

**Evidence Check**

Women and women  
with children  
residential  
rehabilitation best  
practice

An **Evidence Check** rapid review brokered by the Sax Institute for the NSW Ministry of Health, Centre for Population Health, Alcohol and Other Drugs Branch. November 2017.

**This report was prepared by:**

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Monash University

November 2017  
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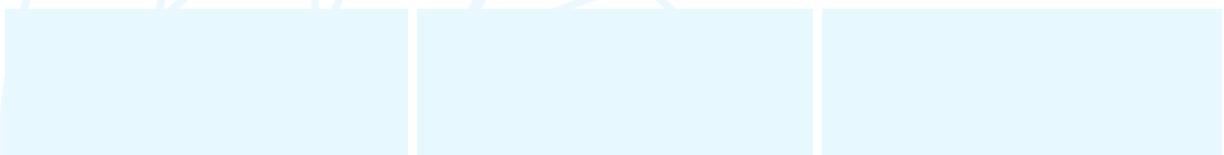
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# Women and women with children residential rehabilitation best practice: a rapid review

An **Evidence Check** rapid review brokered by the Sax Institute for the NSW Ministry of Health. November 2017.

This report was prepared by Brett Williams, Kelly-Ann Bowles, Samantha Chakraborty, Bronwyn Beovich, John Bowles, Megan Jepson.



# Contents

1	Executive summary .....	5
	Review questions.....	5
	Search results.....	5
2	Background .....	7
3	Introduction .....	8
	Aims .....	9
	Methods used in current review .....	10
	Results and discussion .....	12
4	Results .....	14
	Review Question 1: What are the best models of care for women with dependent children in residential rehabilitation for alcohol and other drug problems?.....	14
	Review Question 2: What are the best models of after-care delivery that ensure that women with dependent children continue engagement with their treatment? .....	19
	Review Question 3: What is the evidence of benefit to women and/or to their dependent children of treatment services which allow the children to remain with the parent during treatment?.....	20
	Additional findings outside the research question .....	23
	Grey literature.....	26
	Gaps in the research (Gap analysis).....	30
	Potential subsequent phase of research .....	30
5	Limitations of this review.....	32
6	Conclusion .....	33
7	References .....	34
8	Appendix 1 .....	36
	Table A: Summary of studies used in this review.....	36
9	Appendix 2 .....	40
	Table B: Quality assessments for publications in the review.....	40
10	Appendix 3.....	42
	Table C: Assessment of overall quality (grade).....	42
11	Appendix 4.....	44
	Table D: Existing women and women with children residential rehabilitation programs.....	44

# 1 Executive summary

The effects of drug and alcohol problems can be devastating on patients and their families, and also place a large financial burden on government budgets. Research has shown that allocating funds to drugs and alcohol treatment is a strong investment, with a \$1 contribution to treatment resulting in a \$7 monetary benefit to society. Some treatments with positive outcomes for clients include women-only programs, and early intervention programs for pregnant women, which have resulted in positive outcomes for the baby's health. Before governments contribute large amounts of spending on residential rehabilitation women-only programs it is imperative that the current evidence be reviewed to ensure the best outcomes for governments, clients and the wider community.

## Review questions

This review includes three questions relating to residential rehabilitation for women with drug and alcohol problems, which were drafted by the commissioning body. The specific questions were:

1. What are the best models of care for women with dependent children in residential rehabilitation for alcohol and other drug problems?
2. What are the best models of after-care delivery that ensure that women with dependent children continue engagement with their treatment?
3. What is the evidence of benefit to women and/or to their dependent children of treatment services which allow the children to remain with the parent during treatment?

## Search results

The designed search strategy resulted in 5939 publications from four databases. After 2145 duplicate publications were removed, 3794 abstract and titles were reviewed. On review, 3654 publications were removed that did not meet the inclusion criteria. The remaining 140 full text publications were reviewed, with a further 127 reviews excluded, leaving 13 peer-reviewed publications. Hand searching resulted in an additional three publications, and so 16 publications are included in the review (two publications are on the same study results). Five of the articles included in the final yield were reviews of international literature. Of the remaining articles, 10 of the 16 articles were from the US and one was from Finland. In addition to the five review articles, six articles were qualitative studies, three articles had a cohort research design, two were cross-sectional and one was quasi-experimental. Fourteen of the included articles focused on outcomes for mothers participating in residential rehabilitation with two studies focusing on children's outcomes.

To date, the current evidence would suggest that women have positive outcomes when participating in women-only residential rehabilitation. It is suggested that these programs should have a minimum length of stay of six months, and should include comprehensive or integrated programs including prenatal services, child care and mental health programs. Although there is no evidence recommending one model of care over another, individual evaluations have highlighted the benefits of various components.

Unfortunately, there is no strong evidence suggesting one model of after-care compared to another. Researchers have highlighted barriers to continued engagement but not all have focused primarily on women with dependent children.

The current evidence would suggest that allowing children to stay with their mothers during treatment can increase motivation to seek treatment and remain in treatment. It is also reported that having the children in treatment can assist in the mother developing her parenting skills in a safe environment and can help build the mother-child bond. The research does not ignore the fact that having the children in treatment can increase stress during this already difficult period of time. Other research does suggest that having children in treatment can be beneficial for other women in the program (in addition to the mother). Overall, the research suggests that women find it beneficial to have their children with them during treatment.

Although the evidence has allowed for some recommendations, as this area of research is still in its infancy, the following areas of research should be considered:

- Future research should include mixed method designs, including qualitative and quantitative data
- A full economic or cost benefit analysis on different models of care
- Comparative research to test either superiority or non-inferiority for one model of care over another
- Consistent, reliable and valid measures to ensure research quality
- Longitudinal research to determine the long-term effect of the different models of care
- Models of care that have been established in the US need to be evaluated in the Australian setting. Programs such as the Oxford House design (with women living in a share house to support each other) warrants further investigation
- Treatment outcomes for diverse cultural groups need to be evaluated. Specific attention should be given to Indigenous communities, where respect is a cultural requirement to ensure client engagement
- The effects on children who reside with their mothers during residential rehabilitation
- Understanding the clientele in the Australian context and the current and potential funding models for these patients.

This rapid review collates the current evidence and also presents a list and discussion of residential rehabilitation programs currently available for women. Future government spending should be prioritised to this aspect of the health service and all new services should be systematically evaluated to ensure the model of care provides the best opportunity for recovery for women with drug and alcohol problems.

## 2 Background

In the NSW Drug Package (from the 2016-17 NSW Budget), \$8 million dollars has been allocated to increasing residential rehabilitation for women and parents with dependent children. Over the four years of the package, the aim is to assist an additional 1000 people to access drug and alcohol rehabilitation services. The NSW Ministry of Health will ensure that people will receive the best treatment by only investing in best practice models of care.

This review aims to identify best-practice models of residential rehabilitation services for women (including pregnant women) and women with dependent children.

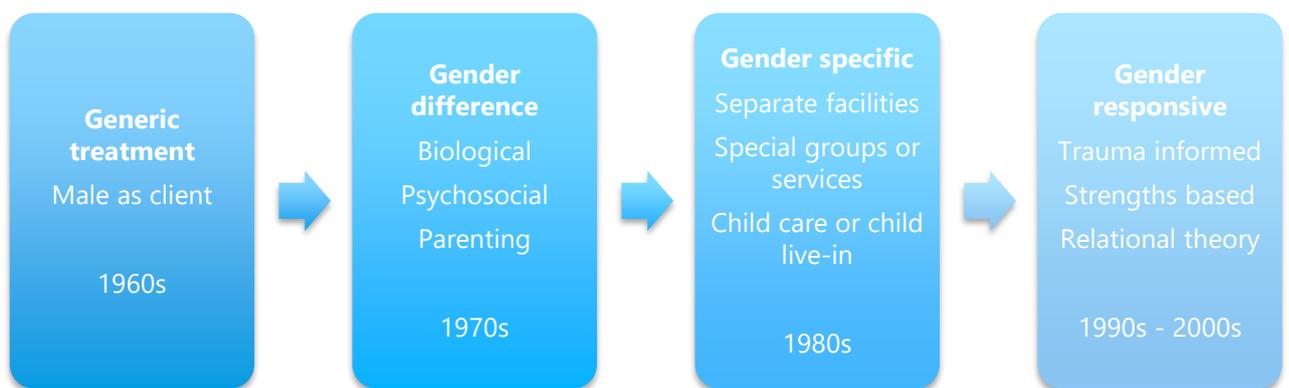
Drug and alcohol services in the NSW public health sector are focused on acute management of withdrawal and detoxification. There are currently no public health services offering residential rehabilitation. The Drug Package funding may be used to develop new services but it will not be for capital works. Existing services are provided by non-governmental organisations (NGOs) and it is expected that NGOs will submit proposals for enhancing existing residential rehabilitation services. There is little information, however, about the effectiveness of existing services provided by NGOs and the real cost of providing these services. In addition, there are substantial variations in the characteristics of such services including eligibility criteria, age and demographic characteristics of clients, length of stay, age of dependent children permitted to stay with the parent, and the scope of other support, transitional services and aftercare.

To assist the NSW Ministry of Health in future decision making, this review will address the evidence regarding: models of care for women in residential rehabilitation for drug and alcohol problems; models of after-care that improve continued engagement in treatment for women with dependent children; and the benefits of dependent children remaining with their mothers during treatment. For the purpose of this review the focus is on women-only services, and services for women with dependent children, that involve residential rehabilitation.

# 3 Introduction

The Australian National Council on Drugs has reported that the average cost of treating a person in a residential drug treatment facility is \$215 per day or \$16,110 per treatment episode.<sup>1</sup> Although this treatment is costly for a public health service, research has also suggested that a \$1 investment in drug and alcohol treatment can result in a \$7 monetary benefit to society.<sup>2</sup> These findings show that investment in rehabilitation can return a cost saving to government budgets, and therefore it is reasonable to expect that the development of evidence-based models of care will not only continue to improve the monetary return to governments but will improve the quality of life outcomes for those with drug and alcohol problems. As drug and alcohol problems can have devastating effects on patients and their families, a stronger understanding of the current evidence is urgently required.

Traditionally, drug and alcohol treatment programs were designed for male clients. Grella<sup>3</sup> identified the changes in treatment programs for men and women over the past 40 plus years, with Figure 1 graphically illustrating this process. The past 30 years has shown that women have differing needs to men in residential rehabilitation, and women often present to rehabilitation with differing histories, including domestic violence and related trauma.



**Figure 1. Evolving treatment approaches**

Adapted from Grella (2008). "From generic to gender responsive treatment"

Other researchers have also identified the need to address women-specific requirements in residential rehabilitation. Greenfield<sup>4</sup> observed the ratio of men and women in rehabilitation is less than the gender prevalence of substance use in the community. Also, women with substance abuse disorders tend to experience more severe medical and social consequences when compared to men. She noted that the odds of completing treatment were three times higher among adult clients in non-hospital residential rehabilitation facilities when compared to those in outpatient methadone programs. These findings suggest that more needs to be done to ensure that women have access to suitable rehabilitation programs for their drug and alcohol problems, and ideally these programs should incorporate a residential component.

For any treatment to be successful it is important to understand the client. According to Baird<sup>5</sup>, women seeking treatment for substance disorders tend to be in their late 20s or early 30s, are unmarried with several children, are unemployed and have fewer than 10 years of education. These women are more likely to use cocaine, alcohol or methamphetamines as their drug of choice, and are highly likely to also have a mental health disorder, have a history of trauma as a child or adult and have had dealings with criminal

justice or child protection services. By having a better understanding of the client, providers of rehabilitation can identify the barriers to treatment completion and hopefully retain clients to ensure better outcomes for them and their children.

There are major barriers for pregnant women and women with dependent children when it comes to residential rehabilitation. A Canadian information sheet and business plan targeting Indigenous women and children<sup>6</sup>, highlights that there are limited residential options for women with dependent children for drug and alcohol rehabilitation. Some of these women are forced to give up custody of their children to enter residential rehabilitation, and this pressure is compounded with the fear of not having the children returned to them after the treatment. Some women also leave residential rehabilitation programs early due to the fear of the wellbeing of their children. Although these findings may not be completely transferable to the Australia setting, the need for evidence-based models of care for residential rehabilitation is just as important in Australia as it is internationally.

Currently, there is a growing body of evidence supporting the need for women-only residential rehabilitation programs, and there is evidence the early intervention in pregnant women can improve birth outcomes for baby, although these findings are not residential specific. As governments embark on residential rehabilitation programs for women and women with children, the evidence must be reviewed and evaluated.

### **Aims**

This review aimed to identify peer-reviewed and grey literature related to residential rehabilitation models of care for women and women with children. For the purpose of this review, the care model required a residential component, designed to treat women recovering from alcohol and drug addiction in women-only centres. Research pertaining to women in mixed gender programs was not in the scope of this review. Clients in the service should enter treatment voluntarily, and information for all cultural and linguistic backgrounds was included. The review aims to assist policy makers to assess the most effective model of care for the residential treatment of women with drug and alcohol problems in the public health service.

