FINAL REPORT

Review of the Women's Substance Abuse Treatment System in Ontario

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TABLE OF CONTENTS

Acknowledgements ..... **i**

Executive Summary ..... **iv**

Section I: Introduction **1**

1. Project Background 1
   - 1.1 Preface 1
   - 1.2 Purpose, Scope and Structure of the Report 1
     - 1.2.1 Purpose 1
     - 1.2.2 Scope 1
     - 1.2.3 Structure 1
   - 1.3 Context of the Review 2
   - 1.4 Deliverables 2
   - 1.5 Methodology 3
   - 1.6 Project Activities 3
     - 1.6.1 Confirmation of Project Approach 3
     - 1.6.2 Survey of Practices and Policies 3
     - 1.6.3 Key Informant Interviews with Individual Agencies 4
     - 1.6.4 Provincial Agency Data Requests 4
     - 1.6.5 Interim Report 5
     - 1.6.6 Consultation with Provider Networks 5
     - 1.6.7 Literature Review 5
     - 1.6.8 Data Analysis and Preparation of Final Report 6

Section II: Findings and Analysis **6**

2. Issues Related to Collection and Interpretation of Data 6
   - 2.1 Survey of Agency Practices 6
   - 2.2 Respondent Familiarity with *Guidelines* 8

3. Summary and Analysis of Survey Results 8
   - 3.1 Profile of Respondents 9
   - 3.2 Operational Practices 9
     - 3.2.1 Governance 9
     - 3.2.2 Education and Training 10
     - 3.2.3 Hiring and Staffing 11
     - 3.2.4 Physical Facility 12
     - 3.2.5 Physical Facility for Pregnant and Parenting Women 13
   - 3.3 Addressing Barriers 15
     - 3.3.1 Stigma 15
     - 3.3.2 Complex and Multiple Needs 16
     - 3.3.3 Accessibility 20
   - 3.4 Flexible Admission Criteria 20
   - 3.5 Treatment Planning Issues 22
     - 3.5.1 Assessment and Referral 22
     - 3.5.2 Duration of Treatment 23
   - 3.6 Clinical Practice Issues 24

3.6.1 Gender-Relevant Services 24
3.6.2 Stages of Change, Motivational Counselling, and Harm Reduction 25
3.6.3 Gender Balance in Mixed-Gender Services 27
3.6.4 Gender-Specific Approaches to Health/Wellness 28
3.6.5 Gender Sensitive Relapse Prevention Approaches 29
3.7 Specialized Issues – Co-occurring Mental Health Issues 29
3.8 Specialized issues – Trauma 32
3.9 Pregnant and Parenting Women 34
3.9.1 Engagement and Retention 34
3.9.2 Access to Services 35
3.9.3 Effective Services 36
3.9.4 Relationships with Children 36
3.9.5 Child Protection Issues 37
3.10 Monitoring and Evaluation 38

4. Successes and Innovative Strategies in Implementing Best Practices 38

5. Innovations in Other Jurisdictions 42

6. Challenges in Implementing Best Practices 44

7. System Functioning 47
7.1 Admission Policies for Women Taking Psychotropic Medications 47
7.2 Admissions Policies for Women Receiving Methadone Maintenance Therapy 47
7.3 Referral Patterns and Linkages with Adjunctive Services 48
7.4 Diversity and Equity Issues 49
7.5 Wait Times and System Capacity 49
7.6 The Potential Impact of Health Care System Restructuring 52

8. Resource and Support Needs 53

Section III: Conclusions 60

Section IV: Recommendations 64

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- Representatives of 24 agencies who agreed to be interviewed as key informants and whose input was critical to gaining in-depth information in relation to specific practice areas.
- Members of the WAAN Network, the ECD[1] Addictions Network, the Toronto Women's Services Cluster, and attendees at the Addictions Ontario conference

[1] In September 2000, Ontario's Minister joined Canada's other First Ministers in signing the First Ministers' communiqué on Early Childhood Development (ECD). The ECD was the federal, provincial and territorial governments' commitment to help families and communities support their children. It committed the federal government to transferring incremental and predictable funding to the provinces. It committed the provinces to allocating the funding to children from their prenatal period up to six years of age. Since 2001, Ontario has invested its share of federal ECD funding in a number of initiatives across the Ministry of Health and Long-Term Care (MOHLTC), the Ministry of Community and Social Services and the Ministry of Children and Youth Services. These ECD initiatives complement or expand upon existing programs and services, and include universal programs available to all children as well as programs and services that support the healthy development of children with special needs. The Early Childhood Development (ECD) Addictions Initiative is one of several programs funded by the MOHLTC under the ECD umbrella. The ECD Addictions services are delivered on a transfer payment basis by existing addictions sector transfer payment agencies that provide services for women. (ECD) Addictions Initiative is one of several targeted programs funded by the MOHLTC. ECD Addictions programs are delivered on a transfer payment basis by existing addictions sector transfer payment agencies that provide services for women.

who participated in network consultations that allowed us to obtain collective input.

We also appreciate the input of two provincial agencies – Connex Ontario, which operates the Drug and Alcohol Registry of Treatment (DART), and the Drug and Alcohol Treatment Information System (DATIS) – both of whom responded quickly and thoroughly to our requests for information, and 'went the extra mile' to provide additional information and consultation where needed. The data provided by these provincial resources was vital to the review.

Finally, we want to thank each and every person who responded to the survey. Agencies were asked to complete a lengthy questionnaire at an exceptionally busy time of year. Their response was indicative of both their support for this review and their commitment to best practices for women.

Project Team

The review was conducted by Gates Consulting Inc. Project work was completed through the collective efforts of the consultant team comprised of Virginia Carver, Elizabeth Hull, Valerie Johnston, and Wendy Reynolds (Co-Lead), and Janine Gates (Project Manager and Principal Consultant). Each member of the consultant team brought significant expertise and dedication to developing a comprehensive review of the substance abuse service system for women. In the administrative role for the project, Rosanne Baumhard provided superlative support, problem solving, and skill to tasks ranging from launching and managing the web-based survey to production of the final report.

Executive Summary

Introduction

In February 2006, Gates Consulting Inc. was engaged to conduct a review of the women's substance abuse service system in Ontario. The review was supervised by a project Steering Committee comprised of the Ministry of Health and Long Term Care (MOHLTC), the Ministry of Children and Youth Services, the Ontario Federation of Community Mental Health and Addictions Programs, Addictions Ontario, and representatives of MOHLTC funded women's treatment services.

This report has been prepared for the project Steering Committee to provide results of the review and recommendations for supporting implementation of best practices in Ontario substance abuse treatment services for women.

Background

Over the last 20 years, research has demonstrated that substance-involved women have distinct treatment needs. Best practices have been developed that call for gender-specialized approaches that are responsive to the context of women's lives. In 2001, Health Canada published a compendium of new knowledge and key expert input about best practices in services for substance-involved women (Health Canada: *Best Practices Treatment and Rehabilitation for Women with Substance Use Problems*).

In 2002, the Ontario MOHLTC established a Women's Services Strategy Work Group to support substance abuse treatment services in implementing best practices for women. Building on Health Canada's best practices publication, the Work Group developed a program evaluation tool, *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services (Guidelines)*, which was released by the MOHLTC in October 2005. The goal of the *Guidelines* is to support agencies in providing gender-appropriate accessible services for women across all categories and types of substance abuse treatment services. The release of *Best Practices in Action* served as a catalyst for the review of the women's substance abuse treatment system that is the subject of this report.

The report provides an assessment of:

- The degree to which the system is implementing the *Guidelines* set out by *Best Practices in Action;*
- System successes in meeting the *Guidelines;*
- System challenges in meeting the *Guidelines;*
- System-level issues that affect the implementation of the *Guidelines;*
- Agency-level and system-level supports required to meet the minimum requirements of implementing the *Guidelines;* and
- Innovative strategies and activities from programs/services in Ontario and other jurisdictions that have the potential for broader application in the Ontario women's substance abuse treatment services system.

Methodology

The review provided a unique opportunity to gather baseline data about the performance of the system against best practices guidelines provided by the MOHLTC. In keeping with the intent of *Best Practices in Action*, the review sought to validate the strengths and successes of the system while also making a realistic assessment of progress to date and requirements for further growth and development. One overarching principle informed the scope of enquiry for the review: *that any woman should be able to access consistent, effective services throughout the women's substance abuse treatment service system.*

To ensure a realistic and well-grounded assessment of agency practices, data was gathered and synthesized from four key information sources:

1. Baseline data was collected through a provincial survey of agency practices. All MOHLTC transfer payment agencies funded to provide substance abuse treatment services for women were invited and encouraged to participate in the survey, including all *types* (restricted, specialized, and generic) and all *categories* (assessment/treatment planning, community treatment, residential, and withdrawal management) of services. An on-line survey tool was developed based on the *Guidelines*. Seventy-seven (77) agencies completed the survey, representing 62% of target agencies.
2. Analysis of baseline data was informed by input about agency practices and the context in which services are provided; input was obtained through interviews with key informants and consultations with service provider groups and networks. Qualitative data from these stakeholders was critical to the development of a full understanding of the issues and challenges that affect agency efforts to implement best practices. Key informants were selected to ensure the inclusion of perspectives of agencies representing a broad range of geographic locations, treatment philosophies, and approaches.
3. Targeted data about provincial service issues was provided by two provincial agencies: the Drug and Alcohol Registry of Treatment (DART), and the Drug and Alcohol Treatment Information System (DATIS). DART provided provincial data in respect to wait time and accessibility issues, including specific information about admission policies (priority admissions for pregnant women; criteria for accepting psychotropic medications, methadone, and mental health issues). DATIS provided both provincial and targeted data in respect to demographic patterns and referral patterns.
4. Additionally, a review of innovative practices in Ontario agencies and other jurisdictions was conducted to identify promising models and strategies that may be utilized to strengthen services in the Ontario system. Ontario agencies were invited to provide examples of innovative strategies used to implement best practices. A literature search identified current best practices principles and models, as well as promising program models from other jurisdictions.

Summary Observations

Ontario's substance abuse treatment system is undergoing profound shifts in its understanding of best practices and its approaches to women's substance abuse treatment. The review identified six key areas in which such shifts are evident:

- Greater attention to women's treatment issues and to gender-specific and gender-appropriate programming;
- Increased awareness of the inter-relationship of trauma and substance use and the implications for treatment;
- Efforts to broaden admission policies and build expertise to meet the needs of women who have co-occurring mental health problems;
- Increasing acceptance of Methadone Maintenance Therapy (MMT) as an essential treatment option for some women;
- Successes and ongoing efforts to build collaborative relationships with allied sector services; and
- Development of Early Childhood Development (ECD) Addiction programs that meet the unique service needs of pregnant and parenting women, as an essential element of the system landscape.

The review also identified supportive factors that have been particularly important in promoting positive change:

- Targeted funding (such as ECD Addictions funding) has catalyzed the development of new approaches in areas where significant change is required.
- MOHLTC interest and support has leveraged uptake of emergent best practices approaches (such as MMT).
- Leadership, often from agencies providing specialized services, has helped to profile the importance of, and need for, best practices-based services for women.
- Funding to stabilize and regenerate core services in the substance abuse treatment system has had a significant impact on practices wherever it has been made available.

Levels of Adherence to the Guidelines

Most agencies that responded to the survey of practices reported a commitment to best practices in almost all major areas, however it is clear that having a commitment does not necessarily enable agencies to fully achieve all guidelines. While high levels of achievement of some of the guidelines were reported in six of the seven major areas surveyed[2], poor levels of achievement were also reported in respect to some guidelines in all seven major areas. For over a third of the 80 guidelines covered by survey questions, less than 50% of respondents reported full achievement. It is notable that where agency practices do reflect full achievement of guidelines, those practices have been implemented in a context of fiscal constraint – a remarkable accomplishment that stands as testimony to the resourcefulness and dedication of the field. For some guidelines, a significant percentage of respondents reported partial achievement; these reports are indicative of the efforts of agencies to work toward best practices.

[2]A high level overview of reported achievement to all Guidelines is provided in Table A, which follows Recommendations section of the Executive Summary.

Innovative Practices

Many respondents reported that they have developed innovative responses to the practical limitations and to the other constraints within which they operate. Respondents and key informants cited an array of service approaches designed to increase program flexibility, provide gender-specific programming, facilitate practical supports, advocate for clients, and partner with other sectors to deliver services in more accessible locations and models. Many of the innovative responses that have been implemented by Ontario service providers reflect promising practices in other jurisdictions within and outside of Canada.

While the innovative practices reported by Ontario respondents are too numerous to fully discuss in this summary, the following provides a sample of practices that have potential for broad application in the Ontario service system:

- Facilitated access and wrap-around services for pregnant and parenting women;
- Program models and treatment components that address trauma as a core issue;
- Outreach, intensive case management, and home visiting service components;
- Non-traditional and low-threshold service models for women living in vulnerable circumstances;
- Programming that provides enhanced access and/or cultural appropriateness through partnership and co-service delivery with allied services;
- Services that operate in a harm reduction and stages of change framework; and
- Programs that address lifestyle, social context, personal concerns and health issues.

Challenges and Support Needs

The review identified four primary areas where additional support is required for implementation of the *Guidelines*:

1. Lack of awareness of the *Guidelines*

Best Practices in Action provides comprehensive information about treatment issues for women, including a specific rationale for each guideline – the more familiar agencies are with the document, the better equipped they are to implement best practices. The document was released approximately six months before the review, and some respondents had not seen or reviewed *Best Practices in Action* at the time of survey completion, while others had only scanned the *Guidelines*.

It was apparent from survey responses that some agencies lack a thorough understanding of the full application of the *Guidelines*. In particular, some agencies appear to consider some guidelines as 'not applicable' to their services because they work with both men and women in a mixed gender setting, do not provide specialized services for women, or do not provide group programming. Agencies need clear direction from the MOHLTC that the *Guidelines* are universal and applicable to all services (in both restricted and 'co-ed' settings) and all categories of service that are provided to women, unless otherwise stated by specific guidelines.

If the full application of the *Guidelines* is clearly understood and consistently adopted across the service system, some guidelines can be fully or partially implemented within existing system resources or with minimal investments from the funder. For example, changes to agency policy and procedures can be made with no new funding (although some changes to corresponding practices may require additional resources). In some agencies, positive practices are already in place but are not yet documented and supported by corresponding policies. Limited investments of grant or capital funding can leverage significant improvements in practices (e.g. for improvements to physical facilities or targeted training).

2. Lack of agency resources to implement the Guidelines

Lack of funding was identified by most respondents as the most significant barrier to implementing the *Guidelines*. For some guidelines, agencies simply do not have the resources necessary to implement best practices. Where partial achievement of specific guidelines was reported, it appears to reflect a lack of necessary resources to implement best practices rather than a lack of awareness or commitment.

Respondents noted that funding is required to sustain services and to assist agencies in developing (or re-developing) and delivering service elements that reflect best practices. Such funding is critical for a sector where a lack of base funding increases for several years has meant that many agencies struggle to even maintain existing core services and to meet demands for services. To fully implement the *Guidelines*, a substantial infusion of resources is required for:

Staffing:

- expanded levels of staff;
- adequate compensation to attract and retain appropriately skilled staff;
- staff training, clinical supervision, and professional development; and
- increased agency expertise and external resources to meet complex needs (e.g. of women who have co-occurring mental health issues).

Infrastructure:

- expansion and/or retrofit of physical facilities; and
- adequate agency infrastructure.

Service Development and Delivery:

- outreach, accessible service locations, and low threshold service models;
- case management and advocacy functions;
- development and delivery of additional gender-appropriate programming and service options, including options for pregnant and parenting women; and
- specialized and non-traditional service models to engage marginalized and under-served populations of women.

Cross-sector Linkages

- education and stigma reduction; and
- development of linkages, partnerships, cross-sector training and knowledge sharing with allied and adjunctive services.

Funding is also required as a catalyst for innovation. While respondents reported an impressive array of creative service and problem solving approaches, many noted that innovation is severely restricted by lack of funding. In many agencies, staffing resources are fully committed to service provision, leaving little opportunity to engage in the service development and change processes necessary to implement best practices. As one respondent noted: *"Current resources do not allow time for innovation and program development. Every hour that we take away from direct service for program innovation adds stress for staff that's already stressed. Staff put time into a review of best practices anyway, and then were told that there's no funding to implement their creative thinking."*

3. Lack of system capacity to support best practices

A review of capacity data indicates that resources are required to reduce wait times, build additional capacity, and establish new or additional services. The *Guidelines* emphasize timely engagement and access to appropriate levels of services as key elements of an effective service system. Currently, long wait times for some services create barriers to timely engagement, while gaps in the continuum of services undermine the ability of agencies to match women with appropriate types and categories of services. To support implementation of the Guidelines, the system needs to be resourced to provide:

- Timely and accessible responses to service demands
- Specialized high support services for women who have co-occurring mental health issues and/or women who require ongoing use of psychoactive medications;
- Services for pregnant and parenting women (including childcare, children's programming, and mother-child programming) across the service continuum and in all communities;
- Increased availability of stabilization and supportive housing (pre- and post-treatment);
- An appropriate continuum of local services in every LHIN area, including:
    - accessible local service options for gender restricted withdrawal management and community treatment services, and
    - access to restricted and specialized residential women's services, either in each LHIN area, or through access to programs with provincial catchment areas, where not provided by the local continuum of services.

4. Need for enhanced system functioning

The overall functioning of the system has a profound effect on the ability of agencies to implement best practices. Analysis of system functioning is outside the mandate of this review, however a number of key issues that impact directly on implementation of the *Guidelines* were identified during the course of the review. Enhanced ministry direction, policy support, and service system management are required in the following areas:

- Clearly articulated expectations for implementation of the *Guidelines*, and appropriate mechanisms for monitoring and reporting progress, are required to support accessible and appropriate services for women in all services.
- Provincial benchmarks are required for access, wait times, local capacity and service continuum availability in each LHIN area.

- System-based models and tools for program evaluation and collection of standardized data are needed to monitor and support adherence to best practices.
- More thorough and consistent reporting to provincial agencies (DART and DATIS) is required to ensure that full, accurate information about admission policies and practices, referrals, and linkages is available to stakeholders and funders.
- Validation and guidance of funders across ministries and within the MOHLTC is needed to generate and guide cross-sector collaboration (particularly between addictions agencies and mental health, child welfare, child oriented services, and services for pregnant women)
- At the system level, policies and practices that exclude some medications and place restrictions on medication use continue to act as barriers to services for many women, despite the efforts of many agencies to develop more open and accessible admission policies for women who take medications.
- While recognition of methadone as a legitimate treatment approach has gained considerable acceptance across the addictions sector, acceptance does not necessarily guarantee access. Respondents cited numerous barriers to methadone access in local communities and in some agencies.
- Best practices guidelines for addressing the varied needs of diverse populations need to be developed before system performance in this area can be assessed.

Concluding Remarks

For the most part, the findings revealed a system that, in many areas, is poised to embrace best practices in its work with women. There are however, caveats surrounding that positive conclusion:

- The lack of objective measures (such as benchmarks and universal definitions) may have resulted in over-reporting of achievement for some guidelines.
- While most agencies reported reasonably good performance against most of the guidelines and some reported excellent compliance with all of the indicators, it is clear that some agencies will require Ministry direction and support to meet minimum requirements.
- Even with the full commitment and creative energies of all agencies, the system does not appear to be adequately resourced to fully implement the *Guidelines* provided by the MOHLTC in *Best Practices in Action* within current capacity and funding levels

This review provided substantial and detailed baseline data about agency practices. The results identify a significant level of commitment to best practices among many service providers, and point to further work that is required in order to ensure accessible and appropriate services for substance-involved women in Ontario, as described in the recommendations below.

It is clear that the current positive momentum of agencies in implementing best practices must be supported by widespread distribution of *Best Practices in Action,* clear statements of expectations and direction from the funder, adequate resources, and effective monitoring and reporting.

Recommendations

The report provides 54 recommendations which, when fully implemented, will assist agencies to meet the standards outlined in Best Practices in Action. Recommendations do not appear in order of priority, but have grouped in three sub-sections, according to the level and type of resources required for their implementation.

I. Recommendations for implementation within existing funding, or with moderate levels of grant and/or targeted funding.

The following recommendations require adjustments to agency policy and practice, more creative use of existing tools and resources, and increased communication and collaboration, both within the substance abuse system, and between that system and allied service sectors. Some require moderate levels of grant and/or targeted funding for *full* implementation, but can still be *partially* addressed if funding is not made available. These recommendations are provided for all agencies that provide services for women in any category of service.

To support implementation of the *Guidelines*, it is recommended that:

1) All agencies (including restricted, specialized and co-ed agencies) conduct a thorough review of Best Practices in Action, with the understanding that the guidelines therein apply equally to all agencies, unless guidelines are explicitly identified as applicable only for specific program types or categories of service.

2) Agencies re-examine all aspects of their services against the Guidelines and, where agencies have mistakenly considered universal guidelines as applicable only to certain program types or service categories, they ensure uptake of applicable guidelines including, but not limited to:
   - Mission, goals and objectives.
   - Sexual harassment policies and procedures.
   - Education, training, and clinical support in respect to best practices for women's services for counselling staff.
   - Safety and confidentiality of physical setting.
   - Clear information about treatment choices, rights, and options.
   - Policies and procedures to ensure that all requests for service are considered and that admission criteria do not discriminate.

3) Agencies utilize accessible tools (such as Health Canada publications, Best Practices in Action and literature resources cited in that document, and on-line information), and access the expertise of peer agencies to develop a deeper understanding of the issues that provide a context for best practices.

4) Existing knowledge exchange vehicles, such as the WAAN network, the ECD list serve, and other service provider groups should be used to explore opportunities for sharing information, building on existing innovative models, and forming mentoring relationships.

5) Where co-ed agencies have experienced difficulty in attracting sufficient numbers of women to provide women-only groups or gender balanced groups, they should ensure that gender-sensitive services are delivered and build visibility for those services in the local community by:
   - Cultivating service relationships and seeking referrals from allied sector women's services in the local community.

- Initiating outreach services that will make the agency's services better known and more accessible to women.
- Seeking advice and mentoring from other co-ed agencies that have been successful in attracting women clients.

6) Co-ed agencies provide, as part of their core services, gender-specific approaches and access to female staff – whether in groups, individual counselling, assessment, or treatment planning.

7) All agencies that provide any category or type of services for women work toward development of written policies to ensure sound and basic practices for pregnant and parenting women as outlined in best practices, including but not limited to:
   - Priority admissions for pregnant women;
   - Appropriate policies and practices for reporting of child protection issues and collaborative relationships with child protection agencies;
   - Provision of methadone (or linkages for provision) for opioid dependent pregnant women as soon as possible;
   - Linkages for pregnant women to facilitate access to practical supports and enhance protective factors;
   - Provision or facilitation of childcare and/or mother-child visits, where needed;
   - Linking children affected by addiction with diagnostic services or programming;
   - Linking all children whose mothers are substance-involved with appropriate community agencies; and
   - Working with adjunctive services for pregnant and parenting women to develop co-ordinated or wrap-around service models that address the needs of this population in a holistic manner.

8) Agencies providing assessment/referral and community treatment services develop approaches to reduce barriers for pregnant and parenting women through strategies such as:
   - Provision of off site and/or co-located services.
   - Provision of low-threshold services.
   - Flexible assessment, admission, and intake processes.

9) All agencies seek opportunities to build competencies for providing appropriate services for diverse populations of women, including uptake of existing tools to improve awareness of diversity (such as tools provided by United Way).

10) All agencies closely examine their capacity to be more flexible in admission criteria, particularly in respect to policies for accepting women who are taking medications, have co-occurring mental health problems, or are receiving Methadone Maintenance Therapy.

11) Programs conscientiously and clearly report admission criteria (including medications policies) to DART, to facilitate informed referrals and ensure that DART is able to provide clear information to callers.

12) Closed cycle programs or groups examine options for providing more flexible service options through strategies such as continuous intake, telephone pre-treatment supports, and extended stay, and that agencies which struggle with this issue seek out advice of agencies that have been successful in developing increased flexibility.

13) All agencies undertake training and clinical supervision to ensure that staff and services are 'trauma-informed' (including formal programming, individual counselling, assessment, treatment planning and withdrawal management functions)

14) All agencies (in all service categories and types) provide gender-specific approaches as indicated by the *Guidelines* (e.g. provide accurate information about physical health aspects of substance use), whether group or individual counselling modalities are utilized to provide services.

15) Agencies build on the numerous models of successful partnership and collaboration contained in this report, and that formal partnership agreements be developed wherever feasible.

16) Agencies engage in formal and informal activities to reduce stigma through strategies such as:
    - Community education, speaking engagements, media tools to increase awareness of addiction as a health issue, participation on task forces.
    - ECD programs engage in stigma reduction for pregnant or parenting women.
    - Continued education and collaboration with Child Welfare agencies to effectively bring about solutions to issues faced by pregnant and parenting women with addictions.
    - Non-judgmental support for pregnant women in making decisions about pregnancy.
    - Staff training, raising of awareness, and training in stigma reduction.

