Time Held Gently

When the recovery clock is ticking

Contributors

Nelson Trust

Over the last 40 years, The Nelson Trust has supported thousands of men and women to achieve long-term recovery. Our gender-specific residential service has capacity for 44, within four single-sex houses nestled throughout our recovery village. We empower individuals to develop their recovery capital using a trauma-informed approach.

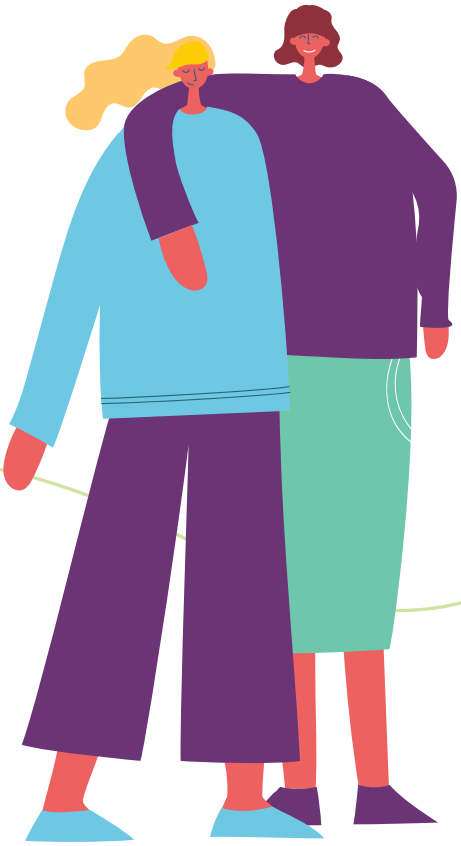
Our residential rehabilitation program provides a safe and supportive environment for individuals to achieve abstinence from substance misuse through trauma-informed care and a strength-based approach. Our treatment model centralises around trauma-responsive interventions with specialised programmes for women with a history of selling sex, male survivors of trauma, co-morbidities and multiple unmet needs. We provide a comprehensive, holistic suite of interventions from point of referral to long term recovery.

We offer various modalities of therapy including EMDR, holistic therapies, DBT, art therapy, CBT and have twice-weekly visits from our resident therapy dog, Jess.

Ophelia House

Phoenix Futures has been delivering residential treatment services for over 55 years, opening Ophelia House in 2023. With an all-female staff team, Ophelia House is a Therapeutic Community offering CQC registered drug and alcohol residential care to women.

The service has been developed to meet the needs of women who require abstinence-based residential substance use treatment in a safe and therapeutic environment. Residents stay in a newly redeveloped and refurbished property in the leafy suburbs of Oxford. A multi-disciplinary team provide personalised support through one-to-one counselling and key-working, groups and complementary therapies within a Therapeutic Community Approach. Gender-specific treatment features a bespoke group programme designed by their clinical interventions team. In addition, an accredited programme to support women who have experience domestic abuse is delivered on site. The model has been developed using evidence and best practice around trauma-informed care, with staff trained to recognise and respond sensitively to the effects of trauma including onsite counsellors and registered mental health nurse.



Hannah Shead

Hannah has worked in the drug and alcohol / women's sector for over 25 years. She has worked in both community and residential services.

Her most recent role before moving into freelance was CEO of a women's charity, which included in its services a mother and baby rehab.

She is the Treasurer for UK Feminsta – an organisation that is trying to combat sexual exploitation and tackle sexism in schools and a Director for Choices Rehabs - a consortium of independent addiction treatment providers in the United Kingdom.

Helen Bell

Helen is a mum and a nanna. She was lucky enough to go through a mother and child rehab nearly 10 years ago, and has been in recovery ever since...

She is passionate about getting good outcomes for women, and trains social workers about how to treat mums with compassion and respect.

She is an IDVA and a trained Freedom programme facilitator. Helen currently delivers both the Freedom Programme and the Stephie Covington's Women's Way through the 12 steps. When Helen isn't working on her recovery, or supporting other women in theirs, she can usually be found looking after one of the grandkids!

Contents

What We Wanted To Know

We wanted to understand a woman's residential treatment journey.

What We Did

We listened to women in treatment at two women only rehabs.

We listened to women who have completed treatment.

We listened to staff working in two women only rehabs, and other professionals working in the wider treatment sector.

We reviewed client data and looked at previous research.

What We Heard

Women only residential rehabs offer a safe space for women.

Women's treatment needs go deeper than the substance – they include relational trauma, mental health and motherhood.

It takes time for women to settle into treatment and build trusting relationships.

12 weeks is rarely long enough for woman to be in residential rehab – especially when working through trauma.

There is a post code lottery for funding.

Seeking extensions for funding is unsettling and disruptive to a woman's treatment journey.