### **Review Questions**

This review includes three questions relating to residential rehabilitation for women with drug and alcohol problems, which were drafted by the commissioning body. The specific questions were:

1. What are the best models of care for women with dependent children in residential rehabilitation for alcohol and other drug problems?
2. What are the best models of after-care delivery that ensure that women with dependent children continue engagement with their treatment?
3. What is the evidence of benefit to women and/or to their dependent children of treatment services which allow the children to remain with the parent during treatment?

## Methods used in current review

A rapid review of both peer-reviewed and grey literature was conducted to provide a holistic evidence check for all three review questions. The research team were commissioned in December 2016 to complete the rapid review, and the search strategy was discussed and agreed with the commissioning group later that same month. This initial summary of findings was submitted for feedback in January and the final report was submitted in March 2017.

## Peer-reviewed literature

The following databases were used to provide the academic literature for this review:

- Ovid Medline (1946 – current)
- CINAHL (1937-current)
- EBM database (1991 – current)
- PsycINFO (1806 – current).

## Search strategy

In accordance with the original request from the Sax Institute, a search strategy was devised by the research investigators in consultation with the commissioning group to identify relevant studies published between 2006 and current day in the English language. A representative list of free-text keywords was generated and entered into electronic databases for mapping to subject headings. A final database search was conducted in December 2016 and January 2017. The following combination of keywords and subject headings was used as follows:

1. Wom\$n\* OR female\* OR mother\*
2. Substance abuse treatment centers/ OR alcohol rehab\* OR drug rehab\* OR residential rehab\* or addict\*
3. Managed care programs/ OR self care/ OR models, organizational OR primary health care/ OR delivery of health care/ OR delivery OR recovery OR treatment service\* OR treatment program\* OR intervention
4. Limit to English, human and 2006 to current.

The search strategy did not include the word "pregnant" as the use of women/woman, mother/s or female/s would ensure that anything on this group of people would be identified. A member of the research team did a subsequent re-run of the search with the addition of the term "pregnant wom\$n" with no additional articles retrieved. In addition, the word "parent" was not included in the search strategy as the research questions directed the focus on women only and women with dependent children services. In the same manner, the word "child" was avoided as this would have added all articles for children that are in rehabilitation. As the review was interested in all aspect of the rehabilitation programs, a very wide scope was developed in this search strategy, with inclusion and exclusion criteria used to narrow search outcomes. Therefore, it would be reasonable to assume that research focusing on women with dependent children in rehabilitation, would include the word woman/women, female/s or mother/s in the title, abstract or keywords.

## Study eligibility criteria

All study eligibility criteria were devised in accordance with the research proposal provided by the Sax Institute and subsequent discussions with the commissioning group. As the quantity of existing literature pertaining to this topic was not expected to be high, a broad scope was employed in order to maximise the inclusion of potentially relevant information. A final list of the inclusion and exclusion criteria can be found in Table 1.

**Table 1. Review inclusion and exclusion criteria**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"><li>• Research pertaining to models of care for women in residential rehabilitation for drug and alcohol problems</li><li>• Research including programs where children may or may not reside with the mother during rehabilitation</li><li>• Research discussing women's health and wellbeing in rehabilitation</li><li>• Research discussing child's health and wellbeing</li><li>• Research discussing the mother-child bond</li><li>• Research discussing engagement in the rehabilitation programs.</li></ul>	<ul style="list-style-type: none"><li>• Publications not in English</li><li>• Research prior to 2006</li><li>• Research is not from Australia, NZ, Canada, US, UK or Europe</li><li>• Rehabilitation does not have a residential component</li><li>• Services must be women-only not mixed gender</li><li>• Research based in prisons or women who are incarcerated.</li></ul>

## Study selection, data extraction and data items

Following searches of the databases, abstracts and titles were screened by two independent investigators, applying the criteria listed in Table 1. In the instance of disagreement, consensus was determined via a third independent reviewer. Full text publications were then reviewed by two independent researchers with conflicts again resolved by a third reviewer. Data regarding publication details, patient cohort, length of the program, where children were in residential care and study conclusions were extracted (Appendix 1) by a single reviewer with checks for accuracy by a second reviewer.

## Quality/risk of bias assessment of literature

To assess the quality of the literature in this review, each publication was scored in line with the criteria described in Buckley et al.<sup>7</sup>, with a score out of 11 recorded on the publication summary table (Appendix 1). Publications with a score of 7 or above are classed as higher-quality research. This tool assesses a range of quality indicators known to affect overall study quality (including evaluation of bias risks and writing transparency) but is flexible enough to be applicable to a range of differing study methodologies (e.g. randomised and non-randomised clinical trials).

The overall quality of review findings was also assessed in line with the Grading of Recommendations, Development and Evaluation (GRADE) principles. This approach enables an evaluation of the strength of key findings according to pre-defined criteria (risk of bias, inconsistency, indirectness, imprecision, publication bias, large effect size, plausible confounders and dose-response gradient) and synthesises an overall judgment of the quality of the evidence (high, moderate, low, very low) to enhance the transparency and implicitness of reviewer judgments. It is important to note that GRADE criteria are conventionally applied to

individual outcomes, however the exploratory nature of this review meant it was applied to the overall range of outcomes.

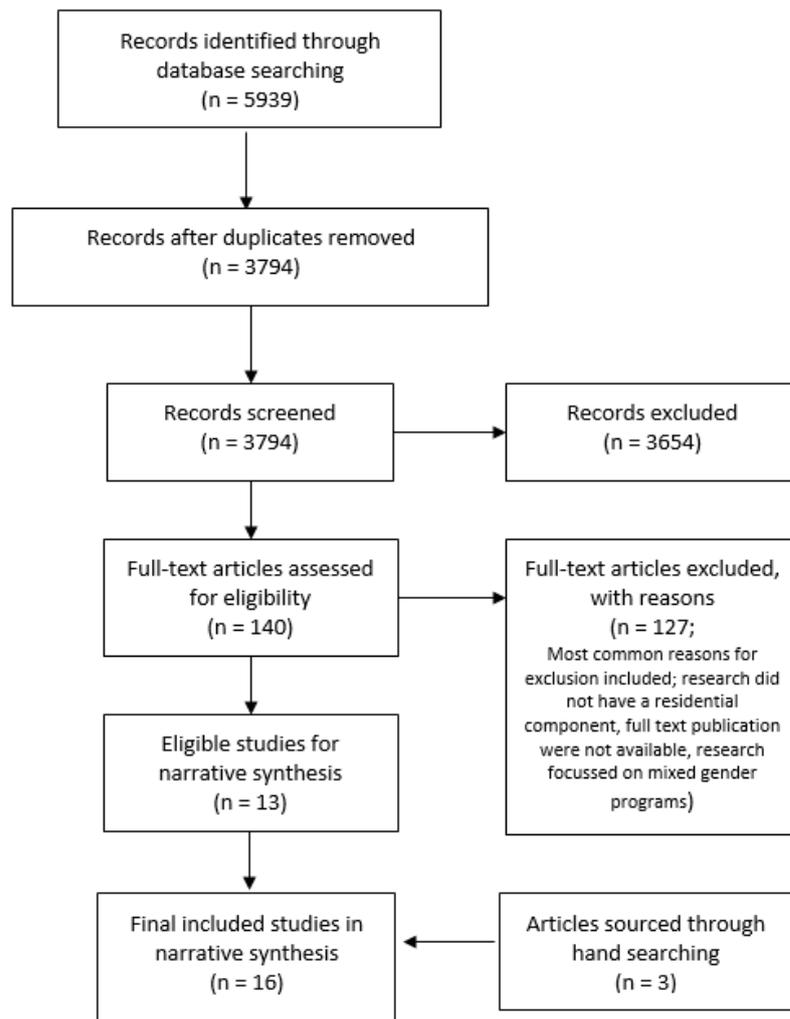
### Grey literature

Grey literature was sourced from web-based searches targeting residential rehabilitation for women and women with children, via similar free text key word terms used in the search strategy. These terms were placed into Google Scholar as an initial source. The search then developed to include direct hand-searching of government websites and health service websites. These searches were completed over December 2016 and January 2017.

### Results and discussion

The above search strategy resulted in 5939 publications from four databases. After 2145 duplicate publications were removed, 3794 abstract and titles were reviewed. On review, 3654 publications were removed that did not meet the inclusion criteria (listed above). The remaining one hundred and forty full text publications were reviewed, with a further 127 reviews excluded, leaving 13 peer-reviewed publications included in this review. Hand searching resulted in an additional three publications, and so 16 publications are included in the review (two publications are on the same study results<sup>8,9</sup>). Figure 2 illustrates the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA<sup>10</sup>) flow chart for the peer reviewed literature included in this review. This chart does not include sourced grey literature. A summary of the studies included in the review is presented in Appendix 1.

Five of the articles included in the final yield were reviews of international literature. Of the remaining articles, 10 of the 16 articles were from the US and one was from Finland. In addition to the five review articles, six articles were qualitative studies, three articles had a cohort research design, two were cross-sectional and one was quasi-experimental. Fourteen of the included articles focused on outcomes for mothers participating in residential rehabilitation with two studies focusing on children's outcomes.



**Figure 2. PRISMA flow diagram for peer-reviewed literature in this review**

### Quality/risk of bias assessment

The majority of the studies included in this review were of good quality, with most receiving a score of 7 out of 11 (mean 7.53, range 4 – 9; see Appendix 1 and 2). This suggested that the research addressed the majority of the requirements in the quality and bias assessment. Regardless of the quality assessment score received, all relevant research was included in the review. All articles had a conclusion consistent with the presented research outcomes, and most articles included appropriate statistical analysis. However, most articles did not fully comply with required reporting of ethical considerations and many lacked triangulation.

The overall body of the evidence was graded as having low quality/low rigour. Although the included research was often of good quality when assessed as individual research studies, the fact that no randomised or non-randomised control trials were available in this area of research, limits the quality of the body of evidence. The fact that the vast majority of the included articles in this review were narrative reviews or qualitative studies adds to this low-quality assessment. The fact that all studies in this review were of lower ranking on the hierarchy of research design, results in a low quality/low rigour scoring for this body of evidence.

# 4 Results

## **Review Question 1: What are the best models of care for women with dependent children in residential rehabilitation for alcohol and other drug problems?**

No research completed a comparative assessment of different models of care for women in residential rehabilitation for drug and alcohol problems. Much of the research assessing care models gathered quantitative or qualitative data from a cohort of clients in a set model of care, without control groups and randomisation. The literature in the area of substance abuse treatment for women is in its infancy with different aspects of care models receiving some attention in the literature. Although slightly outside the suggested time frame for this review, work completed by Ashley et al.<sup>11</sup> provides a foundation for future models of care with key care model aspects that should be considered. Although the review by Ashley et al.<sup>11</sup> included research on residential and outpatient programs, this review related to each care model component with as much emphasis on residential programs as possible. In their review, Ashley et al.<sup>11</sup> suggested that all of the following aspects were necessary for a comprehensive substance abuse program for women:

### **Child care**

A review of the literature by Greenfield et al.<sup>4</sup> found that child care facilities within rehabilitation settings did not lead to improvements in treatment completion but were positively related to increased length of stay. It was not clear from the review if the literature leading to this conclusion was related to residential rehabilitation programs or included outpatient data.

### **Prenatal care**

The review by Milligan et al.<sup>12</sup> found that pregnant women participating in integrated rehabilitation programs were more likely to return a negative drug test and/or report abstinence from drug and/or alcohol use at the time of birth, when compared to women not in a treatment programs. This finding was from two quasi-experimental studies, one of which was an outpatient program, and the other a residential program. The details of the integrated programs were not included in the review.

### **Women-only admissions**

As with child care, Greenfield et al.<sup>4</sup> found that having women-only services did not lead to an increase in program completion but did correlate with an increased length of stay. It was noted that the women involved in the women-only programs often had additional pressures and issues including pregnancy and the responsibility of children. In addition, it was unclear if the review by Greenfield<sup>4</sup> was related to residential rehabilitation programs.

### **Supplemental service and workshops for women's specific issues**

It is believed that women find it more difficult to sever ties with negative people when compared to men. In addition, women in treatment have been identified as having low self-esteem and insecurities.<sup>13</sup> It has been highlighted that these feelings of inadequacy can greatly affect a women's recovery and her post-treatment choices. The work by Mendez<sup>13</sup> suggested that although severing ties with negative people may not be possible post treatment, women should be taught tools to set their own boundaries. Women also need to be taught parenting skills while in treatment, along with strategies to help deal with feelings of guilt as they see how much of their children's life they have missed out on due to their addiction.

### Length of stay

Baird<sup>5</sup> suggested that the length of stay in the rehabilitation program was important, with some authors suggesting that programs of at least six months duration having significantly better outcomes when compared to shorter programs. From the review, it is not clear whether the six months is entirely residential or incorporates an outpatient component.