17) All agencies document the linkages provided for women, by providing full data to CATALYST about referrals that have been made during and following treatment.

18) All agencies utilize the guidelines provided by Best Practices in Action as a starting point for evaluation of agency practices and a method of self-monitoring implementation of best practices; that they seek collateral input from clients, referral agents, and community/allied sector agencies about the quality of their practices in respect to services for women; and that they document and report progress toward implementing best practices guidelines in their annual reporting process to the funder.

II: Recommendations Related to System Change

As indicated in the conclusions, funders (MOHLTC/LHINs) can leverage significant system change through adjustments in policy and communication of clear expectations to the field. The development of service benchmarks, training and leadership strategies, program evaluation tools, and a framework for ongoing monitoring and evaluation of best practices would signal the Ministry's commitment to ensuring that appropriate and accessible services for women are provided across the province.

Toward that end, it is recommended that:

19) The Ministry entrench best practices for women by articulating a clear commitment that best practices are essential and, therefore, policies, funding, and accountability mechanisms support their implementation.

20) The Ministry re-issue Best Practices in Action, as a bound copy, with clear communication as to expectations for implementation.

21) Ministry/funder expectations for implementation of best practices guidelines by individual agencies be supported by monitoring of adherence and requirement for action planning where adherence is not demonstrated, and provision of resources where required to implement specific guidelines.

22) Annual agency reports be utilized as a mechanism for monitoring and reporting adherence to, and progress toward, implementation of best practices to funders, and that best practices guidelines be formally reflected in the goals and objectives of the annual operating plan (or performance contract) that is provided to the Ministry (or LHINs).

23) The Final Report of the Review of Women's Substance Abuse Treatment System in Ontario be made available to addiction treatment providers and to LHINs across Ontario, for their information and review.

24) The Ministry provide LHINs with comprehensive information about the nature, strengths, and needs of the women's service system, including the importance of best practices to ensure equitable and appropriate services.

25) The Ministry support access to an appropriate continuum of substance abuse treatment services for women in each LHIN area by:

    a) identifying the baseline level of services (including generic, specialized and restricted services) that should be available in, or accessible to, women in each LHIN area in order to meet best practices requirements for timely access to appropriate services;

    b) providing each LHIN with an analysis of the current availability of women's substance abuse treatment services that are either provided in the LHIN area or accessed through referral to another specialized (e.g. restricted residential) program in another LHIN area; and

    c) advising LHINs as to the critical role of restricted and specialized residential women's programs in providing access to services for women in LHIN areas where a full continuum of services does not currently exist in the local system.

26) The Ministry develop a dedicated provincial advisory group to monitor new practice developments, ensure that Best Practices in Action is updated accordingly, and advise the Ministry in respect to implementation issues at the system level.

27) The Ministry develop benchmarks and definitions where needed, as identified within the report (e.g. benchmarks for wait times, staff credentials, case management, priority admissions of pregnant women; definitions of anti-stigma activities, advocacy, and integrated approaches to concurrent disorders services).

28) The Ministry further develop the *Guidelines* provided in Best Practices in Action to include guidelines for diverse populations of women.

29) The Ministry build on lessons learned from the success of the ECD Addictions initiative to develop similar models of partnership-based, coordinated, low-threshold services in respect to other marginalized populations.

30) One or more agencies with expertise in specific areas of best practices be identified and funded by the Ministry to provide provincial leadership and/or mentoring for implementation of best practices, generate system-wide expertise, and support dissemination of innovative models, promising practices, and lessons learned.

31) The Ministry work with other ministries and within relevant areas of the MOHLTC to:
    a) ensure harmonized government policies that support women who have substance abuse problems in accessing services needed to achieve wellness, stability, and positive health outcomes;
    b) utilize inter-ministerial committees to identify and reduce practical barriers for women who have substance abuse problems, change punitive or exclusionary policies and practices, and to engender support for sector-to-sector collaboration at the funder level;
    c) build a clear understanding among allied sectors of the role and legitimacy of harm reduction strategies, where indicated, to support women's health, wellness and recovery at varying stages of change.
32) The Ministry make available to substance abuse treatment agencies a portion of resources available through Accord funding, to support implementation of best practices for women with co-occurring mental health issues.
33) The Ministry facilitate and support the development and system-wide implementation of program and outcome evaluation tools that incorporate the elements of best practices guidelines.
34) Gender-based analysis be utilized in studies, reviews, and development of materials funded by the Ministry and/or LHINs to ensure that data specific to women is included, and that the implications of issues are equitably identified for both women and men.
35) The Ministry support identification of screening tools for co-occurring mental health problems that are validated for use with women, as a gender, for system-wide implementation.
36) The Ministry conduct ongoing monitoring and evaluation of system practices, utilizing the data developed in this review as a baseline for assessing progress in implementation of best practices for women, and toward that end, that the Ministry invest in the development of a provincial evaluation framework (as has been implemented for the ECD initiative).
37) Provincial agencies collect and disseminate data that is relevant to women's treatment needs (e.g. in CATALYST, collect data in respect to number and age of children, and data as to whether children reside at home or in care).

III. Recommendations that require a significant infusion of funding.

Although much can be achieved within existing resources, the system will not be able to achieve full implementation of best practices without a significant infusion of new funding. At the agency level, achievement of some guidelines will require new resources for staffing, retrofit, or expansion of existing facilities, training, development, and provision of new program models and components, and support for partnership development. Additionally, new resources are required to address global service issues including: stabilizing and regenerating the core continuum of services; addressing gaps in specific categories of services; and meeting needs for specialized, gender-specific service approaches in service areas such as concurrent disorders, pregnant and parenting women, and trauma.

To support system capacity it is recommended that:

38) Sufficient funding be provided to all agencies to attract and compensate staff with skills and expertise to address the diversity of women's experience and complexity of treatment issues (including but not limited to trauma, violence, abuse, mental health issues, and eating disorders).

39) Sufficient funding be provided for staffing to support development and delivery of gender-appropriate programming in all co-ed agencies (including gender-specific program and service elements and approaches, and female counsellors for individual counselling and group facilitation).

40) Sufficient funding be provided to agencies (in accord with their mission and goals) for staff to implement approaches to engagement that have been shown to be effective in addressing barriers, particularly for marginalized or isolated populations of women (e.g. satellites, outreach services, co-locations, flexible hours of service, flexible duration of programming, low threshold models, childcare and children's programming, community withdrawal management).

41) Sufficient funding be provided to residential and withdrawal management services for staffing to ensure that female staff are available to work with women on all shifts, and to conduct bed checks.

42) Sufficient levels of funding be provided to residential agencies to ensure appropriate staffing levels to provide adequate support and services for women with complex treatment needs and issues (e.g. women who have co-occurring mental health problems, including 'serious mental illness'; women who have experienced trauma; women who take psychoactive medications).

43) Funding be provided to all agencies for advocacy training and for sufficient staffing levels to provide case management and advocacy.

44) Funding be provided to enable all agencies to allocate and utilize a portion of their budgets for practical supports (e.g. transportation, childcare) that are important to the engagement and retention of women.

45) Funding be provided to agencies that currently operate on fixed cycle programs or groups to allow development and implementation of more flexible program structures.

46) Funding be provided to all programs and communities (where needs are identified) to improve availability of MMT, reduce barriers to methadone access, and reduce barriers to service access for women who use methadone, including development of low threshold models in community treatment and residential agencies.

47) Funders (MOHLTC/LHINs) ensure that every agency designate and utilize a percentage of annual funding for ongoing development of staff knowledge and skills in best practices, and provide adequate agency funding for training, consultation, clinical supervision, and 'backfill' for staff attending training.

48) Resources be provided to agencies, as required, to build relationships with allied sector women's services and other community services for the purpose of developing cross-sector training; protocols; service relationships; collaborative and innovative approaches; co-locations and co-service delivery.

49) Grant or capital funding for equipment, retrofit, and repairs to physical facilities, and/or ongoing funding for additional space be provided (in accord with identified needs) to support implementation of best practices guidelines in relation to: safe, secure, and confidential facilities; separate spaces for women in co-ed facilities;

and spaces for expanded programming (including gender-specific program elements in co-ed agencies and space for childcare, children's programming, mother-child visits in all agencies that serve women) and accessible spaces for women who have physical disabilities.

50) Funding be provided to strengthen and build capacity in the core continuum of services for the purposes of: stabilizing services that are struggling to maintain core levels, and providing timely access to a congruent continuum of services that includes gender-specific components and gender-appropriate approaches as integral elements of core services.

51) New services be funded to address gaps in the continuum of services, with specific attention to gender-restricted services for residential stabilization, supportive post-treatment housing, withdrawal management services, and other gap areas identified within the report.

52) ECD Addictions funding be continued, expanded, and extended to build specialized services in every LHIN area and to 'mainstream' appropriate services for pregnant and parenting women and their children as core concerns of the entire service system for women.

53) Restricted residential programs for mothers and children be developed as provincial programs, building on models from other jurisdictions and drawing on the knowledge and expertise of Ontario women's service providers.

54) Gender-restricted residential services be developed and funded to ensure availability of service for women who require high support specialized concurrent disorders services and for women who take psychoactive medications and require support for selective abstinence goals.

TABLE A

Survey of Agency Practices: Summary Chart of Self-Assessment Ratings[3]

			Guideline Achievement			% Not Appli-cable
			% Full	% Partial	% Not Ach.	
Operational Practices						
GOVERNANCE *Average achievement* • *62% Full* • *23% Partial* • *12% Not Ach* • *6% Not Appl*	2.1	Your mission, goals, and objectives identify the unique needs of women and interventions specific to women. (N=77)	22	38	25	15
	2.2	Freestanding restricted women's agency only: The majority of your Board of Directors is comprised of women. (N=12)	83	8	8	n/a
	2.3	Freestanding specialized or co-ed agency only: A minimum of 50% of your Board of Directors is comprised of women. (N=41)	58	24	17	n/a
	2.4	Sponsored restricted women's program with dedicated Program Advisory Committee only: The majority of the Program Advisory Committee members is comprised of women. (N=15)	80	7	13	n/a
	2.5	Your agency's program, policies and practices reflect and support Best Practices principles at all governance levels. (N=77)	43	51	4	3
	2.6	You have programs and procedures in place for Board of Directors, staff, volunteers, and clients if sexual harassment claims are made or other complaints are raised. (N=77)	86	10	4	0
EDUCATION AND TRAINING *Average achievement* • *36% Full* • *57% Partial* • *7% Not Ach* • *2% Not Appl*	3.1	You ensure that all counsellors who work with women receive education and training in effective therapeutic approaches and core issues identified by best practices. (N=77)	38	**55**	**7**	**1**
	3.2	You engage in cross-training with other substance abuse agencies and/or with other systems/sectors that have expertise in women's issues. (N=77)	33	**58**	**7**	**3**

[3] **Percentages may not add up to 100% due to rounding.**

			Guideline Achievement			% Not Appli-cable
			% Full	% Partial	% Not Ach.	
HIRING AND STAFFING *Average achievement* • *74% Full* • *12% Partial* • *3% Not Ach* • *21% Not App*	4.1	In gender - specific (restricted) programs or services, your policies and procedures require female staff for all clinical, program delivery, and residential support positions. (N=30)	87	**7**	**7**	**n/a**
	4.2	In co-ed services, your policies and procedures ensure that female staff is available to work with women in clinical, program delivery, and residential support positions (both day and night). (N=54)	76	**19**	**6**	**n/a**
	4.3	Only female staff conducts bed checks. (N=29)	86	**14**	**0**	**n/a**
	4.4	Female clinical staff is available for individual counselling work. (N=76)	87	**9**	**1**	**3**
	4.5	Women-only groups or women-focused sessions are facilitated by female clinical staff. (N=75)	69	**4**	**0**	**27**
	4.6	Mixed groups are facilitated or co-facilitated by female clinical staff. (N=76)	41	**21**	**4**	**34**
PHYSICAL FACILITY *Average achievement* • *72% Full* • *21% Partial* • *3% Not Ach* • *12% Not Appl*	5.1	The physical safety and confidentiality of women is ensured by your policies and procedures (such as security systems, lighting inside and outside, and screening of visitors). (N=77)	**68**	**21**	**0**	**12**
	5.2	In co-ed residential settings, you have designated separate women-only spaces (including sleeping area, lounge/eating area, and program/counselling spaces). (N=18)	**61**	**33**	**6**	**n/a**
	5.3	Residential women-only services are located in a separate and dedicated women's facility. (N=23)	**87**	**9**	**4**	**n/a**
PHYSICAL FACILITY FOR PREGNANT AND PARENTING WOMEN *Average achievement*	6.1	In all residential services (women-only, specialized and co-ed), you provide a dedicated private and comfortable space for mothers to visit with their children. (N=35)	**46**	**43**	**11**	**n/a**
	6.2	In residential (women-only, specialized and co-ed) and non-residential services, you provide a dedicated space for children's programming, childcare, and mother-child programming; or where space cannot be made available onsite, you have linked with allied services to fill this gap. (N=77)	**13**	**14**	**25**	**48**

			Guideline Achievement			% Not Appli-cable
			% Full	% Partial	% Not Ach.	
• *24% Full* • *21% Partial* • *39% Not Ach* • *48% Not Appl*	6.3	In residential women-only services, you have a dedicated physical space for both mothers and children to reside within the treatment facility. (N=16)	**14**	**6**	**81**	**n/a**
Addressing Barriers						
STIGMA *Average achievement* • 55*% Full* • *40% Partial* • *5% Not Ach* • *1% Not Appl*	7.1	You and your community partners work on initiatives to de-stigmatize substance use problems among women (through participation in activities such as public awareness, health fairs, and education/training of allied professionals). (N=77)	**36**	**57**	**5**	**1**
	7.2	You actively engage in advocacy on behalf of your clients to facilitate access to needed services and assist them in situations where stigmatization is likely to occur. (N=75)	**73**	**23**	**4**	**0**
COMPLEX AND MULTIPLE NEEDS *Average achievement* • *49% Full* • *40% Partial* • *7% Not Ach* • *5% Not Appl*	8.1	You have established linkages with other community services for women to develop partnerships for co-service delivery (such as services for women of different cultures, languages, abilities, ages, sexual orientation, living situations, legal status, physical and mental health status, geographic locations, as well as services for women who inject drugs or are street- or sex trade-involved). (N=76)	**40**	**54**	**5**	**1**
	8.2	Your policies and procedures ensure that women are provided with case management support, including advocacy for other needed services, either by you or by a partner service. (N=76)	**66**	**28**	**5**	**1**
	8.3	You provide support and advocacy to women leaving violent or abusive situations and to other marginalized women who require assistance in meeting basic needs (e.g. shelter, food, and transportation arrangements through either internal mechanisms or advocacy with other sectors). (N=75)	**64**	**29**	**3**	**4**
	8.4	You have established linkages (for example, through service agreements) with the range of support services women require (such as health care services, legal services, social housing, social services and employment/training services, trauma services, Violence Against Women services, and victim support services). (N=76)	**35**	**58**	**4**	**3**

			Guideline Achievement			% Not Appli-cable
			% Full	% Partial	% Not Ach.	
	8.5	You have established links/partnerships with resources for stabilization and/or residential support in the local system, including substance abuse-specific resources and other sectors (e.g. shelters). (N=74)	**47**	**43**	**7**	**3**
	8.6	You have established linkages with harm reduction services (such as Methadone Maintenance Therapy). (N=74)	**60**	**30**	**3**	**8**
	8.7	You have partnerships or service agreements with prenatal services and other services for pregnant and parenting women (including Methadone Maintenance Therapy). (N=76)	**41**	**34**	**12**	**13**
	8.8	Where transportation is a barrier to treatment, you provide assistance for transportation arrangements (through either internal mechanisms or advocacy with other sectors). (N=75)	**36**	**44**	**14**	**5**
ACCESSIBLE SERVICE LOCATIONS *Average achievement* • *49% Full* • *29% Partial* • *9% Not Ach* • *13% Not Appl*	9.1	Your agency has centrally located service delivery sites, with proximity to public transportation whenever possible. (N=74)	**78**	**14**	**4**	**4**
	9.2	Outreach and assessment/referral are provided in a variety of locations (i.e. through satellite offices, off-site program offerings, and mobile services). (N=74)	**43**	**27**	**11**	**19**
	9.3	You offer services through co-locations and partnerships in order to enhance accessibility to women who are involved with other women's services. (N=73)	**26**	**47**	**12**	**15**
Treatment Planning Issues						
FLEXIBLE ADMISSION CRITERIA ***Average achievement***	10.1	You ensure that women are clearly informed about their treatment choices, rights, and options at all phases of treatment. (N=74)	**95**	**4**	**0**	**1**
	10.2	You have policies and procedures to ensure that all requests for service are considered and that your admission criteria do not discriminate (based on factors such as race, sexual orientation, language or ethnicity, HIV/HCV status, legal status, drug use, or other factors that differentiate clients). (N=74)	**91**	**10**	**0**	**0**

			Guideline Achievement			% Not Appli-cable
			% Full	% Partial	% Not Ach.	
• ***82% Full*** • ***15% Partial*** • ***2% Not Ach*** • ***2% Not Appl***	10.3	Your admission procedures are flexible and welcoming (e.g., allowing women to bring a support person, accepting children during the process, and providing flexible hours of service). (N=73)	**52**	**40**	**8**	**0**
	10.4	You accept and support women on adjunctive pharmacotherapies (including Methadone Maintenance Therapy, other opioid substitution therapies, Antabuse, Zyban, and Naltrexone) when the need for their use has been established through a medical assessment. (N=75)	**76**	**17**	**1**	**6**
	10.5	You accept and support women who are taking prescribed medications (such as anti-psychotics, anti-depressants or anti-anxiety medications) when the need for their use has been established through a medical assessment. (N=74)	**95**	**3**	**1**	**1**
	10.6	You ensure that women who cannot be admitted to your program due to unavoidable program limitations are connected with alternative resources within the community. (N=73)	**81**	**16**	**0**	**3**
ASSESSMENT AND REFERRAL *Average achievement* • *68% Full* • *20% Partial* • *5% Not Ach* • *6% Not Appl*	11.1	You have a client centred and flexible approach to administering provincial assessment tools and admission criteria (including service strategies such as partnerships with other substance abuse services, off-site assessments and pacing of assessment completion). (N=74)	**80**	**18**	**0**	**3**
	11.2	Your initial assessment and subsequent referrals include information about core issues and is respectful of and consistent with each woman's stage of change. (N=73)	**85**	**10**	**1**	**4**
	11.3	You obtain information about core issues from women who do not receive a standard assessment in order to identify her immediate needs for support and linkages (for example, using adjunctive screening instruments such as the Routine Universal Comprehensive Screening (RUCS) Protocol for Woman Abuse). (N=72)	**40**	**33**	**15**	**11**
DURATION OF TREATMENT *Average achievement* • *76% Full* • *19% Partial* • *4% Not Ach* • *0% Not Appl*	12.1	When possible, you offer a flexible treatment duration based both on the assessed needs of each woman and on recommended best practices. (N=72)	**76**	**19**	**4**	**0**

			Guideline Achievement			% Not Appli-cable
			% Full	% Partial	% Not Ach.	
Clinical Practice Issues						
GENDER RELEVANT SERVICES *Average achievement* • *64% Full* • *24% Partial* • *7% Not Ach* • *10% Not Appl*	13.1	For specialized, women-only services only, you offer programming that is gender specific in content and delivery, and addresses core issues. (N=25)	**96**	**4**	**0**	**n/a**
	13.2	For co-ed services only, you offer programming that provides women-only, gender specific, specialized sessions on core issues. (N=45)	**38**	**42**	**20**	**n/a**
	13.3	For co-ed services only, you offer programming that provides women-only, gender specific program streams or groups as well as gender specific individual counselling with a female therapist. (N=47)	**36**	**51**	**13**	**n/a**
	13.4	Your programs for women incorporate educational, skill building, and experiential learning approaches and provide a balance of cognitive behavioural components (problem solving, change strategies) and affective components (feelings, emotions). (N=71)	**75**	**14**	**4**	**7**
	13.5	Your programs for women are collaborative, non-hierarchical, empowering, relational and strengths-based. (N=69)	**74**	**16**	**1**	**9**
	13.6	Your programs for women are informed by motivational and harm reduction approaches. (N=69)	**78**	**9**	**3**	**10**
	13.7	Your programs for women incorporate trauma informed approaches. (N=70)	**50**	**31**	**6**	**13**
STAGE OF CHANGE BASED APPROACHES *Average achievement* • *80% Full* • *15% Partial* • *2% Not Ach* • *4% Not Appl*	14.1	You use motivational counselling and stages of change based approaches in all phases of engagement and programming. (N=64)	**91**	**9**	**0**	**0**
	14.2	If you cannot provide services to women that suit her stage of change and treatment goals, you connect these women to other resources in the community. (N=68)	**88**	**10**	**0**	**2**
	14.3	You integrate harm reduction approaches into the treatment approach of your program. (N=68)	**79**	**16**	**2**	**3**
	14.4	You make available, or link with allied services in the community in order to provide, adjunctive pharmacotherapies (in particular, Methadone Maintenance Therapy). (N=69)	**70**	**22**	**3**	**6**

		Guideline Achievement			% Not Appli-cable
		% Full	% Partial	% Not Ach.	
	14.5 Your policies and procedures support using harm reduction approaches to address the needs of women who choose non-abstinence treatment goals or require adjunctive pharmacotherapy (such as Methadone Maintenance Therapy). (N=69)	**74**	**16**	**3**	**7**
GENDER BALANCE IN MIXED GENDER SERVICES *Average achievement* • *55% Full* • *33% Partial* • *12% Not Ach*	15.1 At a minimum, co-ed treatment groups are comprised of at least one third women. (N=41)	**34**	**46**	**20**	**n/a**
	15.2 If your program cannot achieve gender balance in co-ed groups, you provide women with individual counselling onsite or you make referrals to women's services in the community. (N=43)	**67**	**26**	**7**	**n/a**
	15.3 A female therapist facilitates (or co-facilitates) co-ed treatment groups. (N=44)	**64**	**27**	**9**	**n/a**
GENDER SPECIFIC APPROACHES TO PHYSICAL HEALTH AND WELL-BEING *Average achievement* • *51% Full* • *28% Partial* • *19% Not Ach* • *4% Not Appl*	16.1 For specialized, women-only services only, you provide information and discussion about the effects of substance use on women's bodies and physical health as a core issue. (N=25)	**80**	**20**	**0**	**n/a**
	16.2 For co-ed services only, you provide information and discussion about the effects of substance use on women's bodies and physical health in specialized women-only sessions led by a female counsellor. (N=42)	**38**	**26**	**36**	**n/a**
	16.3 You provide information and education about the effects of tobacco on women's health and support to women who wish to quit smoking. (N=69)	**36**	**39**	**20**	**4**
GENDER SENSITIVE RELAPSE PREVENTION APPROACHES *Average achievement* • *60% Full*	17.1 You offer women-specific relapse prevention, education and strategies that focus on situations of particular risk for women (e.g. interpersonal relationships, emotional/physical triggers). (N=68)	**53**	**28**	**16**	**3**
	17.2 Your policies and procedures ensure that relapse is seen as a learning opportunity, supporting women to remain in treatment and renegotiating their treatment plans. (N=67)	**75**	**21**	**5**	**0**

		Guideline Achievement			% Not Appli-cable
		% Full	% Partial	% Not Ach.	
• *20% Partial* • *7% Not Ach* • *13% Not Appl*	17.3 If your program discharges a woman on relapse, you make referrals that support her continued engagement with the substance abuse treatment system at her appropriate stage of change. (N=68)	**53**	**10**	**0**	**37**
Specialized Issues					
CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH ISSUES *Average achievement* • *63% Full* • *30% Partial* • *5% Not Ach* • *4% Not Appl*	18.1 You have partnerships in place for integrated assessment, treatment planning, and intervention when a mental health issue is identified. (N=69)	**48**	**44**	**9**	**0**
	18.2 Your admission criteria reflect a client centred and individualized decision making process for admitting women with serious mental health issues or who are taking prescribed medication for mental health problems. (N=69)	**77**	**16**	**0**	**7**
TRAUMA *Average achievement* • *49% Full* • *42% Partial* • *7% Not Ach* • *3% Not Appl*	*19.1* Your programming is trauma informed and, at a minimum, includes program components that incorporate techniques for establishing safety as part of Stage 1 trauma work (such as grounding techniques). (N=68)	**54**	**34**	**7**	**4**
	19.2 All program staff is trauma informed and can respond appropriately to women experiencing the consequences of trauma. (N=67)	**44**	**49**	**6**	**2**
Pregnant and Parenting Women					
ENGAGEMENT AND RETENTION *Average achievement* • *49% Full* • *20% Partial* • *15% Not Ach* • *17% Not Appl*	20.1 You provide outreach to or linkage with sites of first contact for pregnant and parenting women (such as Community Action Program for Children or Canada Prenatal Nutrition Programs) to engage and involve women in substance use counselling. (N=69)	**52**	**22**	**12**	**15**
	20.2 When possible, you offer services off site in order to engage substance-involved pregnant and parenting women. (N=68)	**46**	**18**	**18**	**19**

		Guideline Achievement			% Not Appli-cable
		% Full	% Partial	% Not Ach.	
ACCESS TO SERVICES *Average achievement* • *47% Full* • *16% Partial* • *12% Not Ach* • *25% Not Appl*	21.1 Your policy ensures rapid access to residential and community-based services for pregnant women based on first available bed or service space; pregnant women take precedence over all other clients who may be awaiting service. (N=69)	**51**	**10**	**17**	**22**
	21.2 Although it is desirable for pregnant women to complete standardized admission tools, your priority access policy is not contingent on completion or results of standardized admission tools. (N=69)	**58**	**16**	**9**	**17**
	21.3 Methadone Maintenance Therapy as the treatment of choice is offered to opioid dependent pregnant women as quickly as possible. (N=69)	**33**	**23**	**9**	**35**
EFFECTIVE SERVICES *Average achievement* • *61% Full* • *20% Partial* • *7% Not Ach* • *14% Not Appl*	22.1 Your program incorporates supportive strategies to enhance the factors that are protective to the health of the fetus (such as prenatal care, nutritional counselling, basic life supports, health care, safe accommodation). (N=69)	**49**	**29**	**10**	**12**
	22.2 You support reduced substance use strategies or safer use strategies as intermediary harm reduction approaches in appropriate situations. (N=69)	**73**	**10**	**3**	**15**
RELATIONSHIPS WITH CHILDREN *Average achievement* • *28% Full* • *24% Partial* • *22% Not Ach* • *27% Not Appl*	23.1 You provide children's programming and child development assessments or ensure these are provided by relevant community services. (N=69)	**30**	**20**	**16**	**33**
	23.2 You facilitate a barrier free service through outreach, one stop service, and an integrated systems approach among both substance abuse services and other sector services that can provide childcare, food, and transportation when needed. (N=69)	**25**	**28**	**28**	**20**

			Guideline Achievement			% Not Applicable
			% Full	% Partial	% Not Ach.	
CHILD PROTECTION ISSUES *Average achievement* • *54% Full* • *39% Partial* • *5% Not Ach* • *2% Not Appl*	24.1	Your policies establish a positive and ongoing relationship with local child protection services (including cross training). (N=68)	**47**	**44**	**4**	**4**
	24.2	Your policies and procedures address child protection issues in accordance with mandatory reporting guidelines. Formal protocols with child protection services have been established to ensure that appropriate reporting and supportive linkages are made. (N=67)	**61**	**33**	**6**	**0**
Monitoring and Evaluation						
PROGRAM MONITORING AND EVALUATION *Average achievement* • *31% Full* • *52% Partial* • *16% Not Ach* • *2% Not Appl*	25.1	You have a monitoring or evaluation process in place that includes best practices guidelines. (N=68)	**31**	**52**	**16**	**2**

SECTION I: INTRODUCTION

1. Project Background

1.1 Preface

In February 2006, Gates Consulting Inc. was engaged to conduct a review of the women's substance abuse service system in Ontario. A Steering Committee (Appendix A) comprised of the Ministry of Health and Long Term Care (MOHLTC), the Ministry of Children and Youth Services, the Ontario Federation of Community Mental Health and Addictions Programs, Addictions Ontario, and representatives of MOHLTC-funded women's treatment services developed Terms of Reference for the review (Appendix B) and supervised the project. This report has been prepared for the Steering Committee to provide results of the review and recommendations for supporting implementation of best practices in women's treatment services.