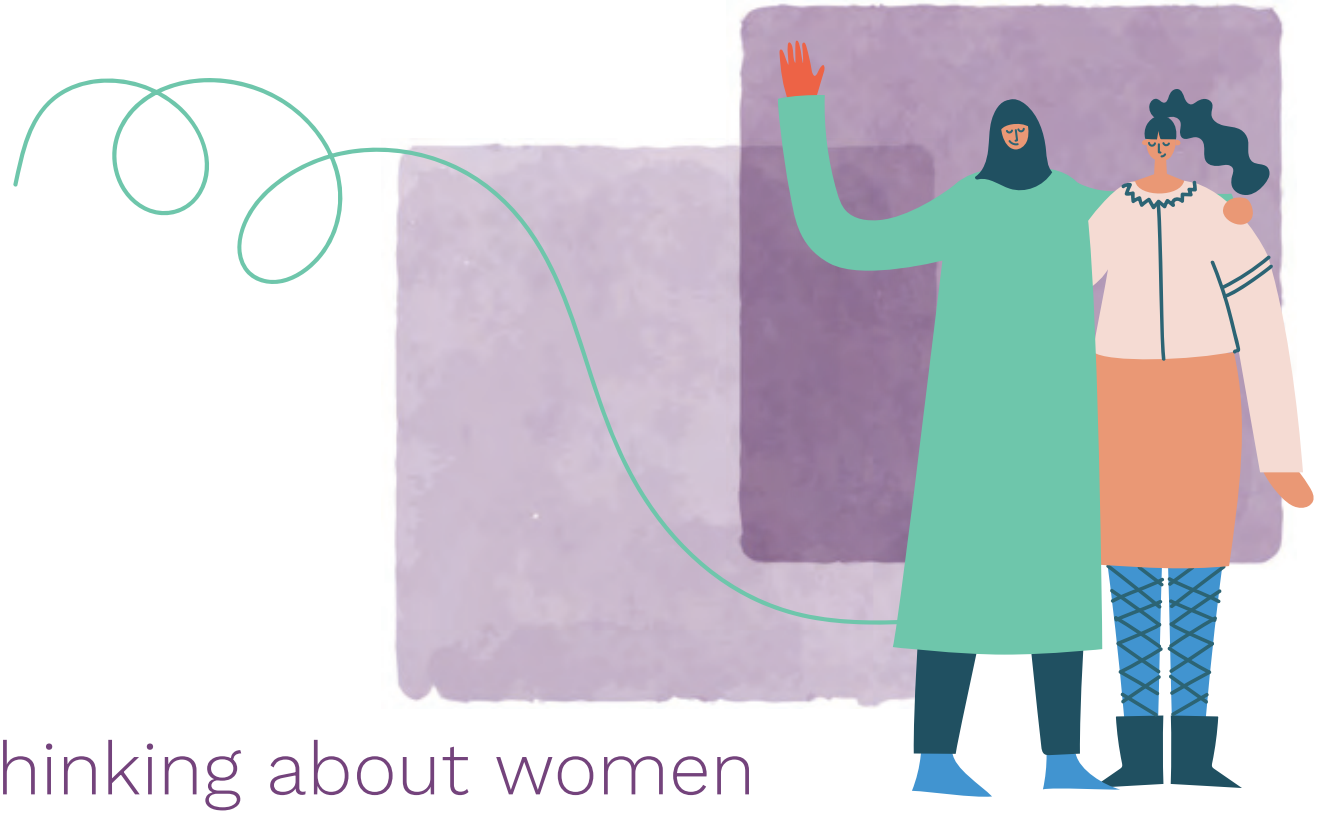
Longer placements are associated with better outcomes.

There are false assumptions about value for money – these should be challenged.

What we think should change

We have five recommendations that we believe will lead to better outcomes for women.

1. **Abolish the requirement for women to write to panel**
2. **Implement 'woman centred' funding arrangements**
3. **Develop the gender informed evidence base**
4. **Mother focused data collection**
5. **Reimagine 'value for money' in women's treatment**



Thinking about women

The addiction and recovery sector has previously been accused of being 'gender blind', that is – not cognisant of the specific needs of women. Some have even gone so far as to describe it quite simply as a system designed **by men for men.**

Thankfully, recent years have seen both a growing awareness of, and an interest in women's experience of drug and alcohol drug treatment. Over the the last four years, we have seen five different reports, each commissioned with a specific focus upon women's needs.[i]

Common themes emerge throughout.

There appears to be a growing shared understanding of the other issues impacting women who use substances, such as **previous trauma, domestic abuse** and **sexual violence.**

The reports identify specific barriers that women face when trying to access help, such as fears around contact from children's social services and reluctance to attend male dominated treatment services. These barriers are further compounded by the stigma that pervades women's substance use.

They reflect upon how services can better respond to the different needs of women, highlighting the extent to which women benefit from an approach that is flexible. There needs to be greater consideration of the impact of motherhood and childcare responsibility. There is also a call for better awareness about women's mental health needs.

The reports emphasise the importance of women only spaces and the value of the peer support model. Unsurprisingly, the need for a trauma informed approach is consistently raised as paramount.

These reports are focused very much on women's treatment **within the community**. There is little reference to what a women's treatment experience might look like within a residential setting.

"Women don't go into rehab much because you keep it together. A lot of my female friends who I hung around with, they are casual users. If you said to them - go into rehab - they would say, who's going to have my kids? What's everyone else going to say? Am I going to get my kids back? It's like having a chain around your neck, you've got kids, bills, home, job, you can't let it go."

EXCERPTS FROM A system designed for women?

"I was in hostels for a year and a half and they never told me about drug support - they never told me. When the lady said would you go into rehab I said what's that? I'd never heard of it. They don't offer you any kind of way out."

For example, whilst **A system designed for women?** does not specifically focus on rehab, it is interesting to note that the women who were spoken to as part of the report, do mention it within the context of being a part of the treatment system that was challenging to access.

"To be listened to... and actually heard" includes some specific practice recommendations for residential rehab, particularly around the importance of managing an effective transition from rehab back to the community.

There remains a space for deeper conversations about women's residential journey.

- How are a woman's needs different to her male counterparts?
- Are we, as a treatment system, doing all that we can to offer women **equitable access** to recovery?
- What improvements can we make to enable the best possible **treatment outcomes** for women?

Time Held Gently does not attempt to set out the merits of residential treatment.

These are well documented elsewhere. Rehab is both NICE recommended and recognised as an important part of the treatment and recovery landscape.

It does, however, seek to begin an exploration into how well the specific needs of women are understood and addressed within the residential rehabilitation context.

This is especially pertinent in light of emerging evidence that suggests women may experience better outcomes in residential treatment settings compared to community-based alternatives.

We are particularly interested in the length of time that a woman might need within a residential setting, and the impact upon her recovery journey of requesting a funding extension / the funding process.

Nelson Trust & Ophelia House

There are three ‘women only’ residential rehabs in the UK: Nelson Trust women’s service, Ophelia House (part of Phoenix Futures), and Jasmine Mother and Child. The latter is a mother and child provision and was not included within this research project.

At the time of writing, there is no women only detox unit in the UK.

Nelson Trust and **Ophelia House** combined are able to work with 61 women at any one time – this equates to 0.06% of the overall female treatment population. [ii]

Whilst there are variations in their specific programmes and delivery styles, there are many shared themes and experiences within the community of women that the two services are supporting.

As part of this research project, we spoke with women who were **currently in treatment** within both services, as well as women who had **moved into recovery housing**.