In contrast, Banerjee<sup>14</sup> found no significance difference in substance use post treatment for women who were in residential programs for fewer than 30 days, from 30 to 60 days, or for more than 60 days. The author reported that those who stayed in treatment for more than 60 days also reported more adverse events after treatment, however baseline data on the comparative groups was not provided to ensure equity across groups prior to treatment.

Although Mendez<sup>13</sup> did not suggest a set length of stay for residential rehabilitation, she did find that women benefit from a long stay. In her qualitative study, facilitators of programs identified that women often do not realise that they need help when they initially enter into treatment. This realisation can take a considerable amount of time and, with short stays, may occur after the client has left the residential facility. Some facilitators suggested that residential programs should be for two years, highlighting that many of the women have been using drugs or alcohol for years and that six months is not enough time to detox from these substances and learn everything they need to. One facilitator suggested a two-year residential program, followed by a transitional program lasting for six to 12 months, where the women would be encouraged to work and come to an outpatient/community treatment centre twice a week.

### Mental health programming

Numerous mental health programs within women-only rehabilitation models have been evaluated. All were gauged as successful to some extent, however a precise description of the program content was often unclear.

Greenfield et al.<sup>4</sup> suggested that women who were in non-hospital residential facilities or facilities that combined a mental health and substance abuse treatment program were more likely to complete the planned treatment than those in an outpatient facility. Additionally, women attending combined mental health and substance abuse treatment programs were less likely to complete the program than those completing standalone substance abuse treatment programs. It was not clear if these programs were women-only in nature.

Other researchers have evaluated discrete mental health programs as a part of residential rehabilitation models of care. Amaro et al.<sup>15</sup> evaluated the feasibility, acceptability and potential benefit of a Mindful-Based Approach to Relapse Prevention (MBRP-W) program for women with substance abuse disorder in treatment programs. This research included 316 clients, of which 235 were in residential treatment programs. The client group included women with a mean age of 34 years, of mixed ethnicity and education levels. The women spent an average of 157 days in treatment, however it is unclear if this time was spent in the one program. There is no mention of the percentage of women in the research that were mothers of dependent children, or if the children spent any time in the residential rehabilitation centre.

The program evaluated by Amaro et al.<sup>15</sup> consisted of nine sessions, where one or two facilitators worked with a group of eight to 15 women. In these 1.5 to 2-hour sessions the women learnt meditation techniques, practiced gentle yoga, and developed self-regulation strategies including the use of mindfulness skills to manage stress and emotions. Approximately 36% of the clients completed five to nine sessions of the program. The authors stated that this level of attendance was the cut-off point deemed clinically significant, however the determination of this was not discussed. The researchers also stated that the clients in these

programs had demanding schedules, at times conflicting with the sessions. Overall, the program appeared to reduce alcohol and drug severity in those patients who attended five or more sessions when compared to those who attended fewer sessions. The authors believed that the program may reduce perceived stress among clients and have a positive effect on their recovery.

Banerjee<sup>14</sup> assessed the effectiveness and equitability of another program named Health Realization. The author suggested that this program “teaches the nature of human psychological functioning” with the program focusing on health rather than the diseases or disorders. There was not a strong explanation of the distinct features that differentiate the program from a more traditional 12-step program but it does cite a model developed by Mills<sup>16</sup> and Pranksy<sup>17</sup>. This randomised trial was based in two women’s residential rehabilitation facilities in the US, and included women with mixed ethnicity, with the majority unemployed and not seeking employment on entry into the program. The average age of the participants was 35 years and although there was some discussion of mothers being included in the cohort, it was not clear what percentage did have dependent children or if the children were permitted to be in the treatment facility with their mothers. Overall, the research showed a significant decrease in substance use post treatment, however no significant difference was found between those allocated to either the Health Realization program or the more traditional 12-step program. In conclusion, the author stated major limitations to the research, but suggested that Health Realization models can be as effective as the more traditional 12-step model for women in residential rehabilitation programs.

Reflective functioning is another psychological concept that has been evaluated in residential rehabilitation settings. This concept develops the client’s ability to understand another person’s mental status and understand the effect of others’ mental status on their own. This concept is thought to be highly relevant for women with substance abuse disorder and their children. In Finland, a number of residential rehabilitation facilities have been established that house five mother-baby pairs and one family as a whole. Pajulo et al.<sup>18</sup> evaluated the mother’s reflective functioning via video tapes, interviews and questionnaire, in 34 mother-child pairs. Although the reflective functioning levels in the mothers at four months postpartum was low, it was an improvement from the very low levels seen during pregnancy. It was also noted that very low levels of reflective functioning postpartum was seen more readily in the mothers who relapsed or later had their children removed and placed in foster care. The authors felt that these were positive and useful findings, but also acknowledged that participant numbers were low, there was no control group for comparison and there was a large amount of diversity in the mothers in the program.

### Comprehensive programming

The definition of a comprehensive program is varied across the literature. Some view comprehensive programming as those programs that work with outside agencies<sup>5</sup>, including criminal justice agencies and child protection agencies. Others view comprehensive programs as integrated programs that offer onsite pregnancy, parenting and child-related services in addition to the substance abuse treatment<sup>12</sup>. Baird<sup>5</sup> highlighted the need for rehabilitation programs for women to encourage collaboration between treatment providers and child protection services and criminal justice agencies for both parent and child outcomes.

Milligan et al.<sup>12</sup> reported that integrated programs resulted in decreased maternal substance use and a decrease in the number of days of use. Details of the integrated programs were not included and it is unclear how many of these programs included a residential component. The authors attempted to assess differences between integrated and non-integrated services but the limited number of studies with consistent measures of service success made this difficult. From the included articles in the review by Milligan et al.<sup>12</sup> it would appear that patient outcomes for clients participating in integrated residential programs were not statistically significant from non-integrated residential programs. The authors stated that

current research does rely on measures that would have questionable accuracy, including self-report measures from clients. They also commented that current research designs, mainly cohort studies, do not allow for a true comparison of this model to other models of care, and therefore further research is required to determine the importance of integrated programs in rehabilitation settings.

The same group of researchers assessed the literature to determine the effect of integrated programs on child outcomes.<sup>19</sup> More detail regarding the included components for the integrated model were included in the review, with programs including *“group and individual addiction treatment, maternal mental health services, group and individual parenting education and counselling, life skills training, prenatal education, medical and nutrition services, education and employment assistance, obstetrical and paediatric care, child care, children’s services, and aftercare.”*<sup>19</sup> From this review the authors suggested that integrated programs appear to have a positive effect on child development, and emotional and behavioural functioning from intake to post testing. Integrated programs resulted in improved child development and child growth outcomes compared to those receiving no treatment. Although it was found that integrated programs resulted in improved child emotional and behavioural development when compared to non-integrated programs, no studies were found that compared child growth and development outcomes between integrated and non-integrated programs. As with the previous publication, the authors did acknowledge the low to moderate quality of the articles included in the review.

Further research from this group assessed the components of integrated care models that the literature had evaluated.<sup>20</sup> From mainly a qualitative research synthesis, the research reported that mothers participating in rehabilitation needed to develop: a sense of self (including self-worth, self-identity and self as a partner in a relationship); a personal agency (understanding the ability to achieve your desired outcomes through your own choices etc.); the ability to give and receive social support networks; the ability to engage with program staff; self-disclosure; recognition of destructive patterns; and goal-setting strategies. They also reported that the women benefited from the motivating presence of children. This review mainly included qualitative research and acknowledged that the findings were based on weak research outcomes and require further investigations.

Connors et al.<sup>21</sup> investigated the outcomes of a specific program in the US, with an integrated residential program for women and their children. This program included all the components of the above review, as well as educational and mental health services for the children. The planned length of the stay was four to six months, although nearly 60% of clients left before their program was completed. The researchers found that substance use (either drug or alcohol) was significantly reduced over the time of the treatment, with a positive effect seen in the women’s self-sufficiency (in regards to living arrangements and employment). Mental health measures and attitudes towards parenting were also improved for women in the program. As with other research in this area, the authors commented that the lack of a comparative group affected the quality of the research and the ability to draw a causative link between the positive outcomes and the program itself.

Other evidence regarding models of care included the staffing of treatment facilities. Mendez<sup>13</sup> found that women in rehabilitation want contact with staff who have had addiction problems and have recovered. They admitted that as clients they can be manipulative in their behaviour and feel that past addicts will identify this more readily. They also felt that seeing women who have recovered was more powerful than advice from other rehabilitation staff.

In a slightly different approach, some models of residential rehabilitation have seen women come together in self-run recovery homes where six to eight residents agree to abstain from substance use, pay rent and avoid disruptive behaviours.<sup>22</sup> As these houses do not have professional staff in residence, and the clients

contribute to the cost, the overall government contribution is less. A number of the houses established in the US are for women-only and approximately 34 are established for women and their dependent children. To be a resident in these houses clients have to abstain from drug/alcohol use for 30 days prior to entry, and therefore this model of care may be more suited to aftercare or transition models, rather than an initial stage of residential rehabilitation.

Overall, there appears to be a large number of models of care or model components that should be considered when establishing women's residential rehabilitation services. Although the current research is not strong in its recommendations, service providers should first identify the potential clientele in their services and the cost and benefits to providing each aspect of the model of care. No research was found evaluating the cost effectiveness of models of care and although some research did identify individual characteristics (including having fewer children<sup>4</sup> etc.) that could predict relapse, no investigation gave strong evidence for the selection of one model over another.

*Authors such as Bair<sup>5</sup> have stated that "women who attend comprehensive residential treatment programs of six months or longer with their children are more likely to complete treatment, be abstinent at six months post discharge, and to be living with and have custody of their children". To date the current evidence would suggest that women do have positive outcomes when participating in women-only residential rehabilitation. It is suggested that these programs should have a length of stay of a minimum of six months, and should include comprehensive or integrated programs including prenatal services, child care and mental health programs. Although there is no evidence recommending one model of care over another, individual evaluations have highlighted the benefits of various components.*

## Review Question 2: What are the best models of after-care delivery that ensure that women with dependent children continue engagement with their treatment?

No research systematically evaluated models of after-care delivery, with most of the research focusing on the demographic predictors of those most likely to relapse or leave treatment. To best answer this research question, this review identifies key aspects that researchers found were barriers for women attending rehabilitation.

Although the focus of their research was not on models of after-care, Amaro et al.<sup>15</sup> did suggest that providing child care and possibly transportation, may assist women to continue to engage in treatment when they are no longer in residential rehabilitation. In a review by Greenfield<sup>4</sup>, the factors that may be associated with higher rates of retention in treatment programs were discussed. Although the research was again not focused on models of care, it highlighted characteristics of the clients who were more or less likely to continue their treatment. It was found that having fewer children, higher levels of personal stability, less involvement with child protective agencies, and fewer family problems predicted better success in women-only programs.

A thesis by Mendez<sup>13</sup> highlighted some of the concerns of leaving a residential facility. In this qualitative study, the women commented that the “loss of protection” felt when leaving the residential facility was a major concern. Clients were concerned that they would move into bad residential areas and start using drugs and alcohol again. They also feared boredom, which may lead to relapse. As they did not have jobs, they were concerned that their lack of daily structure would result in a relapse, and they also feared that their drug history (and possible criminal convictions) would make employment more difficult. Some clients had lost their driver’s licence, which again may alienate the women. The women did raise transportation as a major challenge they would face once they had left residential treatment facilities. The facilitators suggested that along with transport; education, housing and employment were major issues for women post treatment.

*Therefore, as with the previous question there is no strong evidence suggesting one model of after-care compared to another. Researchers have highlighted barriers to continued engagement but not all have focused primarily on women with dependent children.*

### **Review Question 3: What is the evidence of benefit to women and/or to their dependent children of treatment services which allow the children to remain with the parent during treatment?**

In contrast to the other research questions, a number of publications have evaluated the effects of children remaining with their mothers in residential rehabilitation. Some studies have focused on the parent outcomes, while a small number have assessed child outcomes.

A study included in the Greenfield<sup>4</sup> review suggested that those women with two or more children residing with them in residential treatment, who were daily drinkers and had little support from a spouse or partner, were more likely to leave the residential program. That said, this review states that policies which allow children to be with their mother in residential treatment can lead to a positive impact on treatment retention. This finding was confirmed by a randomised trial and a quasi-experimental study, although both these studies dated back to the mid-1990s.

