for the needs analysis completed the organisational survey
Consistent with the views of services consulted for the needs analysis, no women-only services were located in regional or rural NSW.

All specialist women-only services were offered from a single site, with four providing services to women who resided in any area of NSW. Two services accepted clients from any location in Australia, while one service was accessible only to women living in the local area. Six of the seven services offered a residential component in their suite of programs.

**Types of services provided**
The seven women-only services catered primarily to women aged 18 years and over (with children and family considered clients in some services). All of the services provided case management, and the majority offered psychosocial counselling, with one service indicating this was a ‘critical need area’.

Six of the seven women-only programs had a residential component. Two services offer 13-week residential treatment, two services offer up to 26-week stays, and two services provided a therapeutic community program\(^{14}\), one of which targets women on a program of methadone maintenance and their children. Three organisations also provided services through outreach and one service offered a day program.

Residential withdrawal support (with and without medication) was offered by one organisation only. No outpatient withdrawal services were available at the time of writing, the absence of which was considered by some respondents as a substantial gap in services for women.

Supported living and transitional housing programs were also reported as being needed and were provided by three of the seven services\(^ {15}\). Two services reported providing opioid maintenance treatment, with no services funded to provide needle and syringe programs.

**Service utilisation and client access**
Estimates of the number of clients that received a service on an average day ranged from 6 to 20. A rough estimate of aggregated data suggests that about 91 women receive a service from a non-government women-only treatment program each day.

Of the seven services, only two reported that women had no difficulties with accessing their programs. The most common difficulty for clients was considered to be a lengthy waiting list, although this was not an issue for the one participating non-residential service. Three services reported clients had difficulties with accessing their services or programs due to distance and travel requirements, with one state-wide service indicating distance is an issue when providing outreach services to clients that had completed a residential program. Two services identified language and/or cultural barriers as issues for some clients, and the non-residential service indicated service operating hours may present difficulties for some clients.

---

\(^{14}\) One of these services is included in the two that offer up to 26-week residential stays

\(^{15}\) Although accurate at the time of writing, services are subject to change following future funding rounds.
Each one of the six residential programs surveyed reported a client waiting list for access, with considerable variance in the average length of waiting time and number of clients waiting for each service. The shortest estimated average client waiting time was 2-4 weeks. The longest waiting list period was greater than 12 weeks (one service). The average number of clients on the waiting lists ranged from ‘up to 5’ (two services) to ‘more than 30’ (one service).

Three organisations reported they are able to accept clients who are already engaged in an opioid substitution therapy program.

**Barriers to access**

Of the three main reasons clients were not accepted into a service, the two most commonly reported were the need for drug or alcohol withdrawal and being on an opioid substitution therapy program. Severe mental health issues that required acute care, and having a cognitive impairment were also highlighted as barriers to access.

Other barriers reported were related to language issues, lack of available transport, being unable to complete waiting list requirements (i.e. maintain phone contact), poor program fit, and not meeting the age criterion for admission. One service indicated the main reason clients were not accepted was being on an unstable medication regime, or if they have a significant history of (perpetrating) violence.

**Complex presentations**

Concerns about risks of harm to children and/or involvement with FaCS were reported by the majority of services as one of the main issues that increased the complexity of caring for women. Other commonly identified issues were homelessness or risk of homelessness, experience of anxiety and/or depression, and experience of domestic violence. Personality disorders and ‘bipolar or schizophrenia’ were both recognised by services as a main issue. One service reported recent release from prison as a main complexity of their client group.

**Changing patterns in demand for services**

The majority of specialist women’s services reported having noticed a changing pattern in demand for services over the past five years, with four services identifying increased numbers of clients presenting with multiple and complex needs.

One service reported they now had a greater number of women presenting whose children had been removed from their care resulting in fewer requests from women to enter the service accompanied by children. In contrast, another service indicated that demand for services had increased, especially for women with children, and that current service provision was not keeping up with this demand. In addition, one service reported a greater number of clients presenting who “have not had positive drug and alcohol treatment experiences”. Another service emphasised the increased number of clients with concurrent mental health issues, especially borderline personality issues, while another service noted that more clients were re-using their services due to homelessness. This latter service also reported an increase in young clients attending the service, and that their younger clients were increasingly polydrug users.
**Staffing and resources**
All specialist women’s services were staffed by women, with the exception of one service, which along with seventeen female staff, reported having one male staff member. The total number of staff at each service ranged widely, from a non-residential service with only two staff positions to a service with around 27 staff positions that included some managerial and non-clinical positions. No services indicated having any currently vacant positions.