1.2 Purpose, Scope, and Structure of the Report

1.2.1 Purpose

The report presents a review of the extent to which agencies that provide substance abuse treatment services to women are meeting the guidelines provided by *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services*.

1.2.2 Scope

The report provides an assessment of:

- The degree to which the system is implementing *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services in Ontario (Guidelines).*
- The system's successes in meeting the *Guidelines.*
- The system's challenges in meeting the *Guidelines.*
- The system-level issues that affect the implementation of the *Guidelines*
- The agency-level and system-level supports required by agencies to meet the minimum requirements of implementing the *Guidelines.*

Additionally, the report identifies innovative strategies and activities on the part of programs/services in Ontario and other jurisdictions that have the potential for broader application in the Ontario women's substance abuse treatment services system.

1.2.3 Structure

To address these issues, the report draws upon information from four key sources: (1) a provincial survey of agency practices, (2) consultations with stakeholders, (3) data from provincial agencies, and (4) a review of literature, including studies of women's treatment needs and experiences, recently published guidelines, best practices, and model strategies.

Section II of the report presents summary findings of data from each of these four information sources; findings have been woven together and analyzed to develop a comprehensive assessment of agency practices, with more detailed data provided in Appendices G, H, I and J. In Section III, high level observations and conclusions are presented. Finally, Section IV provides recommendations to support implementation of best practices in services for women.

1.3 Context of the Review

Over the last 20 years, research has demonstrated that substance-involved women have a distinct set of issues and treatment needs. There are substantial differences in the social context, etiology, and physiological consequences of women's substance use, as compared to that of men. Gender differences are apparent in epidemiology, and in differing patterns of help-seeking behaviour, as well as in service access, utilization, and retention. Best practices indicate that services for women need to utilize gender-specialized approaches that respond to the context of women's lives. In recognition of these advances in knowledge, Health Canada published *Best Practices Treatment and Rehabilitation for Women with Substance Use Problems* in 2001. The document has been widely disseminated as a guide for service providers who work with women.

In 1999, Ontario's Ministry of Health and Long-Term Care (MOHLTC) policy document, *Setting the Course: a Framework for Integrating Addiction Treatment Services in Ontario,* identified women as one of a number of key populations for whom services should be improved. *Setting the Course* called upon addiction agencies to utilize best practices to develop more accessible and effective services for women. In 2002, the MOHLTC established the Women's Services Strategy Work Group to support services in implementing best practices.

Based on the best practices identified in the Health Canada publication, the Work Group identified standards and criteria for addiction treatment services for women. To support agencies in implementing best practices, the Work Group developed *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services* (*Guidelines*).

The *Guidelines* were released by the MOHLTC in October 2005; they were intended to serve as a tool for assessment of practices in individual agencies, with the overall goal of supporting appropriate and accessible women's services across the treatment system. The *Guidelines* were designed for use by all types and levels of women's substance abuse treatment services, including those that are specialized and/or restricted to women, as well as those that work with both women and men in mixed treatment groups and/or in generic programs.

1.4 Deliverables

The Terms of Reference for the project identified the following deliverables:

- An Interim Report of the results of a review of services for women against the standards articulated in the *Best Practices in Action Guidelines*
- A Final Report that includes a description of findings and recommendations

Deliverables were completed in the following seven phases:

1. Project Planning and Orientation
2. Review of Agency Practices
3. Interim Report to the Work Group Sub-Committee
4. Key Informant Inputs
5. Literature Review
6. Analysis of Findings
7. Final Report

1.5 Methodology

The project approach was based on the following central values and assumptions:

- Transparency and clear communication about the intent and purpose of the review are required to enlist stakeholder involvement and input.
- The full range of addiction agencies (including restricted, specialized, and generic) that provide services for women will be invited and encouraged to participate in the review.
- An assessment of system practices must be grounded in a comprehensive collection of baseline data and informed by qualitative input from stakeholders about the issues and challenges that affect their efforts to implement best practices, including perspectives from the varied treatment philosophies and approaches of the organizations that comprise the women's treatment system in Ontario.
- The review will validate the strengths and successes of the system while also making a realistic assessment of progress to date and requirements for further growth and development. Recommendations will be sensitive to sector history, challenges, and the current pressures that impact on addictions services and the system as a whole.
- As an overarching principle: any woman should be able to access consistent, effective services throughout the women's addiction treatment service system. Toward that end, all agencies that work with women should seek to implement best practices and be prepared to measure their efforts against the *Guidelines* provided in *Best Practices in Action*.

1.6 Project Activities

1.6.1 Confirmation of Project Approach

An initial meeting was held between the Steering Committee and the Consulting Team to finalize the work plan and time lines. During this meeting, it was determined that the service providers represented on the Steering Committee would assist in piloting the survey used to collect baseline data about agency practices.

1.6.2 Survey of Practices and Policies

To obtain baseline data for the review, a survey of addiction agencies that provide services for women was conducted. An abbreviated version of the guidelines provided in *Best Practices in Action* was developed to provide a workable survey tool for agency completion. The survey tool was piloted with five Steering Committee members and one

additional community treatment agency. Following minor revision based on feedback from the pilot group, the survey was circulated to 120 substance abuse treatment agencies (Appendix C*)* on March 20th, 2006. Survey recipients were identified based on information from the Drug and Alcohol Registry of Treatment (DART).

Recipients of the survey tool were informed that the overarching purpose of the review was to improve services for women, and that the review would focus on system performance in respect to the *Guidelines*, rather than on individual agencies. A background document (Appendix D), that provided an overview of the review, and of the historical lead up to it, was made available to survey recipients on request. *Best Practices in Action* was redistributed to the field by the MOHLTC to ensure that all participants had received the final version.

Respondents were asked to complete the survey by April 7th using a web-based tool; the completion date was extended and the survey was subsequently re-opened with a final date of May 16th to maximize the number of responses. Email and telephone prompts were utilized to stimulate additional participation. The survey had excellent support from the field; 77 agencies (62%) (Appendix E) responded[4]). Given the numerous other time pressures that agencies experienced during the survey period (reporting obligations, health system restructuring issues, day-to-day responsibilities of service delivery), the Consultants considered this to be an excellent response rate.

1.6.3 Key Informant Interviews with Individual Agencies

Key informant telephone interviews were conducted to add breadth and depth to baseline survey results and to provide additional information in respect to specific areas not covered by the *Guidelines* (e.g. wait lists, resource issues). Twenty-four interviews (Appendix F) were conducted with a cross section of agencies that serve women. Key informants represented a balanced range of restricted, specialized and mixed gender (co-ed) non-specialized[5] service types; geographic and LHIN coverage; sponsored and free-standing services; and multi-program/ single program services. Informants were selected to include services that specialize in, or provide services for, key populations of including: youth; women over 55; francophones; aboriginal women; pregnant and parenting women; homeless and marginalized women; and rural/urban women.

1.6.4 Provincial Agency Data Requests

Requests for targeted information were made to DATIS and DART. DATIS provided data in respect to patterns of service utilization and referrals, including:

- Demographic data for 25 agencies that agreed to be interviewed as key informants.

[4] 82 agencies opened the survey; however 5 survey responses were abandoned before a usable level of information was input. Unusable survey responses were deleted from survey results for the purpose of this report.

[5] Restricted services provide gender specific programs in dedicated, women-only residential or non-residential settings. Specialized services provide dedicated, gender specific programming in women-only groups or individual counselling that may be offered within residential or non-residential settings where services for male clients are also offered. Non-specialized services offer services to mixed populations of men and women in co-ed residential or non-residential settings.

- The top five sources of “referrals in” to those 25 key informant agencies and the top five types of services to which they made referrals (”referrals out”).
- Provincial data comparing the number of women and men admitted to treatment.
- Provincial data showing the age ranges of individuals served.
- Comparison data related to the gender of individuals served in residential withdrawal management and community withdrawal management.

DART provided statistical reports about wait times, medication policies, and methadone policies, as well as qualitative input in respect to:

- Factors that contribute to wait times and the impact of wait lists/wait times.
- Effects of the following variables on service accessibility and availability:
    - admission policies related to medications
    - admission policies related to mental health issues
    - admission policies and practices related to methadone maintenance and other harm reduction approaches
- Availability of priority admissions for pregnant women.
- Accessibility and availability of services for pregnant and parenting women, including childcare and children’s programming.
- General observations and comments on other issues that affect access and availability.

1.6.5 Interim Report

An Interim Report was provided to the Steering Committee on May 1, 2006.

1.6.6 Consultation with Provider Networks

To obtain collective input from service providers, consultations were held with women’s service provider networks including: WAAN Network (Provincial teleconference), ECD Addictions Network (email request for feedback), Toronto Women’s Services Cluster (June meeting), Addictions Ontario Conference Participants (presentation and feedback session conducted by members of the Steering Committee), and Survey Respondents (email invitation to provide feedback). Consultation topics included:

- Presentation and discussion of summary results from the review of agency practices.
- Discussion of specific issues identified for the review.
- Opportunity to discuss other issues not specifically identified in the review and results.

1.6.7 Literature Review

A review of the literature was conducted to further identify innovative strategies and activities in Ontario and other jurisdictions that may have application for the Ontario women’s substance abuse treatment services system.

1.6.8 Data Analysis and Preparation of Final Report

The Consultants synthesized and analysed data obtained in all project phases to develop a comprehensive assessment of the extent to which agencies that provide substance abuse treatment services for women are meeting the standards outlined in *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services.* The analysis included:

- Current practices of agencies that provide services for women, measured against the standards and criteria articulated in the *Guidelines*.
- The strengths and successes of agencies in respect to implementing best practices.
- Challenges that agencies face in implementing best practices, and the supports required to move forward.
- Systemic issues that affect the ability of the system to provide appropriate services for women.
- Innovative strategies and activities that could be considered for implementation in the Ontario women's substance abuse treatment services system.

SECTION II: FINDINGS AND ANALYSIS

2. Issues Related To Collection and Interpretation of Data

2.1 Survey of Agency Practices

Several factors should be considered with respect to data collection and interpretation:

Survey Timing

Not unexpectedly, a number of concerns were expressed by agencies over the course of the review. Largely, these concerns focused on the timing of the survey. Some respondents felt that it was unrealistic to expect participation at a time when agencies were under considerable pressure due to fiscal year-end responsibilities (including submission of Operating Plans and first use of the MIS) and other surveys simultaneously being conducted in the field. Although the response rate was good, it is likely that some agencies would have been in a position to more fully develop their responses if the survey had been conducted at a less busy time of year.

Consistency of Responses

Given that agency participation in the survey was voluntary, not all agencies contacted completed the survey and some agencies submitted partially completed surveys. Consequently, there are variations in the number of responses as well as some variability in the list of responding agencies from question to question.

Clarity of Responses

In the case of multi-functional agencies, the survey does not identify a program/service to which survey responses apply. *Best Practices in Action* was designed for use by a specific program or service; however for the purposes of the survey, it was not realistic

to ask multi-functional agencies to complete a separate survey for each program or service. To provide a workable alternative, respondents from these agencies were asked to respond to survey questions in ways most representative of their agency's *overall* approaches to serving women. Since there may be considerable variation in policies and practices between programs and services in multifunctional agencies, responses may not fully represent the range of practices in these organizations.

Clarity of Service Type

Respondent self-identification in regard to type of service (restricted, specialized, or co-ed) appears to vary somewhat from question to question. Apparent inconsistencies may be the result of agencies reporting on different programs/services within the survey or a differing mix of respondents to different questions; inconsistencies may also be a product of lack of clarity about the definitions of service types.

Self-Assessment Issues

Responses were based on agency self-assessment, hence they are subjective and dependent on individual respondents' understanding of terms and concepts. In several areas where universally-accepted definitions, benchmarks, and standards have not been established, reliance on subjective understanding of terms and concepts presented an impediment to meaningful self-assessment of agency performance.

It is not possible to validate self-report within the framework for the review. Refinement of data to validate responses would require a more extensive process, including: a more detailed instrument than agencies could reasonably be expected to complete in the time available for this project; development of clearer definitions for some terms and concepts than are provided by the *Guidelines*; setting of service benchmarks that are understood and accepted by the broad stakeholder group; and the means to validate agency responses.

Full and Partial Achievement of Guidelines

Responses of 'partially achieved' for any guideline are important because they are indicative of the ongoing work of the sector to improve services, in spite of the numerous obstacles and barriers to implementation of best practices experienced by addictions agencies. While these responses are extremely encouraging, they may represent a wide range of activity, hence are too ambiguous to serve as an accurate measure of system progress against the *Guidelines*. To provide the clearest possible assessment of system practices, key informants suggested that conclusions be drawn from responses that reflect *full* adherence to *Guidelines*.

Guidelines Not Applicable

In a number of areas, agencies identified guidelines as 'not applicable'. In some cases this is not surprising, since some questions are targeted to specific service types (i.e. restricted, specialized, or co-ed) or categories (e.g. residential). However, for the significant number of guidelines that are applicable to *any* agency that serves women, a 'not applicable' response indicates, at a minimum, the need for increased agency awareness and greater investment of effort.

2.2 Respondent Familiarity with the *Guidelines*

It is clear from stakeholder input[6] that not all agencies are equally familiar with *Best Practices in Action*. Some agencies have spent considerable time reviewing the document with staff and using the *Guidelines* as a platform for program assessment and improvement; some have read the document but have not utilized it for internal review. Others have had little or no time to review the document, either because of other demands on their time or because they did not receive the document prior to initiation of this review. Some key informants asserted that they had never received *Best Practices in Action* when it was released to the field in the fall of 2005, or even when it was redistributed in March 2006. A few key informants had still not seen *Best Practices in Action* at the time of stakeholder consultations.

Best Practices in Action provides more than a set of guidelines and scales for self assessment – it provides comprehensive information about treatment issues for women, including a rationale for each guideline. The more familiar agencies are with the document, the better equipped they are to fully comprehend the implications of the guidelines on which survey questions are based. Results of data collection may be skewed by varying levels of respondent familiarity with the source document. For example, agencies that are more knowledgeable about *Best Practices in Action* may tend to hold themselves to a higher standard when measuring their performance against the *Guidelines* and, as a result, may give themselves lower ratings on survey questions. Conversely, agencies that lack familiarity with *Best Practices in Action* may not be fully cognizant of the complex responses required by some guidelines and, consequently, may have tended to overestimate their agency's performance in respect to some survey questions.

Agency ratings of performance may also be affected by the familiarity of the respondent completing the survey with 'on the ground' agency practice issues. Some informants observed that staff who are 'closer to the front line' may assess agency performance differently from senior management. It was also noted that agencies may tend to represent their services in the most positive light. This creates the risk of an overly positive portrayal of the system with respect to implementation of best practices.

3. Summary and Analysis of Survey Results

This section provides a review of baseline results gathered from responses to the survey of agency practices. Detailed survey data are provided in Appendix G (Survey of Agency Practices Data). Comments from key informants and feedback from other stakeholders have been cited where they help to clarify data, provide background information, or define issues that require further exploration. Summaries of stakeholder feedback are provided in Appendices H (Summary of Key Informant Input), I (Summary of Provincial Agency Input), and J (Summary of Network Consultations).

[6] Input received during WAAN network consultation and key informant interviews.

3.1 Profile of Respondents

Categories of Services

The complex service mandates of most substance abuse agencies in Ontario make it difficult to clearly delineate the percentage of survey respondents in each *category* of service (community treatment, withdrawal management, residential treatment, etc.). Often, provision of multiple programs/service is thought of only in the context of large multi-functional agencies that provide an array of service types (e.g. assessment, community treatment, residential treatment, withdrawal management). However, among Ontario addiction agencies, even relatively small agencies may deliver more than one category of service. For example, many residential agencies also provide assessment referral services, day treatment, or 'aftercare' and individual counselling (community treatment service *category*). An analysis of responding agencies against the DART data base for agencies that accept women indicates that the vast majority of respondents provide more than one *category* of service.

Types of Services

Many agencies provide more than one *type* of service. For example, a co-ed community treatment agency may provide both mixed gender (generic) and women-only (specialized) groups. Respondents were asked to identify the *type* of service predominantly provided by their agency. According to their report, the following proportions of service types were represented among the 77 respondents:

- 20 respondents (27%) identified their services as restricted;
- 12 respondents (16.2%) identified as specialized;
- 42 respondents (56.8%) identified as generic/co-ed.

3.2 Operational Practices

The Operational Practices section of the *Guidelines* focused on four key elements of agency infrastructure that support understanding and implementation of best practices: (1) Governance, (2) Education & Training, (3) Hiring & Staffing, and (4) Physical Facility (including physical facilities specific to the needs of pregnant and parenting women). The section was comprised of 20 questions that enquired about how best practices are reflected and supported in: mission, goals and objectives; Board/Advisory Committee composition; program policies and practices; staff education and training practices; staffing policies and procedures; and gender-appropriate physical facilities.

3.2.1 Governance

Best Practices in Action notes that a strong commitment to best practices at the Board level is essential to support quality services for women because Boards shape the philosophical and practical approaches of their programs and play a pivotal role in supporting positive changes. To assess commitment to best practices at the governance level, the survey asked 5 questions about composition of Boards/Advisory Committees' program policies, including policies in respect to sexual harassment, and mission, goals, and objectives of agencies.

Survey responses demonstrated a good level of interest in, and adherence to, the guidelines for gender representation on Boards and Advisory Committees. Most respondents from freestanding restricted programs reported that the guideline for female representation on Boards is either fully achieved (83%) or partially (8%) achieved.

Similarly, most respondents from sponsored restricted programs reported that the guideline for gender representation on Advisory Committees is fully (80%) or partially (7%) achieved.

Fewer freestanding specialized or co-ed agencies reported adherence to the guideline for gender representation on Boards; 58% reported full achievement and 24% reported partial achievement.

In respect to the guideline for program, policies, and practices that reflect and support best practices at all governance levels, 43%) of respondents indicated full achievement, however 51% reported partial achievement.

- *"We have a long serving board very familiar and supportive of issues, know lots about best practices, harm reduction, etc. Our staff strives to keep them current."*
- *"We're just beginning the process of educating Board in best practices, taking time to review and bring them up to speed – it's an evolving process."*

Fewer respondents reported achievement of the guideline for agency mission, goals, and objectives that identify the unique needs of women. Only 22% reported full achievement, with an additional 38% reporting partial achievement. Forty percent of respondents reported the guideline as either not achieved (29%) or not applicable (16%). This is a cause for concern, as best practices show that the unique needs of women should be clearly articulated in the mission of any agency that provides services for women, whether restricted, specialized, or co-ed.

Unsurprisingly, most respondents (86%) reported full achievement of procedures for sexual harassment claims, although 3 agencies reported this guideline was not achieved. Obviously, less than 100% achievement of this guideline must be regarded as a gap that requires corrective action.

3.2.2 Education and Training

Best Practices in Action notes that workers who provide services to women require gender-specific training and skills to support their abilities to work with women. The *Guidelines* call for agencies to provide counselling staff with education, training, and clinical support to ensure that staff knowledge of best practices and skills remains current and clinically relevant, and that expertise be built by engaging allied sector services in cross training.

Survey responses generally indicated confidence in the education and training of direct service staff who work with women. Most respondents reported either full (38%) or partial (55%) achievement of the guideline for counsellor education and training in effective therapeutic approaches and core issues.

Somewhat fewer respondents reported full (33%) achievement of the guideline for engaging in cross-training with other substance abuse agencies and/or with other

sectors that have expertise in women's issues; however, a substantial percentage (58%) reported partial achievement.

A small number of respondents reported each of the above guidelines as 'not applicable'; respondent comments did not provide any explanation for why these two guidelines would be considered not applicable by any agency that provides any level of services for women.

Respondent comments did underscore the strengths and challenges experienced by agencies in ensuring that staff is trained in best practices. A few respondents noted that sponsor standards and accreditation processes help to keep them attentive to education and training issues.

Respondents emphasized that training efforts are, and need to be, ongoing. Despite that recognition, some agencies described challenges related to ensuring that staff training fully meets best practices requirements:

- Lack of funding to support continued training and updated skills
- Reduction of budget lines for training due to chronic funding shortages generally, and increasing use of training dollars to cover basic costs of service delivery or facility repairs
- Agency budgets that are not adequate to cover the cost of 'back fill' while staff attend training or cross-training
- Lack of time and funding needed to link up with other community agencies for cross-training
- Lack of benchmarks for staff credentials and professional certification in the field, and variation in levels and types of academic credentials across the sector

Many respondents and key informants noted needs for specialized training in specific areas:

- *"We need access to relevant training that fits our complex client population (Aboriginal, rural/remote, poverty etc)"*
- *"We need to increase our ability to work with trauma, it's such a key issue for women, but we need time, information, and resources."*

Some respondents indicated that they regard guidelines for training as applicable only to agencies that provide specialized or restricted programs:

- *"We're too busy and it's not a priority as there aren't any substantial women's programs delivered in our agency."*

3.2.3 Hiring and Staffing

Best practices require that restricted services have policies and procedures to ensure that female staff fills clinical, program delivery, and residential support positions, and that *all* services (including co-ed) ensure that female staff are available to serve in those roles.

Most respondents from gender-specific (restricted) services reported that guidelines for female staffing in clinical, program delivery, and residential support positions are fully (87%) achieved or partially (7%) achieved.

Co-ed services also reported high levels of achievement of guidelines for availability of female staff to work with women in clinical, program delivery, and residential support positions, with 76% of respondents from co-ed services reporting full achievement and 19% reporting partial achievement.