Baird<sup>5</sup> suggested that families are more able to remain intact if the mothers are able to have their children with them during treatment. Sword et al.<sup>20</sup> also discussed mother- and child-focused outcomes from a qualitative synthesis of the literature and found that not only did the presence of children in residential rehabilitation provide motivation for mothers, it helped the mother build their relationships with their children. Sword also suggests that parenting skill development should be included in residential models of care.<sup>20</sup>

Mendez<sup>13</sup> investigated a number of aspects of residential and transitional rehabilitation treatment for mothers or pregnant women. This research was limited to interviews with six clients and subsequent interviews with six facilitators, perhaps limiting its transferability. Based in a residential rehabilitation facility in the US, the vast majority of these mothers did not have current custody of their children, with only two of the 18 children (between the five mothers) residing with their mothers in the residential facility. These women suggested that having children in treatment could be a distraction to their own rehabilitation as it was difficult for them to concentrate on themselves. Although child care was provided, the women felt that it would be hard to do everything you have to do if the children were present. The author did comment that the majority of the children were in care with extended family and that perhaps this factor did alleviate the stress of the mother. For the mothers whose children were placed in foster care, their wish to get their children back was distracting for their treatment. The motivation of getting better for their children was a strong theme.

The facilitators in the program also believe that the children can be a distraction or that, at least, the women can make the children a distraction to their own recovery. They believe that children should be slowly integrated into programs to give the mother time to address her own needs first. It is suggested that limited time with children in the first 30 days of treatment would be beneficial. It was noted that it is important that the children of mothers who will have custody of them after treatment, spend time with their mother while she is in residential care, as the additional stress of parenting can add to the overwhelming transition of leaving residential care.

Wong<sup>8,9</sup> completed a qualitative study of 10 mothers in a residential rehabilitation program in the US. The project aimed to establish how these mothers perceived their parenting skills in the context of the residential program. With transcribed information collected from interviews with clients, the authors established five major themes regarding the mother-parenting experience. These themes were: a parenting experience was shaped by a parenting desire; coping with ambivalence concerning support received in treatment; developing a new parenting experience (stepping away from the guilt); significance of support; and transforming relationships. The women reported that having their children with them was a motivator to enter and stay in treatment and that this was achieved through family-focused program models. They

reported that when they found parenting difficult, they were encouraged to work through the difficulties rather than walk away. The authors of this work suggested that future research is required to support this non-randomised qualitative study, but do believe that residential programs that have children reside with the mother are more positive for the mother-child relationship.

Wilson<sup>23</sup> investigated the long-term opinions of adults who were once the children of mothers in residential rehabilitation programs. Through qualitative interviews of 13 adults, the clients reinforced the belief that residential rehabilitation services for mothers should include family services. They spoke of the importance of being together as a family unit during their mother's recovery. The clients believed that the structure, stability and community aspect of the residential rehabilitation environment was important for family units often living with the dysfunction of substance abuse. The residential experience increased these children's empathy for those overcoming addiction and also acted as a deterrent to follow a similar path. They also acknowledged that the presence of the child was a motivator for the mother to complete treatment. The author stated there were limitations in the research as only 13 people were interviewed and information was reliant on recollection from the adult's childhood.

D'Arlach<sup>22</sup> assessed the presence of children in the Oxford House residential setting (various sites across the USA) where groups of women live together with their children with residential staff. The research did not discuss how or in what setting the mothers or children received rehabilitation. It did, however, focus on the positive outcomes of having the child reside with their mother, with the mothers reporting that having the children with them helped in their recovery. It was noted that the communal living situation provided support to mothers, as they assisted each other with child care and parenting. The positive effects from the children's presence were not exclusive to the mothers, as women living in the house without children believed that the presence of children in the house was a positive. The research did not discuss the effect of the residential setting on the children.

In a similar manner, Einbinder<sup>24</sup> assessed the Exodus House program (Wisconsin, USA) although it was not discussed if these facilities were for women only. Again, little detail was provided on the components of treatment at this residential program, but the researchers were more interested on the sense of "community" that was developed in this setting. In this qualitative study of past residents, clients commented on the positive "community" feeling that supported the mothers in residence and their children. Overall, the past residents believed that the family- focussed approach that is taken when children reside with their mothers, does set a good foundation for life- long recovery.

Lewandowski et al.<sup>25</sup> targeted a slightly different approach and investigated the effect of having children in foster care and/or receiving child welfare payments while they (the mothers) underwent a 30- day residential rehabilitation program. It should be noted that this residential facility does allow children to reside with their mothers, but for a cohort of women the children were in foster care. Although not statistically significant, the authors found that within this program, mothers who had children in foster care were less likely to complete the program when compared to other clients. The authors did note that the rates of completion for women in this research with children in foster care, were similar to other research focusing on women who had their children in residential programs with them. The study also found that those who received child welfare payments while in the residential programs were less likely to complete the program. In summary, the authors felt that the pressure of regaining custody of the child in foster care and/or the perceived need to meet the requirements of the US child welfare payments, may be triggers for women to leave residential treatment programs.

*The current evidence would suggest that allowing children to stay with their mothers during treatment can increase motivation to seek treatment and remain in treatment. It is also reported that having the children in treatment can assist in the mother developing her parenting skills in a safe environment and can help build the mother-child bond. The research does not ignore the fact that having the children in treatment can increase stress during an already difficult period of time. Other research suggests that having children in treatment can be beneficial for other women in the program (in addition to the mother). Overall, the research suggests that women do find it positive to have their children with them during treatment.*

## Additional findings outside the research question

As literature on women-only residential facilities (that are not court ordered) is limited, other evidence-based findings have been included in this review, which may result in favourable outcomes for women. This evidence may not yet be researched in women-only residential facilities, or the current literature combined various cohorts of patients in which women-only residential facilities may be only one factor. Other research may have included co-morbidities or may not have the reduction in drug and/or alcohol use as the primary focus.

### Seeking Safety program

The Seeking Safety program has shown to be effective in helping women with co-occurring disorders and histories of trauma. The research mainly focuses on women with post-traumatic stress disorder (PTSD) and substance abuse disorder (SUD). The program is based on cognitive behaviour therapy, providing women with strategies to assist them in times of stress. It is a 25-session program, but for some research interventions it may take more than 30 sessions to complete the course.<sup>26</sup>

In short, the Seeking Safety program is successful in improving retention rates in treatment, and in improving post-traumatic stress and mental health symptoms in women.<sup>26</sup> The authors stress that the positive outcomes of the program are more pronounced when assessing improvements in mental health outcomes rather than SUD outcomes, however, they still conclude that screening for past trauma and PTSD should be included in treatment programs. They feel that educating the women in the link between their trauma and other symptoms, and providing them with coping skills to address these stresses is an important feature of drug and alcohol treatment.

### The Healthy Steps to Freedom program

The Healthy Steps to Freedom program (HSF; Nevada, USA) is designed to address body image, body dissatisfaction, and eating-disorder symptoms in women's rehabilitation across a number of different settings. It includes 12, 90-minute weekly sessions with groups of 6 to 25 women, educating them on women's health, body image and self-esteem, physical activity, weight and body composition, basic nutrition (including how to read food labels), disordered eating behaviours, and cognitive distortions related to weight or appearance.

This research conducted by Lindsay et al.<sup>27</sup> found that the HSF program significantly improved attitudes towards body image, appearance, eating disorder symptoms and weight. Prior to treatment, 46% of women were concerned their weight gain could be a trigger for relapse, which decreased to 34% of women post treatment. This suggested that this type of program could be a positive inclusion in all types of rehabilitative treatment settings for women suffering from addiction, particularly for those women who report using drugs for a weight loss effect.

### The Haven Mother's House

The Haven Mother's House (Colorado, USA) is a specialised residential addiction treatment for women only that uses a Modified Therapeutic Community treatment approach (MTC).<sup>28</sup> Women admitted into this program are referred by the Department of Corrections, County Jail, the Department of Human Services, or were previously homeless, or potentially self-referred. This program entails a 12- to 15-month length of stay with generalised programming of cognitive-behavioural techniques, group counselling, peer-run activities, groups, meetings, vocational skills, graduation-equivalence diploma preparation classes, and on and offsite 12-step meetings. Individualised programs for women requiring further treatment for PTSD also take part in the Seeking Safety Program (mentioned earlier). Most importantly, this program allows mothers and infants to reside together, with the close support of a nearby child care facility, which allows women to participate

in ongoing treatment programs throughout the day (without placing their child at increased unnecessary mental risk). This child care facility allows women to be with their child during lunch breaks and liaise with staff for nutritional assistance and parenting support. Women in the program become accustomed to being: in a routine with their child without being drug effected; in a supporting environment that allows them to develop their parenting skills, foster the parent-child bond, and most importantly rehabilitate their drug habit through provided feedback and supportive programs.

Since the beginning of the Haven Mother's house in 2004, more than 130 babies have been a part of the program, with the majority of babies reaching their six-month developmental milestones on time, with little need for an early intervention service (despite being drug exposed at some point during their foetal stage). Of all babies born to mothers who were admitted during their pregnancy, all were born drug-free.

### **Qigong meditation in residential rehabilitation**

A pilot study by Chen et al.<sup>29</sup> investigated the role of Qigong meditation in residential rehabilitation and the differences between men and women. Qigong meditation is an ancient Chinese health practice aimed at integrating body, breath and mind adjustments into Oneness. The program in this particular study included individual and group counselling based on motivational enhancement, cognitive behaviour, and 12-step facilitation therapies. Qigong mediation was introduced to residents in two phases. Phase one included voluntary participation of Qigong practice every evening, whereas phase two allowed residents to choose between practising Qigong or Stress Management and Relaxation Training (SMART), as well as weekly 90-minute mixed gender seminars informing participants of stress management, self-healing, and the application of meditation for healing. Though further research is needed, this preliminary study did find that those who practised Qigong daily reported reduced cravings, anxiety, and withdrawal symptoms compared to those who completed SMART, with women reporting significantly greater reduction in anxiety and withdrawal symptoms compared to men. Qigong meditation participants were also more likely to complete treatment, at a rate of 92% compared to 78% of those in the SMART group, which was found to be also statistically significant.

### **Women in treatment - the differences**

Green<sup>30</sup> discussed the different journeys men and women have from when they first discover they have a drug problem, to seeking assistance and completing a treatment program. Barriers to accessing treatment are a major problem for women. Women are more likely to experience economic barriers, struggle to find the time to attend regular treatment sessions secondary to family responsibilities and transportation, and are more prone to feeling the stigma associated with attending treatment compared to men. Mental health issues can also impact a women's ability to access treatment, as women have a higher prevalence of depression and anxiety, which leads women to be less likely to seek treatment. Lack of information regarding appropriate treatment options was also found to be a barrier to treatment for both men and women. For these reasons, women tend to seek help from other avenues outside of specific drug rehabilitation facilities, including mental health and primary care settings, therefore leading to poorer treatment outcomes than those seen in speciality drug treatment facilities. Once in treatment there are further barriers to completion. These include: lack of child care for parents, particularly mothers; limited income and education; mental health issues and self-efficacy. Evidence shows that recognising these risks and barriers to treatment completion, as well as providing facilitating services such as child care, helps keep women and men in treatment for longer, effectively completing their treatment with a better outcome or drug abstinence.

### Women in women-only and mixed gender outpatient programs

Women-only treatment programs tend to include additional women-specific aspects to the treatment model not otherwise made available in mixed gender treatment programs. These include groups on trauma from physical, emotional, and sexual abuse; development of self-esteem; establishment of growth-fostering relationships; childcare; child development services; sex and health-related issues; nutrition; fitness; grief and loss; and decision-making skills. Women-only treatment tended to also use a less confrontational approach, and are more likely than mixed gender programs to provide assistance in housing, transportation, job training, practical skills training and onsite child-care services. A study by Prendergast et al.<sup>31</sup> compared male and female outpatient treatment programs with respect to four outcomes; drug and alcohol use; criminal activity; arrests; and employment among substance-abusing women.

The results from this study revealed that women in mixed gender outpatient programs were 2.5 times more likely than those in women-only outpatient programs to engage in criminal activity in the 12 months following treatment entry. They were also significantly (2.3 times) more likely to abuse drugs. Women in women-only treatment programs were not less likely to be arrested or improve their employment status compared to women in mixed gender treatment programs. Women in both women-only and mixed gender groups were found to improve their employment status when compared to before treatment, however, one form of treatment method was not more significant than the other.

These above studies continue to support the need for gender-specific programs, and they address the different barriers, needs and reasons for seeking alcohol and other drug rehabilitation in women compared to men. It is important to note that a common theme seen across the literature is that when women do finally seek treatment, particularly those with children, they are often more affected by drugs compared to men, and are more likely to be suffering from other trauma (physical, emotional and sexual abuse) or PTSD, that if left untreated could potentially cause them to relapse after discharge. The biggest barrier to treatment for women, who are pregnant or have children, is the lack of support for them and their child, and the fact that their child may be taken into custody if agreed treatment options are not completed. We have seen throughout the research that women in residential treatment with their children have far better outcomes than those who do not reside with their child. These findings can now form the basis of future research to look into the best models of care for treatment for women in residential treatment programs.

## Grey literature

A number of government and health professional group reports published in the grey literature have provided descriptive summaries of drug and alcohol residential rehabilitation services for women (with and without children) within an overall model of health service delivery, or proposed guidelines for the delivery of residential rehabilitation models of care. Of note, many of these reports have been generated by expert or consumer consensus rather than being informed by empirical data or experimental research.