None of the organisations had specific staff positions for any of the following roles: medical officers, addiction medicine specialists, psychiatrist positions, Aboriginal or CALD drug and alcohol workers, intern psychologists, community development workers, quality improvement coordinators, policy officers, research officers or project officers. None of the services had a specific Aboriginal and Torres Strait Islander or CALD positions, or any staff members that identified as Aboriginal, however four services reported staff with a CALD background.

Three of the seven services felt that current staffing at their organisation was not sufficient to meet the needs of their clients and the community. One service reported that in response to insufficient staffing, they are currently restructuring the agency to ensure staff are in positions that match their knowledge, skills and experience and that they identified the need to change their current roster system to better support consistent and effective case management.

Four organisations reported they had experienced difficulties recruiting staff, with two of these services also indicating they had experienced difficulties retaining staff. Difficulty finding staff with appropriate knowledge, skill and/or qualifications was also reported by three services.

**NADA member services that provided care to both female and male clients**
Twenty-one mixed-gender services in NSW participated in the NADA organisational survey. Thirteen were based in metropolitan Local Health Districts, and seven were located in regional NSW Local Health Districts. Nine organisations provided services to clients living anywhere in Australia, four accepted residents of NSW only and five provided services to clients in their local area only. Around half of the services operated from multiple sites.

Services available to women as well as men were located in the Local Health Districts of:
- Hunter New England (n=3)
- Illawarra Shoalhaven (n=3)
- Mid-north Coast (n=1)
- Murrumbidgee (n=1)
- Northern NSW (n=1)
- Northern Sydney (n=1)
- South Eastern Sydney (n=5)
- South Western Sydney (n=3)
- Sydney (n=1)
- Western NSW (n=2)
Types of services provided
Of the 21 services surveyed, sixteen provided services primarily to adult women and men. Of the remainder, one provided services to young people aged 16 to 24 years; one cared for young people aged 13-18 years; one service responded to parents with young children; one catered for young people aged 12-25 years and their families, and one to young people aged 12-29 and their families.

Most services were funded to provide either psychosocial counselling and/or case management. The majority of organisations provided a psychosocial aftercare or continuing care program, and more than half provided services through outreach.

Nine services provided residential rehabilitation, most commonly as a thirteen week stay. Five organisations offered therapeutic communities\(^\text{16}\), of which one service provided residential treatment for clients on methadone who were working towards abstinence.

Four services offered a rehabilitation day program (26 days or more), and one service identified this treatment type as needed. Two services provided needle and syringe programs and one other service provided opioid maintenance treatment.

Service utilisation and client access
Of the 21 services that participated in the organisational survey, the number of clients estimated to receive a service on an average day ranged from seven to 210. The proportion of women among these clients was not stipulated.

Of all mixed-gender services, only seven reported that their clients had no difficulties with accessing their services or programs. The most common difficulties for clients were considered to be a lengthy waiting time for access and distance and travel requirements. Consistent with the women-only service respondents, nineteen of the 21 mixed-gender services indicated they had a client waiting list, most commonly estimated to be 2-4 weeks wait for services. Four services reported a wait list of up to one week, but two services reported an average waiting time of 5-8 weeks. About half the services indicated that 6 to 15 people were on the waiting list, while one service had more than 30 people on its list.

Barriers to access
Of the three main reasons clients were not accepted into a service, the most commonly reported were that clients were a ‘poor fit’ for the service, that clients required drug or alcohol withdrawal management, and that clients did not meet the age criterion for acceptance. In addition, eight services reported they did not accept clients who are already engaged in an opioid substitution therapy program.

Complex presentations
The majority of services indicated anxiety and depression as main issues that increase complexity of client presentations. Other common issues were homelessness or risk of homelessness, recent release from prison, personality spectrum disorder, child and/or sexual assault, and other trauma. A smaller number of services nominated child risk of harm concerns or involvement with FaCS,\(^\text{16}\) One of these services is included in those that provide residential rehabilitation.
experience of bipolar disorder or schizophrenia, family violence, and physical health as issues that increased the complexity of client’s presentations.

**Changing patterns in demand for services**

The majority of services reported they had noticed a changing pattern in demand for their services in the past five years. The most significant were increases in client numbers and demand for services overall, and an increase in the complexity of clients presenting to services.¹⁷

Some services reported increased number of clients with mental health issues and comorbidity and others reported an increase in younger clients. One service indicated they now had greater engagement with clients who were ‘alienated’ from government health services and indicated a lack of services for Aboriginal populations, especially women.