We also spoke with staff working in both services and interviewed the registered managers of each rehab.

Project Design & Approach

Evidence has been collected from the following sources.

- Two focus groups with women in residential treatment
- One focus group with women who are living in recovery housing having been through residential treatment
- Interviews with ten professionals from across the treatment sector. Roles included care managers, commissioners, Tier 4 leads.
- Focus groups with staff from both Nelson Trust and Ophelia House
- Interviews with the registered managers of Nelson Trust and Ophelia House
- Review of research papers
- Review of NDTMS data
- Review of internal data from Nelson Trust and Ophelia House regarding time in treatment and extension requests.

A Note On Relational Trauma

Women harm and heal in relationships.

The majority of clients going into rehab, male and female, do so in order to work on issues underlying their substance use, which for many will include experiences of abuse and trauma.

It is well documented that women are more likely than men to experience physical and sexual abuse, particularly at the hands of male intimate partners. [iiii,iv]

There is also a consistent evidence base regarding the increased levels of childhood trauma and interpersonal violence experienced by women who use substances. [v,vi]

So, whilst we know that girls are at higher risk of experiencing sexual abuse in childhood, both boys and girls face a **similar likelihood** of the abuse being committed by **family members or people known to them**. The 'stranger danger' myth is often just that ...a myth.

However, as males and females grow into adulthood, this exposure to risk changes.

As males age, subsequent harm, abuse and threats of violence are more likely to be directed at them from **enemies or strangers** (perhaps within the context of gangs, in combat or as victims or crime).

Whereas women are more likely to be subject to further harm and abuse by **people known to them**, as lovers or partners...by men who are saying, "I love you". [vii]

This **relational trauma** therefore comes with an additional element of confusion and distress to the woman, because the person who is harming her is supposed to be someone who loves and cares for her.

For women going into residential treatment, undertaking work around the impact of **relational trauma** is likely to form an integral part of her therapeutic care plan.

It must, however, be remembered that for women accessing services, hearing someone say they will provide care can be unsettling - because, for many women, those who have previously said 'I love you' or 'I care for you' have been the very ones who caused them harm.

Therefore, building a therapeutic alliance founded on **psychological safety** takes time. Once established, it inherently offers a reparative experience of interpersonal relationships.

We also know that having a strong support network is vital for achieving long-term abstinence-based recovery. This process often begins within the treatment setting, through the development of therapeutic relationships with counsellors, staff, and peers.

Women Only Spaces
Women's Treatment Needs

There is a growing body of evidence about the importance of women's treatment programmes that have been designed around the **specific needs of women**. [viii]

This is a matter of tailoring both the **programme content** and **delivery method**.

Programme content refers to issues highlighted elsewhere in this report – targeted work around trauma, relationships, children, whereas **delivery method** includes the provision of women only spaces – which has been identified as particularly important for women in the **early stage of addiction recovery** and for sexual abuse survivors. [ix]

Of course, choice is important – some women may prefer a mixed setting. However, for many women, the **sense of psychological safety** offered by a women-only residential setting will be one of the conditions that enables a recovery from trauma, especially relational trauma to begin.

WOMEN'S VOICES

The power of **women only spaces** was a consistent theme in our conversations with women.
Not only did women talk positively about having support of other women, but they also described a profound sense of safety created within an all-female environment.

"The women only environment has made a difference – I was able to be more open, kinder"

"Where I have been before, it was mixed. This was different – the connectivity of women together"

"I feel like I can be authentic and vulnerable around other women"

Women who had been to detox took longer to settle in and described feeling raw and not knowing who they were. They reflected that they had had to keep a 'mask on' in the mixed sex setting of detox. They had held back and been 'slowed down' and behaved differently around men.

In the women only environment, they had welcomed both the sense of safety and the lack of distractions.

"Men are a distraction – this time should be for women to recover how and who we are"

Nelson Trust and Ophelia House are women only spaces, with support provided by all female staff teams.

"The women only environment has made a difference – I was able to be more open, kinder"

"Where I have been before, it was mixed. This was different – the connectivity of women together"

"I feel like I can be authentic and vulnerable around other women"

"Men are a distraction – this time should be for women to recover how and who we are"

Lottie's Story

We spent time talking with five women who are living in recovery housing...we heard their journeys...listened to their experiences and from that we wrote Lottie's story.

Lottie is not just one woman...she reflects a little bit of many women.

It took me about a good few weeks before I landed. My life has been traumatic, and I was just barely surviving before I came here. I couldn't think of a way out...I was at death's door.

For a while I was 'here' but not working. I was doing the groups, but it wasn't going in. I didn't realise how many traumas I had from childhood, how many relationships I needed to heal from.

I actually didn't want any more funding, I didn't want to look at my stuff. At around six – eight weeks, I still thought I only had a drug and alcohol problem...then I had a bit of a light bulb moment, I thought "oh shit maybe there is a problem".

I think the safety aspect was a big thing for me, being surrounded by women. They were from all different walks of life, but it was new to me, being vulnerable with other women. It also helped that there is lots of lived experience in the staff team.