It is apparent that there is no gold standard practice model for residential rehabilitation for women and women with children, however the available information suggests that women require specialised and gender-responsive treatment due to their unique needs. It has been recommended that a variety of treatment opportunities should be offered without imposing rigid philosophies.<sup>6</sup>

A theoretical framework for a gender responsive model of care, regardless of the type of service, has been developed<sup>32</sup>. The approach consists of four main principles:

1. A client-centred, gender-responsive approach
2. Trauma-informed practice
3. Family-inclusive practice
4. A strengths-based and resilience-oriented framework.

Although gender-responsive services are considered an important model of healthcare service, the Foundation for Alcohol Research and Education (FARE) has identified that there is an under-supply of residential programs in Australia for women with children.<sup>33</sup>

There is also a lack of information available regarding evaluation of existing facilities. Where outcomes were reported, they were typically not supported with rigorous research and quantitative assessment. Two such Australian studies have been identified. The first study is a small qualitative study of such a facility in NSW (Kathleen York House)<sup>34</sup> which suggested that a collaborative, inter-professional and multi-dimensional approach is required. Their program used the skills of both AOD and parenting experts to establish a novel service model, which reported the following outcomes or benefits:

- Acting as child and mother advocates
- Building social networks
- Changing parenting and other constructs (e.g. victim role to being in control, reinforcing that their mothering abilities are 'good enough')
- Developing maternal capacity and competence
- Changing child behaviour outcomes (many children entering the program have behavioural problems)
- Use of the program "Parenting from Afar" for women without custody of their children
- Reported as a positive experience for the families involved.

The second study is an evaluation of another women-only residential rehabilitation program in NSW (Jarrah House) which outlines accomplishments including: *"reduction in the number of children removed from their mothers' custody; higher retention rate in treatment than the national average; three-times higher representation of the Indigenous population in treatment than the national average; and earlier intervention for pregnant women. Also, individual case management and the group therapy program were evaluated most highly by clients as being the most useful."*<sup>35</sup>

Internationally, a US study compared outcomes for women in residential rehabilitation with an outpatient treatment program and found that the achieved high rate of abstinence was 97% for the former and 47% the latter.<sup>35</sup>

Models of care that allow children to stay with their mother in women-only facilities while undergoing drug and alcohol residential rehabilitation are considered a component of best practice in this area<sup>36</sup>. However simply co-locating children with their mother may not be adequate. Children often present with their own set of issues related to their mother's substance abuse, such as behavioural difficulties, poor attachment and self-esteem, and developmental weaknesses. Along with child care and accommodation, these children also require their needs to be met in the form of therapeutic, health and other services.<sup>37</sup>

Similarly, the best model for the treatment of Aboriginal women in residential rehabilitation has not been identified, and to the best of our knowledge, residential rehabilitation specifically for Aboriginal women and their children does not exist in NSW<sup>38</sup>, nor indeed throughout Australia. However, a 2010 report<sup>38</sup> includes eight recommendations when considering such a service. These recommendations are outlined here, however for more complete and comprehensive information, please refer to the Urbis 2010 report:

**1. Site design and location**

The location must have a connection with land, nature and water; accessible by public transport; close to health networks and worksites; spaces for both communal and private time.

**2. Leadership and ownership**

The service must be owned by Aboriginals, primarily females

**3. Governance**

The service should be primarily led by Aboriginal women

**4. Staffing and management**

A multidisciplinary team is needed and volunteers are also important. Staffed 24 hours/day.

**5. Healing journey**

The use of "healing" rather than "rehabilitation" is the culturally appropriate term. There is need to cater for those with co-morbidities (e.g. mental illness). Also, a need to accommodate children, as separation from children is a major barrier to seeking assistance.

**6. Culturally appropriate**

Emphasis on culture, holistic healing approach

**7. Family oriented**

Child care and therapy for children, the men in the women's family to be included in the healing process. The importance of children (and family) involvement in the healing process has also been identified for other indigenous societies such as the Maori culture in New Zealand<sup>39</sup>.

**8. Referral pathways**

Pathways need to be clear, consistent and streamlined, however, some degree of flexibility is also important. Strong emphasis on follow-up procedures.

A proposal for residential rehabilitation for Canadian Indigenous women and women with children also prioritises culturally appropriate care, and as such may have relevance to the Australian Indigenous setting. The program includes<sup>40</sup>:

**Orientation and welcoming ceremonies**

- Should be developed in consultation with Elders, who could also attend the ceremonies. Specific welcome activities should be included for children

**Individual counselling**

- Counselling and goal setting

**Group therapy**

- Core program material delivered

### **History and culture psycho-educational programs**

- *"...to increase clients' pride in their cultural identity, their awareness of pre- and post-contact history and how this history has affected them personally, their families, communities and cultures."*<sup>40</sup>

### **Alcohol and other drugs**

- Education about effects and what issues affect drinking behaviour
- Use of cognitive behavioural therapy (CBT) to decrease relapse and develop coping strategies which are harmonious with their beliefs.

### **Trauma recovery**

- Includes stress management, relaxation, self-care, trigger management, story-telling, support from Elders.

### **Specialised programming for sex workers**

- Includes risk assessment, legal issues, safety issues.

### **Spirituality**

- Empowering women through the use of traditional Indigenous spirituality
- Led by visiting Elders.

### **Grief and loss**

- Includes use of story-telling, art/movement therapy and stress-reduction techniques (e.g. relaxation, meditation, exercise and nutrition, hobbies, talking with others, and recognising and confronting the sources of stress).

### **Social and life skills training**

- Assertiveness and anger management training
- Parenting classes, cooking/other home skills, employment skills, dealing with authorities.

### **Healthy sexuality**

- Healthy/unhealthy behaviours, including cultural sexuality beliefs.

### **Discharge/closing ceremonies**

- To celebrate achievements with culturally appropriate activities.

### **On-the-land activities**

- Events held within their community or on-the-land with Elders and cultural teachers to provide support and reinforce messages of the program

### **Family support**

- Supportive family members to be included in some activities to assist clients in achieving their goals.

### **Follow-up continuing care**

- Those who complete the full program are contacted by phone weekly for a month, and then as frequently as required for support.

### **Existing women and women with children residential rehabilitation programs**

Existing residential rehabilitation facilities exclusively for women and/or women with children were identified. Information was primarily gathered from online resources with additional information from the NADA (Network of Alcohol and other Drug Agencies) NSW service directory. Due to the constraints of the

project, the list of Australian facilities may not be exhaustive and the international facilities are indicative of available services. Within the Australian setting, 16 facilities offering residential rehabilitation to women, with or without children, were identified. Most (9) were located in NSW, with others located in Victoria (3), ACT (2) and WA (1). Twelve facilities were located in major cities, four in regional areas and none in remote areas. Length of stay ranged from 10 weeks to 18 months, with approximately one third of facilities offering three-four months, while most offered six or more months of residence.

The majority of facilities proposed a holistic, multi-faceted approach for the management of alcohol and drug rehabilitation. Common components of these programs included: counselling (individual, group, family), parenting education and support, alcohol/drug and health education, life skills (e.g. budgeting, cooking, gardening), physical exercise, stress management strategies (e.g. yoga, mindfulness, relaxation), as well as other modalities such as art or equine therapies. One facility was faith-based (Christianity), however, it was currently closed due to lack of staff.

Six of the Australian facilities accommodated women only, and 10 facilities also provided accommodation and services for mothers with their children while, one facility in Melbourne provided residential rehabilitation for Aboriginal women only.

Thirty-eight international services were identified from New Zealand, Canada, US and the UK. Use of the 12-steps/Alcoholics Anonymous approach was more prevalent in the international setting, with all but one service using it in the UK and US, and approximately half of the services in Canada. In contrast, only one Australian service reported using the approach (although more may be using this approach than reported). A small proportion of services were faith/spirituality based, with two facilities identified in both Canada and the US. The majority of international programs provided residential services for women only (34), with only four providing services for women and their accompanying children.

## Gaps in the research (Gap analysis)

Currently there is no research determining which residential rehabilitation model of care is most beneficial for women with drug and alcohol problems. Most of the peer-reviewed research follows cohorts of patients, and does not compare outcomes with a comparison group. For this reason, the current research attempts to address the effectiveness of a model of care, or care program component, rather than determine the best model for this client group. Although the grey literature section of this review does discuss and list the current programs available to women with drug and alcohol problems, the vast majority of these programs have not undergone a thorough evaluation to assess the superiority of their model of care over other programs.

No research investigated the efficacy of after-care models for women leaving residential rehabilitation programs. There is a reasonable body of work that aims to predict the variables that may increase a women's likelihood of disengagement or relapse post treatment, however this research focuses on individual characteristics rather than models of care.

Although there is research included in this review that addressed the implications of children living with their mothers during rehabilitation, the vast majority of the research is qualitative with no matching quantitative input. This research also includes very small sample sizes that would affect the bias of the findings. Although qualitative research should not be devalued in the health policy setting, these results do require quantitative outcomes to ensure that client treatment preferences do result in improved patient outcomes in the short or long term.

Across all of the research questions, the vast majority of the research originates from the US with a few international reviews and one study from Finland. This bias could affect the translation of these models of care or care outcomes in our Australian health setting. No Australian peer-reviewed publications were found assessing residential rehabilitation models of care for women. Although some of the included research found statistically significant results, the external variables in the Australian context may differ, affecting the clinical significance of these research finding. Health insurance models, structures for foster care arrangements and parenting payments programs are examples of variables that could greatly effect current suggestions for care models based on the literature.

No cost effective or economic evaluations of models of care were found in the research. Although the cost of drug and alcohol problems is large for both the client and the community, all health policies should include an economic component to ensure that publicly funded health programs result in a return on investment in either the short or long term.

Finally, no research focused on the suitability of models of care for clients based on their personal characteristics. This is of great importance in Australia when we are developing models of care for Indigenous women, women from rural or remote communities or women from diverse cultural and linguistic backgrounds. This is of great importance during the developmental phase of care programs to ensure that these personal characteristics are acknowledged to maximise client engagement with the program.

## Potential subsequent phase of research

There is no question that future research is required for government departments to be confident in their decision-making processes regarding models of care for residential rehabilitation. As has been discussed in the included literature, it is very difficult to complete randomised controlled trials in a functioning health service, as patient care must be prioritised over research outcomes. Therefore, health researchers need to find novel research designs that can allow high-quality research to be completed while not placing unreasonable risk on the health service. Innovative research designs, such as a stepped wedge design

should be considered as they are efficient by allowing each unit of the research to act as its own control, can include predetermined stopping rules at each stage to ensure the intervention is not negatively effecting patient outcomes, and they can allow the effect of the intervention to be assessed over time. These types of research projects are cluster randomised controlled trials and are more commonly being used in service delivery research.<sup>41</sup>

Based on the results of this rapid review and identified gaps in the research, the following subsequent phases of research should be considered:

- Future research should include mixed method designs. A large amount of the research included in this review was completed with qualitative designs. Although this has given an understanding of patient's perceptions, these results have not been supported by quantitative results to allow triangulation of research findings.
- A full economic or cost benefit analysis needs to be completed on different models of care. Although the research in this review does present positive outcomes for children living with their mothers in residential rehabilitation, no economic evaluation has been completed to determine if the additional costs involved in providing facilities for children produce positive enough outcomes to warrant the additional expense.
- Comparative research is required to test either superiority or non-inferiority for one model of care over another. To date, limited research has compared interventions to each other suggesting that future research should include control conditions or comparative interventions to truly determine the effect of the intervention.
- Research needs to include consistent, reliable and valid measures to ensure research quality. Much of the research in this review includes self-report or client recollection, which can add bias and inaccuracy to the results. Researchers should include reliable measures to ensure that research outcomes can be interpreted with more confidence.
- Longitudinal research is required to determine the long-term effect of the different models of care.
- Models of care that have been established in the US need to be evaluated in the Australian setting. Programs such as the Oxford House design (with women living in a share house to support each other) warrant further investigation.
- Treatment outcomes for diverse cultural groups need to be evaluated. Research needs to identify the components of care models that are or are not effective for different groups of women. Specific attention should be given to Indigenous communities that will require respect for cultural requirements to ensure client engagement.
- More research does need to focus on the effects on children who reside with their mothers during residential rehabilitation. Although research has shown the positive outcomes for babies born to mothers seeking rehabilitation during pregnancy, the research was not focused specifically on residential rehabilitation programs. The only residential specific study that assessed child outcomes was a small qualitative study based of participant recollection from childhood. Although it may be positive for mothers to have their children with them during residential rehabilitation, if this is not positive for the child, there are potential long-term effects that could increase future health-care related costs for the children, while also possibly negatively effecting the mother's future as well.
- Further investigation is required to understand the clientele in the Australian context. If we better understand the clientele that require rehabilitation, components of the programs can be included to improve treatment success.