**Staffing and resources**

In the majority of organisations, more than half of the total workforce was female, while five services were staffed entirely by women. Like the women-only services, the total number of staff members at each service ranged widely, from one organisation with two paid staff, to a service with eighty staff members. Thirteen services reported having staff members from a CALD background, and nine services had staff members that identified as Aboriginal or Torres Strait Islander.

Despite high levels of mental health issues among clients, only seven of the twenty-one services reported having designated positions for psychologists. Only one service had a designated position for a part-time psychiatrist, however eight services reported working with a psychiatrist and two worked with a mental health nurse or worker employed by external agencies.

Around one third of services felt that current staffing at their organisation was not sufficient to meet the needs of their clients or the community. Four of these services indicated a need for more clinical and support positions to respond to demand and one service indicated they would benefit from a better gender balance as three quarters of their clients were men.

---

¹⁷ Three services provided detailed figures which indicated the number of requests and/or services provided over the past five years had approximately doubled.
The policy and practice context for delivering drug and alcohol services to women in NSW

The provision of drug and alcohol services by the non government sector to women in NSW is influenced by government policy and the wider health and welfare service system, and a number of important practice guidelines that are described in this section of the report.

Specialist services for women that use drugs and alcohol during pregnancy

There are a number of specialist services for pregnant women who use drugs and alcohol in NSW, including pregnant women enrolled in an opioid pharmacotherapy program. Specialist services include18:

- Drugs in Pregnancy Services (DIPS) located in the Mid North Coast of NSW and Western Sydney
- Chemical Use in Pregnancy Services (CUPS) located at the Langton Centre in the Royal Hospital for Women in Sydney and also in Sutherland
- Drug Use in Pregnancy Services (DUPS) at Westmead and Blacktown
- Substance Use in Pregnancy and Parenting (SUPPS) in Wollongong
- Perinatal and Family Drug Health (PAFDH) located at the Royal Prince Alfred Hospital.

Although there is some variability in practice among these services, they all conduct comprehensive assessments of women for key issues including medical history, mental health, substance use, domestic violence and child protection screening. They are also guided by the SAFE START Strategic Policy and Guidelines that provide a structure for a psychosocial risk assessment and depression screening. Care is provided by specialist services to women throughout pregnancy and a plan for after-care post-delivery, including a visit by a child and family health nurse, and appropriate drug and alcohol support is established at discharge.

Reflecting the scarcity of drug and alcohol services specifically for women outside the major metropolitan areas, few specialist substance use in pregnancy services were available in regional and rural NSW. Secondary consultation was provided to health workers in NSW by staff members from, for example, CUPS at the Langton Centre as required.

---

18 NSW Health (2009) Substance Use in Pregnancy Services and Linkages Review
Drug and alcohol specific guidelines

National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn

Originally published in 2006, NSW Health has commissioned the National Drug and Alcohol Research Centre (NDARC) to update and review these guidelines to inform a consistent approach to the delivery of care to pregnant and newly parenting women in NSW.

The updated guidelines will contain information on the use of buprenorphine maintenance treatment during pregnancy; cannabis use in pregnancy; a recommendation for abstinence from alcohol during pregnancy; and updated information on child protection legislation in NSW. New sections include prescription opioids use in pregnancy; use of antidepressants in pregnancy; management of withdrawal; management of incarcerated pregnant women; and management of women in rural and remote areas.

Neonatal Abstinence Syndrome Guidelines NSW Ministry for Health

These guidelines, published in 2013, outline the minimum standards for the management of babies born to mothers with a history of opioid use or dependence, including women receiving opioid substitution therapy or using prescription pharmaceutical opioids. The guidelines cover antenatal care, the management of withdrawal syndromes in neonates, and postnatal care.

Medicines, such as morphine and barbiturates if required, are administered to babies in accordance with the severity of their withdrawal symptoms. The guidelines recommend a hospital stay of at least five days for babies at risk of withdrawal from maternal dependence on opioids, and up to two weeks for babies at risk of withdrawal from benzodiazepines. Contraindications for discharge include excessive infant weight loss, ongoing withdrawal symptoms, and parenting practices that pose risk of harm to the child.

New South Wales Opioid Treatment Program: clinical guidelines for methadone and buprenorphine treatment of opioid dependence

Published in 2006, these guidelines are the latest in a set of clinical practice guidelines for administering opioid treatment to people who are dependent on heroin and/or other opioids. The guidelines cover the areas of assessment; consent; case management; initiation of treatment; maintenance therapy and take away doses; pregnancy, breastfeeding and neonatal withdrawal; and cessation of treatment.