All agencies (both restricted and co-ed) that conduct bed checks reported that the guideline for female staff conducting bed checks was either fully (86%) achieved or partially (14%) achieved. Full adherence to this guideline is obviously desirable in this sensitive area; however, in some co-ed agencies, union policies may make it difficult to ensure that overnight shift staff always includes female staff.

Most respondents reported full (87%) or partial (9%) adherence to guidelines for availability of female clinical staff for individual counselling; however, *availability* of female staff does not necessarily guarantee *accessibility*. In some co-ed agencies, female staff is available only on request, and/or with a wait time for service. For example, one agency noted that its staff covers a wide catchment area through rural satellite offices, and that current resources do not allow the agency to place a female staff person in each satellite office. Female staff can, however, be made available on request.

Guidelines for group facilitation were less well met. Only 69% of respondents reported full achievement of the guideline requiring that female staff facilitate gender-specific groups or sessions, and only 41% reported that female staff facilitate or co-facilitate mixed-gender groups. A substantial percentage of respondents reported both of these guidelines as 'not applicable'. This group may include agencies that do not provide groups at all, do not provide women-only groups or women-focused sessions, or do not provide women staff to facilitate or co-facilitate groups. As a result, the findings are inconclusive as to the percentage of co-ed agencies that do not ensure that female staff facilitate or co-facilitate mixed gender groups.

Survey comments indicated that some agencies want to provide women-only groups but struggle to assemble adequate numbers of women to allow delivery of women-only groups or sessions at any given time – this is true in both co-ed residential and community treatment agencies. Respondents also noted that insufficient staff resources create barriers to provision of gender specific programming:

- *"We cannot follow some of the guidelines with existing staff complement. We can't separate a group of men and women to give gender-specific programming."*
- *"We need to be able to provide all female counsellors for women."*
- *"We don't have adequate staffing for female staff on site during every shift."*

3.2.4 Physical Facility

The focus of guidelines in respect to the physical facility in which services are delivered is to ensure the safety, comfort, and provision of gender-separate spaces for women in both community treatment and residential (including co-ed, restricted residential and withdrawal management services) services.

Only 68% of respondents reported full achievement of the guideline requiring facilities that ensure physical safety and confidentiality for women, with an additional 21% reporting partial achievement. It is troubling that over 10% of respondents (9 agencies) perceived this guideline as 'not applicable'. The rationale for this perception is not clear.

It appears that some agencies understood this guideline as applicable to residential services only, although the *Guidelines* indicate that every agency that serves women should be concerned with safety and confidentiality.

In co-ed residential settings, respondents reported that the guideline for designated separate women-only spaces is achieved by a majority of agencies, with 61% reporting that the guideline is fully achieved and 33% reporting partially achieved.

The majority (87%) of residential women-only services are located in a separate and dedicated women's facility. Three respondents who reported this guideline as partially (9%) or not (4%) achieved are most likely agencies where a restricted program is provided by an agency that also provides services for men in a different part of the same building.

Positive reports in respect to these three guidelines appear to demonstrate a good understanding of the importance of best practices in the design of physical facilities; however respondents indicated that some agencies are unable to provide adequate levels of security (lighting, security cameras) due to lack of funding. Additionally, co-ed agencies noted challenges in providing separate spaces for women, due to either lack of adequate space and/or lack of funding for renovations and retrofit.

- *"We need to retrofit the layout of our facility to make room for women's space, childcare, parenting, children's programming, child visitations more often, and to allow women to attend community treatment."*

3.2.5 Physical Facility for Pregnant and Parenting Women

Best Practices in Action states that, to support the relationships of mothers and their children, treatment environments must be welcoming of pregnant women and women with children. Dedicated spaces for visits with children, childcare, children's programming, and mother-child programming are needed in both residential and non-residential services. Three guidelines were provided to gauge the ability of agencies to provide treatment environments that support these best practices.

The majority of respondents from residential agencies (restricted, specialized, or co-ed) reported full (46%) or partial (43%) adherence to the guideline for provision of mother-child visiting space. It is notable that 10% of residential agencies do not provide space for children to visit with mothers. While this represents a relatively small number of agencies, the lack of visiting space must be a considerable burden for women who receive treatment in these few agencies. Agencies that have only partially achieved or have not achieved the guideline indicated that it is a struggle to provide space for mother-child visits.

- *"We're very proud of our residence for women but lack space (can't have family room, lounge, child visits, don't have space to accommodate women and children) and we desperately need more treatment space."*
- *"For children, if not necessarily a program, at least places for parental visits."*

Dedicated space for children's programming, childcare, and mother-child programming was reported to be less well supported in the system. Only about one-quarter of programs (restricted, specialized, or co-ed) reported full (13%) achievement or partial

(14%) achievement of the guideline for childcare or children's programming. It is disturbing to note that almost half of respondents to this question (48%) reported the guideline as 'not applicable'; this response appears to indicate a lack of appreciation for the barriers that parenting women experience when seeking treatment, as well as a lack of understanding of best practices. Only 2 respondents (13%) from restricted residential programs reported full achievement of the guideline requiring dedicated physical space for both mothers and children to reside within the treatment facility.

While the lack of adherence to guidelines for childcare, children's programming, and mother-child residential services is distressing, it is not surprising. Childcare and services for parenting women and their children have historically not been a focus of the Ontario substance abuse treatment system. Although the importance of providing these services and their contribution to better outcomes for women has been established in the literature for some time, the Ontario service system is far behind in implementing best practices in this area.

The inception of ECD Addictions programs has generated a new and increasing awareness of the importance of providing childcare and children's programming in women's treatment services. Respondents' comments indicated that many services outside of funded ECD Addictions programs are frustrated at not having the basic resources (physical plant, funding, staffing) required to provide childcare and children's programming. Comments also indicate that some residential service providers have made efforts to address these needs through linkages with allied providers off site, including linkages and partnerships with ECD Addictions programs.

- *"Our partnership in the ECD [Addiction] program is allowing engagement of women who ordinarily wouldn't approach mainstream services."*
- *"The ECD [Addictions] programs have become essential in the continuum of care – unimaginable what the impacts would be if this funding does not continue."*

Funding was reported to be a critical barrier to implementing best practices for pregnant and parenting women. Respondents reported that agencies are struggling to provide basic core services within budgets that have changed little over the last 10 years. In the context of program resources that are already 'spread too thin', agencies are hard pressed to develop new services for childcare, child programming, and mother-child services. Other than ECD Addictions funding for a limited number of programs, no new resources have been provided to the sector for this purpose. And, while ECD Addictions programs have made a substantial difference with respect to both the availability of services and the culture of the addictions sector, they are not available in all areas of the province, and are restricted in their scope by limited funding. Further, respondents noted that ECD Addictions programs are currently waiting for a decision around future funding. Stakeholders agree that it is imperative that ECD Addictions funding continue and expand, and that services such as childcare, children's programming, and mother-child service options be 'mainstreamed' as core concerns of the entire service system for women, rather than residing in ECD Addictions programs alone. Restricted residential programs for mothers and children, in particular, would require a significant investment of resources and program re-design well beyond current system capacities.

3.3 Addressing Barriers

Best Practices in Action identifies a wide range of barriers that affect the access, engagement, and retention of women in treatment services. This section of the survey addressed implementation of practices to overcome barriers arising from stigma, complex and multiple needs, accessibility of service locations, and flexibility of admission criteria. Within each of these general categories, guidelines for specific issues and specific strategies were identified.

3.3.1 Stigma

Best Practices in Action identifies stigma as a key barrier to services; since women are more stigmatized as a result of substance use than men, stigma can prevent women from seeking help, or even seeking information about substance use issues. Women who have substance use problems, and are also marginalized by other factors (such as poverty, disability, culture, language, and age), carry a double burden of stigma and often require advocacy.

The intent of survey questions about stigma reduction and advocacy was to gauge the amount of advocacy and the importance placed on such activities. The survey enquired about agency activities in respect to both individual advocacy and more generalized anti-stigma activity (such as public education and cross training activities with allied service providers).

Only about a third of respondents reported full (36%) achievement of the guideline for work with community partners to de-stigmatize substance use problems among women, however a substantial percentage (57%) reported partial achievement. By contrast, most respondents reported full (73%) achievement or partial (23%) achievement of the guideline for advocacy to facilitate access to needed services and assist women in situations where stigmatization is likely to occur. From the response to both questions, it would appear that there is good recognition of the importance of these activities; however, without accepted benchmarks for anti-stigma activities or a universal definition of advocacy, ratings of activity are based entirely on each agency's internal definitions and expectations.

Examples cited in respondent comments and key informant interviews demonstrated that a range of strategies is utilized for advocacy and stigma-reduction:

- *"We coach the women … as having the right to their privacy when accessing services such as education and for job interviews. We help them to advocate for themselves for medical services differently – to give medical personnel a complete history of their medical status in order to assist themselves in receiving appropriate medical services."*
- Community education, speaking engagements, media tools to increase awareness of addiction as a health issue, participation on task forces
- ECD Addictions programs engage in stigma reduction for pregnant or parenting women, as well as education and advocacy with child protection services
- Non-judgmental support for pregnant women in deciding whether to continue or terminate pregnancy
- Training in stigma reduction

Stigma reduction and advocacy work were particularly well demonstrated in the comments provided with respect to ECD Addictions programs. The following passage from a letter written by the Maternal Child Program of a hospital illustrates the major impacts of the local ECD Addictions program on the perceptions and attitudes of hospital staff and the community, as well as on the care that women are receiving:

> *"In the early days of our partnership, it was not uncommon for staff to make references to 'junkies' and 'addicts' who were 'uncaring and selfish'. Staff struggled with trying to understand how a mother could 'purposely harm her baby like that'. The staff at the [ECD Addictions] program, recognizing the extent of the need, were instrumental in approaching, not only the Maternal Child Program, but the various community agencies that have some investment in supporting this population. The emergence of the Substance Use and Pregnancy Committee, and the subsequent work of the committee, has been an invaluable contribution to the Maternal Child Program. There has been a palpable shift in the attitude of the staff on the floor. Staff began to see 'the women behind the drugs' and they began to recognize the challenges these mothers were facing. Referrals started to emerge that were not for the 'addict', but rather for the 'mom who was having a hard time and could use some support'. We began to hear mothers share positive experiences; mothers would share that the staff made a very difficult experience a little bit easier because of their support and compassion. They would share that they appreciated not being judged. Although there remains room for growth, a different culture has definitely emerged in the hospital. Staff are now seeking out consultations … with respect to pain management questions. Staff are in consult with [ECD Addictions] staff with respect to planning for a delivery and making referrals for mothers who are not yet connected. Staff are dialoguing about how best to support a mother and her child through the process at the hospital. The passion of the [ECD Addictions] team has been invaluable in moving the Maternal Child staff through this growth process.*

3.3.2 Complex and Multiple Needs

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

This section of the survey focused on how substance abuse service providers help to address complex needs through case management and development of service relationships with both allied sectors and other addiction agencies.

Linkages and Case Management

The guideline for co-service delivery with community partners was reported to be fully achieved by 40% of respondents, with an additional 54% indicating partial achievement of the guideline. Similarly, while only 36% of respondents reported full achievement of the guideline for linkages with a range of support services for women, an additional 58% reported partial achievement. As in numerous other guidelines, respondents reported that resource issues create barriers to fulfillment of best practices:

- *"Until addiction services are sufficiently funded, our lack of staff (of either gender) will reduce our capacity to be flexible, mobile and always individualized in responding to any client, including women. However, whenever we've had a chance …, we advocate with community partners for establishing needed services and for overcoming barriers already experienced by our clients."*

More positive reports were provided in respect to case management, support, and advocacy. Over 90% of respondents reported full (66%) achievement or partial (28%) achievement of the guideline for case management. Similarly, over 90% reported full (64%) or partial (29%) achievement of the guideline for support and advocacy for marginalized women and women leaving violent or abusive situations. It should be noted that the lack of universally-accepted definitions of the terms 'case management' and 'advocacy' makes it difficult to assess the true nature and extent of these activities. It is a matter of some concern that 5 respondents reported that guidelines for case management, advocacy, co-service delivery, and linkages with support services were either not achieved or viewed as 'not applicable'.

In a sample of different types of linkages garnered from key informant interviews, numerous types of partnerships were cited, including several examples of co-service delivery. It would appear that service relationships with allied providers more commonly take the form of informal and collaborative relationships than written partnership agreements, and often arise from actual case work (negotiation of supports and case management for individual clients).

Survey comments and interviews with key informants provided numerous concrete examples of efforts to link with other services:

- *"Our program has a formal written service agreement with another community resource program. All other linkages and partnerships are informally maintained through constant communication. This works well. The times when it is unsatisfactory are always related to high demand for those services and thus length of the waitlists. i.e., psychiatric assessments."*
- *"In this LHIN, partnerships and collaboration often have to occur across provincial and federal jurisdictions (e.g. First Nations woman requires Non-insured Health Benefits to cover transportation to residential addictions treatment services, or withdrawal management services)."*
- *"We work from 8 sites across our catchment area in order to be accessible and offer flexible appointment times to the extent that our resources allow at this time; we have the equivalent of 3.5 counsellors to respond to about 650 referrals a year in a large catchment area; we are constantly working on links with CAS, probation services, and women specific services."*

Although the majority of respondents do not report *full* achievement of the guidelines for linkages and case management, responses demonstrate good recognition of their importance. Many respondents noted that increased cross-sector knowledge and understanding has been an important by-product of partnerships and linkages with allied sectors, when staff time can be made available for such activities.

Respondents indicated that barriers to linkages arise from lack of resources to seek out and build relationships with other community services, initiate or participate in service networks, and travel to other agencies. Barriers also arise from gaps in other community

services with which linkages can be made; particular gaps were noted in services for trauma, eating disorders, and other mental health services. As indicated by one key informant:

- *"Development of partnerships requires that willing partners exist, as well as the time and energy for development of service relationships".*

It was also noted that linkages with some sectors can be more difficult to maintain. For example, some respondents noted that societal stigma and lack of clear understanding of some treatment strategies, such as harm reduction approaches, make it difficult to establish linkages with Child Welfare agencies in some areas of the province. Nevertheless, a few respondents (particularly those funded to provide ECD Addictions programs) reported good success in forging collaborative relationships with Child Welfare agencies [7].

Respondents also emphasized that gaps in the continuum of service and wait times for services can make it very difficult to ensure timely and appropriate linkages within the substance abuse treatment system itself, especially in respect to stabilization, supportive residential options, and gender-restricted withdrawal management services for women. Residential agencies with provincial service mandates emphasized the importance of linkages to community treatment 'aftercare' resources in women's 'home' communities, and noted that referral to appropriate services is extremely difficult where gender-specific services are not available in local communities, or where there are wait times for such services.

Linkages to Stabilization and Residential Support

The majority of respondents reported full (47.3%) adherence or partial (43.2%) adherence to the guideline for linkages to stabilization and/or residential support in the local system. These levels of reported adherence are surprisingly high, considering that few services are funded to provide residential stabilization for women. Many respondents and key informants noted the lack of residential stabilization as a critical gap in the continuum of addiction services. In light of that gap, it is likely that the high level of reported adherence is achieved through stabilization that has been 'cobbled together' through linkages with community partners. For example, one respondent noted that

- *"Although we are not a woman-specific agency we do everything possible, in many creative ways, to link women up with appropriate services, and to support them to the best of our ability. We have a crisis shelter in town so we receive and give referrals to them."*

In some areas, withdrawal management services may be functioning as de facto residential stabilization options by providing access to beds to bridge the gap between detoxification and admission to treatment programs.

[7] For example, in Toronto Region, a written cross-sector protocol has been jointly developed between Child Welfare agencies and addictions agencies. Training for child protection workers to enhance understanding of FAE (Fetal Alcohol Effects) and increase capacity to identify pre-natal alcohol use and make necessary referrals has also been developed and delivered.

Linkages to Harm Reduction Services and Resources

The majority of respondents reported full (60%) or partial (30%) achievement of the guideline for linkages with harm reduction services such as Methadone Maintenance Therapy (MMT). Only 10% of respondents reported non-achievement of the guideline, while six agencies (8%) reported this guideline to be 'not applicable'.

Positive reports in respect to linkages for MMT appear to signal a substantial shift from concerns about substitution therapies that have historically created barriers to MMT access in abstinence-based addiction services. However, high rates of adherence reported for the guideline for MMT linkages are tempered by survey comments about numerous barriers to MMT access. Some respondents noted barriers from lack of local MMT availability, particularly but not exclusively, in rural/remote locations. It was also noted that some agencies support harm reduction approaches in some aspect of their services but not others (e.g. in individual counselling but not in group; in non-residential but not in residential treatment).

Additionally, it should be noted that, even where linkages to MMT services have been established, they do not necessarily mean that MMT is fully accessible. Respondents from residential programs reported limitations in respect to providing methadone on site (including physical plant, pharmacy standards for storage, sponsor policy, and liability issues). It was also noted that, in some residential agencies, dose limits are so restrictive as to make admission for most women receiving MMT out of reach. These restrictive requirements mean that some women receiving MMT still cannot access services.

Where agencies have identified this guideline as 'not applicable', it is probable that they operate from a philosophy that precludes all medications, including methadone. Some of these agencies report culture shifts that may increase acceptance of some medications (e.g. abstinence-only policies are reported to be under review in some agencies).

Linkages for Pregnant and Parenting Women

The majority of respondents reported full (41%) achievement or partial (34%) achievement of the guideline for linking pregnant and parenting women with appropriate services. Positive reports in respect to this guideline are indicators of increased recognition of the importance of facilitating connections with adjunctive services for pregnant and parenting women. Respondents and key informants widely attributed advances in these service approaches to the influence of ECD Addictions projects, which have had a significant impact on awareness in the addictions sector and have generated substantial new capacity for cross-sector collaboration.

Almost a quarter of respondents reported that the guideline is either not achieved (12%) or 'not applicable' (13%); it is disturbing that a substantial percentage of agencies appears to be unaware of the critical importance of their role in facilitating linkages. Clearly, ongoing effort is needed to ensure that all agencies make efforts to connect this vulnerable population with the appropriate services.

Transportation Barriers

Assistance in overcoming transportation barriers was reported by the majority of respondents, with 36% reporting full achievement of the guideline and 44% reporting partial achievement. Respondents reported that lack of transportation remains a significant barrier in both rural and urban settings, in spite of agency attempts to overcome these barriers.

Many respondents expressed concern about their limited ability to provide practical supports in this area; however a few positive examples were also cited. One rural agency provides transportation for women who do not have access to public transportation. An urban agency provides monthly transit passes to women in need, using fundraised dollars to cover the expense.

3.3.3 Accessibility

Best Practices in Action notes that, in order to increase accessibility, services should be offered in easy-to-reach locations and in non-traditional settings. Outreach services offered in partnership with women's services in other sectors (for example, with women's centres or shelters) will broaden the availability of information to the community and facilitate service coordination.

To obtain information about accessibility of services, the survey asked questions about service locations and proximity to public transportation, availability of outreach and assessment/referral in community or satellite locations, and co-location with other women's services.

The majority of respondents (78%) reported that their sites are central and easily accessible, with the notable exception of rural services. Obviously, agencies in rural communities where public transportation systems do not exist cannot, and will not, be able to adhere to this guideline.

Reported adherence was somewhat less positive for the two guidelines for off-site service provision to enhance accessibility. A majority of respondents reported full (43%) or partial (27%) adherence to the guideline for outreach and off-site assessment services. Respondent comments indicated that, although many agencies want to increase community access through satellites and outreach, they lack either the funding or the mandate to do so. Similarly, fewer respondents (26%) reported that the guideline for co-locations and partnerships is fully achieved, although a substantial number (47%) reported partial achievement.

Respondent comments provided numerous examples of innovative strategies for off-site services, partnerships, and co-locations. It is clear that some agencies have been extraordinarily successful in making these types of linkages. These agencies provide examples of innovative practices that can serve as models for others.

3.4 Flexible Admission Criteria

Best Practices in Action notes the importance of providing women with a range of options and choices. Traditional service structures and agency-specific intake and admission criteria can present obstacles to women, especially for those who are most

marginalized and most in need of flexible strategies for engagement and building trust. Best practices challenge traditional service structures to increase flexibility, so that options can be offered to meet women's individual needs and goals.

This section of the survey enquired into whether women are accepted into services without discrimination, are met with a welcoming approach that accepts the presence of support persons or children during the admission process, and can access services during flexible hours. The section also queries policies with respect to admission for women who use Methadone or other prescribed medications, and practices for connecting women with alternative resources if an agency absolutely cannot accept them into its program. Respondents reported very high achievement of all of these guidelines; however respondent comments raised questions in a number of areas.

The vast majority (95%) of respondents reported full achievement of the guidelines for clearly informing women about treatment choices, rights, and options. It is surprising that 3 respondents reported the guideline 'partially achieved' and one reported 'not applicable'. Similarly, most respondents (90.5%) reported full achievement of policies and procedures to ensure that all requests for service are considered and that admission criteria do not discriminate. Again, it is surprising to note that almost 10% (seven agencies) report this guideline only partially achieved. It is unclear why less than 100% achievement of these two very basic guidelines for clinical practice has been achieved.

Only 52% of respondents reported full achievement of the guideline for admission procedures that are flexible and welcoming, however 39% reported partial achievement. Respondent comments indicated that, while agencies appreciate the importance of engaging women with welcoming practices, many do not have the staffing resources to offer flexible hours of service.

The majority of respondents indicated full (78%) achievement or partial (17%) achievement of the guideline for accepting women on adjunctive pharmacotherapies such as methadone. Four respondents who identify this guideline as 'not applicable' are, in all probability, agencies that operate from an abstinence-only philosophy. Comments of some respondents indicate that some agencies regard pharmacotherapies as inappropriate in an abstinence framework. In those agencies where adherence to the guideline has been reported, it should be noted that access may be limited by the lack of availability of substitution therapies in some communities or undermined by internal policy issues in some sponsor organizations. Additionally, some agencies place limits on the methadone dose level allowable for admission. When limits set by agencies allow only very low dose prescriptions, admission to the program may be out of reach for a substantial number of women who are taking substitution therapy drugs[8].

Although the vast majority of respondents (95%) reported full achievement of the guideline for accepting and supporting women who are taking prescribed medications, this positive report may be an over-statement of system practices. Input from stakeholders[9] indicates that a minority of residential programs in Ontario accept *all* prescribed medications. Respondents and key informants noted that admission of

[8] Source: DART - anecdotal input.
[9] Input gathered through key informant interviews, network consultations, and consultation with DART re medication policies.

women on prescription medications may be restricted by: (a) acceptance of some medications and not others; (b) negotiation with the prescribing physician to reduce the amount prescribed or change to a different medication; and (c) contracting with the woman for limited use during a residential stay. Additionally, some agencies noted that admission of women taking prescription drugs is determined on a case-by-case basis, and some indicate that such admissions are made as an exception rather than as a common practice.

Given the prevalence of depression, anxiety, and other mental health problems in the population of women who present for treatment, women who require psychoactive prescription medications should be able to access both community treatment and residential treatment options. Barriers that stem from medication policies were reported to present particular barriers for senior women, who statistically are more likely to be prescribed benzodiazepines:

- *"Medication use is a huge issue when referring to residential treatment. We feel a lot of frustration when trying to refer women on benzodiazepines, pain medications, and occasionally women on methadone."*

Additionally, there is a need for DART to receive clear, consistent, and detailed information from all agencies about medication policies including: what medications are accepted; what restrictions and limits are applied; and what pre-conditions are placed on admission of women taking medications.

Virtually all respondents report that they have fully (81%) or partially (16%) achieved the guideline that encourages agencies to connect women with alternative resources when women do not meet program admission requirements. Given that numerous gaps in alternative resources were identified by stakeholders, this may be an over-statement of agency practices. While agencies may make every attempt to connect women with alternate resources, it is difficult to *ensure* such connections in some communities, given the gaps in services (and particularly in stabilization services), wait times, and barriers to the implementation of harm reduction approaches identified by both survey comments and key informants.

3.5 Treatment Planning Issues

3.5.1 Assessment and Referral

Best Practices in Action emphasizes the importance of comprehensive assessment in addressing barriers to treatment entry and developing a holistic treatment plan for women. Assessment should look beyond substance use patterns to incorporate an understanding of core issues that inform each woman's life. The standardized assessment tools and protocols used by Ontario's substance abuse treatment services gather information about the strengths and needs that will inform women's treatment plans, but they are not gender specific.

In order to ensure appropriate initial assessment of women, assessment/referral processes should gather information about the core issues of importance to women as identified by best practices, promote flexible utilization of the standard provincial assessment tools, and incorporate stages of change approaches. In cases where it may not be possible for a woman to complete the standardized assessment process (e.g.

when she is not sufficiently stable to complete the standard assessment package), best practice guidelines encourage agencies to determine a woman's immediate need for support on core issues.
The vast majority of respondents[10] reported that agencies offer a flexible approach to standardized assessment that is client centred and responsive to the woman's stage of change; 80% reported that the guideline is fully met, and 18% reported partial achievement.