## 5 Limitations of this review

The current review has been completed as a rapid review and may therefore have some limitations. The search terms, while extensive, may have omitted phrases or words relevant or specific to women's residential rehabilitation guidelines or models. Differences in the terminology used to describe residential rehabilitation services and after-care for the review may have resulted in some relevant papers being overlooked. In restricting the research countries, we may have excluded potentially useful findings of clinical trials of relevant medical conditions due to perceived differences between their and Australia's health care systems. The timeframe within which the review was conducted also precluded the ability to further develop or refine search terms or conduct comprehensive hand-searching of relevant journals, websites and reference lists of included papers.

## 6 Conclusion

This rapid review of the literature has demonstrated that limited research has been conducted assessing models of care for residential rehabilitation for women with drug and alcohol problems. The evidence to date suggests that women-only programs are beneficial for client outcomes and that these models should include a comprehensive or integrated program with child care, prenatal care and mental health programs. Although the evidence cannot recommend one model of care over another, a number of models have been shown to be effective in assisting women in their recovery. More research is required to evaluate models of care for residential rehabilitation and after-care programs. The evidence does suggest that children should reside with their mothers during residential rehabilitation, and previous research has proven positive outcomes for both the child and the mother. It has been suggested that some mothers may benefit from an initial period of time without their child residing with them, but that children should be integrated into the residential setting prior to the mother leaving the residential program. Due to the rigour of the evidence presented in this review, recommendations should be taken with caution, with governing bodies acknowledging the practicality of some of the recommendations within their health care systems.

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## 8 Appendix 1

**Table A: Summary of studies used in this review**

First author and year	Study design	Country	Setting	Cohort	Length of program	Children in residential care	Study conclusion	Quality rating score 1-11*
Amaro 2014	Cohort study	US	Metro	Low socio-economic and cultural diversity	9 session pre-designed mindfulness program	No	Mindfulness-based relapse prevention programs can decrease addiction severity. For the program used in this study, participants must attend at least 5 sessions to get positive benefits.	7
Baird 2008	Review	International	Metro	All women	Varied	Varied	Review includes others work stating that there are six components necessary in a comprehensive substance abuse program for women: (1) child care, (2) prenatal care, (3) women-only admissions, (4) supplemental services and workshops to address women specific issues, (5) mental health programming, and (6) comprehensive programming. Programs with lengths of stay of at least six months have significantly better outcomes.	6
Banerjee 2007	Quasi-experimental	US	Metro	Women	30 days, 30 – 60 days, 60+ days	N/A	“Health Realization” did lead to a significant degree in substance abuse, a positive effect on anxiety and an	7

							equivalent effect on depression compared to a 12-step treatment program. This was regardless of length of stay.	
Milligan 2010	Review	International	Metro	Women	Varied	Varied	Integrated treatment programs are successful in reducing maternal substance use, but are no more successful as non-integrated programs.	9
Niccols 2012	Review	International	Metro	Women	Varied	Varied	Integrated treatment programs do result in improved outcomes for children of addict mothers. Literature is limited but there is a current trend that integrated treatment programs may be more beneficial for child outcomes when compared to non-integrated programs.	9
Conners 2006	Cross-sectional study	US	Metro	Mothers	Varied	Yes and No	Longer stays in residential rehabilitation did result in more positive outcomes, however an optimal length of stay was not given.	7
D'Arlach 2008	Cross-sectional study	US	Metro	Women	Undefined	Yes and No	The presence of children had a positive effect on all women, not just the mothers.	9
Einbinder 2010	Qualitative	US	Metro	Women	18 month	Yes	Women felt that having their children with them was a positive as was the integrated approach with parenting classes, individual therapy and informal guidance from others.	4

Lewandowski 2008	Cohort	US	Metro	Women with children	30 days (with addition outpatient components)	Optional	Women with children in foster care were less likely to complete their treatment when compared to other women.	7
Pajulo 2012	Cohort	Finland	Metro	Women with children	4 months	Yes	Mothers who showed lower postnatal reflective functioning levels relapsed more readily after the treatment program and their children were more likely to be placed in foster care.	8
Sword 2009	Qualitative synthesis	International	N/A	Women	Varied	Yes and No	Having children present during treatment can be a motivator for recovery for women. Having children present during treatment can assist in the mother learning to parent and can aid in the mother child relationship.	9
Wong 2009 and 2006 (same data set)	Qualitative	US	Metro	Women	Min. 3 months	Yes	Women reported that having their children in treatment motivated them to seek and stay in treatment, although the additional stress was acknowledged. Having children with mothers in treatment provided a safe environment to develop parenting skills.	7
Greenfield 2007	Review	International	N/A	Women	Varied	N/A	Although women-only treatment programs may not affect patient outcomes, many women prefer this model of care.	8
Mendez 2008	Qualitative	US	Metro	Women	Varied	Optional	Women with substance abuse disorders need time to rehabilitate in residential	8

							settings. It is suggested that women spend more than 6 months in residential settings and children should be integrated to the residential setting during the rehabilitation. This study also discusses challenges for women when leaving residential rehabilitation.	
Wilson 2015	Qualitative	US	Metro	Adults who resided with their mothers in residential rehabilitation when children.	Varied	Yes	Adults reported that their experience as children in residential rehabilitation not only improved their relationships with their mothers but also affected their attitudes towards addiction and those with substance abuse struggles.	8

## 9 Appendix 2

**Table B: Quality assessments for publications in the review**

Study	Criterion	Amaro 2014	Baird 2008	Banerjee 2007	Milligan 2010	Niccols 2012	Conners 2006	D'Arlach 2008
Research question	Research questions stated or identified?	√	X	√	√	√	X	√
Study subjects	Subject group appropriate?	√	√	X	√	√	√	√
'Data' collection methods	Are methods reliable and valid for the question and context?	√	X	√	√	√	√	√
Completeness of 'data'	Have subjects dropped out? Attrition rate less than 50%? Questionnaire response rate 60% or above?	√	√	√	√	√	√	√
Confounding variables acknowledged	Have multiple variables been acknowledged where possible?	X	√	√	√	√	√	√
Analysis of results	Stats or analysis appropriate?	√	X	√	√	√	√	√
Conclusions	Can the data justify the conclusions drawn?	√	√	√	√	√	√	√
Reproducibility	Could study be repeated?	X	X	X	X	X	√	√
Prospective	Does the study look forwards?	√	X	√	√	√	X	√
Ethical issues	Were all relevant ethical issues addressed, including application number and date?	X	√	X	√	√	X	X
Triangulation	Were results supported by data from more than one source as appropriate (in accordance with research design)?	X	√	X	X	X	X	X
<b>Total score</b>	<b>Out of 11 (maximum)</b>	<b>7</b>	<b>6</b>	<b>7</b>	<b>9</b>	<b>9</b>	<b>7</b>	<b>9</b>

Study	Criterion	Einbinder 2010	Lewandows ki 2008	Pajulo 2012	Sword 2009	Wong 2006/2009	Greenfield 2007	Mendez 2008	Wilson 2008
Research question	Research questions stated or identified?	X	√	√	√	X	X	√	√
Study subjects	Subject group appropriate?	√	√	√	√	√	√	√	√
'Data' collection methods	Are methods reliable and valid for the question and context?	X	√	√	√	√	√	√	√
Completeness of 'data'	Have subjects dropped out? Attrition rate less than 50%? Questionnaire response rate 60% or above?	√	√	X	√	√	√	√	√
Confounding variables acknowledged	Have multiple variables been acknowledged where possible?	X	X	√	√	X	√	√	X
Analysis of results	Stats or analysis appropriate?	X	√	√	√	√	√	√	√
Conclusions	Can the data justify the conclusions drawn?	√	√	√	√	√	√	√	√
Reproducibility	Could study be repeated?	X	X	√	√	√	X	X	√
Prospective	Does the study look forwards?	√	√	X	X	√	√	√	√
Ethical issues	Were all relevant ethical issues addressed, including application number and date?	X	X	X	√	X	√	X	X
Triangulation	Were results supported by data from more than one source as appropriate (in accordance with research design)?	X	X	√	X	X	X	X	X
<b>Total score</b>	<b>Out of 11 (maximum)</b>	<b>4</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>7</b>	<b>8</b>	<b>8</b>	<b>8</b>

# 10 Appendix 3

**Table C: Assessment of overall quality (grade)**

	<b>Risk of bias</b>	<b>Inconsistency</b>	<b>Indirectness</b>	<b>Imprecision</b>	<b>Publication bias</b>	<b>Large effect</b>	<b>Plausible confounding</b>	<b>Dose-response gradient</b>	<b>Overall quality</b>
Item description:	Evaluates the limitations in study design or execution that may affect the quality of evidence for included outcomes.	Evaluates the consistency of results across included studies and whether any inconsistency may have affected the quality of evidence for included outcomes.	Evaluates the directness of the included evidence to answer directly the health care question and whether any indirectness may affect the quality of evidence for included outcomes.	Evaluates the precision of results of included studies and whether any imprecision may have affected the quality of evidence for included outcomes.	Evaluates the probability of publication bias (e.g. are positive findings only available from studies of the relevant topic?) and whether reporting bias may have affected the quality of evidence for included outcomes.	Evaluates whether any studies with large or very large effects should 'upgrade' the quality of evidence for relevant outcomes.	Evaluates, in studies with no 'downgrading' due to other factors, the influence of all plausible confounders on demonstrated effects to determine whether the quality of evidence for included outcomes should be 'upgraded' (due to an absence of confounders).	Evaluates, in studies with no 'downgrading' due to other factors, the influence of a dose-response gradient on demonstrated effects to determine whether the quality of evidence for included outcomes should be 'upgraded' (due to the presence of such a gradient).	High / moderate / low / very low

<b>Judgement:</b>	<b>Serious</b>	<b>Serious</b>	<b>Moderate</b>	<b>Serious</b>	<b>Unable to be formally assessed</b>	<b>No</b>	<b>Yes</b>	<b>N/A</b>	<b>LOW</b>
Comments to substantiate judgements:	Although studies were completed to a good standard there is a significant risk of bias due to research designs.	There was a lack of evidence with consistent outcomes across studies and inconsistent measures used.	There was no direct evidence to answer 2 of the 3 research questions in this review.	Study design affected the precision of study results and effected overall quality of outcomes.	Varied study designs and outcomes precluded from undertaking a formal evaluation of publication bias.	No large effects were observed across any study.	Limitations in study designs for several studies means results could have been influenced by confounding variables.	Not applicable.	

The Grades of Recommendation, Assessment, Development and Evaluation (GRADE) approach (The GRADE\* working group. *Grading quality of evidence and strength of recommendations*. BMJ 2004; 328:1490-1494 printed, abridged version) involves rating the quality of evidence for included outcomes and determination of an overall quality of evidence across outcomes. The quality of evidence reflects the extent to which we are confident that an estimate of the effect is correct. Judgements regarding overall evidence quality are made relative to the specific context the evidence is to be used. For transparency and simplicity, overall evidence quality is rated as one of four grades:

- **High:** Further research is very unlikely to change our confidence in the estimate of effect
- **Moderate:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
- **Low:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate
- **Very low:** Any estimate of effect is very uncertain.

# 11 Appendix 4

**Table D: Existing women and women with children residential rehabilitation programs**

Program Name	Location (*ASCG remoteness classification)	Target population	Capacity	Duration	Eligibility	Referral	Model of Care
<a href="#">Jarrah House (NSW)</a>	Malabar, NSW (RA1)	Women; Aboriginal and Torres Strait Islander women; Women on methadone and suboxone (incl. pregnant women)  +/- children	24 women 6 children	10 week (Detox-4 weeks Rehab-6 weeks)	NSW resident  Ineligible- Males/Women who are transgender and have not completed post-operative surgery.	self	Trauma informed strength based. 4 week CBT; 6 week DBT  CBT group model with individual case management  Communication skills, stress management, relapse prevention, relationships  DBT - personal relationships, parenting experiences and physical and psychological wellbeing  Yoga, art therapy, parenting groups, mindfulness and relaxation groups, and gentle exercise  After-care - meet with an alumnus group for continuing support  Child-care support and age-specific activities. School-aged children attend the local primary school on a temporary basis.