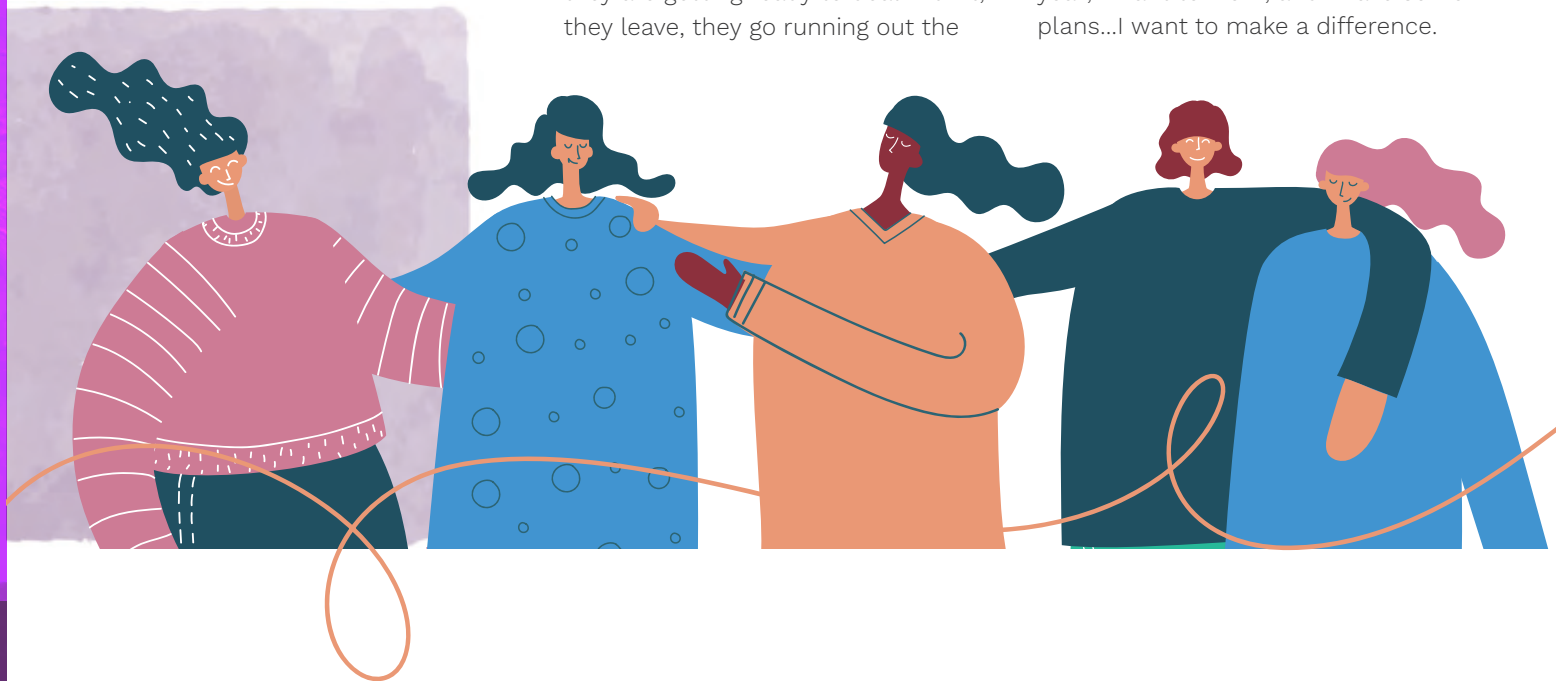
I have been to rehab before, but not for as long and I used again when I left. I wonder now, maybe if I had done six months the first time, things might have been different?

I have seen with other people, they are only starting to think about their trauma at 12 weeks. Then just as they are getting ready to deal with it, they leave, they go running out the door with open wounds. People go back out there at 12 weeks and die. They are not safe to leave, which is how I was before.

I think that people come for wrong reasons, so you need to make sure that you are putting funding in the right place. Everyone needs to do six months, it is pointless for less...a waste of money. You should just invest properly in first place.

I am still working on lots of things – on my relationships and my trauma. But I am living life on life's terms, and on mine.

I have my family back in my life and I have started to see my children again. I am off to college later on this year; I want to work, and I have some plans...I want to make a difference.



The Rationale For 12 Weeks

One of the key questions we wanted to explore was why **12 weeks** is increasingly considered the optimal length of time for funding a woman's treatment.

What does the evidence say about the relationship between length of stay and treatment outcomes?

Much of the research into rehab effectiveness shows that the benefits of treatment are most evident after a **minimum stay** of 90 days.

We can therefore conclude, that staying in residential rehab for **at least 90 days** significantly increases the likelihood of a positive outcome.

However, it seems that over the last 5-10 years in the UK, this 90-day **minimum** (equivalent to about 12.8 weeks) has gradually been adopted as a **standard** treatment duration of 12 weeks.

Beyond 90 days is optimal

A 2015 Australian study reviewed the impact of longer lengths of stay upon treatment outcomes.

It found that **each additional 90-day period** in treatment **doubled the chance of change** in areas such as emotional, social, and psychological well-being.

Notably, the difference between just under 90 days and around 18 weeks (approximately 4.5 months) marked a **critical juncture**, with clear evidence of reliable improvement only emerging after the longer stay.

This begs the questions as to whether **18-week programmes** should be considered the minimum, as opposed to 1**2 weeks**. [x]

Service Data Review

We analysed the data from **September 2024 – April 2025 (Q3 and Q4)** for both Nelson and Ophelia to see how long women were typically funded for at the outset.

Across the two services, **96 women** started treatment during that period. 85% of them were given 12 weeks funding initially; 40% of whom went on to seek additional funding.

Initial Funding and Treatment Completion

- **15%** of the women in the sample were initially granted **24 weeks** of treatment.
- Of those, **75%** have **successfully completed treatment** or are **still engaged**.

This suggests a **positive correlation between extended initial funding and treatment retention**.

Early Exits

- **All of the women (100%)** who **left treatment before 12 weeks** had only been funded for **12 weeks** at the outset.
- This indicates that **shorter funding durations may contribute to early dropout.**
- **This is of obvious concern given the negative outcomes associated with early exit**

Presenting needs of women going into rehab

NDTMS Data Review

We reviewed the NDTMS admission data from both Nelson and Ophelia between 2024-2025. During that period, **147 women** were admitted into the two rehabs, ranging in age from 18 – 66 years old.

In addition to **demographic data**, NDTMS collects information about the following:

- Domestic abuse – past and present
- Selling sex - past and present
- Mental health
- Parental status

Domestic Abuse

Given that this data is collected within the first few days of arriving at a service, and therefore before women have begun to build trust, we would expect to see an **under reporting** in some of the information given.

At the point of admission, **76% of women** disclosed current or previous experience of domestic abuse (3 out of 4 women).

This represents a substantially higher prevalence rate when compared to the general population of 27% (1 in 4).[xi]

Current or previous victim of domestic abuse

76% of women disclosed current or previous experience of domestic abuse

Selling Sex

Women are asked at point of admission if they have exchanged money or goods in return for sex. We know that this is an area where women will under report due to stigma and shame, however one in five women report this as something that they have experienced.