Respondents also reported a high level of adherence to the guideline requiring attention to 'core issues' identified by the *Guidelines*. The majority reported that information about core issues is gathered as part of the standardized assessment and referral process, with 85% reporting full achievement.

Fewer respondents reported that the guideline is met for identifying immediate needs for support and linkages for women who do not receive a standard assessment. Only 40% of respondents reported meeting this guideline fully, and 33% reported partial achievement. This is not surprising, since many agencies only admit women who have already completed the standard assessment.[11]

Comments highlighted the importance of client-centred assessment that considers the context of women's lives:

- *"The client is the central focus. We work with her unique needs to help develop a relevant and realistic plan. It is her investment into the process that is the key."*
- *"Women's unique living circumstances are considered when developing any treatment plan and of course they are part of the planning process."*
- *"In addition to the provincial assessment tools, we are continually gathering information from clients during their stay through assignments, daily journals, one to one interviews, etc., and treatment plans are revised as necessary."*

It is, however, unclear whether all respondents have placed the same meaning on the term 'core issues'. The source document, *Best Practices in Action*, provides an outline of core issues to be considered; however, not all respondents have read, worked with, and absorbed into practice, the concepts presented by that document. For example, one agency noted that they don't differentiate gender issues in assessment and treatment planning:

- *"As with all clients, we have a client centred approach with women and allow them to tell us their needs and decide their goals and then assist them to get their needs met and goals achieved. "*

3.5.2 Duration of Treatment

Flexibility and responsiveness are fundamental to treatment planning. Non-residential services are well positioned to individualize the duration and structure of their services, but programs that operate on fixed-length cycles experience challenges in providing

[10] It is interesting to note that 96% of respondents indicate that they do administer the provincial tools.
[11] Some clients may not be physically or cognitively stable enough, or at an appropriate stage of change, to complete the assessment tools.

flexible and individualized services. This section focused on the capacity of agencies to provide flexible duration of treatment, based both on the assessed needs of each woman and on recommended best practices.

The majority of respondents reported that the guideline for flexible duration of treatment is fully (76%) achieved or partially (19%) achieved. In agencies where both fixed-length residential and open-ended community treatment programs are provided, duration of treatment may be flexible in one program only (e.g. an agency may provide both fixed-length residential and flexible-length community treatment).

Survey comments indicated that agencies with fixed-length or fixed-cycle programs are attempting to incorporate more flexible treatment options; however, many agencies struggle with this issue. Many respondent comments noted the importance of continuing these efforts to provide more flexible services:

- *"Women's lives are very busy and this is not often recognized within traditional addiction treatment. Women's programs need to be modular so they are more flexible. Women should be offered flexible appointment times and access to care."*

Residential programs cited a variety of strategies for increasing flexibility, including: implementation of continuous intake, inviting women to extend time in a fixed length program, and reframing early discharge as 'a good beginning' rather than a 'failure to complete'. Some respondents noted that increasing flexibility in fixed-cycle residential services would require re-thinking and re-designing existing program structures – a process that would require resources beyond the reach of many agencies.

3.6 Clinical Practice Issues

This section of the survey highlighted several issues related to the provision of gender-appropriate services including: (1) gender specific content and delivery that addresses core issues; (2) utilization of stages of change, motivational counselling, and harm reduction approaches; (3) appropriate gender balance in mixed gender services; (4) gender-specific approaches to health and wellness; and (5) gender-specific relapse prevention approaches.

3.6.1 Gender Relevant Services

The importance of gender-specific treatment approaches has been widely recognized in policy, best practices, and expert opinion. Effective services for women need to be gender-specific, consider women's life experiences, and incorporate both a holistic theory of substance abuse and a theory of trauma.

As elements of gender-relevant services, *Best Practices in Action* calls for inclusion of a basic set of core issues in gender-specific programming. Clinical or therapeutic approaches that are particularly effective for use with women are also identified. To gauge service practices in respect to these issues, the survey included nine questions related to guidelines for gender-relevant clinical approaches.

In specialized, women-only services the vast majority (96%) of respondents reported full achievement of the guideline for programming that is gender specific in content and delivery, and addresses core issues.

By contrast, only 38% of respondents reported full achievement of the guideline that requires co-ed services to provide women-only, gender-specific, specialized sessions on core issues, with an additional 42% reporting partial achievement. It is concerning to note that 20% of respondents (9 agencies) reported that *no* gender-specific program sessions are provided. It is possible that some of these agencies provide assessment, treatment planning, and individual counselling only, and do not offer 'program sessions' as such, however gender-specific attention to core issues should also be available within these individual counselling components.

Similarly, only 36% of respondents from co-ed services reported full achievement of the guideline for provision of women-only, gender-specific program streams or groups and gender-specific individual counselling with a female therapist; with 51% reporting partial achievement. The explanation for agencies that reported non-achievement of this guideline is unclear since, even agencies that do not provide group programming, should offer women gender-specific individual counselling with a female counsellor.

Among all types of programs, the majority reported full (75%) or partial (14%) achievement of the guideline for educational, skill building, and experiential learning approaches and a balance of cognitive behavioural and affective components. Five respondents reported this guideline as 'not applicable'.

Almost 90% of respondents from all program types reported that the guideline for collaborative, non-hierarchical, empowering, relational, and strengths-based approaches in programming for women is met fully (74%) or partially (16%). The basis for 'not applicable' responses by 6 respondents is unclear.

Similarly, the majority of respondents from all program types reported full (78%) or partial (9%) achievement of the guideline regarding the use of motivational and harm reduction approaches.

The guideline for trauma-informed approaches was less well met. Only 50% of respondents reported full achievement, with an additional 31% reporting that the guideline is partially achieved. Given the prevalence of trauma and the interrelationships of trauma and substance abuse, it is troubling that almost 20% of respondents reported no achievement of trauma-informed approaches (6% reported 'not achieved' and 13% reported 'not applicable).

3.6.2 Stages of Change, Motivational Counselling, and Harm Reduction

Best practices strongly support strategies based on the stages of change model. Lack of appropriate service responses to women at early stages of change is also a major barrier to access and retention for some women. Motivational counselling has been shown to be an effective approach for working with women in varied stages of change. Harm reduction approaches have been shown to be effective at early stages of change and useful during any stage of change to encourage incremental progress that will eventually produce lasting change.

To support work with women at all stages of change, *Best Practices in Action* identifies guidelines for support, assessment, referral, and treatment approaches and services that are responsive to women's stage of change (or readiness to change) and choices.

All respondents reported either full (91%) or partial (9%) achievement of the guideline for providing motivational counselling and stages of change-based approaches in all phases of engagement and programming.

Similarly, the majority of respondents reported that harm reduction approaches are integrated into the treatment approach of their programs, with 79% reporting full achievement and 16% reporting partial achievement.

Almost all respondents also reported full (88%) or partial (10%) achievement of the guideline for connecting women with resources in the community when they are unable to provide services appropriate to the client's stage of change.

Fewer respondents reported that guidelines with respect to harm reduction approaches were fully met. In regard to the guideline for availability of adjunctive pharmacotherapies (on site, or through linkages with allied services in the community), 70% of respondents reported full achievement and 22% reported partial achievement. Six respondents reported this guideline as not achieved or considered the guideline 'not applicable'. A majority of respondents (74%) reported that the guideline for harm reduction approaches to address the needs of women who choose non-abstinence treatment goals was fully met, with 16% reporting partial achievement.

Although high adherence was reported in respect to most guidelines in this section of the survey, respondents' comments suggest that, even where agencies report full or partial achievement, some still struggle with the practical or clinical issues associated with some harm reduction strategies. For example, some respondents noted that moderation goals are clinically inappropriate for the client population served in many residential programs.

Support for 'stage of change' and harm reduction approaches was indicated by many comments:

- *"We support women to establish their goals; this may include abstinence or harm-reduction approach; we provide education and orientation specific to her needs; we refer to other services for additional supports including methadone treatment, treatment & medications for mental health concerns, supports related to physical health, pregnancy, parenting."*

Comments also illustrate shifts in concerns about some harm reduction approaches:

- *"We now accommodate women on Methadone in our residential program. Our relapse policy allows for multiple lapses with quick re-entry into the program. We have an MD - Addictionologist on site."*
- *"Harm reduction principles are slowly being integrated into an abstinence-based program...we have a way to go!"*
- *"Our program is for women who have a goal of abstinence. However, we have answered the questions re harm reduction as providing harm-reduction services due to (a) the services we provide following a relapse – working through the relapse and*

a recommitment to a goal of abstinence, and (b) we accept clients who are in methadone therapy. When a client does not feel ready to recommit to a goal of abstinence after a relapse, we assist them in accessing other services in the community."

Even when addictions organizations have achieved internal acceptance of harm-reduction approaches, they cite numerous challenges in their communities. Some find that allied service providers may not understand or accept harm reduction; others note that where adjunctive resources are lacking, referrals to other health services or community agencies who utilize harm-reduction approaches may be difficult or non-existent:

- *"We face challenges in linking women who are not prepared to engage in treatment with other community resources as such resources (harm-reduction focused) simply do not exist."*
- *"We practice harm reduction but are limited regarding methadone treatment because it is not available here."*
- *"The closest methadone maintenance service is 2.5 hours away. The barrier is at the pharmacist and physician level."*

A small number of respondents report that their agencies work from an abstinence-only framework, do not accept clients on Methadone (or other substitution therapies), and do not embrace harm-reduction approaches that call for moderation goals or behaviours. Abstinence-based residential agencies note that their intensive programs fulfill a legitimate function in the array of services by providing a 'safe' place for women who have severe substance-abuse problems and are poor candidates for moderation or selective-abstinence goals:

- *"The system needs to recognize that abstinence has a legitimate place on the continuum, abstinence services are devalued.*

3.6.3 Gender Balance in Mixed Gender Services

Co-ed services face challenges in providing a supportive environment for women's treatment. Research has demonstrated that women tend to minimize their focus on their own treatment issues in mixed gender treatment groups. Additionally, mixed-gender groups may not provide safety for women, particularly for women who have experienced trauma, violence, and/or abuse.

To establish an environment in which women can connect with each other and in which discussion of their experiences and concerns is well supported, *Best Practices in Action* indicates that mixed-gender groups be comprised of a minimum of 30% to 50% women, and that mixed-gender groups be facilitated or co-facilitated by a female therapist. When these conditions cannot be met, the *Guidelines* indicate that women should be referred to individual counselling or to other women's services.

Of respondents from co-ed programs, only 34% of respondents reported that mixed-gender treatment groups are comprised of at least one-third women, although an additional 46% reported that the guideline is partially achieved. Almost 20% of respondents from co-ed agencies reported that this guideline is not met.

Over 90% of respondents from co-ed programs reported that individual counselling or referrals to women's services in the community are provided if the program cannot achieve gender balance in mixed gender groups, with 67% reporting full achievement and 26% reporting partial achievement of the guideline. From the high compliance reported, it would appear that agencies see these strategies as viable strategies to compensate for the lack of balance in co-ed groups.

Similarly, 64% of co-ed respondents report full adherence to the guideline for female therapist facilitation (or co-facilitation) of co-ed treatment groups, and 27% report partial adherence.

Given the mixed adherence to the above guidelines, it is clear that, some agencies struggle with these issues. Both survey respondents and key informants from co-ed programs reported that it is sometimes difficult to attract sufficient numbers of women to achieve gender balance in every group. It was also noted that agency (or union) policies may not support a staff gender mix that allows for women counsellors to facilitate or co-facilitate every group. Resource limitations were also cited in respect to ensuring the availability of female counsellors to either co-facilitate groups and/or to provide individual counselling.

3.6.4 Gender Specific Approaches to Health/Wellness

There are substantial differences in the physical effects, consequences, and risks of substance use for women, as compared to men. Women experience faster intoxication and more negative physical impacts from ingesting smaller amounts of alcohol and other drugs, and experience more negative impacts over a shorter period of substance use. Women with substance-use problems are often also regular smokers and (as with other substances) are more vulnerable than men to the health consequences of tobacco use. Women smoke for different reasons than men and may have a more difficult time than men when they attempt to quit smoking.

Best Practices in Action provides guidelines for both women-only and co-ed programs indicating that programs should provide clear, accurate information and opportunities for discussion of the physical health aspects of substance use and recovery. A guideline is also provided in respect to information and education about tobacco use, and supports for women who wish to quit smoking.

All specialized women-only services reported either full (80%) or partial (20%) adherence to the guideline related to information and discussion of the effects of substances on women's physical health.

Fewer respondents from co-ed programs reported adherence to the related guideline for delivery of specialized women-only information sessions led by women counsellors about the physical impacts of substance use on women; only 38% reported full adherence, with 26% reporting partial adherence. It is concerning to note that 36% reported that the guideline is not achieved. Women in mixed-gender sessions may not feel comfortable asking questions and discussing the different impact that substances have on women's bodies, or exploring sensitive issues related to impacts of substance use (such as sexual health and reproductive issues).

Mixed adherence was also reported in response to the guideline for provision of information and education about the effects of tobacco on women's health and support to women who wish to quit smoking. Of respondents from all service categories and types, 36% reported full adherence, 39% reported partial adherence, and 20% reported no adherence. Surprisingly, 3 respondents identified this guideline as 'not applicable'.

3.6.5 Gender Sensitive Relapse Prevention Approaches

Relapse is a part of the experience of recovery for many women; with appropriate support, it can be a positive impetus for exploring client growth and change. Research shows that when women relapse, it is often associated with specific triggers such as unpleasant emotions or interpersonal issues. For example, women who have experienced trauma may experience relapse triggers rooted in flashbacks or trauma-related feelings.

Best Practices in Action calls for relapse prevention approaches that focus on situations of particular risk for women (interpersonal relationships, emotional/physical triggers) in all types of programs (restricted, specialized, and co-ed). Additionally, if relapse does occur, the *Guidelines* call for programs to support retention in treatment, renegotiate treatment plans, and assist women who are discharged on relapse to connect with another treatment service appropriate to their stage of change.

Mixed adherence to the guideline for gender-specific relapse prevention was reported; while the majority of respondents reported that the guideline is fully (53%) or partially (28%) met, almost 20% reported that the guideline is either not achieved (16%) or considered 'not applicable (3%).

By contrast, the vast majority of respondents reported adherence to the guideline for supporting women to remain in treatment and renegotiating their treatment plans, with 75% reporting full achievement and 21% reporting partial achievement.

Fewer respondents reported full (53%) or partial (10%) adherence to the guideline for supporting continued engagement with the treatment system for women who have been discharged due to relapse; however, survey comments indicated that a high percentage of respondents (in particular, community treatment services) do not discharge if a woman relapses.

3.7 Specialized Issues – Co-occurring Mental Health Issues

Research has shown that co-occurring mental health problems are common among substance-involved women. Since women who experience co-occurring mental health problems may use substances to self-medicate, mental health issues may emerge as substance use is reduced or ended. *Best Practices in Action* states that the substance abuse treatment system needs to recognize the role that substance use plays in mitigating some mental health problems and be prepared to provide integrated gender-appropriate approaches to the mental health issues and concerns of women.

To gauge the quality of service responses to women who have co-occurring mental health issues, the survey asked about practices in two areas: (1) integrated approaches to assessment, treatment planning, and intervention when a mental health issue is

identified, through collaboration and partnerships with mental health services; and (2) admission criteria that are inclusive of women with serious mental health issues and/or who are taking prescribed medications for mental health issues.

Integrated Approaches to Assessment, Treatment Planning, and Intervention

Most respondents indicated full (48%) achievement or partial (44%) achievement of the guideline for provision of integrated assessment, treatment planning, and intervention through partnerships with mental health services. Only 6 respondents (9%) indicated non-achievement.

The high level of reported adherence to this guideline must be examined in the light of comments from survey respondents, key informants, and other stakeholders. Participants in network consultations suggested that survey results may have been inflated by respondents' varying understandings of the term 'integrated approaches'. The lack of common definitions and benchmarks makes it difficult to draw conclusions about the data or to determine the exact nature of the 'integrated' activities. Similarly, the term 'partnership' needs to be universally defined, since not all agencies apply the same criteria when reporting that a community partnership is in place.

It was also noted that, although programs attempt to facilitate solutions for individuals, most services are not systemically integrated. Progress has been made in building capacity to provide services for women who have concurrent disorders; however, service levels are still inadequate and women are still 'falling through the cracks'. Survey comments identified notable barriers to partnerships with, and access to, psychiatric and other mental health services:

- *"It has been extremely difficult to obtain mental health assessments, treatment or consultations. Generally, most psychiatrists do not appear interested in serving our clients and cannot provide services to our agency in an affordable and timely fashion."*
- *"There is an enormous gap in the field regarding the need for a safe place (not a hospital or stabilization unit) that is non-stigmatizing and supportive for women or men that are experiencing a mental health crisis."*
- *"The mental health system recently received funding and agencies are madly trying to hire staff and expand services. Although certainly interested in working with addiction agencies, it is a challenge for them to find time to focus on partnering with addictions agencies."*

Key informants reported that barriers to integrated approaches have also arisen from gaps in addiction-sector funding and expertise:

- *"We need to look at retention rates as well as admission policies. If programs admit women who have concurrent disorders but can't adequately support them, it may set women up for poor treatment experiences and outcomes."*
- *"Women who have concurrent disorders require long-term treatment strategies that include stabilization and aftercare. The lack of funding means that a lot of needs are not addressed."*

Varying admission policies impact relationships among substance abuse service providers. One informant noted that when some agencies do not accept women with

mental health problems or those who take psychotropic medications, it creates pressure on those who do admit these women; it was also noted that, although those agencies treat a disproportionate number of women with concurrent disorders, they are not differentially funded to work with a more complex population.

DART reported substantial barriers to services for women who require high support, specialized concurrent disorders programming. Only two Residential Medical/Psychiatric programs are shown on the DART data base in Ontario, and both are co-ed. Effectively, there is no residential gender-specific service in Ontario for women who require *specialized* concurrent disorders services. Additionally, both existing Medical/Psychiatric programs have limited catchment areas; hence they do not provide services to women in all parts of the province.

DART also noted that, although there are some community treatment options for women who have concurrent disorders, it is unknown how many of these are gender-specific. Further, DART observed that options are extremely limited for women who do not function well in the cognitive and group-based modalities most commonly utilized by residential treatment programs.

Admission Policies for Women with Serious Mental Health Issues

With respect to admission policies for women with serious mental health issues, or who are taking prescribed medication for mental health problems, most respondents indicated either full (77%) achievement or partial (16%) achievement of the guideline for admission criteria that reflect a client-centred and individualized decision-making process. It would appear that there have been shifts in the historically cautious stance of the addictions sector about admitting clients who are taking psychoactive medications, however the high level of reported adherence to this guideline must be examined in the light of comments from survey respondents, key informants, and other stakeholders. These comments are discussed in relation to each guideline in the following section.

DART reported that more residential programs now indicate some willingness to admit women who have 'mild mental health problems'. Admission decisions are often based on case-by-case assessment, designed to determine the ability of the client to function in the program, and the ability of the program to work with the client. Decisions may be dependent on a number of intersecting factors such as: stability, cognitive functioning, medication needs, and ability to function in group-based programs. Clients may not be admitted if their level of functioning may prevent them from benefiting from the program, if they are symptomatic to the point where they negatively impact other people, or if the program may not be able to manage the behaviours that may arise.

Survey respondents observed that many agencies find it beyond their capabilities to work with women who have 'serious mental illness' (e.g. schizophrenia, borderline personality disorder). Admissions are more commonly accepted for 'mild' co-occurring mental health problems such as depression and anxiety. Similarly, a number of key informants reported that agencies cannot accept women who have mental health problems unless their conditions are stabilized. One informant observed that: "*some programs don't believe they are well equipped to deal with complex mental health issues but are reluctant to disallow admission, therefore they require stabilization prior to admission*".

Concerns about stability were particularly noted in residential settings where lack of staff resources may not allow time to safely manage the situation if a woman becomes destabilized. Some agencies reported exclusionary criteria for women with 'serious mental illness' because rural locations preclude access to nearby psychiatric services. A few key informants reported exclusionary criteria for women with *any* mental health problems (one reported that the program is considering changes to admissions policy and "hope to admit clients with mild mental health problems").

Agency medication policies can be used as an indicator of accessibility for women with co-occurring mental health issues, in that they may limit access to services for women who take psychotropic medications. Data with respect to medication policies shows considerable variation. In both the DART data base and the sample group of key informants, some agencies reported no exclusionary criteria for medications, while others do not admit clients on *any* 'mood altering' medication, including anti-depressants and anti-psychotics. It would appear that many programs are cautious about accepting prescribed medications due to a concern that some physicians over-prescribe and others appear to be uninformed about addiction issues. Case-by-case assessment is also widely utilized in making decisions about whether to admit women who are taking medications. When psychoactive medications are permitted, programs tend to be 'vigilant' about whether women really need to take medications and work closely with physicians and psychiatrists to assess need and monitor use. Many programs encourage women to seek alternatives strategies to manage symptoms or to work with the referring physician to determine if alternatives medications are available.

Key informants from the community treatment sector expressed frustration over difficulties encountered when attempting to refer women on medications (especially benzodiazepines and pain medications) to residential treatment agencies. It was noted that this is a particular difficulty for older women, who are more likely to be taking benzodiazepines. However, limits on medications are also found among categories of services other than residential. Analysis of the DART data-base reveals that 21% of initial assessment and treatment planning services, 17% of community treatment, 46% of community day/evening treatment, and 43% residential withdrawal management services report that they accept either no medications or only certain medications.

3.8 Specialized Issues – Trauma

Research has shown that significant numbers of women who participate in substance abuse treatment report experiences of trauma (including sexual abuse and/or physical abuse). It is also well recognized that trauma may act as a trigger for substance abuse or other self-harming behaviours. Because of this, *Best Practices in Action* provides guidelines indicating that substance abuse treatment services for women should be *trauma-informed* (i.e. at a minimum, workers should be knowledgeable about the effects of trauma and its relationship with substance use, and programs should provide components that help women to learn techniques for establishing safety and coping with trauma-related issues).

Over half of respondents (54%) reported that the guideline for providing trauma-informed programming was fully met, with an additional 34% reporting that the guideline is partially met. However, almost 15% of respondents reported that trauma-informed

programming is not provided – either because the guideline is not achieved (7%) or because it was considered 'not applicable' (4%).

In respect to the guideline for staff knowledge about the effects of trauma and its relationship with substance use, 44% of respondents reported the guideline to be achieved, with an additional 49% reporting partially achieved. Four respondents reported non achievement and one respondent perceived the guideline as 'not applicable'.

Positive reports in respect to achievement of these two guidelines indicate that many agencies have been sensitized to the incidence of trauma and the need for trauma expertise in working with women. However, without benchmarks, it is difficult to determine the quality of 'trauma-informed' responses. The number of agencies that responded 'not achieved' and 'not' applicable', though relatively small, indicates a need to raise awareness about the importance of this issue. Given that trauma is highly correlated with substance-abuse problems, achievement of these guidelines should be sought in any agency that provides any level of service for women.

Comments indicate that some agencies have developed a strong level of understanding, commitment, and expertise in working with trauma, within the limits of their mandates and roles:

- *"All staff are cognizant and employ stage 1 techniques to keep the residence/living environment safe for residents' daily living."*
- *"Our staff deals with trauma and crisis on a daily basis. We have a great working relationship with the police when it comes to protection of the client etc."*
- *"Staff is trained in trauma-related issues. Women-specific groups often focus on coping with flashbacks, assertiveness, safety planning, etc."*
- *"Working in a youth agency understanding child physical and sexual abuse is critical as is understanding child development."*
- *"We have trained staff in DBT, in concurrent and in post trauma issues. There is an ongoing commitment to education around these issues."*

Key informants with extensive knowledge of trauma emphasized the importance of developing an integrated response: *"Given the tremendous incidence of trauma in the lives of women we serve, we need to think about substance use as a response to trauma; whether women first access the addictions system or mental health system, we are really dealing with trauma issues."*

Informants also noted that it is difficult to refer women to a trauma specialist in some communities due to long wait lists or a complete lack of appropriate services; however, several examples of trauma groups were provided. Sometimes these groups are run in partnership with allied sectors; in other cases, substance abuse treatment agencies themselves have developed the internal expertise necessary to work in an integrated manner, to teach techniques to deal with trauma issues, and to provide tools to help women establish safety.

To obtain sample data on the type of trauma training in addiction agencies, key informants were asked about the level of training among their staff. Substantial variations were reported, ranging from strong clinical training and background to basic workshops.

Both survey respondents and key informants reported that training and resources are required to support development of trauma-informed staff and programming.

3.9 Pregnant and Parenting Women

Best Practices in Action states that priority access to treatment services and access to services such as prenatal care, childcare, child programming, and parenting programming are particularly important for women's treatment. Ontario's substance abuse treatment system has historically lacked the capacity to offer these basic services.