<a href="#">Kamira House</a>	Wyong, NSW (RA1)	Women 18-65 yo (incl. pregnant women)  +/- children ≤8 yo	22 beds for women and children	6 months	No acute mental/ physical health issues	self	Group program and individual counselling based on DBT, ACT, mindfulness skills training, and trauma-informed mood regulation practices. Child and Family Program based on attachment play therapy for mothers and children, and infant massage. Individual treatment plans and case management for women and children. Healthy dietary plans, yoga, physical training, art therapy and regular exercise groups.
<a href="#">Kathleen York House</a>	Glebe, NSW (RA1)	Women (incl. pregnant women)  >21 yo  +/- children ≤11 yo	7 women & up to 5 children	6 months	Completed detox  Released from prison/Mental Health Unit (provide clean urine screens & documentation from health professionals)  Able to pay two weeks' rent.  Need to arrange child care or school attendance during program hours  Ineligible -Women who are transgender and have not	self	DBT; Yalom Psychotherapy; Art therapy; Yoge & Philosophy; Nutrition & Sexual; Health; Psycho-drama; Psychodynamic group; Individual therapy; Circle of Security; ACT Self-help Groups  Individual care: intensive case management, individual assessment, yoga and meditation, living and social skills, Court support and advocacy, pregnancy support  Clinical care: Mental health assessments and reviews, one on one counselling, group therapy, relapse prevention, psycho- education, Tresillian parenting skills and support, children's health, art therapy

					completed post-operative surgery; diagnosed Intellectual Disability.		After-care - weekly groups with other after-care peers, individual counselling, home visits and Tresillian parenting support if required.  Community housing is also an option for some after-care clients, for up to 12 months.
<a href="#">Phoebe House</a>	Arncliffe, NSW (RA1)	Women >20 yo on methadone maintenance or regular access  + dependent child < 5 yo	9 women and up to 5 children	6 months	Actively participating in an Opioid Treatment program  Either have a child under school age, who will live with you, or have a child under school age, who you have access to at least once each fortnight;  Not have any outstanding criminal matters  Not be pregnant	Agencies, government depts, GPs, counsellors	Relapse prevention, anger management, stress reduction, domestic violence, self-esteem, self-advocacy, health and nutrition, education including hepatitis C, yoga and physical exercise, lifestyle skills, counselling.  Budgeting and taking responsibility for arranging and keeping appointments.  Parenting program - education on issues such as abuse and neglect, attachment and bonding, behaviour management and child development and nutrition.  Child care is provided while mothers attend group sessions.
<a href="#">Detour House</a>	Glebe, NSW (RA1)	Women only ≥ 18 yo with recent substance use problem	6 women	15 month. Including 3 months residential then in	Completed detoxification & substance free for ≥ 7 days prior to admission	Self	Abstinence based  12-step program meetings, individual case management, relapse prevention.

				supported independent living	Prior rehabilitation experience		<p>After 3-month in-house program, we assist our clients to find safe longer-term accommodation.</p> <p>Peer and Transition Groups: Clients who have transitioned to independent living attend weekly groups and continue to receive weekly support from caseworkers.</p> <p>Assistance in finding long-term housing, health education to assist in your recovery, art therapy and living skills.</p>
<a href="#">Guthrie House</a>	Enmore, NSW (RA1)	Women ≥18 yo (incl. pregnant women) +/-Child ≤5yo	9 women & their children	3-6 months	<p>Completed detox</p> <p>Involved in the criminal justice system (i.e. must have an active legal order)</p> <p>Homeless or at risk of homelessness</p> <p>Priority to:</p> <ul style="list-style-type: none"> <li>-Aboriginal and Torres Strait Islander women</li> <li>-pregnant women</li> <li>-women with children &lt;5 yo in their care</li> <li>-cases of domestic violence</li> </ul>	Via service provider referral	<p>Abstinence-based program that promotes a healthy lifestyle model through relapse prevention and life skills.</p> <p>Case management. Referrals as needed, Drug and alcohol assessment, counselling and group work, support to access and re-integrate family, group work and living skills activities, Recreational activities, court support, assistance with housing/appropriate accommodation on completion of the program</p> <p>After-care:</p> <p>Case management, referrals to community, weekly home visit visits, housing, legal and personal finances, access to a weekly SMART group, support in developing strategies to repair relationships, re-integrate with family and access child visits,</p>

					-if medium/high risk of re-offending		assistance navigating community involvement and personal development such as TAFE or other courses.
<a href="#">WHOS New Beginnings</a>	Rozelle, NSW (RA1)	Women only ≥18 yo	24 women	4-6 months	Ns Ineligible-pregnant women	self	Therapeutic Community Model of Care ACT based approach, Trauma informed approach, parenting courses, family support, children visits including liaison with FaCS, addiction education including drug overdose and relapse prevention, social and communication skills, assertiveness skills and self-esteem building, sexual health, skills-based education (e.g. relationship skills, communications skills, conflict resolution), stress management and exercise, harm minimisation including education on HIV/Hep C as well as CPR.
<a href="#">Destiny Haven</a>	Clarence Town, NSW (RA2)	Women only ≥18 yo	15 women	6-12 months	ns	ns	Not specified
<a href="#">Sherwood Glen</a>	Glenreagh, NSW (RA3)	Women only ≥18 yo	15 + women	6-18 Months	ns	ns	Faith-based (Christianity) Currently closed due to lack of staff

<a href="#">Ngwala Willumbong's Winja Ulupna Women's Recovery Centre</a>	St Kilda, Vic (RA1)	Koori Women Only ≥18 yo	8 women	≥3 months	Koori Women Only	ns	Parenting skills, women's health and nutrition, abuse and group therapy, self-esteem and anger management, family and domestic violence, AA & NA meetings, individual/group counselling, relapse prevention, computer skills, art.
<a href="#">Bridgehaven</a> (Salvation Army)	Preston, Vic (RA1)	Women +/- children	16 women	4 month residential 4-6 month after-care.	Completed assessment and withdrawal or detox from alcohol and/or other drugs.	Self or medical referral	Individual/family counselling, group therapy, life skills training, assistance in securing long-term housing, strategies to support healthy parenting and family relationships, mother-child therapy sessions.  Supports mothers and their children to remain together while the mother engages in treatment.
<a href="#">Hader Women's Rehab</a>	Wombat State forest, Vic (RA2)	Women only ≥18yo	ns	30-90 days +	ns	ns	Supervised medical withdrawal, individual counselling, educational groups, therapeutic groups, case management, self-help meetings, relapse prevention, peer support, yoga, naturopathy, massage.  Recreation and fitness activities, family support, massage, acupuncture, equine and art therapy, counselling, support groups, group activities.  A transitional housing program is offered to individuals that have completed one of

							our 30- to 90-day residential treatment programs.
<a href="#">Lesley's Place – Toora Women</a>	Western Creek, ACT (RA1)	Women ≥16 yo +/- children ≤12 yo.	9 women and 2 children.	3 months	Completed a supervised withdrawal	ns	All expected to attend the WIREDD Day Program  Case management, development of a recovery plan that may include attending outside services such as: AA, NA, Relapse Prevention Groups and other counselling services.
<a href="#">Marzenne House – Toora Women</a>	Western Creek, ACT (RA1)	Women ≥16 yo +/- children ≤12 yo.	ns	12 months	Established recovery and seeking additional longer term support before returning to the wider community.	ns	Differs from Lesley's Place in that eligible women have already established their recovery, and are seeking additional longer term support before returning to the wider community. Women that live at Marzenne are required to participate in case management, weekly house meetings, and continue with their recovery plan. They are also eligible to attend the day program.
<a href="#">Fresh Hope</a>	Toowoomba, QLD (RA2)	Women (incl. pregnant) ≥18 yo + children	ns	≤18 months	ns	ns	Therapeutic Communities Model of Care Based on Christian principals.  Counselling, craft/ cooking/ Horses 4 Healing/ budgeting, parenting, anger management / self-esteem, boundaries drug and alcohol education, life skills, (e.g. cooking, maintenance, painting, gardening moving furniture, cleaning, purchasing food)

							Stage 1: 1–6 weeks, Stage 2: week 7–6 months, Stage 3: 6–12 months, Stage 4 (community transition): 12–18 months
<a href="#">The Saranna Women and Children’s Program</a>	Perth, WA (RA1)	Women with children in their care.  Children up to primary school age	ns	ns	Applicants must show a commitment by attending support and counselling sessions while preparing for residential treatment.	ns	Therapeutic Communities Model of Care + further targeted interventions pertinent to the client group: Parenting skills training, child development, vocational program, onsite child care, group work, 1:1 counselling, protective behaviours education.
<a href="#">Ararimu Lodge</a>	Drury, NZ (rural Auckland)	Women only	ns	ns	ns	ns	Emphasis is placed on self-reflection and daily self-care activities. Counselling, psychiatrist.
<a href="#">The 2nd Floor Women’s Recovery Centre</a>	Alberta, Canada	Women only ≥15 yo pregnant /at risk of pregnancy with AOD issues	ns	28 days – 6-7 months	ns	anyone	Regular access to the addiction counsellor, case coordinator, career & life readiness programmer, registered nurse, physician, and other community service providers.
<a href="#">McDougall House</a>	Edmonton, Canada	Women only	ns	ns	Completed an in-patient treatment program as the McDougall House program is an extension of treatment.	ns	Individual/group counselling, educational workshops designed for needs of women, 12-step/other self-help community program, behaviour modification through knowledge, awareness and personal evaluation.

					Minimum 7 days' abstinence.		
<a href="#">LIFE Recovery</a>	Abbotsford, BC, Canada	Women only ≥ 19 yo	ns	Approx. 3 months	<p>Completed TB test.</p> <p>All other medical issues under control.</p> <p>Desire to overcome and substance addictions.</p> <p>Commit to a minimum of 3 months' treatment.</p> <p>Willing to participate fully and comply with program requirements.</p> <p>Open to growing spiritually in Christ.</p> <p>Make payment arrangements for treatment prior to entry.</p>	ns	<p>Faith-based (Christianity).</p> <p>AA, NA, one-on-one and group Christian counselling, life skills program (including devotions, art therapy, music therapy, weekly guest speakers, sing-along time, physical exercise).</p>
<a href="#">West Coast Wellness Centre for Women</a>	Maple Ridge BC, in the Greater Vancouver area, Canada	Women only ≥ 19y o	ns	45, 60 and 90-day	<p>Medically/psych stable to participate.</p> <p>Prepared to participate in a program.</p>	self	<p>Spirituality a capstone of full recovery.</p> <p>One-on-one counselling, the 12 steps of self-esteem and the 12 steps of AA, Group sessions including: building self-esteem, addiction, changing beliefs, stress management, boundary setting, managing stress, anxiety, feelings, conflict resolution,</p>

					All clients need to call and request to be put on wait list.		anger management, relationships, assertiveness  After-care program:- The starting time should be about the fifth week of the six-week program.
<a href="#">Seaside Wellness Centre</a>	Powell River, BC, Canada	Women only	9	42 day	ns	ns	Yoga, aerobic exercise, sailing & kayaking, walking & hiking, art, golf, dance, writing & storytelling, massage, healthy eating classes, pedicures & manicures, cultural, heritage & ecology Tours.  During the final week -spouses, partners and family members are invited to participate in a 3-day session to increase their understanding and how they can help as well as other challenges.  A 4th day is set aside for couples to focus on rebuilding relationships, effective communication, intimacy and working in partnership to address life's challenges.  After-care: referrals to individual counselling as well as involvement in groups, recovery living, other alternative therapies.
<a href="#">Lilith House</a>	Surrey, BC Canada	Women only	24	ns	ns	ns	Holistic recovery model incorporating physical wellness and art/music/dance therapy into program.

<a href="#">Hope Place Women's Treatment Centre</a>	Ontario, Canada (rural)	Women only ≥ 18 yo	15	33 day	Drug replacement therapy patients referred elsewhere.	ns	<p>Abstinence-based approach. 12-Step meetings.</p> <p>Psycho-educational groups, process groups and individual counselling, working through addiction-related issues: trauma, guilt, grief, denial, unresolved anger, assertiveness, self-esteem, and relapse prevention, building healthy relationships and practicing effective communication skills. Participating in healthy leisure activities: yoga, swimming, art therapy, dance and drumming.</p> <p>After-care: CONNECTIONS Group (Shame &amp; Resiliency), Healing trauma group, Woman's Way through the 12 Steps group, Sober Moms Group, Women's Peer Support Group, Living Sober, Parenting Basics Group, individual counselling, Family &amp; Friends Peer Support Group, couples &amp; family Counselling, NADA Auricular (ear) acupuncture, yoga</p>
<a href="#">The Jean Tweed Centre</a>	Toronto, Ontario, Canada	Women only	ns	21 day	ns	Self or addiction counsellor	<p>Individual counselling, groups (including self-esteem healthy relationships, managing emotions, effective communication, wellness, safe coping skills)</p> <p>Acupuncture, journaling, expressive art, recreation &amp; leisure, guided discussions.</p>

<a href="#">House of Sophrosyne</a>	Windsor, Ontario, Canada	Women only ≥ 16 yo (incl. pregnant)	ns	35-day	Valid Ontario Health Card  Withdrawal from substances 3-5 days prior to admission.  Physical / mental health must be stable enough to fully participate.	Self or others	<p>Holistic approach. A client-centric, harm reduction model</p> <p>Evidence-based curriculum combines “Helping Women Recover” and “Beyond Trauma: A Healing Journey” developed by Dr. Stephanie Covington.</p> <p>Strengths-based counselling and empowerment, exercise and recreation, art therapy, meditation, nutrition, reiki and acupuncture treatments. Building healthy relationships and practicing effective communication skills. Psycho-educational groups, process groups and individual counselling. Working through addiction-related issues: trauma, guilt, grief, denial, unresolved anger, assertiveness, self-esteem, and relapse prevention. Healthy leisure activities: yoga, walk, art therapy and dance.</p>
<a href="#">Graham Munro Centre</a>	Toronto, Ontario, Canada	Women only ≥ 16 yo	ns	21 day	ns	Referrals are accepted from all sources.	Group and individual counselling, relapse prevention and psycho-education using a 12-step program foundation and using supplementary educational materials with a 12-step program framework. Orientation and introduction to programs such as AA and NA.