It is likely that this data has failed to capture some of the more nuanced exploitative behaviours that women are sometimes subject to, such as exchange of sex for drugs (either for themselves or others), or the demand of sexual activities to pay drug debts (theirs or a partners).

These are experiences that surface later on within the therapeutic journey, once a woman has begun to work through her boundaries and explore occasions when they may have been compromised.

Selling sex is also linked to a heightened risk of both physical and sexual violence[xii]. It takes time and specialist support to enable women to process these experiences.

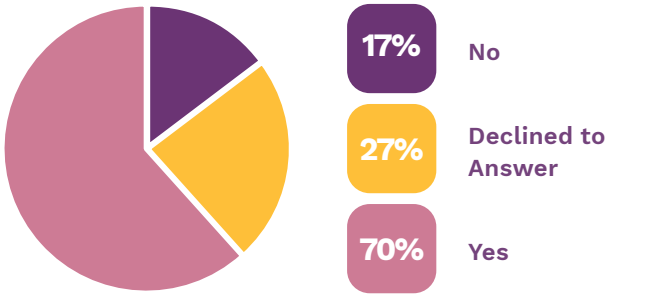
Past or Current Selling Sex

We know that this is an area where women will under report due stigma and shame, however one in five women report this as something that they have experienced

Mental Health

Nearly three in four women coming into rehab reported having a mental health need.

Staff working within the services fed back to us that it is not uncommon for a woman to have received a diagnosis (typically around trauma) but not to have accessed appropriate treatment.



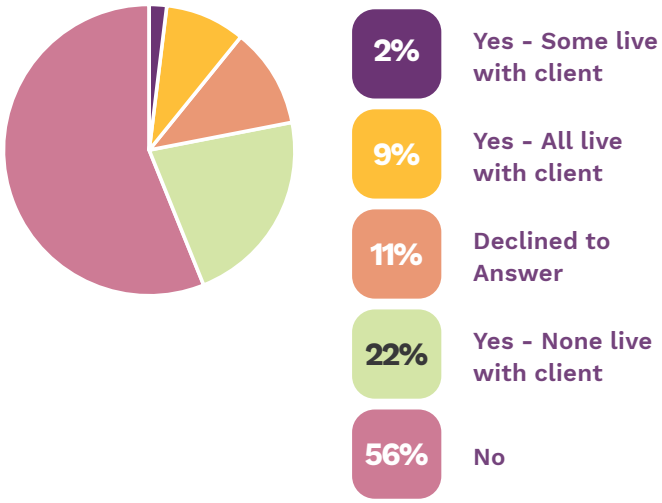
Parental Needs

NDTMS collects data regarding children in cases where the woman has parental responsibility.

This does not therefore capture cases where children have been removed from a woman's care, or other situations in which a woman, for any reason, does not hold parental responsibility for her child.

A woman who has had her child removed is still a mother—yet in such instances, her maternal status is not being recorded.

As a result, we are unable to accurately determine how many mothers are currently in our treatment system.



Motherhood And Maternity

We have already highlighted the limitations of NDTMS data collection – it does not record the maternal status of mothers who have children removed, or those who do not have parental responsibility.

It also fails to include women with older children, over 18 years of age.

At the time of writing, **76% of the women in the two services are mothers.**

We heard in the focus groups about the various challenges that women were facing directly related to their children – young and old.

We heard from the staff teams about the difficulties faced by women with children currently in the care of the local authority.

This included some of the practical issues around contact with their children, alongside the distressing experience of being separated from their child.

We heard of one woman who had left treatment early, so that she could continue in the community her fight to have her child back in their care.

Once again, we heard the phrase **setting women up to fail.**

The focus of this report was not maternity and motherhood, however conversations with women and professionals made it clear that motherhood is a core part of many women's identity.

It should therefore be no surprise that the well-being and whereabouts of their children will significantly influence a woman's recovery journey.

"The addicted woman is attacked not only for her failure at motherhood, but for her abandonment of more general nurturing and caretaking functions that are at the core of the female role. 'Good' women are primarily concerned with the needs and welfare of others...and when women are no longer willing or able to serve, even for reasons beyond their control, the response is usually not support or sympathy"

Marian Sandmaier, The Invisible Alcoholics (1980)

A Woman's Residential Journey - Women's Insights

Landing Takes Time

Women shared with us how it feels to come into residential treatment.

Women described feelings of fight / flight. Unanimously they described being overwhelmed and fearful:

"My emotions were all over place"

"My head was in overdrive"

"I was angry and resentful, I challenged everything"

"I arrived feeling traumatised – I wanted to drink to take away pain and discomfort"

They reflected how long it took to settle, with periods ranging between two weeks to ten weeks. For most women it seemed that six weeks was the point at which they felt something shifted.

"Takes six weeks to start to trust"

"Started to click at week six or seven"

Trust was a consistent theme. Trust in staff and peers and feeling able to talk openly about their emotions and past experiences.

Within the focus groups that we carried out, women in treatment talked about what might be going on for them **as women** coming into residential rehab. They talked about **trauma** as an underlying issue, compounded by feelings of guilt and shame.

"It's so much more than putting down the substance".

"I had traumas I didn't even know about"

Women shared some of the things that they were working on. For many women, they were working on deep rooted issues. Things that take time and specialist support to recover from. They were not limited to substance use and included support around mental health and eating disorders.

As suggested earlier in regards to **relational trauma**, we found it was the case that many of the women's therapeutic work took place in the context of relationships, their **relationship** with their children, relationships with abusive partners, their past experiences of childhood trauma, domestic abuse and sexual violence.

Women talked about having to hold it all together. They shared a sense of having to carry a lot of responsibility on shoulders.

"Everything falls on us as women"

"All the roles that women take on"

They talked about how caring responsibilities made it hard for them to be away, and reflected that **"life still carries on outside"**

During both groups we heard lots of examples of this, as women talked about what was happening for their children whilst they were here (both young and older children).

It was evident that women were managing a range of issues, and mothering 'long arm' whilst in treatment. This included navigating contact with children and ongoing liaison with social services.

12 Weeks Is Not Long Enough

It is not surprising that all women felt strongly that 12 weeks was just not long enough to make changes.