These guidelines did not recommend buprenorphine to be prescribed for pregnant women due to insufficient evidence at the time for safe use in pregnancy; however the updated National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn provides more recent evidence as to the safety profile of buprenorphine and will recommend its use by pregnant women.
Other guidelines and action plans that influence drug and alcohol service provision to women in NSW

Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants
Published by NSW Department of Health in 2009, Safe Start is one of a suite of three documents aimed at integrating care for women, infants and families in the perinatal period. This document provides guidance on conducting psychosocial assessment, risk prevention and early intervention. Strategies to coordinate clinical responses to issues identified during assessment are also suggested, including effective responses to parental mental health problems and perinatal psychosocial issues, as well as advice on assisting mothers that have problems with substance use.

Keep Them Safe: A shared approach to child wellbeing
In response to findings from the Wood Special Commission of Inquiry into Child Protection Services in NSW, the NSW government enacted a five year plan entitled Keep Them Safe, which spans the years 2009-2014. Keep Them Safe was designed to enhance the broader service system in NSW to improve prevention and early intervention services; protect children at risk; support Aboriginal children and families; and to strengthen partnerships with non government agencies to improve service delivery to vulnerable families. As a result of Keep Them Safe, a number of guidelines and legislative changes have taken place in the child protection arena in NSW, which are described briefly below.

Child Wellbeing and Child Protection – NSW Interagency Guidelines
Published in 2006, these guidelines were produced by Family and Community Services to support collaborative efforts to improve child wellbeing and child protection in NSW. They cover inter-agency collaboration initiatives; roles and responsibilities of agencies in child protection matters; making a child protection report voluntarily or through mandatory reporting requirements; exchange of information with FaCS; criminal proceedings; and best practice in working with children and families.

NSW Mandatory Reporter Guide
All non government drug and alcohol service providers in NSW are mandatory reporters under child protection legislation. To assist workers to navigate the ‘grey areas’ and make confident decisions when considering making a child protection report to Family and Community Services, a Mandatory Reporter Guide is available online.

Future legislation and treatment models that may influence drug and alcohol service provision to women in NSW

Potential amendments to legislation governing the ‘Parent Responsibility Contract’
At the time of writing, the NSW Government was considering introducing amendments to the Parent Responsibility Contract arrangements that are in place in NSW. Currently, the contract with the Children’s Court is entered into voluntarily by parents of a child or young person for a maximum

period of six months. The contract is designed to strengthen the commitment of parents to improve their parenting skills through, for example, support offered by welfare services. In cases where the contract is breached, a breach notice can be filed with the Children’s Court and the need for care and protection of the child or children are considered by the court and relevant actions are taken.

Reforms to extend the contract to women who are pregnant are now being considered. According to an information brochure available on the FaCS website:\(^{20}\):

\[\text{Currently there is no power within the Children and Young People (Care and Protection) Act 1998 (Care Act) to require parents who have disengaged with voluntary early intervention support to attend a parenting capacity program, counselling, or other personal development or support group (e.g. drug and alcohol counselling and domestic violence support groups). Under the proposed reforms, the Children’s Court will be able to issue a new stand-alone parenting capacity order and stipulate attendance at a particular service or program.}\]

Should these reforms be passed through both houses of NSW parliament, there may be implications for the way in which non government drug and alcohol services deliver services to pregnant women under care and protection orders, particularly in light of the existing issues in working collaboratively with FaCS that were identified by services during the consultations. The potential amendments may impact on, for example, engaging pregnant women into treatment, strengthening pregnant women’s motivation for maintaining treatment, and managing pregnant women who drop out of treatment prematurely, particularly as treatment non-compliance may lead to the removal of children from a client’s care.

**Drug and Alcohol Clinical Care and Prevention Planning Project**

The NSW Ministry for Health and the Australian Government Department of Health have funded the Drug Policy Modelling Program at NDARC to build the first national population based model for drug and alcohol service planning that will estimate the need and demand for services and calculate the resources needed to provide such services.

Care packages will be developed for young people, adults and seniors over the age of 65 years for a range of service types, including community, residential, inpatient hospital, inpatient community and primary care services. A tool will be produced that will allow each jurisdiction to plan for drug and alcohol service provision. Services for pregnant women who are using drugs and alcohol will be considered and ‘spread across the model’:\(^{21}\).