<a href="#">Port Colborne General Hospital &amp; New Port Centre Residential Treatment</a>	Port Colborne, Ontario, Canada	Women only ≥ 16 yo	ns	18-day	ns	From drug and alcohol treatment providers	The women's residential experience can be either a blend of the co-educational and the women's specific content or exclusively women's program content only, as determined by the client. There is a separate courtyard and separate living space for women. Program focuses on stabilisation, education, skill development, health promotion, and after-care planning. Activities include process groups, workshops, individual counselling, smoking cessation counselling and recreation. Programming relevant to women's interests is available. CBT used.
<a href="#">Sister Margaret Smith Centre</a>	Thunder Bay, Ontario, Canada	Women only ≥ 18 yo	ns	ns	ns	ns	Treatment models offered are holistic, multi-disciplinary and incorporate stages of change and harm-reduction strategies. Focus on CBT, family systems, and DBT skills. Individual/group counselling and education sessions examine grief and loss, coping skills, relapse prevention, stress management, leisure and recreation. On site self-help meetings are available. These are women only groups within a restricted living and group room area.
<a href="#">HER Program (Relapse Prevention Program) Monarch Recovery Services</a>	Sudbury, Ontario, Canada	Women only ≥ 16 yo	ns	1 week	Must have completed an addictions program or have been involved in a treatment outreach program for	ns	A relapse-prevention refresher course, with emphasis on building self-esteem. It uses experiential therapy, including hands-on

					a period of at least three months, or must have been successful at maintaining treatment goals for a period of two months.		work such as song, dance and art. 24-hour access to support.
<a href="#">Homestead Addiction Services</a>	Toronto, Ontario, Canada	Women only ≥18yo	ns	6-10 weeks based on client need	Must be detoxified 72 hours. Sixteen- and 17-years old considered on a case-by-case basis.	ns	Phase 1 - week-long assessment. Phase 2- Structured program. Treatment is based on 12 Step, relapse prevention and life skills classes, group, and individual counselling. Health, fitness, journaling, recreation, and spiritual care are also included in program. Program can be adapted to a variety of special needs. AA model offered. Attend AA/NA/CA 1 meeting/week. Phase 3 Community Readiness. Voluntary commitment to the 10-week abstinence program. Anger management group. Trauma informed practice. CBT used.
<a href="#">Dave Smith Youth Treatment Centre</a>	Carp, Ontario, Canada	Women only 18 - 21 yo	ns	3 month	Completed application package is required for referral.	All sources	Academic programming provided on-site. Model of services is client-centred and based on evidence-based practices. Modalities including individual, group and family counselling. Comprehensive approach targets important life domains and issues, including: mental health, trauma, relationships, physical health and nutrition, and work/academics.

<a href="#">Vesta Recovery Program for Women</a>	Ottawa, Ontario, Canada	Women only ≥ 18 yo	ns	5-12 weeks	ns	ns	This integrated programming approach. Short-term treatment includes Intake and Discharge Planning, stabilisation, group dynamics, education and Relapse Prevention 1 for a total of 80 hours. Comprehensive life skills program consisting of 75 hours; and, the personal business and recreation modules consisting of 100 hours. Phase II offers 74 additional hours of intensive educational groups and, Relapse Prevention 2. While in Phase II, the women maintain their participation in the life skills, personal business and recreation modules. Also, offers: Seeking Safety Program, Acupuncture Detox, and a tobacco free facility. Nicotine replacement therapy is available for clients. CBT and DBT used.
<a href="#">Tennant House</a>	Brockville, Ontario, Canada	Women only ≥ 19 yo	ns	Average length 4 - 6 months	Must make a commitment of at least 3 months. Clients must be detoxified prior to admission.	ns	Structured group sessions on biopsychosocial/spiritual recovery and relapse prevention skills development. Standardised residential treatment materials delivered in a group format. Build peer supports, access mutual aid supports. Daily routine includes house duties. Link with other needed supports and individual counselling. Focus on therapeutic environment, communications skills and life skills development. Support is offered 24 hours/day. CBT used.

<a href="#">KWE Program</a>	Sudbury, Ontario, Canada	Indigenous Women only ≥ 16 yo	ns	1 week	Completed an addictions program or have been involved in a treatment outreach program for a period of at least 3 months, or successful at maintaining treatment goals for a period of 2 months.	ns	A relapse-prevention refresher course, with emphasis on building self-esteem. It uses experiential therapy, including hands-on work such as song, dance, art, drumming. 24-hour access to support.
<a href="#">Dilico Alcohol and Drug Treatment Centre - Thunder Bay</a>	Fort William, Ontario, Canada	Women only ≥ 18 yo	ns	ns	Need to be detoxified only if an intake worker deems it necessary.	Local withdrawal management service centre.	Treatment models offered are strength-based including: psychosocial, bio-psychosocial, cognitive-behavioural, stages of change, and Ojibway culture and traditional ceremonies. Must participate in all activities. Cultural activities and Ojibway language stressed. Attend AA/NA. Solution-focused approach.
<a href="#">Alcontrol</a>	Kitchener, Ontario, Canada	Women only ≥ 18 yo	ns	4-10 weeks	Must be substance free 72 hours prior to admission. TB test also required.	ns	Structured program. Treatment models offered are the holistic approach, cognitive-behavioural, therapeutic community-milieu therapy, and multidisciplinary. Attend AA/NA, two meetings per week. Abstinence required. Random drug testing. Ongoing assessment during treatment. Clients can go home on weekends as part of discharge planning.

<a href="#">Grant House</a>	Toronto, Ontario, Canada	Women only ≥ 18 yo	ns	6 months	Cannot be under the influence of drugs or alcohol.	Community agencies and the correctional system	It follows a holistic, abstinence-based model encompassing mind-body-spirit modalities and provides in-depth individual and group counselling. Uses CBT and DBT.
<a href="#">Maison Renaissance</a>	Hearst, Ontario, Canada	Women only ≥ 16 yo	ns	ns	Francophones only	ns	Client is assigned a female counsellor. Model of service is cognitive-behavioural. The 12-Step program is presented in a way which respects the freedom of each client in their beliefs, values, and choice of abstinence (Traditional or Universal 12-Step program).
<a href="#">Pinewood Centre - Women's Residential Treatment Program</a>	Whitby, Ontario, Canada	Women only ≥ 16 yo	ns	ns	Must be Early Childhood Development clients	ns	Group based, process-oriented and women-centred program, designed to involve clients in developing their goals. Models used are biopsychosocial, CBT, first-stage trauma treatment, including stages of change and harm reduction principles. Holistic program offering group and individual counselling in a variety of approaches (process, education, psychodrama, creative expression, etc.). Pregnant women are given priority access to services.  Abstinence-based with the exception of methadone and prescribed psychotropic medications.

<a href="#">Empathy House of Recovery</a>	Ottawa, Ontario, Canada	Women only ≥ 18 yo	ns	Minimum 3 months	Empowerment philosophy requires that the client wants treatment herself. Individuals must be substance free 72 hours prior to admission.	ns	Feelings groups, Psycho educational groups, Cognitive-behavioural, chores, AA/NA meetings, exercise, assignments, abstinence program, empowerment philosophy and creating connection.
<a href="#">New Directions for Women</a>	Southern California, US	Women +/- children (?age)	30	30 days– 1yr Av. 90 days	ns	ns	Holistic - detox and rehab. 12-step AA program, yoga, meditation, psychodrama, physical exercise, art, gardening, equine therapy, trauma therapy.  Children–counselling, art, storytelling, role playing, recreation, journaling.  Aftercare
<a href="#">Providence Women's Recovery program</a>	Georgia, US	Women only	ns	90 days	ns	ns	Faith based. Christian 12-step program, spiritual regeneration  Individual, group and drug counselling, trauma recovery, life skills, work therapy.
<a href="#">Sunspire Health the Rosebriar</a>	Oregon, US	Women only	ns	ns	ns	self	Latest evidence-based approaches to addiction recovery.  Holistic and alternative approaches e.g. Meditation, yoga, and acupuncture. Individual / family-based therapy, shame reduction, art group, 12-Step philosophy, grief & loss, spirituality, relapse prevention, self-esteem work, co-dependency work, sex, love relationship issues and healthy

							boundaries, Anxiety and obsessive disorders, coping skills, life skills, anger management, yoga/Qigong/meditation, family programs, faith and spiritual renewal.
<a href="#">Timberline Knolls</a>	Illinois, US	Women and adolescent girls (12+)	ns	ns	ns	self	One-on-one therapy sessions, expressive and experiential therapy education about disease processes and recovery, dietary support, group sessions (behaviour modification and emotion management), family therapy (including family participation), 12-step meetings, psychiatry, trauma awareness and recovery, educational services for school-age women, art therapy, equine-assisted psychotherapy, dance/movement therapy, empowerment group (experiential trauma recovery), outdoor recreation (e.g. volleyball, basketball, soccer, badminton, gardening).
<a href="#">Residence XII</a>	Near Seattle, Washington, US	Women only	ns	Approx. 4-5 weeks	ns	self	A 12-step abstinence-based program, individual / group therapy, films, lectures and activities, family program.  Comprehensive exit planning including: outpatient and addiction After-care programs

<a href="#">Women's Treatment Center</a>	Chicago, Illinois area, US	Women 18+ yo (incl. pregnant) +/- children ≤6 yo	70 women & 35 children	Av. 30-90 days	ns	self	Multidisciplinary. Individual counselling, parenting services, medical monitoring, trauma recovery.
<a href="#">Hope House</a>	South West London, UK	Women only ≥18 yo	23	12 or 24 weeks	Completed detox. Free from all mood-altering substances for ≥ 2 weeks. Priority to women who have completed a first-stage treatment program & familiarity with 12-Step approach.	self	12-Step abstinence model, group therapy, one-to-one counselling, relapse prevention training, life skills training, family based work, assistance with housing and resettlement, education and support relating to food disorders, health education workshops, art therapy, reflexology, yoga and visits to a local gym, a 'buddy' system for mutual support, participation in the running of the house e.g., shopping, tidying and budgeting Structured after-care
<a href="#">Trevi House</a>	Plymouth, UK	Women (incl. pregnant) +/- children	ns	ns	ns	self Medical referral for detox	Abstinent based service, detox. Recovery Training- motivation, relapse prevention Parenting, music therapy, 1 to 1 counselling, AA / DAA / NA and SMART recovery meetings, Healthy Relationships, domestic violence support, gym, mindfulness, cookery, craft, yoga

							<p>Transitional phase - include attending local children's centres, work around housing, linking in with volunteering and budgeting</p> <p>After-care- telephone support, short return visit if required. Local families - free after-care service (groups, counselling, crèche and lunch).</p>
<a href="#">Naomi Women's Project</a>	Kent, UK	Women only	9	Usually 3-6 months	ns	ns	<p>Holistic, 12-step model of recovery.</p> <p>Individual/group therapy, family education, life skills, leisure activities, building self-esteem, support with reintegration into communities.</p> <p>After-care: supported housing, telephone support or return visit.</p>
<a href="#">The Nelson Trust Women's Programme</a>	Gloucestershire, UK	Women ≥17 yo +/- children	10	12+ weeks	Completed detox Drug and alcohol free on arrival.	ns	<p>Abstinence-based. Trauma recovery group, eating recovery group and a specialist women's workshop program, sexual health support, courses, groups / individual counselling, family therapy, sports, country walks, tai chi and gardening.</p>
<a href="#">THOMAS Women's Residential Rehabilitation Unit</a>	Manchester, UK	Women only 18-75 yo Day visits for children	≤9	First stage-3 weeks second stage -18 weeks	ns	ns	<p>12-step program, CBT/social learning, Therapeutic community.</p>

<a href="#">Grace House</a>	North London, UK	Women only ≥18 yo	ns	12-24 weeks	ns	self	Triple P: Positive Parenting Program, domestic violence/sexual violence program, sex work group, healthy eating groups, recovery through nature, equine-assisted psychotherapy, Hearing Voices network, 12-step fellowship meetings, Clean Break, play therapy, Women in Prison, Solace Women's Aid, Chrysalis Project
<a href="#">Hebron House</a>	Norfolk, UK	Women only ≥18 yo	10	ns	ns	self	Life skills, CBT, parenting, relapse prevention, relationships workshops, art, swimming and badminton.  12-steps program.

ns= nil specified

\*ASGC Remoteness Areas Classification:

- RA1 - Major Cities
- RA2 – Inner Regional
- RA3 – Outer Regional
- RA4 – Remote
- RA5 – Very Remote

(source: <http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/locator>)