A clear theme was the need for women to **regulate emotionally** before they could begin to work on their underlying issues.

"It takes time for your emotions to settle"

"You need to be resilient enough to do the work"

"I slowly dropped my mask; I am now able to be vulnerable for the first time"

This first part of the process takes time. Whilst certain variables might help, such as a positive admissions process, coming into a more settled treatment community, or striking up a good rapport with a worker, it was acknowledged as a process that simply took time.

Women were clear in their need to settle and to **feel safe** before they could start working on some deep rooted and traumatic life experiences.

"I needed to trust – it takes time. I would not have opened up to anyone if I was only here 12 weeks"

Women talked emphatically about the value of groupwork, and the impact of being able to use the space to work through past issues.

"The groups are difficult, but rewarding"

"I can see the programme is working"

Women talked about the importance of feeling safe enough to do this. Safety was in part provided by an absence of males, in part by the skills and expertise of staff in the centres, but also in knowing that there would be the time to work through past traumas.

In addition to doing the therapeutic work, women talked of the need to learn skills and prepare to return to the community.

"I need to relearn the outside world".

"Groups are one part of the process, but also just getting used to waking up and not needing to use".

Women were largely in agreement that six months was an optimum time to be in residential treatment, although were mindful of becoming institutionalised

"Don't want to lose real world skills"

The Funding Process Is Inconsistent And Disruptive

The women within the focus groups reported a range of experiences around funding and seeking extensions. This included women who had been granted six months at the outset and women who knew that their area would not give funding for longer than 12 weeks.

Women also shared their dissatisfaction about what they perceived as an **inconsistency between local authorities**. This was a particular point of contention around client contributions, which, whilst a sperate issue, was relevant in terms of feeding a general sense of distrust of the process more broadly.

One woman described being given a further six weeks funding, which had to be requested four weeks at a time. Another woman expressed frustration that she hadn't been told at the start of treatment that more funding would even be an option, she had only been asked towards the end of her stay, at which point she was preparing to return to the community.

When we explored with women what it was like to request an extension, they described how hard it was to ask for things in life anyway. They had a sense of feeling less important if they don't get it, **experiencing extra rejection**.

A number of women had been asked to write a **'letter to panel'** in support of their application, either at the initial funding phase and / or at the point of requesting an extension. They described feeling like their **lives and trauma were being judged.** One woman spoke about the dilemma of knowing what to write – if she wrote about how much she had learned, it might be deemed that she didn't need any more funding, but if she had not progressed enough, people might think it wasn't working and deny it on those grounds.

Women talked about the impact of waiting to hear back, describing feelings of anxiety, ambivalence and not being able to concentrate on anything.

It was apparent that for some women, the waiting period, which ranged from days to weeks, dominated that period of their treatment time.

"It was the uncertainty and the fear of the unknown, my whole life was at stake"

One woman had waited three weeks for an answer, and during this time had found it hard to move forward therapeutically.

"I needed to trust – it takes time. I would not have opened up to anyone if I was only here 12 weeks"

"I was feeling under pressure. I couldn't focus on getting well and better, and was only thinking about the time"

In both sessions we spoke with women who had been given six months funding from the outset. One described how she had only wanted or expected three months, so felt *"totally blessed".*

They talked about how this had enabled them to approach their residential journey differently to some of their peers – with one woman describing how she felt as if she had been given time to settle into programme and do groups, but also time to plan for future.

"The pressure off is for me. I know I've got enough time to work on my trauma"

"It's made a difference knowing I had six months – I couldn't see another way of staying clean, I didn't know my place in the world."

In one case, a woman had been granted a **potential of six months** funding, with the proviso that there would be a call from her care manager at six weeks to see if the full six months would be needed. She described how that had enabled her to

"feel settled and solid...made me feel safe and valued"

Women said it made a difference if you had someone in your corner... someone who could

"understand the weight of your recovery".

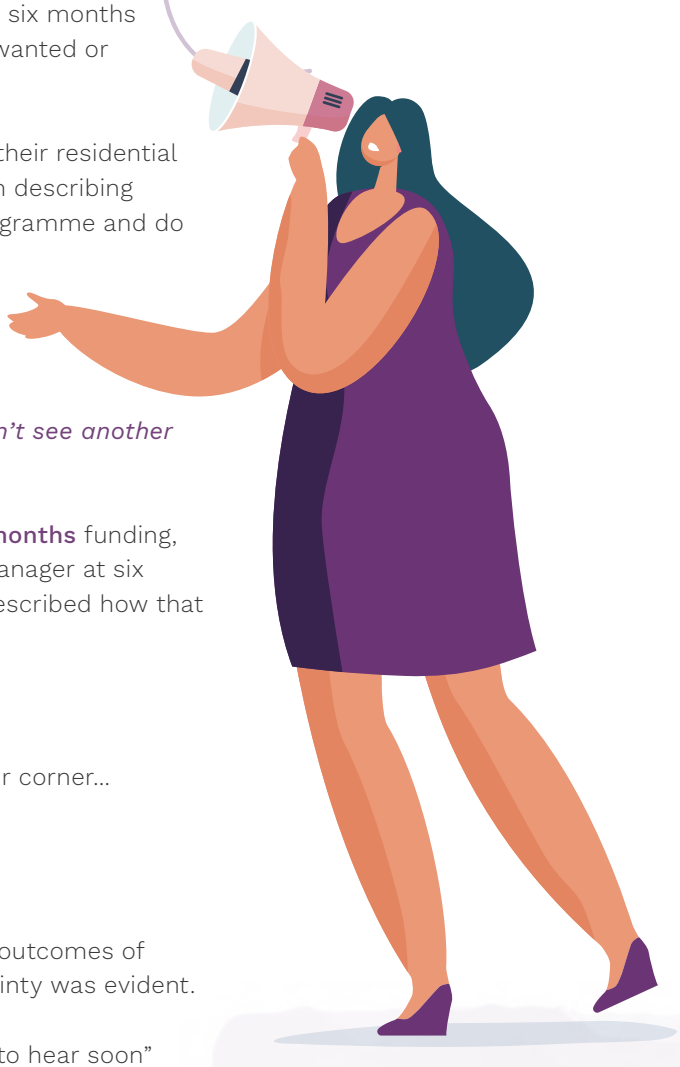
In both focus groups, there were women currently awaiting outcomes of requests for further funding, and the impact of this uncertainty was evident.