---


Summary and recommendations

This section details the recommendations for consideration by NADA to enhance the non government drug and alcohol sector for women in NSW. The recommendations are based on a synthesis of all data collected during the needs analysis, and were developed in response to the following questions:

a) What constitutes good and best practice in women’s drug and alcohol treatment?
b) What are the main issues in providing drug and alcohol services to women in NSW?
c) What are the needs of women who seek treatment for drug and alcohol issues?
d) What are the views of the Women’s Alcohol and Other Drug Services Network and other NADA member services?
e) What is currently offered by the non government drug and alcohol sector in NSW and where are the gaps?

Among those consulted for the needs analysis, there was broad agreement that places in specialist women’s drug treatment services were insufficient to meet demand, with one such service reporting that more than 200 women were waiting to gain entry. Both the consultations and data from NADA’s organisational survey of members revealed that most specialist women’s services and mixed-gender services had established waiting lists for treatment, with some clients waiting in excess of 12 weeks for a treatment place.

In addition to a general lack of capacity to provide specialist drug and alcohol services to women with and without children in a timely way, a number of other key issues were identified by members of the Network, many other members services and women clients. These were:

- Inconsistency in communication and collaborative partnership arrangements between drug and alcohol service providers and case workers from FaCS in regard to child protection matters and care planning for mothers.
- Lack of coordination and formal collaboration between drug and alcohol service providers and opioid pharmacotherapy prescribers and other clinic staff in relation to wrap-around care for women on pharmacotherapy programs.
- Absence of specialist women’s drug and alcohol services in regional and rural NSW.
- The increasing complexity of client presentations, including high prevalence of mental health problems and experiences of trauma.
- The variable capacity of specialist drug and alcohol treatment services to meet the needs of Aboriginal women.
- The variable capacity of specialist drug and alcohol treatment services to meet the needs of women from CALD backgrounds.
- The difficulties women face when navigating the drug and alcohol service system, particularly gaining access to sufficient information about the services that are available including criteria for admission/acceptance into programs.

In light of the information gained through the needs analysis, the following strategies for enhancing the drug and alcohol non government sector in NSW to respond to the needs of women are
considered to be the highest priority at this time and are therefore recommended for consideration by NADA and specialist women's drug and alcohol treatment services in the context of the Women's Alcohol and Other Drug Services Development Program. It is recognised that some of the recommendations would require additional funding beyond that available, however they are included here to provide context for those initiatives that could be reasonably funded through the Development Program.
Recommendation 1 refers to the overall lack of specialist women’s drug and alcohol treatment places available in NSW, including places for specific groups of women.

### 1. Increase the number of women-specific drug and alcohol treatment places in NSW

Of all drug and alcohol closed treatment episodes in NSW in 2010-2011, only about 32% were provided to women. All specialist women’s residential treatment services had a waiting list for entry at the time of reporting, as did most mixed-gender non government services that responded to NADA’s organisational survey. The needs analysis found that no specific places for Aboriginal women or those from CALD backgrounds were available in specialist women’s treatment services; there were no women-specific non government drug and alcohol treatment places available outside of metropolitan Local Health Districts; and only one women’s specialist service offered withdrawal management, for which in excess of 220 women were waiting for a treatment place. To meet the needs of substance-using women in NSW, more treatment places - both inside and outside of the metropolitan area - are required.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the number of women-only treatment places available for women in all areas of NSW. Places would include both residential and non-residential places (including day programs) for women; women with children; and pregnant women.</td>
<td>● Women, who are under-represented in drug and alcohol treatment compared to men, have greater access to gender-specific treatment places and are afforded greater choice both in treatment setting and the location of treatment.</td>
</tr>
<tr>
<td>2. Increase the number of specialist places that offer withdrawal treatment to women and women with children.</td>
<td>● The lengthy waiting list for withdrawal beds is reduced and women that are subject to Care and Protection Orders may complete withdrawal in a timely way for their own benefit and that of their children.</td>
</tr>
<tr>
<td>3. Examine models of care for Aboriginal women that could be adapted for use across services in NSW (for example, the outreach model practiced by Lyndon Community), and establish the type of treatment places in sufficient numbers and locations to meet the identified needs of Aboriginal women.</td>
<td>● Culturally-appropriate services are offered to Aboriginal women in NSW and equity of access to services is established.</td>
</tr>
<tr>
<td>4. Examine models of care for CALD women that could be adapted for use across services in NSW, and establish the type of treatment places in sufficient numbers and locations to meet the identified needs of CALD women.</td>
<td>● Culturally-appropriate services are offered to CALD women in NSW and equity of access to services is established.</td>
</tr>
</tbody>
</table>
Recommendation 2 addresses the capacity of the non government drug and alcohol sector overall to assist women in NSW.