To assess current system capacity to provide appropriate services for pregnant and parenting women, the survey incorporated a separate section of questions which addresses five areas: (1) engagement and retention, (2) access to services, (3) effective services, (4) relationships with children; and (5) child protection issues. Guidelines subsumed within these broader categories include: outreach; linkages with allied service providers; rapid priority access to addiction services; harm reduction approaches; enhancement of protective factors; children's programming; and fostering strong working relationships with child protection services. Additionally, key informant interviews and network consultations were utilized to obtain collateral input about services for pregnant and parenting women.

3.9.1 Engagement and Retention

Best practices indicate that outreach and off site services are essential to the engagement and retention of pregnant and parenting women. Timely and effective engagement of pregnant women is particularly important, given that urgent timelines are in play to reduce potential fetal harm related to use of alcohol and other drugs. The survey enquired into adherence for two guidelines in respect to: engagement and retention.

Only 52% of respondents reported full achievement of the guideline for outreach to, or linkage with, sites of first contact for pregnant and parenting women, with an additional 22% reporting partial achievement. Over a quarter of respondents reported that the guideline is either not achieved (12%), or considered 'not applicable' (15%).

Fewer respondents reported full (46%) achievement of the guideline for provision of off-site services to engage substance-involved pregnant and parenting women, with an additional 18% reporting partial achievement. Over a third of respondents reported that the guideline was either not achieved (18%) or considered 'not applicable' (19%).

High levels of adherence were commonly associated with affiliation with ECD Addictions programs, which have had significant impact on the development of engagement strategies for women not traditionally served by the substance abuse system. Respondents and key informants noted the positive impact of ECD Addictions projects on linkages with allied service providers:

- *"The local ECD program collaborative is a means of engaging and connecting with partners in health care, services in kind are shared with one another, and gaps addressed."*
- *"Most of this work is done collaboratively and this benefits women the most."*

3.9.2 Access to Services

Access to services for pregnant and parenting women was covered by three specific guidelines within the survey: (1) priority access for pregnant women to addictions services; (2) access that is not dependent upon full completion of standardized assessment tool; and (3) provision of methadone to opioid-dependent pregnant women as soon as possible.

In regard to the guideline for agency policies that ensures rapid access to residential and community-based services for pregnant women, 50% of respondents reported full compliance, with an additional 11% reporting partial compliance. It is disturbing that over 40% of respondents reported that this guideline is not achieved (17%) or 'not applicable' (21%).

Key informants reported more positive results in respect to priority admission policies for pregnant women; 78% of key informants reported that they have a priority admission policy for pregnant women and also noted that when full service cannot be provided, some intervention is offered. Given the importance of accessible services for pregnant women, it is troubling that 22% of the key informants interviewed either did not appreciate the need for policies to prioritize access for pregnant women, or appeared to regard pregnant women as a population with needs or medical issues too complex to be served within all programs:

- *"We don't have a policy for pregnant women, but the agency is not well equipped to meet the needs of pregnant women – no specific facilities, no doctor on staff or nearby in the rural setting, no flexibility in the demanding program schedule."*

The majority of respondents reported that priority access for pregnant women is not contingent on completion or results of standardized admission tools, with 58% reporting the guideline as fully achieved and 16% reporting partial achievement; however, over a quarter of respondents reported that the guideline is either not achieved (9%), or considered 'not applicable' (17%).

Fewer respondents reported that Methadone Maintenance Therapy is offered to opioid-dependent pregnant women as soon as possible. Only 33% of respondents reported full adherence to that guideline, while an additional 23% reported partial adherence. Since best practices have clearly established the importance of providing methadone for opioid-dependent pregnant women, it is disturbing that over a third of respondents (35%) considered this guideline to be 'not applicable'.

The overall responses to this set of guidelines indicate substantial gaps in very basic building blocks of service accessibility; where full achievement is not indicated, it strongly highlights the need for improved awareness. Particular attention is required in respect to priority access for pregnant women to all services and facilitation of access to methadone.

3.9.3 Effective Services

Best Practices in Action indicates that effective services for substance-involved pregnant and parenting women should provide a wide range of supports, including those that

focus on reducing harm and/or enhancing 'protective factors', and may not require substantive reduction in substance use.

About half of all respondents (49%) reported full adherence to the guideline for incorporating supportive strategies to enhance protective factors (such as prenatal care, nutritional counselling, basic life supports, health care, safe accommodation), with an additional 29% reporting partial adherence. A substantial percentage of respondents reported that the guideline is not met (10%) or not applicable (12%). No rationale was provided by respondents to clarify why this guideline would be considered 'not applicable' by any agency that serves pregnant women.

By contrast, the vast majority reported support for reduced substance-use strategies or safer-use strategies as intermediary harm reduction approaches; 73% reported full adherence to the guideline and 10% reported partial adherence.

Survey responses to these two guidelines appear to demonstrate that many agencies are making efforts to provide a variety of supports for pregnant and parenting women. Key informants and provider networks observed that guidelines are fully achieved where ECD Addictions projects are in place.

Comments from ECD Addictions projects staff indicated a degree of surprise about the high levels of adherence reported by agencies overall. From the perspective of one ECD Addictions program staff:

- *"We have a long way to go in terms of the system's capacity to respond adequately to pregnant and parenting women."*

Another informant took a more sanguine view:

- *"I was surprised at the levels of adherence reported, but when I looked at some specific services in my region and considered the efforts being made to be consistent with Best Practices, I think it is reflecting the change in the addictions field as a whole."*

3.9.4 Relationships with Children

The survey queried two key dimensions of agencies' abilities to provide or link with children's programming and to engage with other service sectors that provide outreach, childcare, food, and transportation.

The guideline for providing children's programming and child development assessment was not well met. Only 30% of respondents reported full achievement, and an additional 20% reported partial achievement. This is not surprising considering that, prior to the inception of ECD Addictions programs in recent years, little attention and few resources were aimed at services to support women's relationships with children. It is, however, of concern that 33% of respondents reported this guideline 'not applicable'. Key informants emphasized that, for many agencies, lack of full adherence to this guideline is more related to lack of resources than to lack of awareness or interest. Indeed, considerable frustration was expressed in comments from survey respondents and key informants about their inability to provide space and staff resources for these important service components.

DART notes that lack of childcare and children's services has major impacts on women's access to services:

- *"Lack of onsite childcare is huge. We probably don't pick up the full extent of the need because there is such fear among women with children that child protection will apprehend their children if women ask for help. This fear is alluded to in calls we get."*

DART also noted the need for residential options for mothers and children:

- *"ECD programs have been great and very innovative in affording community treatment. But there are no residential options for women who have children and who aren't not involved with child protection, or don't have a supportive family member."*

Similar results were reported in respect to the guideline for providing barrier-free services through outreach, one-stop service, and integrated systems approaches to practical supports (childcare, food, and transportation). Only 25% of respondents reported full adherence to the guideline, with an additional 28% reporting partial adherence. The substantial percentage of respondents who reported the guideline to be not achieved (28%) or considered it to be 'not applicable' (20%) appears to signal a lack of appreciation for the importance of reducing barriers for this population. As in other areas, ECD Addictions projects were widely credited by informants with supporting the level of adherence that does exist in relation to the above two guidelines.

3.9.5 Child Protection Issues

Best Practices in Action notes that the risk of children being apprehended by child protection authorities presents a considerable barrier for pregnant and parenting women. Best practices emphasize the importance of building relationships with Child Welfare agencies and developing formal protocols to ensure that supportive linkages are made and that reporting obligations are met. The survey queried the policies of agencies in respect to the above linkages.

In respect to the guideline for establishing positive and ongoing relationships with local child protection services, only 47% of respondents reported full achievement; however an additional 44% reported partial achievement.

Most respondents also reported full adherence (61%) or partial adherence (33%) to the guideline for addressing mandatory reporting. Four agencies (6%) reported that this guideline is not achieved. This represents a small percentage of total respondents, but it is troubling, given the importance of prompt attention to child protection issues and of constructive relationships with child protection agencies.

Although some respondents reported success in forging productive linkages with the child protection sector, other respondents and key informants reported significant challenges in establishing collaborative cross-sector relationships with Child Welfare agencies in some regions. Some respondents identified that the absence of an affiliated ECD Addictions project limited their ability to effectively engage with Child Welfare agencies; others noted a lack of collaborative response from the child welfare system, even when an ECD Addictions project is involved. Respondents also reported that the differing philosophical approaches of the two sectors can create barriers to communication and collaboration, especially in relation to goal achievement for pregnant and parenting women. For example, in some areas of the province, respondents

reported that the efficacy of harm reduction approaches was not well understood or well received by some child welfare workers[12]. Further education and collaboration between the two sectors will be a critical success factor for future progress.

3.10 Monitoring and Evaluation

Program monitoring and evaluation is critical to ensuring that services remain relevant to clients and to the larger community. *Best Practices in Action* emphasizes that program evaluation and outcome measures should consider psychosocial issues and not be limited to women's substance use status. Examples of psychosocial issues to be considered include improvements in: physical health status; family relationships; education and vocational status; self-esteem; mental health status; and lifestyle (housing, recreation, leisure, handling of stress, etc.). This section of the survey enquired about agency use of monitoring and/or evaluation processes that incorporate best practices for women.

Most respondents reported that agencies have fully (31%) or partially (53%) achieved the guideline for monitoring or evaluation processes that include best practices. However a substantial percentage of respondents reported that this guideline is not met (16%) or not applicable (2%). Comments indicate that evaluation practices vary widely. Practices range from extensive accreditation processes, to regular or occasional client satisfaction surveys. Some respondents identified the ECD Addictions evaluation initiative as a useful model. Generally, few comments showed a strong awareness of how gender-specific elements may be considered or incorporated in evaluation practices, although some agencies have begun to use the *Best Practices in Action Guidelines* for internal program monitoring and evaluation purposes

4. Successes and Innovative Strategies in Implementing Best Practices

Survey respondents described a range of successes and innovative strategies; additional feedback was elicited from key informants and network consultations. Detailed information about successes and innovations is provided in Appendices G (Survey of Agency Practices Data), H (Summary of Key Informant Input), and J (Summary of Network Consultations). For the purpose of this report, feedback from all sources has been synthesized and analyzed to provide a high-level view of stakeholder input. We have included a number of direct quotations to provide a first-hand glimpse of the creative energy and problem-solving skills of addiction agencies and the innovative strategies they have developed to provide effective services to women.

Many examples were provided of innovation that reduces barriers and supports engagement, particularly of marginalized populations of women:

- Outreach, off-site services, home visiting, community case management, and satellite offices: *"In spite of having a huge catchment area, we are able to take our substance abuse counselling service to women in their own community, incorporating a harm-reduction approach."*

[12] A member of the Steering Committee noted that the mandate of the child protection sector plays a major role in defining the types of strategies and approaches that it can endorse.

- Flexible hours of service and procedures for admission and intake: *"Late afternoon and early evening programs are designed to respond to needs of the community."*
- Flexible treatment planning and goal setting to increase empowerment of women
- Flexible length of stay to meet the individual needs of women*: "Lengths of stay have increased, which is a benefit to women with multiple issues."*
- Provision of practical supports: *"We offer our clients additional supports like bus tickets and childcare to assist them in accessing our treatment services. "*
- Community education about addiction, and advocacy for individuals: *"Advocacy for women, especially with CAS, especially with respect to methadone maintenance has made a difference in perception, attitude, and behaviour of CAS staff and their expectations regarding women on methadone maintenance"*

Respondents also noted the important impacts of strengthening working relationships with other services:

- Numerous linkages have been forged with services for pregnant and parenting women, many as a result of ECD Addictions programs. Linkages include Child Welfare agencies, Early Years Centres and maternity homes*: "Partnership in the ECD [Addictions} program is allowing engagement of women who ordinarily wouldn't approach mainstream services."*
- Strong partnerships with community agencies have allowed substance abuse treatment agencies to influence allied sector practices and increase their core competencies related to substance misuse: *"Cross training with other women's services has paid big dividends in ongoing client care."*
- Knowledge exchange with allied sectors:"*We provide Professional Development to allied sectors in the area of women and addictions, including women and problem gambling. We also receive Professional Development workshops from allied sectors for staff and clients on a variety of topics. We have to be creative since we don't have funding for expensive Professional Development opportunities."*
- Service agreements with other addiction agencies have supported seamless models of care: *"Partnering with community withdrawal management program to link women to services seamlessly after community withdrawal".*
- Linkages with community services for trauma, sexual assault, and violence have helped to improve care and to build coordinated and congruent community responses.
- Cultural awareness has improved through collaboration with other services: *"Collaboration with aboriginal agencies has allowed program to incorporate some culturally appropriate practices (e.g. healing circle, smudge room on site)"*
- Linkages with hospital sponsors help to expand the range of services in key areas: *"Eating disorders program helps with dietary or nutritional stabilization as well as treatment issues"*
- Community networks engage service providers across sectors in working together: *"Shared/joint training programs with other agencies"*

- Operational practices are strengthened: *"Information sharing and working collaboratively with other agencies around Human Resources policies/procedures/challenges"*

Respondents cited successes in implementing gender-specific programming and increasing the gender-appropriateness of programs and services:

- Development of restricted women's services: *"Before implementation [of a separate women's program] we had very few women accessing our co-ed service. We now have a waiting list of 7 months for a bed and wish for more funding."*
- Development of gender-specific innovative program components for women: *"Our EMPOWER program is a lecture/workshop series available to both clients and women from our community. This program has been hugely successful and keeps evolving to respond to the changing needs of contemporary women."*
- Specialized groups and programs, often in partnership with community agencies, to support women by addressing specific issues such as trauma, sexual assault.
- Specialized groups for women who have co-occurring mental health problems: *"We provide a long term program for women with Borderline Personality Disorder to build the skills needed for success in recovery."*
- Development of multi-functional service models and multi-disciplinary teams of front-line, management, and advisory group professionals that have the capacity to provide one-stop service for women and children.
- Wellness Programs for women, and prevention programs for children, offered in partnership with Community Health and/or Resource centres, as well as with other women-specific service providers.
- Programming for Lesbian, Gay, Bisexual, and Transexual populations: *"We are working to address issues of inclusive language and homophobia."*
- Strategies to maintain recommended gender balance in groups: *"We offer individual or next session of group if insufficient number of women for any given group."*
- Trauma-informed programming and use of screening tools to identify trauma and Post Traumatic Stress Disorders.
- Treatment components that incorporate effective approaches for women: strengths-based approaches (helping women to focus on the positive things in their lives, supporting practical skills); relational work, couples therapy group, family therapy group; and family programming for family members of women in treatment

Numerous innovations were reported in services for pregnant and parenting women and children, largely generated by, or connected with, ECD Addictions funding:

- On-site childcare: *"Childcare is provided by one program for women who want to attend 12-step meeting. Drop-in childcare is offered day and evening – the response has been overwhelming."*
- Priority admission for pregnant women: *"Our residential treatment facility has 2 beds designated for pregnant and parenting women."*

- Programming that addresses family issues: *"We have developed a Family Weekend in Recovery Program for families with one or more family members in recovery, ages 7 yrs. and older."*
- Home visiting services for women: *"We have a Pregnancy/ Parenting Outreach Program for substance using women parenting ages 0-7, offering home visits, assessments, harm reduction to abstinence treatment goals, parenting programs."*
- Development of home-like spaces in residential programs for mother-child visits
- Programming and services for children: *"We have a Drug Abuse Prevention Program for children (8-12 years) as well as a Play Therapy Program for children (3-7 years)."*

A few very promising examples of approaches to enhance capacity to serve women with co-occurring mental health issues were provided:

- Addition of mental health specialists to substance abuse treatment teams: *"Addition of a Community Crisis Outreach Clinician to assist in connecting clients with appropriate mental health services and supports, including psychiatric assessments."*
- Co-service delivery models: *"Partnership with the CMHA to offer a program for clients with concurrent disorders"*
- Low threshold services for women at early stages of change: *"Implementing a one year pilot with the Crisis Unit of Ottawa Hospital to provide one bed for women with Concurrent Disorders for short term stabilization."*

Respondents also reported gains in the capacity of residential substance abuse treatment services to implement some harm reduction approaches:

- More flexible medication guidelines: *"Biggest leap has been to bring women who are using methadone into the residential program"*
- More flexible relapse policies and acceptance of methadone: *"We have grown increasingly flexible in our provision of services to women, including expanding our relapse policy to include several allowable relapses; allowing for Methadone using client in residence… We have been able to do so with positive support from staff members."*

Respondents also cited operational practices that support best practices principles within organizations:

- Empowering and non-hierarchical practices in residential programs.
- Inclusion of clients and staff in annual program review and planning activities: *"Annual meeting between CEO and residents to review the program. Annual meeting between CEO and team staff to review operational/service plan with team and project plans for the coming year."*
- Staffing changes to allow for female night staff. (2)
- Upgrades to the security system to increase safety for clients and female staff.

Creative approaches to obtaining resources for implementation of best practices were also identified:

- Research involvement through partnerships: *"A partnership with a Northern Medical School and local hospitals will assess what effect programs are having on a number of dimensions. The project will include pre and post testing re: depression, affect, changes in self esteem, coping sills, and cognitive distortions."*
- Links with medical institutions: *"Student placements from an area medical school are helping the next generation of physicians to have a better understanding of addictions."*
- *"Successful fundraising to be able to provide services the ministry does not fund"*
- Efforts to take advantage of free or low cost training opportunities, in the absence of adequate funds for staff training.

5. Innovations in Other Jurisdictions

The literature search conducted as part of the project identified several examples of innovative strategies and program models from jurisdictions outside Ontario that may have application in the Ontario system. The full literature review is provided in Appendix K, however the following provides a sample of key strategies and models utilized in other jurisdictions to reduce barriers to access, engage women in treatment, and improve outcomes for different populations of women.

Services that provide "enhanced programming" for women have been found to increase retention and improve outcomes compared to "standard programs". Enhanced programs have the following characteristics:

- Gender-specific/ women-only admissions, women-only groups, and women's program/services.
- Facilitated access to services such as prenatal care, childcare, mental health services and workshops/education that address women-focused topics such as parenting, sexuality, self esteem, assertiveness.

Successful program models for pregnant and parenting women who are using substances emphasize outreach, and intensive case management/mentoring to support women and link them to wrap-around services in the context of a harm reduction and stages of change framework. Examples include:

- *Stop FAS* in Manitoba: a home visiting/mentoring program that provides extensive assistance and emotional support to help women identify personal goals, stay in recovery, choose a family planning method, get child health care and immunizations, connect with community services, get transportation to appointments, address housing, domestic violence and child custody problems and overcome barriers to service.
- *Kids First* in Saskatchewan: designed to help parents be the best parents they can be and have the healthiest children possible. This program offers support through a home visitor who provides assistance in the areas of child development, parenting, and connecting to the community and accessing services.
- *Enhanced Services for Women* (ESW) in Alberta: emphasizes recognition of the complexity of women's lives, outreach, case management, harm reduction,

linking clients to addictions services and other community supports and building a relationship with clients by making accessibility a first priority.

- *Sheway* in BC: a partnership initiative that provides a single point of access to a comprehensive range of health and social services through both outreach and drop in to mothers and their infant children.

Similar best practice approaches to reducing barriers and engaging older adults in treatment are employed by age-specific model programs in Ontario, as well as those in other provinces:

- Outreach/home visiting.
- Individualized support and case management to link with needed services.
- Harm reduction.
- Treatment and support that addresses lifestyle, social context, personal concerns and health issues and creates a social support network.

Innovative program models in both Canada and other countries for women living in vulnerable circumstances include:

- Specific days or times restricted to women with gender-responsive program elements in the context of co-ed, low threshold, and drop-in services.
- A full range of low-threshold services for women who have long-term substance use problems and may also be homeless and/or engaged in sex trade work. Services include an outreach bus, low-threshold service/day care through a women's café, counselling, methadone, support for workforce reintegration and some housing support.
- Though not gender specific, a shelter that provides an onsite methadone clinic, and has an accessible and cooperative pharmacy, flexible attendance requirements, an open and responsive attitude, and acceptance of harm reduction goals that do not require abstinence from illegal drugs.

Curricula and program manuals that address integration of relational issues and the experience of trauma as core issues in women's treatment:

- Stephanie Covington (1999, 2003) has published two curricula: *Helping Women Recover* which integrates a multidimensional framework for understanding addiction, a theory of psychological development based on connection as the guiding principle of growth for women, and an understanding of the connection between addiction and trauma. She has also developed *Beyond Trauma* which is complementary to *Helping Women Recover*, and builds on and expands trauma work.
- Lisa Najavits (2002) has published: *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* which was initially developed and tested with women. Seeking Safety treatment covers 25 topics divided among cognitive, behavioural, and interpersonal domains - each addressing a safety coping skill.
- Program models that address the interconnections between substance use, mental health issues, and the experience of violence:
- Women, Co-Occurring Disorders and Violence Study – SAMHSA in the US has provided funding to 14 sites for the development and evaluation of integrated services system strategies for women with concurrent substance use and mental

health issues who are also victims of violence. The study is now in its second phase and includes 4 study sites with interventions for children designed to reduce or prevent the intergenerational perpetuation of violence and mental health and substance use problems, and to reduce the impact of violence in the lives of children whose mothers have concurrent disorders. The project has produced a variety of different program models and numerous innovations such as a curriculum for families affected by concurrent disorders and violence, and a peer run drop-in centre for women in recovery from violence and concurrent disorders, as well as a website with information on different program models/curricula.

- Innovative program models are being developed in BC. Examples include partnership models such as *Willow WAI*, a four agency partnership to meet the needs of women "at the intersection of homelessness, sex trade work, addictions and violence" and Victoria Women's Sexual Assault Centre that collaborates with the Vancouver Island Health Authority and five community-based women's agencies to offer "Seeking Safety". The Battered Women's Support Services in Vancouver, which offers groups using both Seeking Safety and the Trauma Recovery and Empowerment Model (TREM), while the Pacifica Treatment Centre, also in Vancouver, offers "Continuing the Journey" groups as part of aftercare.

6. Challenges in Implementing Best Practices

This section of the report provides a summary of eight challenges identified by survey respondents, key informants, and other stakeholders. Detailed input from these groups is provided in Appendices G (Survey of Agency Practices Data), H (Summary of Key Informant Input), and J (Summary of Network Consultations).

System level challenges in providing access to timely and appropriate services were identified. These included a number of critical issues related to the current continuum of services:

- Wait times for initial assessment and treatment planning present substantial barriers to engagement.
- Lack of practical supports (e.g. transportation and childcare) creates barriers to services, particularly for marginalized populations of women.
- Lack of system capacity results in lengthy wait times for all categories of services.
- Lack of specialized options for diverse populations of women can further disenfranchise women who area already marginalized.
- Gaps in gender-restricted services, particularly stabilization, supportive residential, and withdrawal management services, create challenges in providing continuity of service.
- Residential services that women can access with their children are virtually non-existent.
- Residential gender-specific concurrent disorders services are lacking for women who require high support or specialized Medical/Psychiatric services.

- Concurrent disorders capacity is generally lacking across service types.
- Limited options for pregnant and parenting women, in spite of inroads made by ECD Addictions programs.

At the program level, respondents and key informants widely noted that, in many agencies, current base funding levels provide limited opportunities to implement best practices. Funding constraints over a period of several years have left some agencies hard pressed to sustain existing 'core' services. Although many agencies are well aware of areas where their 'core' services and practices are not in line with best practices, they lack the resources required to make the necessary changes.

Among the program-level challenges reported, **insufficient staffing** was seen as a critical barrier. Agencies reported that they need more staff to provide timely access to the full range of services and supports identified in the *Guidelines*. Higher compensation levels are also required to attract and retain staff with the necessary skills and competencies. Increased numbers of staff and enhanced levels of staff expertise are needed to:

- Build capacity to meet demands for services in a timely manner.
- Develop service relationships, partnerships, and knowledge exchange mechanisms with other allied sector agencies.
- Meet guidelines and ministry expectations for documentation, record keeping, data entry, monitoring, and evaluation.

Development of **gender-specific service components** requires resources for staff and service development. Currently, agencies struggle to:

- Provide accessible service options (through outreach, extended service hours, satellite offices, etc.).
- Enhance individual supports for women (such as case management, individual counselling, advocacy, and pre/post treatment support).
- Offer more flexible program options in fixed-cycle programs.
- Meet the support needs of women with complex treatment issues (such as co-occurring mental health issues) in residential services.
- Develop and deliver specialized programming for pregnant women, parenting women, and their children, in *all* service categories.
- Develop and deliver gender-specific and specialized program components (such as women-only sessions or specialized groups) and ensure access to female staff in co-ed services.

Constraints imposed by **physical facilities** present multiple challenges related to best practices. Respondents and key informants reported that:

- In both residential and non-residential services, additional space is needed to deliver various types of program components identified in the *Guidelines*.
- Site maintenance and minor capital grants are required for repair and retrofit of physical facilities to meet guidelines for safe, comfortable spaces for women's services.
- Some co-ed services require additional space or retrofit of existing facilities to create safe, separate areas for women.