"I've only just started to settle, what if I don't get it? I hope to hear soon"

There was a tangible impact upon the wider house. Women were worrying for one another and sharing in the angst of what they experienced as a waiting game. It was described as a **conversation that is always there** and something that took up a lot of emotional energy within the residential community.

"You all feel it; it wastes the last few weeks"

"I am just worrying about how much time is left"



"It's made a difference knowing I had six months – I couldn't see another way of staying clean, I didn't know my place in the world."

A Women's Residential Journey - Staff Reflections

Staff shared with us the range of needs that women come into rehab with.

It is rare that the substance use is a stand-alone issue – eating disorders and self-harm feature highly.

Staff reflected that the majority of women they see are survivors of trauma – the themes of relational trauma were consistent across both services.

Staff described women arriving into rehab in a heightened state

"their nervous system needs time to settle down"

They talked about the time it took for women to start to settle and be able to engage in treatment.

Staff in both homes talked about the **therapeutic needs** of women coming into rehab. They talked about there being false expectations about what can realistically be achieved within 12 weeks.

They reflected that it may be the first time that a woman has opened up about some of her past experiences, and how important it is that women can build a therapeutic alliance.

"They need long enough to both open and close the box"

Staff also talked about **the role of residential rehab** itself; it is more than two groups a day. It is a space where women are learning to grow, connect with others, and discover their sense of self. It is a place that provides women psychological safety; that **holds and contains** women emotionally in between groups and during the therapeutic process.

Staff in both services shared that **12 weeks is simply not long enough** to process everything – the addiction, the trauma. They have observed that it takes time for women to settle into the programme, and to be 'resourced enough' to begin the therapeutic work, either within groups or via 1-2-1 counselling.

"It has to be done safely – women need to have opportunity to regulate, and to be safe".

Staff discussed the time it took to secure the right support for women with more significant mental health needs - either via starting medication, accessing the appropriate treatment or receiving an accurate diagnosis. This was rarely achieved within 12 weeks.

They also talked about the importance for everyone of knowing ending dates and being able to plan around it.

This applied for the individual women but also enabled family members to plan and prepare – especially important for women with children.

"If women knew how long they had, it would make a difference"

They raised concerns about the ethical impact of women who felt under pressure to start doing deep work, and echoed the observations made by the women in the focus groups about women who left treatment not having had sufficient time to complete the therapeutic work required.

In talking to staff working with the rehabs, there appeared a frustration at how different local authority areas operated, and the inequity that this created within the homes.

We heard examples of women coming into rehab thinking they would be staying for longer than 12 weeks, but with only confirmation in place for 12 weeks, therefore staff needed to try to manage resident expectations alongside seeking additional funding.

Conversely, we were given examples of women who had initially come into treatment with 12 weeks funding, who had then been offered an extension by funders, but refused it. We heard of cases whereby it was evident that the woman would have benefited from longer in treatment, but she had prepared herself psychologically for 12 weeks...there was also a sense that by giving a funding package of 12 weeks, women are given the message that 12 weeks is enough...any longer is unnecessary.

We heard about current cases where there were delays in giving an answer – in one scenario a staff member had been told that the area needed to

"use the money for someone else"

They talked about the impact that this has upon women – it manifests itself as women being unable to focus in groups and a sense that women were not able to be present / fully engaged during the waiting period.

They also talked about the impact upon the wider community – the extent to which women dysregulate whilst waiting for their peers to hear; after all the residential journey can be an experience where women form deep connections with one another:

"they all go through it"

They also saw how it created a sense of unfairness, and in some cases, jealousy between residents, which undermined relationships.

Staff also shared the impact upon them as workers. The uncertainty was unhelpful in terms of knowing how long they had to undertake work with women. There was significant time commitments associated with securing further funding. This included writing additional reports, liaison with busy professionals, proving updates to panels, chasing paperwork and of course managing the emotional impact upon women.

Like the women that we spoke with, staff expressed concerns about the requirement for women to write and make their case to funding panels.

"Women come to us, asking for help to write a 'begging letter' saying this is why I am worth it"

They reflected upon the impact for women who did not get funding – this was translated into feeling not worth it and was internalised into feelings of rejection, further validating a woman's low self-worth.

Staff talked about the impact upon team morale. They are passionate about the work, their care for women was palpable, and it was evident that they were troubled by the external factors that were impacting upon a woman's chance of achieving lasting recovery.

Like the residents who we spoke with, staff described working within a wider system that **'sets women up to fail.'**

A Woman's Residential Journey - Stakeholder Perspectives

In our interviews with professionals, we asked about any themes that they were seeing in terms of the **specific needs of women** going into rehab.

The recurrent themes were **domestic abuse, mental health and trauma.**

We heard reflections about multifaceted trauma – women who had experienced childhood trauma, but then also the harms experienced on a daily basis for women surviving within a 'drugs world'....frequent exposure to coercion, violence and abuse.

One care manager talked about some of the barriers that women face; their trauma results in behaviours that are more likely to be medicated / receive diagnoses. This in turn can make it harder for them to access residential treatment.

We heard about cases involving pregnant women who were subject to high levels of high-risk domestic abuse, and the challenges of being able to get the right support in place.

They reflected how it takes time to adjust to the environment, to learn about boundaries and relating to others. Crucially, it takes time to build trust.

We heard about the importance of **preparing for rehab** – in some areas there is a more formalised pathway, with clients required to attend rehab prep groups beforehand, in other areas this was more organic.

We also heard about the value of **therapeutic limits** – the importance for clients in knowing how long they have to work through their issues within a safe space. This echoed the comments made from the staff within the rehabs about knowing clear time frames to 'do the work'.

We were encouraged to hear that despite women presenting for rehab with high levels of need, there is a sense that women respond well to the residential offer. One care manager talked about this within the context of the power of connection for women – a theme that was also mirrored by the women within the focus groups.