### 2. Promote a ‘women-friendly’ non government drug and alcohol service system

With limited places available in women-only specialist drug and alcohol services, and none available outside of the metropolitan Local Health Districts, mixed-gender services also need to be appealing to women and services in regional and rural NSW require added support. Strategies to increase women’s access to effective, gender sensitive and culturally appropriate drug and alcohol treatment are required.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Based on the upcoming guidelines that will be produced by NADA in 2014, create a ‘women-capable’ drug and alcohol endorsement system for service development. A self-assessment framework could be included in the practice guidelines to facilitate this system. The Women’s Network is well-placed to endorse services as women-friendly or ‘capable’ upon application. Endorsed services could then promote themselves to women who are seeking treatment in NSW as having special interest in, and capacity for, women’s drug and alcohol treatment.</td>
<td>• Services are assisted to voluntarily self-assess for their capability to provide gender-sensitive and effective services to women against set criteria and make improvements accordingly.</td>
</tr>
<tr>
<td>2. Establish a yearly or biannual symposium on women’s drug and alcohol treatment and related support that is free of charge or low cost to attend. This could coincide with NADA conferences or events.</td>
<td>• Women are provided with more information about available services to support informed decision making in treatment seeking.</td>
</tr>
<tr>
<td>3. Create a new position for a senior nurse (e.g. Clinical Nurse Consultant for Women’s Drug and Alcohol Treatment) in one of the women-only specialist services. The nurse would have a state-wide capacity building role and would provide secondary consultation to mixed-gender services in NSW (including those in rural and regional areas), and monitor the initiatives that are funded by NADA through the Service Development Grants. The nurse would assist NADA to disseminate the practice guidelines and offer training to support translation of the guidelines to practice.</td>
<td>• Programs are showcased, emerging issues are identified, research and innovation is encouraged, and links and partnerships are strengthened in NSW and nationally.</td>
</tr>
<tr>
<td>4. Build an online presence for women’s drug and alcohol treatment in NSW (adding an area to the existing NADA website could be considered) that acts as a portal for information sharing and may also be used by women to find an appropriate service. The Dovetail website for youth drug and alcohol services in Queensland is an example (<a href="http://www.dovetail.org.au">www.dovetail.org.au</a>) of what may be achieved with adequate resources.</td>
<td>• Women’s drug and alcohol treatment is identified as a sub-speciality within drug and alcohol treatment.</td>
</tr>
<tr>
<td>• Provides a dedicated position that drives the momentum of capacity building initiatives and is a central point of contact for services in NSW.</td>
<td></td>
</tr>
<tr>
<td>• Services are assisted to enhance collaboration with pharmacotherapy prescribers, FaCS, CUPS, DIPS and other specialist government services for pregnant women who use substances.</td>
<td></td>
</tr>
<tr>
<td>• Provides a coordinated approach to information dissemination.</td>
<td></td>
</tr>
<tr>
<td>• Encourages a ‘community of practice’ in women’s drug and alcohol treatment.</td>
<td></td>
</tr>
<tr>
<td>5. The senior nurse and endorsed ‘women-capable’ services support drug and alcohol non government services in regional/rural NSW with secondary consultation and advice regarding the women clients in their care.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>• Services all over NSW have greater capacity to respond to women’s treatment needs.</td>
<td></td>
</tr>
</tbody>
</table>
Recommendations 3 and 4 are intended to improve coordination of care for women and women with children.

### 3. Improve collaboration between drug and alcohol services and Family and Community Services for women with children who are subject to child protection orders

A coordinated approach by drug and alcohol services and FaCS is required to ensure the best outcomes for women and their children are achieved. In light of the proposed legislative changes regarding the Parent Responsibility Contracts, the importance of collaboration between the sectors to assist pregnant women to meet the requirements of such contracts cannot be overstated. A collaborative approach is consistent with FaCS recommendations.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish a Child Protection Co-ordinator position that would be responsible for a range of activities to promote collaboration between the non-government drug and alcohol sector and FaCS. These activities could include the establishment of an interagency committee that acts as a conduit between FaCS and the drug and alcohol sector, arranging joint training opportunities and other workforce development initiatives, and providing practical assistance to services regarding child protection issues that impact on women’s drug and alcohol treatment.</td>
<td>• The sharing of information on issues related to best practice in drug and alcohol treatment and child protection would be increased. • Barriers to collaboration would be identified and potential solutions could be generated and implemented in ways that best suit the location and the client group.</td>
</tr>
<tr>
<td>2. Trial a program of outreach from a women’s drug and alcohol service into a FaCS office in the Metropolitan Local Health District to determine an effective model for liaison and collaboration that could be adapted for implementation in other geographical areas.</td>
<td>• The working relationship between drug and alcohol services and FaCS in the trial area would strengthen. • Should the trial be successful, the model may be adapted and implemented in other locations in NSW.</td>
</tr>
<tr>
<td>3. Work with FaCS to identify satisfactory arrangements for women with children on care and protection orders that are on a waiting list for a place in a specialist women’s service.</td>
<td>• Women for whom retaining children in their care is contingent on receiving drug and alcohol treatment are supported during the wait for a treatment place.</td>
</tr>
</tbody>
</table>