- Some services lack the necessary safety features (e.g. lighting, security systems)
- In many residential services (restricted and co-ed) space for mother-child visits is not available.
- All types and categories of services reported a need for space to provide childcare, children's programming, and mother-child programming.

Survey respondents and key informants also identified challenges in **developing links with allied services** – at the levels of both service provision for individual clients and inter-sectoral working relationships:

- Some communities lack access to competent, gender-appropriate psychiatric and other mental health services and/or specialist resources for trauma issues and eating disorders.
- Access to family physicians and medical care is very limited in some communities.
- Agencies in rural settings find it difficult to link with medical, mental health and methadone services.
- Establishing collaborative relationships with allied sector agencies (particularly Child Welfare) requires staff training, cross-sector protocols, and anti-stigma education.

Challenges in incorporating harm reduction approaches were widely identified in both residential and community treatment service categories:

- In some communities methadone is unavailable or difficult to access.
- In some addiction agencies, allied sector agencies, and communities, attitudes and philosophies create barriers to women's access to substitution therapies.
- Some stakeholders observed that the important role of abstinence-based residential programs in the continuum of services needs to be validated.
- It was also observed that women who require high support services that provide selective abstinence options (i.e. who are required to take some psychoactive medications, or who are not prepared to embrace an abstinence goal) should have improved access residential services, including low threshold options.

Lack of gender-appropriate approaches also arises from other factors:

- Some co-ed agencies report difficulty in attracting sufficient numbers of women to run women's groups or to ensure that co-ed groups have an appropriate balance of women clients.
- Some co-ed agencies take a 'generalist' approach to best practices, and do not recognize that gender differences result in substantial requirements at policy, procedure, and service levels.
- There is inadequate knowledge of the *Guidelines* in some agencies (at staff and/or governance levels).
- Adequate promotion and policy support is required to reinforce and entrench best practices for women.

7. System Functioning

The overall functioning of the system has a profound effect on the ability of agencies to implement best practices. An assessment of system functioning is obviously not within the mandate of this review, however a number of key points that impact directly on women's services are discussed in this section of the report.

7.1 Admission Policies for Women Taking Psychotropic Medications

Agency medication policies were discussed in relation to guidelines for addressing barriers and co-occurring mental health issues. As noted in those sections of the report, both residential and non-residential agencies in all categories of service place limits or exclusions on some types of medications.

Survey respondents indicated that many agencies are developing open and accessible admission policies for women who take psychotropic medications, within the bounds of agency expertise, philosophy, and resources. In spite of these efforts, medication continues to pose a barrier to treatment for some women. DART observed that, although there are now more programs that will consider accepting a woman who is taking psychotropic medications, many programs will only accept certain medications, and most will assess on a case by case basis.

Barriers arise, not just from exclusions on some types of medication, but also from restrictions (dosage, for example) placed on medications that are accepted by the agency. Consequently, women who need psychotropic medication on an on-going basis may find it very difficult to access the services they need. Women who are taking benzodiazepines or opioids may be particularly disadvantaged, since exclusions for these medications were reported to be prevalent. Access to residential services was also reported to be particularly difficult for older women, who are more likely (statistically) to be prescribed benzodiazepines.

7.2 Admission Policies for Women Receiving Methadone Maintenance Therapy

Agency admission policies for women who are involved in MMT were discussed in relation to guidelines for addressing barriers, co-occurring mental health issues, and pregnant and parenting women. As noted in those sections of the report, while methadone has gained recognition across the addictions sector as a legitimate treatment approach, that recognition does not necessarily guarantee accessible services. Respondents cited numerous barriers to methadone access and administration. Additionally, for some abstinence-based residential agencies, methadone is not consistent with the agency philosophy and approach.

DART data related to agency policies regarding methadone demonstrate both system strengths and areas for improvement. On the positive side, the vast majority of service categories report to DART that they accept methadone. Some agencies (36%) indicate in the DART data base that they accept methadone (36%), while others indicate that they accept and provide other additional services related to methadone (50%) such as arranging methadone therapy, detoxifying, and/or supporting the person to maintain methadone therapy. However, 14% across all service categories indicate in the DART data base that they either have no policy or do not accept clients on methadone. Of

particular concern, 11% of services in the Initial Assessment and Treatment Planning category either have no policy or do not accept clients on methadone. This may present a significant barrier to engagement with the treatment system for women already prescribed methadone or who would be appropriate candidates for MMT.

DART data also identifies restrictions related to the use of methadone. The most common restrictions relate to the need for individuals to be stabilized on methadone before being accepted by the service, referring to/consulting with the local methadone clinic or prescribing physician, the need for clients to make their own arrangements to obtain their daily methadone from the pharmacist or methadone clinic, and the lack of appropriate storage facilities for methadone on-site. Several services specified that they would only accept clients on a low dosage of methadone and/or specified the maximum dosage levels acceptable. This would appear contrary to the need to individualize dosage levels in response to the needs of the individual.

DART notes that a lack of medically supervised withdrawal is a major barrier. Options for medically supervised withdrawal management are extremely limited across the province.

- "*It is extremely difficult for people who need to be tapered off methadone to access support early in the tapering process. These clients have a difficult time getting help from the medical community and generally cannot access withdrawal management services until they are at an extremely low dose."*

7.3 Referral Patterns and Linkages with Adjunctive Services

Several survey questions explored the nature and extent of linkages made by agencies, particularly in respect to guidelines for addressing barriers to, and providing services for, pregnancy and parenting women. Although the types of linkages and levels of collaboration vary widely, survey and key informant responses indicate that many substance abuse treatment agencies are making considerable effort to form collaborative relationships. Despite that, the connections that respondents cited with allied sector agencies were not much in evidence in findings from CATALYST data that was provided by DATIS.

DATIS provided reports of the top 5 referral sources and the top 5 types of referrals made by the agencies that consented to act as key informants. Looking at this group and this 'layer' of referral patterns as a sample, data for the top 5 referral sources were much as would be expected for the categories of services provided. For both community and withdrawal management services:

- Referral sources most commonly cited were self or family.
- Of allied services that refer, medical and health care services were more commonly identified as referral agents than other allied service providers.

For residential treatment and residential supportive treatment:

- Referral sources most commonly cited were assessment/referral agencies and withdrawal management services, and self.
- Medical and health care services were more commonly cited than family.
- Referrals from allied services were relatively rare.

Findings related to the top 5 types of referrals made during or after treatment were somewhat less predictable. Data showed that most (18 of 23) agencies reported *no* referrals made for the majority of clients who have been discharged and, in some cases, for 'open admissions' (clients who are still receiving services). Of the relatively small number of referrals reported to CATALYST, referrals were most commonly reported to other addiction treatment services and self-help programs. Some referrals were reported to other sector services, including physicians and medical services, mental health services, and allied sector and social services.

It is striking that, while agencies consistently report that they serve a population with complex and multiple needs, few referrals were reported to CATALYST. The apparent lack of referrals is even more puzzling, given the considerable emphasis placed on collaborative service relationships and service linkages by the majority of key informants. It should be noted that mandatory fields in CATALYST require that agencies note either 'no referral' or that they note at least one referral. It has been speculated that the lack of reported referral is just that – a lack of reporting on the part of agencies, rather than a lack of actual referrals. While this may well be the case, there is no way to substantiate and analyse the nature of referral activity if data has not been input to the CATALYST system.

7.4 Diversity and Equity Issues

As noted in *Best Practices in Action*, additional work is required to identify best practices for addressing the varied needs of diverse populations. Since relevant guidelines have not been yet developed, it was not possible to assess system adherence to best practices in this area. However, a few observations can be offered.

Additional service development is required to meet the needs of diverse populations. While some respondents reported efforts to provide services that meet the needs of specific populations (e.g. Aboriginal women, older women, Francophone women, homeless and marginalized women), it appears that there are few such specialized services. That deficit can be attributed, at least in part, to a lack of funding to develop new service components. At the same time, however, some addictions agencies have made inroads in linking with grass-roots organizations that work directly with diverse populations to increase cultural competency and begin to address barriers.

It appears that some agencies lack understanding and appreciation of the impact of diversity on women's experience. For example, one respondent observed that the community in which the service is located has little diversity because people are primarily Caucasian and English-speaking. That narrow view of diversity will inevitably create barriers for women whose diversity takes a different form (e.g. women who have disabilities).

7.5 Wait Times and System Capacity

By all accounts, wait times resulting from inadequate system capacity represent one of the most substantial barriers to implementing best practices in the women's treatment system. One key informant posed a critical question:

- *"Waiting times and system capacity were not mentioned in the best practices guidelines, yet they have a huge impact on the quality of services. Even if services*

are excellent, if only 50% of women can access the treatment they need how can the system be compliant with best practices?"

Best Practices in Action provides comprehensive *Guidelines* at the level of individual programs and services; however it does not offer provincial benchmarks for access, capacity, and other system issues that form the context in which services are delivered by agencies.

The *Guidelines* do address the need to facilitate access to treatment, to reduce barriers, and to be responsive to women at all stages of change. Data provided by DART call into serious question the system's ability to support these best practices, given the lengthy wait times that currently exist for a number of service categories, particularly in some LHIN areas. Wait times for categories of services shown in Appendix I vary widely across LHIN areas. For example, wait times for Initial Assessment/Treatment planning, averaged over a 7 month period, range from a low of 7.6 days in one LHIN area to a high of 53 days in another.

DART notes that wait times for assessment and treatment planning, in particular, have serious impacts on both the client and on other components of the treatment system:

- *"The wait for assessment services is very disheartening for clients who would benefit with some sort of contact shortly after making the decision to seek treatment. Requiring individuals who have dependency issues to wait several months for initial assessment is almost guaranteed to discourage them from pursuing treatment. It is close to impossible for someone who is homeless and living in a shelter or living in an unsupportive environment to stay the course for several months."*

Key informants supported this view:

- *"We try to be flexible and innovative. It becomes very frustrating when you have a women motivated to make changes and there is a long wait to treatment date and/or out-patient counselling. Often plans made are not the best."*
- *"Lack of resources has created a 3 ½month wait list so we cannot respond well to women requesting service. Significant attrition is occurring as a result of the wait. More resources would allow more immediate service."*

DART reports that wait times for assessment also put additional pressures on other service providers:

- *"Many clients are resorting to using withdrawal management services in order to have their assessments done faster. The impact on these wait times is putting added strain on withdrawal management services who are having to handle difficult withdrawal needs along with clients who want to access treatment faster by foregoing a two month wait for assessment to go for a three day stay in WMS."*

Over the same 7-month time span, wait time averages for other categories of service included: between 10.6 and 130.8 days for co-ed community day/evening treatment; between 8 and 70 days for restricted residential treatment; and between 4.3 and 214 days for co-ed residential treatment. While some of these wait times are extremely distressing in and of themselves, it must be remembered that wait times may be compounded when women are referred from one service to another; for example, a woman may wait for several days for access to initial assessment and treatment

planning and, once treatment planning identifies a further step, she is likely to experience a further wait for a treatment space or bed.

Lengthy wait times and lack of system responsiveness in the treatment system can undermine fragile motivation and result in ongoing substance abuse, which is likely to create escalating health impacts and other risks of harms. For women reluctant to seek treatment because of stigma, lack of support from significant others, or fear that their children will be taken into care, an extended wait time may serve as one more significant barrier to access. This may be particularly true for women who are living with a partner who has introduced them to, and helps to maintain, their substance use and for women living in other high risk situations, such as domestic violence, where an immediate response can be crucial.

Though pregnant women may have priority access to treatment in some services, those who are unable to reduce or stop their substance use while waiting for assessment and/or treatment risk further damage to their health and to the health of the fetus. This situation becomes even more critical for women who are reluctant to reveal their pregnancy for fear that their newborn may be seized; these women may wait even longer to seek treatment.

Best practices emphasize the importance of early engagement and system responsiveness, but the provincial service system is straining to provide an adequate level of service. Many programs report that they do not have the resources necessary to support women on waiting lists through supportive phone calls, drop-in groups, or other strategies, while they wait for initial assessment and/or treatment. Though some services have attempted to address wait times (by introducing group assessments, pre-treatment groups and/or continuous program entry), these mechanisms are not viable for all agencies within existing funding, nor are they necessarily recognized, by all programs, as steps toward implementing best practices.

Lack of capacity in the substance abuse system also results in gaps in some categories of service. As noted earlier in this report, while gaps in gender-appropriate services were reported across the continuum of services, restricted residential withdrawal management, stabilization, supportive housing, and services for pregnant and parenting women are in particularly short supply. Lack of some services frustrates agency efforts to refer women to appropriate types and levels of services; for example:

- *"Childcare is often a barrier that must be considered in the Treatment Planning; a woman may require residential treatment, however childcare responsibilities may result in outpatient referral only."*

DART notes that the lack stabilization beds impacts upon other service providers, as well as on women who are in need of services:

- *"There would appear to be a huge need for residential supportive beds, particularly for women who are waiting for treatment. Having a few more of these facilities would take pressure off the withdrawal management beds and would allow vulnerable clients a better chance at sobriety."*

Key informants also noted impacts of the lack of capacity on sector relationships:

- *"Lack of service capacity in the system sets up conflicts and tensions between different service partners. Providers are often asked to deal with what clients have not received somewhere else (e.g. stabilization)."*

Lack of specialized services was also reported to be a barrier for women who have co-occurring mental health issues, women who require ongoing use of psychoactive medications, and women who have experienced trauma.

Service gaps in specific communities are addressed, in part, by residential services that have provincial catchment areas and are mandated to provide services for women across the province; however, some glaring gaps exist in local services:

- *"Some communities and LHIN areas do not have ANY stabilization services or restricted residential services."*
- *"The closest withdrawal management facility is 3 hours away (250 kms); the closest women's focused residential treatment centre is 7 hours (650 kms) away."*

7.6 The potential Impact of Health Care System Restructuring

Of the respondents who commented on the potential impacts of health care restructuring, most expressed concerns that the inception of LHINs will further erode resources in a system that they see as already inadequately supported. In the substance abuse treatment sector, a number of residential programs have historically fulfilled a provincial service role, typically accepting clients from across the province. Stakeholders expressed real concerns that access to services across LHIN areas will be jeopardized if LHINs fail to appreciate the importance of provincial services in maintaining a continuum of addiction services.

- *"The political focus of LHINs on local services threatens access for clients to specialized programs that serve the province."*
- *"I'm concerned that women's residential programs with a provincial mandate will lose the capacity to accept women from all over the province."*

Stakeholders are also concerned about the impact of LHIN boundaries on hard-won service relationships.

- *"LHINs are chopping up the province and have the potential to really interfere with long standing partnerships and linkages in the interest of so-called efficiencies."*
- *"LHIN boundaries carve up natural service areas and threaten service alliances."*

Finally, concerns were expressed about whether LHINs will understand the importance of substance abuse treatment services in health care, and hence, fail to provide the resources to maintain core services and support best practices:

- *"I have concerns that addictions will get lost among or lose funding supports in highly politicalized local service scenarios."*
- *"It's really important that, as an 'industry', addiction treatment has been the poor stepchild of mental health and that poor begging identity has become our identity. We need to market addictions as a health issue … It shouldn't be mental health and addictions, but addictions and mental health."*

8. Resource and Support Needs

Funding

As noted in Section 5, funding was identified as the critical resource by the vast majority of survey respondents and key informants. Primary needs for fiscal resources are reported in several areas, as noted in the following subsections. A number of respondents identified a need for dedicated funding for separate women's programs. Respondents also emphasize the need for system-level funding to adequately resource the whole system, build capacity to address wait lists, and fill service gaps.

Staffing and Infrastructure

Survey respondents, key informants, and other stakeholders all identified a need for increased staffing to deliver best practice-based, gender-specific services. Implementing best practices requires time and resources for program development and sufficient staff to deliver services such as women-only groups, access to female counsellors, childcare, parenting and child programming. Agencies are struggling to provide those services with their existing staff complement. Even if the *number* of FTEs was adequate, more appropriate salary levels are also needed to support retention and hiring of appropriately *skilled* direct service staff. Needs for non-service staff were also noted – a lack of adequate supervisory and management infrastructure can undermine the ability of agencies to deliver and develop services:

- *"Current resources do not allow time for innovation and program development. Every hour that we take away from direct service for program innovation adds stress for staff that's already stressed."*
- *"Funding to hire more (female) staff will allow more women's groups and one to one with female counsellors."*
- *"Too much time is required by management to deal with chronic staff turnover (due to poor levels of compensation)."*

Respondents emphasized that there is a need for adequate overall funding to meet basic demands for services:

- *"We need funding for additional staff – clients are waiting 6-8 weeks for their first appointment and according to Best Practices, we should be seeing clients in a more timely manner."*
- *"Our wait list could be eliminated with 2 FTE's for community support/case management."*

Facility and Program Space

Resources are needed to implement best practice guidelines for physical space. Respondents and key informants identified the need to develop or expand space for women's programming, mother-child visits, and children's programming, including retrofits to physical plants and increased functional space. Some agencies noted that resource constraints have prevented them from offering gender-specific programming or flexible length of stay. Lack of funding for basic safety features like adequate lighting and security/surveillance systems mean that some agencies cannot meet guidelines for safety.

- *"We are limited in space and therefore we cannot keep a client for an extended period of time. We attempt to be as flexible as possible depending on the case*
- *"We're very proud of our residence for women but lack space (can't have family room, lounge, child visits, don't have space to accommodate women and children) and we desperately need more treatment space."*
- *"We need double the space we have. We need individual rooms and there is no place for women to have visits with children."*

Reduction of Barriers

Respondents identified supports required to engage women with multiple and complex needs:

- *"Reduce barriers to access – clients are increasingly complex with multiple needs. Transportation issues generally are enormous, including lack of safe transportation alternatives in rural areas."*
- *"With current resources, we cannot meet the increasingly complex needs of clients who have interconnected medical, psychological, trauma-based issues."*
- *"Women's lives are very busy and this is not often recognized within traditional addiction treatment. Women's programs need to be modular so they are more flexible. Women should be offered flexible appointment times and access to care (especially the addiction treatment programs that penalize clients for missing a session)."*

Agencies also struggle to adequately serve specific populations of women within existing funding:

- *"We would be better able to meet the needs of marginalized women if funding were increased for staffing and resources required to provide [services]."*
- *"We are limited in resources to provide specialized services, especially to pregnant women or women with children. "*

Services for Pregnant and Parenting Women and Their Children

Women who are pregnant, and who have children, have been historically under-served by the addictions system. Funding for ECD Addictions programs is identified as a particularly pressing issue – respondents noted that existing ECD Addictions funding needs to be secured for existing sponsors and extended to more agencies to expand the availability of specialized services for pregnant and parenting women.

Survey results revealed substantial gaps in service for this population. Most respondents noted a lack of necessary staffing and space to ensure adequate service access for pregnant and parenting women and their children:

- *"Although we have an ECD program associated with our residential program, it provides childcare only during the day and is only for women involved in ECD programming; in addition, children over 6 years old can't come. At the very least, we would like to be able to offer drop-in childcare while AA and NA meetings are occurring."*
- *"More flexibility in the program to address issues for pregnant and parenting women – currently our program is very highly structured and can't adequately accommodate mothers with children."*

- *"Funding for childcare is obviously a critical need. But especially the physical plant issues for having children on-site are huge. We've hired childcare providers in the past but the space is really inadequate."*
- *"We need to retrofit the layout of our facility to make room for women's space, childcare, parenting, children's programming, child visits, and to allow women to attend community treatment."*

Development and Delivery of Gender-Appropriate Services

Implementation of current and emerging best practices requires sufficient staff numbers to provide gender-specific (specialized and restricted) core programming and to ensure availability of female staff for work with women. Resources are also required to adequately compensate staff with the skills and expertise to work with complex clinical issues, such as trauma.

- *"We need to offer groups that are gender specific so that they're not all generic – we do it here because it's a need and identified in goals and objectives, but don't have the funding to do it properly and consistently."*
- *"We need to be able to provide all female counsellors for women."*
- *"We need to increase our ability to work with trauma, it's such a key issue for women, but we need time, information, and resources."*
- *"We don't have adequate staffing for female staff on site during every shift."*

Training and Information Resources

While many staff in many agencies are reported to have knowledge of women's issues and appropriate approaches, *Best Practices in Action* offers an extensive and complex set of guidelines; some staff require additional knowledge and skills to meet those guidelines. Additionally, since best practices continue to emerge and to be refined, professional development must be an ongoing process that receives continuing support through training, access to information, and skilled clinical supervision.

Training needs were identified by respondents, key informants, and other stakeholders, including specific needs for clinical training in the following areas:

- Women's treatment issues
- Women-focused approaches
- Specific modalities, such as harm reduction, CBT
- Concurrent disorders
- Trauma work
- Eating disorders
- Cross-cultural and culture-specific approaches
- Cross-sector training and knowledge exchange, particularly with child welfare systems

Respondents noted that, since most agencies have, at best, modest training budgets, there is a need for low cost or no cost training. Even when training is available, resources are required to provide coverage for staff to attend training.

Developing connections for cross-training with allied sectors also requires staff time.

- *"We are already partnering but our staff require more training and there is the difficulty in finding staff time to do the required cross district networking."*

Respondents reported that cross-sector training often results in numerous benefits – beyond the primary goal of enhancing expertise, cross-sector training can help to generate mutual understanding and respect between workers, reduce the stigma associated with substance abuse, break down barriers between sectors, and serve as a platform for building partnerships.

Program materials appropriate for women and information related to clinical issues (trauma, concurrent disorders) were identified as additional resource requirements.

Advocacy and Practical Supports

Women are marginalized by a number of factors, most of which are beyond the control of substance abuse agencies. However, many respondents reported needs for funding to assist women with practical supports such as transportation and childcare; a few also noted the need for assistance with health care costs (e.g. dentistry and prescription drugs – including methadone). Some agencies are providing that assistance with fundraised dollars. At best, however, this is an unstable and uncertain funding source:

- *"We have to raise our own funds for bus tickets – either through fundraising or grants, but it's tough and a lot of work to keep this up."*

Respondents reported that many of their staff advocate on behalf of clients to help connect them with the supports and services they need. They note, however, that additional resources are required to maintain and increase staff time for this activity.

Increasing support for women's access to basic services will require inter-ministerial negotiation. Respondents identified the following requirements;

- Provision of Personal Needs Allowance (PNA) for all women who meet PNA criteria.
- Policy changes to allow substance dependent women to be eligible for Ontario Disability Support (ODSP).
- Changes to regulations in Ontario Works that create barriers for women who participate in residential treatment.

Collaboration Mechanisms

Respondents emphasized the need for system-to-system collaboration with mental health, child welfare, child oriented service sectors, and services for pregnant women. They also noted the importance of linkages with allied community partners (such as women's shelters, trauma-based services, social service agencies, etc.). Development of mechanisms for agency-to-agency and cross-sector collaboration requires an investment of staff time for meetings, networking, and development of working relationships, as well as funding for travel, joint training events and forums. While cross-sector collaboration often arises from grass-roots efforts, validation and guidance from funders for such activities is extremely important.

Respondents also noted specific needs for mechanisms to assist addiction agencies in working together:

- *"A provincial meeting/ training to hear what other agencies have experienced and innovative measures they have taken."*
- *"Clients being able to move through services they individually need without having to fit into "boxes" created by programming procedures developed by individual addictions programs."*
- *"More opportunities for service providers to collaborate over a few days in structured sessions where we could share our frustrations and successes. Learn from each other and network on how to make the most out of our individual resources."*

Service Continuum

Respondents emphasized the need for increased funding to build additional capacity in the overall service continuum. Specific gaps in gender-specific services include: stabilization and supportive housing services for women; outreach and off-site services; services for pregnant women; services for parenting women and children; and improved availability of methadone. A need for base funding for trauma-informed and concurrent disorders-informed services was also noted.