We heard from one area about how they have created a dedicated pathway for women involved in the sex trade. They have a specialist woman's worker who is able to make direct referrals into rehab and circumvent the usual panel process. This person-centred approach is an excellent example of responding flexibly to women's needs.

The predominant approach to funding for residential rehab was a standard of 12 weeks.

In most cases, there was opportunity for this to be extended.

We asked what was considered as **reasonable grounds** to provide additional funding.

It was not surprising to hear **that therapeutic progress** was a key factor – for example if a woman required more intense therapy around specific issue or had come from a particularly traumatic background.

A **challenging detox** was identified as grounds for a woman requiring longer. Professionals also talked about some of the **safety** factors affecting women, such as having been subject to exploitation or if leaving a high-risk relationship.

Supporting with **relocation** or facilitating a smooth transition back into the community were also given as reasons to consider an extension beyond 12 weeks.

Stakeholders acknowledge the postcode lottery – and we heard examples of how this played out in close proximities within local areas.

"if you live a few miles down the road, completely different funding set up"

From talking to stakeholders, it was clear that the key driver for 12 weeks is **budgetary constraints**.

Those areas with greater budgets were, unsurprisingly, those who were more likely to offer longer funding at the outset and apply a more person-centred approach.

We also heard about the pressure to meet targets – for example ten women could go into rehab for 24 weeks or double the number of women could go for 12 weeks.

It was evident that managing this tenson can prove troubling. A number of people talked with concern about hearing recent incidents of residents going into treatment for 4 weeks and queried whether this was a further case of budgets driving decisions.

Stakeholders overwhelmingly agreed that 12 weeks is simply not long enough in most cases. Many women are beginning a recovery from a **"lifetime of trauma"**

Women's Residential - Value for Money?

We know that there is a strong financial case for residential rehab, despite being a more expensive treatment intervention on a unit cost basis. It supports those who have not benefited from treatment within the community. Social return on investment research suggests that each successful completion in Residential Rehabilitation provides net savings of £43,904 per year.[xiii]

It is important that any value for money conversations regarding women are framed within a gender specific context.

This includes thinking about the additional barriers women face when accessing treatment, enhanced caring responsibilities. It includes recognising differences in treatment outcomes – women tend to complete rehab at higher rates than men.

When considering return on investment associated with **women's treatment**, there are additional benefits that must be considered, such as savings from children's social care from keeping families together.

Whilst it may be uncomfortable to talk about money, it came up in every conversation we had.

Throughout this research, a clear and consistent message has been heard; **budget constraints are significantly influencing decisions around rehab placements.**

This included the women who we spoke with, who were all too aware of the wider financial landscape and budgetary restraints – even in terms of the financial year / budget cycles.

Yet, whilst less funding might initially be considered to save money, the cost saving achieved by shorter placements is undermined if, as the evidence base shows, there are higher relapse rates associated with shorter treatment.

In line with the evidence, the women that we spoke to were clear that there was a strong economic argument for funding six months and argued that funding for any shorter risks setting women up to fail.

"Why spend money in the first place, it is a waste in the long run"

"I have had rehab before, but I couldn't do work because there was not enough time"

"I cut the bushes last time, but the seed was still there"

This was backed up by practitioner insights from staff working in the services, who observed that the women who were **given 24 weeks at the outset** were more likely to complete treatment and remain in recovery after discharge.

As flagged earlier in the service data review, 100% of the women who had left treatment early had only been funded for **12 weeks at the outset**.

Contrast this with the outcomes of those who were funded for **24 weeks at the outset** – 75% of whom have either completed or remain in treatment at the time of writing.

This is a small sample – however these trends and observations align to the existing evidence and therefore merit further exploration for women-only settings

It is right that we seek to obtain value for money from a squeezed public purse – **in limiting funding to 12 weeks, women's treatment and the value to society of supporting women and families is undermined.**

Future Recommendations

We hope that this report generates a broader conversation about the needs of women wanting to access residential rehab.

We invite the wider treatment sector to think more deeply about women's treatment within the context of their lives – as women who may have experienced male violence or been systematically failed by services. As women who are mothers – with or without their children.

There are five specific recommendations that we would like to put forward.

1. Abolish the requirement for women to write to panel

We ask commissioners, care managers and budget holders to remove the 'letter to panel' from their rehab pathway.

2. Implement 'woman centred' funding arrangements

We call upon commissioners to move away from a fixed funding term of 12 weeks.

We would welcome an approach that enables women to be assured of adequate time in treatment from the outset – a length of stay that it is determined according to her individual need.

3. Develop the gender informed evidence base

We call upon the sector to continue building an evidence base regarding the therapeutic needs of women who use substances, with particular attention to their experiences of domestic abuse, sexual exploitation, mental health challenges, and motherhood or maternity.

We also need a sector wider understanding of women's longer-term outcomes after discharge from rehab – particularly in regards length of stay. We would welcome investment in research to ensure that future policy and practice is evidence based.

4. Mother focused data collection

We need data that accurately captures maternal status. This is essential in developing a treatment system that fully reflects and responds to the realities of women as mothers.

We ask that work is undertaken by the Office of Health Improvement and Disparities (OHID) to see how this can be achieved.

5. Reimagine 'value for money' in women's treatment

We urge people to move away from the idea that shorter placements represent better value for money, we challenge the prevailing 'less is more' narrative.

We would like to create space for honest conversations about increasing investment in the women's residential sector, with a view to see more women given access to the treatment they need.

References & Acknowledgements

Thank you to the wonderful women, who shared your thoughts with us so openly and graciously. There is nothing quite like sitting with a room full of incredible women... your energy, insights and humour were inspirational. We hope we have done you justice, and we hope that this report will go some way towards making the changes you have asked for.

Thank you to the staff working in the services – your passion for women, and ambition for their recovery shone through. Thank you to both registered managers, you are busy women running busy services... but you found time to support this work and welcome us into your services.

Thank for to the other professionals who we spoke to. You gave your time generously and spoke candidly about the tensions you are managing. Your desire to help us think critically about the system is much appreciated.

Ian Street
Abi Buckle
Helen Murphy
Gary Rickwood
Lee Turner
Lisa Buckely
Aimee Petrie
Matt Bartram
Mary Bell Macleod

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Notes