4. Improve co-ordination of care with pharmacotherapy prescribers for women whose care is shared by non government drug and alcohol services and pharmacotherapy programs.

Collaboration with prescribers and case managers in pharmacotherapy clinics can assist women to access the wide range of additional support services required to promote their optimal well-being.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
</table>
| 1. Trial a program of outreach by staff from a women’s drug and alcohol service into a large pharmacotherapy clinic within the boundary of the metropolitan Local Health Districts to determine an effective model for collaboration that could be implemented in other geographical areas. | • Shared-care arrangements are formalised or strengthened.  
• Pathways of care are established and disseminated throughout the sector.  
• Women have greater opportunities to access a range of support services. |
| 2. Encourage opportunities for joint case conferencing between the non government drug and alcohol sector and pharmacotherapy prescribers and case managers and disseminate effective models to the sector. |               |
Recommendations 5, 6 and 7 address the common barriers women face when accessing drug and alcohol treatment.

5. Put into place a range of strategies to maintain engagement of women on a waiting list for treatment

Most services reported having a waiting list for treatment places and the women consulted for the needs analysis highlighted lengthy waiting lists as a barrier to treatment access. The waiting period for treatment entry poses significant risk for increased substance use or a loss of motivation to begin treatment, and as women are often reluctant to seek treatment in the first instance, wait-list management should be conducted routinely.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support services to establish or strengthen wait-list management strategies such as:</td>
<td>• Women can begin to get help at a time when their motivation is highest.</td>
</tr>
<tr>
<td>• Phone contact /sms contact</td>
<td>• The engagement of women with treatment services would be maintained until a place becomes available.</td>
</tr>
<tr>
<td>• Referral to groups as an entry to treatment</td>
<td>• There is potential for waiting lists to be reduced should women gain benefit from briefer interventions.</td>
</tr>
<tr>
<td>• Routine screening and ultra-brief interventions at the time of initial contact</td>
<td>• Seventy per cent of the services that responded to NADA’s organisational survey reported that they offer some form of aftercare. There is potential to integrate wait-list management strategies into existing aftercare arrangements.</td>
</tr>
<tr>
<td>• Referral to ‘Access to Allied Psychological Services’ (ATAPS) if the waiting period is lengthy</td>
<td></td>
</tr>
<tr>
<td>• Single session brief screening and advice from a worker similar to the mental health ‘Advice Clinics’ or ‘Walk in’ models established in the United Kingdom and the United States of America</td>
<td></td>
</tr>
<tr>
<td>• Self-directed interventions (e.g. self-help booklets, online support)</td>
<td></td>
</tr>
<tr>
<td>• Seventy per cent of the services that responded to NADA’s organisational survey reported that they offer some form of aftercare. There is potential to integrate wait-list management strategies into existing aftercare arrangements.</td>
<td></td>
</tr>
</tbody>
</table>

---

23 Requires GP referral and allows clients to have six sessions with a mental health professional free of charge.

24 Mental health advice clinics have been trialled in Glasgow as part of a stepped care approach to mental health. These advice clinics offer a 30-minute appointment with a clinician. Although there is an appointment system, the appointment may be made immediately and the clinics operate on a rapid-access basis and offer brief assessment and advice, risk assessment and referral. Mental health walk-in and advice clinics have also been trialled in the United States of America.
6. Improve access to information about drug and alcohol and other support services available to women in NSW