- *"We need training and buy-in of the need for outreach services."*
- *"Establishment of a safe house for women suffering from trauma issues to work through their issues in a safe place under supervision. A shelter for homeless women in our region."*
- *"There is no support residential level II for francophone women in all Ontario."*

System-level Issues

Survey respondents identified a variety of system-level issues. Primary concerns focused on the lack of support for the addictions system – and for women's addiction services in particular – with respect to both funding and policy. Many respondents described a need for system-level support for collaboration among addictions agencies and with allied service systems. Others noted a need for program evaluation models, external mechanisms for monitoring compliance, and mechanisms to collect and share standardized data. Five common themes emerged:

1. Lack of Funding for the System as a Whole

- *"Best practices for women needs to be incorporated into the LHINs planning and proposal development; funding flowing from proposals."*
- *"Recognize the complexity of clients we serve and their vast array of needs - primary health care, psychiatric care, parenting, childcare, etc. and resources required to address all of this."*
- *"Integration of addictions and mental health services with primary care, across the lifespan, is a system prerequisite . . . and it ain't going to happen until there are sufficient staff to carry good practice forward to all clients -- and women -- in need.."*

2. Lack of Funding for Women's Services

- *"Additional funding needs to be provided to agencies serving women to enable us to achieve best practices guidelines and standards."*
- *"Provision of mental health services, specifically for the addictions field. Equality of funding for women's addiction programs."*
- *"Funding for research in the area of women-specific research for addictions."*
- *"Annualized funding of the ECD programs for pregnant and parenting women."*

3. Ministry Support for, and Recognition of, Best Practices

- *"A clear commitment from the ministry that best practices are essential and, therefore, policies, funding and evaluations are focused on their implementation. Formal studies are conducted to gather data and develop materials based on women's treatment (as opposed to materials which currently exist which are based on data regarding men) Ensure that a review of agencies not following best practices takes place to ensure that women are not being harmed."*
- *"Have the Ministry support the initiative with resources, training and leadership."*
- *"Recognition of the need for courses/training/education to develop competencies in women's treatment (e.g. college courses/certificates)."*
- *"Link compliance with best practices for women to Operating Plans."*
- *"Funding to implement the best practices standards to ensure it is seen as a core health issue and not marginalized as a fringe player."*
- *"A dedicated provincial advisory group that would continue to produce good and best practice guidelines, maintain the profile of women's treatment service, and provide educational and mentoring opportunities to the field on providing best practices for women's treatment."*
- *"We need policies that reinforce/entrench best practices for women."*
- *"Broad community education regarding the best practices. Developing a template to overlay these best practices with other best practice documents for women's services in the areas of mental health and primary care would make the case stronger and facilitate interest and community uptake."*
- *"Standardized training that addresses treatment with women and is ongoing, with funding attached to send all staff."*

4. General Policy and Ministry Direction

- *"Sharing of resources across ministries (e.g. Federal Corrections treatment materials)."*
- *"That the Ministry mandate (through policy and funding) that mental health services to be available to the addictions sector."*
- *"An equalization of salaries across the ministry sectors to ensure specialized staffing in the addictions field."*
- *"Mandate flexibility/integration of children's & adult mental health, addiction services, and public health. Smoking cessation* [Tobacco Addiction Programs] *delivered through addiction services or agencies."*

5. Interagency and Intra-agency Collaboration

- *"More opportunities to dialogue with one another. More discussion of elements of service delivery such as assessment tools, MMT, adjunctive pharmacotherapies, treatment planning etc."*
- *"Even more collaboration with women/children serving programs....maybe to look at more 'under one roof' models."*
- *"Engage partners in conversation who are not all where you are, instead of treating them like 'other'; we need better, more respectful communication."*
- *"Increased coordination with community partners at the frontline level i.e. referrals, co-facilitate groups/services. Increased participation at system's tables to include agencies that provide other services, not only addiction service providers but also women's shelters, domestic violence programs, nurse practitioners, childcare services, etc."*
- *"Information training/conference for all addictions service providers and allied service providers."*

SECTION 3: CONCLUSIONS

Ontario's addiction system is undergoing profound shifts in its understanding of women's substance abuse issues. Approaches that, just a decade ago, were considered ground-breaking are now gaining currency among substance abuse treatment programs. These conceptual and cultural shifts provide a promising foundation on which to build a system that provides more accessible and appropriate services for women.

This review has identified six key areas in which the system is experiencing a 'sea change':

- Greater attention to women's treatment issues is evident in some survey responses. Many agencies reported changes that incorporate gender-appropriate elements, such as women-only groups and low-threshold engagement practices. Where such changes have not been made, respondents often expressed interest in providing more gender-appropriate services and frustration at the lack of resources required to do so.
- Many agencies have begun to acknowledge the inter-relationship of trauma and substance use and to understand the implications for treatment. The innovative models and solid levels of expertise cited by some agencies can serve as groundwork for 'mainstreaming' trauma-informed responses that are in all agencies across the addictions system.
- For women who have co-occurring mental health problems, many agencies are developing more inclusive admission criteria, seeking to build internal expertise, and working toward collaborative service relationships with mental health programs. These efforts are creating a greater range of options, particularly for women with 'mild' mental health problems. Further development will be needed to ensure that a similar range of services is available for women who have 'serious mental illness' and/or who take psychotropic medications.
- Methadone Maintenance Therapy (MMT) is gaining increased acceptance among residential programs as an essential treatment option for some women. Despite that increased willingness to adopt this approach, barriers to methadone access in some communities still undermine the availability of MMT in both residential and non-residential settings.
- The addictions sector, which has traditionally had a very low profile within the health care system and with allied sectors, is beginning to make itself and the needs of its clients better known. Collaborative relationships with allied sector services have become a common and rewarding practice for some substance abuse treatment agencies, and a work in progress for others. Agencies report that these relationships are 'paying big dividends' in seamless client care, stigma reduction, and improved clinical practices across sectors.
- Perhaps the most profound shift in the system can be seen in the impacts of Early Childhood Development (ECD) Addictions programs. The unique service needs of pregnant and parenting women, once all but 'invisible' in the treatment system, are recognized by an increasing number of agencies. Services designed to address those needs have become an essential part of the system landscape in areas where ECD Addictions programs operate. At the same time, those

programs have broken new ground in stigma reduction and the development of collaborative service models.

Four significant factors have been identified as contributing to those shifts in culture and facilitating the implementation of best practices:

- Small amounts of targeted funding (such as ECD Addictions funding) have catalyzed the development of new approaches in areas where significant change is required.
- MOHLTC interest in and support for emergent practices, such as MMT, has leveraged uptake.
- Leadership, often from agencies providing specialized services, has helped to profile the importance of, and need for best practices-based services for women.
- Funding to stabilize and regenerate core services in the addictions system has had a significant impact on practice, wherever it has been made available.

These factors, which in some cases have only affected a percentage of Ontario's addiction agencies, have the potential to catalyze change in the entire system – they can serve as strategies for supporting the implementation of best practices across all agencies.

Most of the agencies responding to the survey reported a commitment to best practices in almost all dimensions covered by the *Guidelines*. It must be noted, however, that stated commitments are not always actualized at the service, governance, or operational levels:

- Although women are relatively well represented on agency Boards and program Advisory Committees, a substantial number of agencies have not yet developed organizational missions, goals, and objectives that reflect the unique needs of women. Some do not understand the need to do so.
- Adherence to guidelines for hiring and staffing, clinical practice, and gender-specific programming is reported to be generally higher in gender-specific services than in co-ed services.
- Some co-ed services are struggling to achieve appropriate gender balance in mixed groups and some have difficulty providing easy access to female therapists for women clients.
- Although admission policies reflect increasing acceptance of a broader range of medications, exclusions or limits on certain medications still result in numerous barriers for women in both residential and community treatment services.
- While agencies report that they pay significant attention to linkages with adjunctive services for women, referral patterns reported to CATALYST show few referrals during or following treatment.
- There is little evidence that monitoring and evaluation processes, even where they are well developed, reflect best practices for women's treatment.

In some cases, disconnects between best practice guidelines and 'on the ground' practices are the result of system issues that are beyond the direct control of the affected agencies:

- A commitment to early engagement may be compromised by long wait times resulting from inadequate staffing.
- Willingness to work with people with concurrent disorders may be undermined by lack of access to the necessary mental health resources and expertise.
- Efforts to ensure that physical facilities provide a safe and separate space for female clients may be jeopardized by out-dated facilities and lack of funding.
- Staff commitment to providing childcare and children's programming may be thwarted by the inability of agencies to provide appropriate space, staffing, and programming.
- Efforts to improve access to services may by frustrated by inadequate public transportation and lack of resources for outreach.
- Staff who attempt to refer to other treatment services may find no appropriate options in the substance abuse service continuum; for example, DART reports that stabilization and supportive residential services are in particularly short supply.

Many survey respondents have developed innovative responses to the practical limitations and to the other constraints within which they operate. Numerous examples were cited of approaches and initiatives designed to increase program flexibility, provide practical supports, advocate for the rights of disenfranchised clients, and deliver services that are gender-appropriate.

It is notable that, where agency practices do reflect a commitment to the *Guidelines*, those practices have been achieved in a context of fiscal constraint – a remarkable accomplishment that stands as testimony to the commitment and dedication of the field. In several areas where additional work is needed to implement best practices, agencies clearly require additional funding to achieve adherence (e.g. for outreach and satellite offices, children's programming, specialized concurrent disorders services, services for pregnant and parenting women). However in other areas, particularly those related to policy and procedure, the necessary changes can be made within existing resources.

For the most part, survey responses revealed a system that is poised to embrace best practices in its work with women. There are however, a number of caveats surrounding that positive conclusion:

- Many of the stakeholders with whom we reviewed the results of the survey expressed a degree of surprise about the level of adherence reported in respect to some guidelines. They suggested that a variety of factors may have contributed to over-reporting of agency performance in specific areas. The lack of objective measures (such as benchmarks and universal definitions) was identified as one such factor. Since the survey relied entirely on self-report, we are unable to determine what effect, if any, that limitation may have had on survey data.
- The *Guidelines* do not adequately address diversity issues. As noted in *Best Practices in Action*, additional work is required to identify best practices for

addressing the varied needs of diverse populations. It is not possible to assess system adherence to best practices in this area when the relevant guidelines have not been yet developed.

- Most agencies reported reasonably good performance against most of the *guidelines* and some reported excellent compliance with all of the indicators. However it is clear that some agencies will require support and/or direction to meet even minimum requirements. This degree of variability in agency practices makes it difficult for clients to know how responsive services will be to their needs as women.

Despite these caveats, this review provided substantial and detailed baseline data about agency practices. Additional input from key informants proved invaluable in developing a comprehensive view of the system. It must not, however, be considered the final word on this important subject. We hope that the widespread distribution of *Best Practices in Action*, and the interest generated by this project, will provide the necessary momentum to ensure that agencies continue working to implement best practices in their work with women clients.

SECTION IV: RECOMMENDATIONS

Based on the foregoing conclusions, the consultants offer 54 recommendations which, when fully implemented, will assist agencies to meet the standards outlined in *Best Practices in Action.* Recommendations do not appear in order of priority, but have grouped in three sub-sections, according to the level and type of resources required for their implementation. Recommendations that can be achieved within existing resources or with small infusions of grant and/or targeted funding are provided in sub-section I. Recommendations will require system-level changes related to government/funder policy and practice are provided in sub-section II. Recommendations that will require a significant infusion of new funding are provided in sub-section III.

I: Recommendations for implementation with existing funding or with moderate levels of grant and/or targeted funding.

The following recommendations require adjustments to agency policy and practice, more creative use of existing tools and resources, and increased communication and collaboration, both within the substance abuse system, and between that system and allied service sectors. Some require moderate levels of grant and/or targeted funding for *full* implementation, but can still be *partially* addressed if funding is not made available. These recommendations are provided for both restricted and 'co-ed' agencies that provide any category of service for women (except where specific categories of service are referenced in the recommendation).

1) It is recommended that all agencies (including restricted, specialized, and co-ed agencies) conduct a thorough review of *Best Practices in Action*, with the understanding that the guidelines therein apply equally to all agencies, unless guidelines are explicitly identified as applicable only for specific program types or categories of service.

2) It is recommended that agencies re-examine all aspects of their services against the *Guidelines* and, where universal guidelines have mistakenly been considered as applicable only to certain program types or service categories, agencies ensure uptake of applicable guidelines including, but not limited to:
   - Mission, goals, and objectives.
   - Sexual harassment policies and procedures.
   - Education, training, and clinical support in respect to best practices for women's services for counselling staff.
   - Safety and confidentiality of physical setting.
   - Clear information about treatment choices, rights, and options.
   - Policies and procedures to ensure that all requests for service are considered and that admission criteria do not discriminate.

3) It is recommended that agencies utilize accessible tools (such as Health Canada's publication, *Best Practices in Action,* and literature resources cited in that document, and on-line information), and access the expertise of peer agencies to

develop a deeper understanding of the issues that provide a context for best practices.

4) It is recommended that existing knowledge exchange vehicles, such as the WAAN network, the ECD Addictions list serve, and other service provider groups should be used to explore opportunities for sharing information, building on existing innovative models, and forming mentoring relationships.

5) It is recommended that, where co-ed agencies have experienced difficulty in attracting sufficient numbers of women to provide women-only groups or gender balanced groups, they should ensure that gender-sensitive services are delivered and build visibility for those services in the local community by:

- Cultivating service relationships and seeking referrals from allied sector women's services in the local community.
- Initiating outreach services that will make the agency's services better known and more accessible to women.
- Seeking advice and mentoring from other co-ed agencies that have been successful in attracting women clients.

6) It is recommended that co-ed agencies provide, as part of their core services, gender-specific approaches and access to female staff – whether in groups, individual counselling, assessment, or treatment planning.

7) It is recommended that all agencies that provide any category or type of services for women work toward development of written policies to ensure sound and basic practices for pregnant and parenting women as outlined in best practices, including but not limited to:

- Priority admissions for pregnant women;
- Appropriate policies and practices for reporting of child protection issues and collaborative relationships with child protection agencies;
- Provision of methadone (or linkages for provision) for opioid-dependent pregnant women as soon as possible;
- Linkages for pregnant women to facilitate access to practical supports and enhance protective factors;
- Provision or facilitation of childcare and/or mother-child visits, where needed;
- Linking children affected by addiction with diagnostic services or programming;
- Linking all children whose mothers are substance-involved with appropriate community agencies; and
- Working with adjunctive services for pregnant and parenting women to develop co-ordinated or wrap-around service models that address the needs of this population in a holistic manner.

8) It is recommended that agencies providing assessment/referral and community treatment services develop approaches to reduce barriers for pregnant and parenting women through strategies such as:

- Provision of off site and/or co-located services.
- Provision of low threshold services.

- Flexible assessment, admission and intake processes.

9) It is recommended that all agencies seek opportunities to build competencies for providing appropriate services for diverse populations of women, including uptake of existing tools to improve awareness of diversity (such as tools provided by United Way).

10) It is recommended that all agencies closely examine their capacity to be more flexible in admission criteria, particularly in respect to policies for accepting women who are taking medications, have co-occurring mental health problems, or are receiving Methadone Maintenance Therapy.

11) It is recommended that all programs conscientiously and clearly report admission criteria (including criteria for accepting medications) to DART, to facilitate informed referrals and ensure that DART is able to provide clear information to callers.

12) It is recommended that closed cycle programs or groups examine options for providing more flexible service options through strategies such as continuous intake, telephone pre-treatment supports, and/or extended stay options, and that agencies which struggle with this issue seek out advice of agencies that have been successful in developing increased flexibility.

13) It is recommended that all agencies undertake training and clinical supervision to ensure that staff and services are 'trauma-informed' (including formal programming, individual counselling, assessment, treatment planning, and withdrawal management functions).

14) It is recommended that all agencies (in all service categories and types) provide gender-specific approaches as indicated by the *Guidelines* (e.g. provide accurate information about physical health aspects of substance use), whether group or individual counselling modalities are utilized to provide services.

15) It is recommended that agencies build on the numerous models of successful partnership and collaboration contained in this report, and that formal partnership agreements be developed wherever feasible.

16) It is recommended that agencies engage in formal and informal activities to reduce stigma through strategies such as:
    - Community education, speaking engagements, media tools to increase awareness of addiction as a health issue, participation on task forces.
    - ECD Addictions programs engage in stigma reduction for pregnant or parenting women.
    - Continued education and collaboration with Child Welfare agencies to effectively bring about solutions to issues faced by pregnant and parenting women with addictions.
    - Non-judgmental support for pregnant women in making decisions about pregnancy
    - Staff training, raising of awareness, and training in stigma reduction.

17) It is recommended that all agencies document the linkages provided for women, by providing full data to CATALYST about referrals that have been made during and following treatment.

18) It is recommended that all agencies utilize the guidelines provided by *Best Practices in Action* as a starting point for evaluation of agency practices and a method of self-monitoring implementation of best practices; that they seek collateral input from clients, referral agents, and community/allied sector agencies about the quality of their practices in respect to services for women; and that they document and report progress toward implementing best practices guidelines in their annual reporting process to the funder.

II: Recommendations Related to System Change

As indicated in the conclusions, funders (MOHLTC/LHINs) can leverage significant system change through adjustments in policy and communication of clear expectations to the field. The development of service benchmarks, training and leadership strategies, program evaluation tools, and a framework for ongoing monitoring and evaluation of best practices would signal the Ministry's commitment to ensuring that appropriate and accessible services for women are provided across the province.

19) It is recommended that the Ministry entrench best practices for women by articulating a clear commitment that best practices are essential and, therefore, policies, funding and accountability mechanisms support their implementation.

20) It is recommended that the Ministry re-issue *Best Practices in Action*, as a bound copy, with clear communication as to expectations for implementation.

21) It is recommended that Ministry/funder expectations for agency implementation of the *Guidelines* be supported by monitoring of adherence and requirement for action planning where adherence is not demonstrated, and provision of resources where required to implement specific guidelines.

22) It is recommended that annual agency reports be utilized as a mechanism for monitoring and reporting adherence to, and progress toward, implementation of best practices to funders, and that best practices guidelines be formally reflected in the goals and objectives of the annual operating plan (or performance contract) that is provided to the Ministry (or LHINs).

23) It is recommended that the Ministry make the Final Report of the Review of Women's Substance Abuse Treatment System in Ontario available to addiction treatment providers and to LHINs across Ontario, for their information and review.

24) It is recommended that the Ministry provide LHINs with comprehensive information about the nature, strengths, and needs of the women's service system, including the importance of best practices to ensure equitable and appropriate services.

25) It is recommended that the Ministry support access to an appropriate continuum of substance abuse treatment services for women in each LHIN area by:

d) Identifying the baseline level of services (including generic, specialized and restricted services) that should be available in, or accessible to, women in each LHIN area in order to meet best practices requirements for timely access to appropriate services;

e) Providing each LHIN with an analysis of the current availability of women's substance abuse treatment services that are either provided within the LHIN area or accessed through referral to another, specialized (e.g. restricted residential) program in another LHIN area; and

f) Advising LHINs as to the critical role of restricted and specialized residential women's programs in providing access to services for women in LHIN areas where a full continuum of services does not currently exist in the local system.

26) It is recommended that the Ministry develop a dedicated provincial advisory group to monitor new practice developments, ensure that Best Practices in Action is updated accordingly, and advise the Ministry in respect to implementation issues at the system level.

27) It is recommended that the Ministry develop benchmarks and definitions where needed, as identified within the report (e.g. benchmarks for wait times, staff credentials, case management, priority admissions of pregnant women; definitions of anti-stigma activities, advocacy, and integrated approaches to concurrent disorders services).

28) It is recommended that the Ministry further develop the *Guidelines* provided in *Best Practices in Action* to include guidelines for diverse populations of women.

29) It is recommended that the Ministry build on lessons learned from the success of the ECD Addictions initiative to develop similar models of partnership-based, coordinated, low-threshold services in respect to other marginalized populations.

30) It is recommended that one or more agencies with expertise in specific areas of best practices be identified and funded by the Ministry to provide provincial leadership and/or mentoring for implementation of best practices, generate system-wide expertise, and support dissemination of innovative models, promising practices, and lessons learned.

31) It is recommended that the Ministry work with other ministries and within relevant areas of the MOHLTC to:

a) Ensure harmonized government policies that support women who have substance abuse problems in accessing services needed to achieve wellness, stability, and positive health outcomes;

b) Utilize inter-ministerial committees to identify and reduce practical barriers for women who have substance abuse problems, change punitive or exclusionary policies and practices, and engender support for sector-to-sector collaboration at the funder level;

c) Build a clear understanding among allied sectors of the role and legitimacy of harm reduction strategies, where indicated, to support women's health, wellness, and recovery at varying stages of change.

32) It is recommended that the Ministry make available to substance abuse treatment agencies a portion of resources available through Accord funding to support implementation of best practices for women with co-occurring mental health issues.

33) It is recommended that the Ministry facilitate and support the development, and system-wide implementation, of program and outcome evaluation tools that incorporate the elements of best practices guidelines.

34) It is recommended that gender-based analysis be utilized in studies, reviews, and development of materials funded by the Ministry and/or LHINs to ensure that data specific to women is included, and that the implications of issues are equitably identified for both women and men.

35) It is recommended that the Ministry support identification of screening tools for co-occurring mental health problems, which are validated for use with women as a gender, for system-wide implementation.

36) It is recommended that the Ministry conduct ongoing monitoring and evaluation of system practices, utilizing the data developed in this review as a baseline for assessing progress in implementation of best practices for women, and toward that end, that the Ministry invest in the development of a provincial evaluation framework (as has been implemented for the ECD Addictions initiative).

37) It is recommended that provincial agencies collect and disseminate data that is relevant to women's treatment needs (e.g. in CATALYST, collect data in respect to number and age of children, and data as to whether children reside at home or in care).

III: Recommendations that require a significant infusion of funding.

Although much can be achieved within existing resources, the system will not be able to achieve full implementation of best practices without a significant infusion of new funding. At the agency level, achievement of some guidelines will require: new resources for staffing, retrofit, or expansion of existing facilities; training, development, and provision of new program models and components; and support for partnership development. Additionally, new resources are required to address global service issues including: stabilizing and regenerating the core continuum of services; addressing gaps in specific categories of services; and meeting needs for specialized, gender-specific services approaches in service areas such as concurrent disorders, pregnant and parenting women, and trauma.

38) It is recommended that sufficient funding be provided to all agencies to attract and compensate staff with skills and expertise to address the diversity of women's experience and complexity of treatment issues (including but not limited to trauma, violence, abuse, mental health issues, and eating disorders).

39) It is recommended that sufficient funding be provided for staffing to support development and delivery of gender-appropriate programming in all co-ed agencies

(including gender-specific program and service elements and approaches, and female counsellors for individual counselling and group facilitation).

40) It is recommended that sufficient funding be provided to agencies (in accord with their mission and goals) for staff to implement approaches to engagement that have been shown to be effective in addressing barriers, particularly for marginalized or isolated populations of women (e.g. satellites, outreach services, co-locations, flexible hours of service, flexible duration of programming, low threshold models, childcare and children's programming, community withdrawal management).

41) It is recommended that sufficient funding be provided to residential and withdrawal management services for staffing to ensure that female staff are available to work with women on all shifts, and to conduct bed checks.

42) It is recommended that sufficient funding be provided to residential agencies to ensure that staffing levels provide adequate support and services for women with complex treatment needs and issues (e.g. women who have co-occurring mental health problems, including 'serious mental illness'; women who have experienced trauma; women who take psychoactive medications).

43) It is recommended that funding be provided to all agencies for advocacy training and for sufficient staffing levels to provide case management and advocacy.

44) It is recommended that funding be provided to enable all agencies to allocate and utilize a portion of their budgets for practical supports (e.g. transportation, childcare) that are important to the engagement and retention of women.

45) It is recommended that funding be provided to agencies that currently operate on fixed cycle programs or groups to allow development and implementation of more flexible program structures.

46) It is recommended that funding be provided to all programs and communities (where needs are identified) to improve availability of MMT, reduce barriers to methadone access, and reduce barriers to service access for women that use methadone, including development of low-threshold models in community treatment and residential agencies.

47) It is recommended that funders (MOHLTC/LHINs) ensure that every agency designate and utilize a percentage of annual funding for ongoing development of staff knowledge and skills in best practices, and provide adequate agency funding for training, consultation, clinical supervision, and 'backfill' for staff attending training.

48) It is recommended that resources be provided to agencies, as required, to build relationships with allied sector women's services and other community services for the purpose of developing cross-sector training; protocols; service relationships; collaborative and innovative approaches; co-locations and co-service delivery.

49) It is recommended that grant or capital funding for equipment, retrofit, and repairs to physical facilities, and/or ongoing funding for additional space, be provided (in accord with identified needs) to support implementation of best practices guidelines for: safe, secure, and confidential facilities; separate spaces for women in co-ed facilities; spaces for expanded programming (including gender-specific program elements in co-ed agencies and space for childcare, children's programming, mother-child visits in all agencies that serve women); and accessible spaces for women who have physical disabilities.

50) It is recommended that funding be provided to strengthen and build capacity in the core continuum of services, for the purposes of: stabilizing services that are struggling to maintain core services; providing timely access to a congruent continuum of services; and enabling *all* agencies that provide services for women to provide gender-specific components and gender appropriate approaches as integral elements of core services.

51) It is recommended that new services be funded to address gaps in the continuum of services, with specific attention to gender-restricted services for residential stabilization, supportive post-treatment housing, withdrawal management services, and other gap areas identified within the report.

52) It is recommended that ECD Addictions funding be continued, expanded, and extended to build specialized services in every LHIN area and to 'mainstream' appropriate services for pregnant and parenting women and their children as core concerns of the entire service system for women.

53) It is recommended that restricted residential programs for mothers and children be developed as provincial programs, building on exemplary models from other jurisdictions and drawing on the knowledge and expertise of Ontario women's service providers.

54) It is recommended that gender-restricted residential services be developed and funded to ensure availability of service for: women who require high support specialized concurrent disorders services; women who take psychoactive medications; and women who require support for selective abstinence goals.