Services highlighted criteria for admission to programs as a barrier to treatment access and many services that responded to NADA’s organisational survey indicated that clients were often not accepted into their programs due to ‘poor fit’. Many women clients also described having difficulty finding information about available services. As about half of the 51 women consulted had self-referred to the services they were engaged with, and many were receiving help for the first time, women need information to make informed decisions about the services they choose to attend.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish an internet based information portal (or host the material on the service website as described under Recommendation 1) that provides detailed information about the services available, including program content, criteria for acceptance, location, cost, provision for childcare, accessibility by public transport, and contact details. The site should be optimised to be easily found by women (and other service providers to enable appropriate referral) during an internet search, and should contain a robust internal search engine or filter so women can find the type of service they are looking for easily. It could also offer evidence-based self-help materials including an opportunity for drug and alcohol self-assessment. Services that have undertaken a voluntary ‘women-capable’ endorsement should be branded as such.</td>
<td>• Women from any location in NSW have access to accurate and up-to-date information on available services.</td>
</tr>
<tr>
<td></td>
<td>• Women have access to earlier intervention opportunities.</td>
</tr>
<tr>
<td></td>
<td>• Self-help materials may assist with wait-list management.</td>
</tr>
<tr>
<td></td>
<td>• Women are made aware of the services that have a special interest in women’s drug and alcohol treatment and have sought endorsement as ‘women-capable’ services.</td>
</tr>
<tr>
<td></td>
<td>• Service providers also have access to detailed information which may be used to refer women to the most appropriate treatment service to meet their needs.</td>
</tr>
<tr>
<td>2. Consider funding a dedicated telephone number for women seeking information and drug and alcohol treatment through St Vincent’s Hospital Alcohol and Drug Information Service (ADIS), similar to the newly established Stimulant Treatment Line.</td>
<td></td>
</tr>
</tbody>
</table>
7. Improve access to childcare for women receiving drug and alcohol treatment

Services indicated that lack of access to childcare was a barrier for women when seeking treatment for the first time and for maintaining them in treatment. The women clients identified access to childcare as an enabler of treatment and the need for childcare also features strongly in the literature. In some locations, such as the Australian Capital Territory and Western Australia, childcare is subsidised for women who are engaged in drug and alcohol treatment. For example the Western Australia Network of Alcohol and Drug Agencies (WANADA) coordinates a childcare voucher system for women in treatment to be spent at their choice of any one of the 100 participating child care centres.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund a trial of a voucher system for childcare or other initiative that meets to needs of services in particular geographical areas.</td>
<td>Increased ease of entry to treatment by women whose lack of access to affordable childcare is a barrier.</td>
</tr>
</tbody>
</table>

Recommendation 8 addresses workforce development needs to respond to increasingly complex mental health and trauma presentations among women in NSW.

8. Support workforce development initiatives to enhance the capacity of the non government drug and alcohol service sector to respond effectively to women with complex mental health issues and experiences of trauma

The prevalence of mental health symptoms and the enduring, negative effects of trauma on women seeking drug and alcohol treatment are high. The issue of increasing complexity in the presentation of women to treatment services was a hallmark of the consultations conducted for the needs analysis. Women also indicated that they needed a safe place to deal with the ongoing effects of traumatic experiences. Workers require training and ongoing workforce development opportunities in the areas of mental health and trauma.

<table>
<thead>
<tr>
<th>How could this be achieved?</th>
<th>Expected benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. The practice guidelines to be developed by NADA in 2014 will include evidence-based approaches to caring for women with complex mental health and trauma issues. Training for frontline workers in implementing the guidelines will assist in the translation of these guidelines to practice.</td>
<td>The workforce has greater knowledge of these important issues, sustained by mentoring and regular knowledge transfer, resulting in the sector having increased capacity to respond effectively to women with complex presentations.</td>
</tr>
<tr>
<td>4. Establish a ‘community of practice’ with membership drawn from services across NSW to share information and best-practice strategies for complex presentations.</td>
<td></td>
</tr>
<tr>
<td>5. Identify a small team of specialists from within the sector who are willing to act as mentors for other workers and provide secondary consultation and supervision via telephone or in person.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6.</td>
<td>Ensure topics on mental health and trauma are included in the annual Women's Drug and Alcohol Treatment Symposium (as per recommendation 1).</td>
</tr>
<tr>
<td>7.</td>
<td>Fund workers to attend specialised training in this area.</td>
</tr>
</tbody>
</table>
References


23. Burns, L. and C. Breen, *It’s time to have the conversation: Understanding the treatment needs of women who are pregnant and alcohol dependent*. 2013, FARE: National Drug and Alcohol Research Centre, University of New South Wales.


63. Terplan, M. and S. Lui, Psychosocial interventions for pregnant women in outpatient illicit drug treatment programs compared to other interventions, in Cochrane Database of Systematic Reviews. 2007, John Wiley & Sons, Ltd.


74. Centre for Substance Abuse Treatment, *A provider’s introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals*, in DHHS 2001, Substance Abuse and Mental Health Services Administration: Rockveill, MD.


