

What Is the Service Users' Experience of a Woman Only Opioid Replacement Treatment Service?

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ABSTRACT

Purpose: Literature suggests that there are gender specific biopsychosocial factors contributing to women developing addiction, therefore treatment should be tailored to their needs. Does this though mean that the service should be women only?

The purpose was to evaluate the experience of women in opioid replacement treatment, attending a women- only service and to explore the above dilemma.

Methodology: This was a qualitative study with data collected through structured interviews. Interviews were voice recorded and transcribed.

Findings: Most women found the service useful and felt their needs were met. The quality though of the therapeutic relationship with the key worker seemed to be the most important factor. The majority preferred the separate location of the service as it was felt safer and the links with other services focusing on women's needs. Some women feared being judged by others if the service were to be moved to a primary care site.

Conclusion: Given the limitation of the qualitative design and the small sample, our findings support previous literature on the importance of a safe environment and links with other women focused services. It was felt though that this does not necessarily have to be provided within a women only service.

Keywords

Opioids replacement, Women, Services.

Introduction

Data collected over the past decades demonstrate that biopsychosocial factors that contribute to women developing addiction include low self-esteem, history of abuse, traumatic event, drugs introduced by a significant relationship, sexual orientation, co-morbid depression and the lack of social support systems [1-4]. In comparison to men, women have increased history of childhood trauma and abuse, interpersonal violence in adolescent and adult relationships, involvement with child protection services and dependency on others for financial support [5] therefore perhaps use drugs as a primary coping strategy.

A lot of evidence suggests that women are less likely to seek treatment compared to their male counterparts due to financial hardship, physiological complications, the stigma attached to substance use among women which negatively impact women's sexuality, questions their fitness as mothers and often leads to social exclusion [6]. Women who seek treatment were found to be less likely to complete treatment and most of the significant predictors to treatment completion among women were education level, recent arrests and peer deviance [7]. As a result, studies argue that women -only substance misuse services are more effective to meet their needs [8].

Evidence suggests that gender-responsive treatment have positive long-term outcomes by creating a pattern of continued

reductions in substance use and participants voluntarily tend to remain in aftercare treatment for longer period compared to the mixed-gender treatment group [9,10]. Women-focused treatment enhances satisfaction of the treatment compared to mixed-gender programmes. These programmes endorse feeling safe, focus on self, feeling supported and having gender-specific needs met [11].

Existing women only based programmes tend to put a greater emphasis on social model [12], and peer based treatment approaches, and tend to have women in counselling roles create a gender specific environment [5]. Furthermore these programmes offer 'wrap around' services such as the provision of child care, employment assistance, or mental health counselling [13,14], as well as poverty, abuse, domestic violence, race and gender inequality [15,16].

A women only service was established in November 2013, in a West London borough by the local substance misuse service with the aims of (i) providing a safe and calm environment for women with opioid dependence to engage in opioid replacement treatment (ORT); (ii) being able to address their contraception and sexual health needs; (iii) providing a link with domestic violence services, and (iv) other local services or projects for supporting parenting, sex workers and trafficked women. It is run once weekly for half a day by two female recovery workers, with the occasional support of female peer mentors, social work students and a psychiatrist. Service users typically have a 30 minute appointment slots alongside the standard key-working as part of ORT, other social and psychological issues are explored and progress is reviewed. In addition, there is a women only social group linked with this service which is facilitated by the same members of staff but takes place in the main service building (due to space restrictions).

The aim of this evaluation was to study the experience of women attending the service, focusing on the advantages and disadvantages from service users' perspectives and exploring ideas about and opportunities for further improvement.

Methodology

Structured Interviews

Participants were asked about (i) women's experiences of the service and if their needs were met; (ii) links available with other services; (iii) secondary emphasis on opinions on the women-only versus combined services; (iv) service's location and (v) secondary clarification if location within primary care would be preferable. Interviews were conducted face to face and typically lasted between 15 and 25 minutes. The interviews were facilitated by a researcher (NG) who was independent to the clinical team and they were voice recorded. No formal research ethics committee approval was requested. Participants though provided informed consent to participate in the interviews and their anonymised responses to be used in potential academic publications. All data was anonymised. The study lasted for 3 months in 2015.

Data Analysis

Interviews were transcribed verbatim by an administrator and

following transcription voice files were deleted. Responses for each question were examined and discussed by NG and CK, with the aim to look into ways of improving current service provision. Additional demographic information was gathered from electronic notes and prescription logs including demographic information such as age, employment, marital status and housing status as well as treatment details including time within the service, current dose of medication, frequency of medication pick-up and overall treatment progress.

Results

Ten out of forty women attending the service agreed to take part making it an opportunistic sample. Their age ranged between 25 years and 54 years old, with 4/10 being 30-40 years old. Eight women were white British. All were unemployed on benefits except one who was working part-time. They were mostly single (7/10), one was married and two had partners. Two were homeless, with the rest living in their own or rented accommodation. They all had children. For eight women all their children were living with them or family members and two women had children in foster care.

Eight women had a history of using heroin and other illicit drugs (such as cocaine/crack and cannabis) for a long time. The other two women became dependent on prescribed pain relief medication. Two women were attending the service for only 6 months, with the rest attending between 1 and maximum 2 years. None of those women have been attending the women only service since started. In the last 6 months (June - November 2015) out of the total 10, 3 had reduced the dose of methadone or buprenorphine (suggesting an improvement), 2 had increased the dose to achieve stability and the rest (5) had remained at the same dose. The frequency of appointments and pick up of medication was unchanged for 5 clients, reduced for 4 clients (indicating improvement) and increased for 1 patient (indicating deterioration).

Experience from the service

The experience of women attending the service was variable; however most of them reported to have found the service supportive and encouraging. They felt that the service provided them with privacy, emotional support and it important information about treatment and other aspects of their lives. They reported that the service met their needs.

Patient 3: "I normally come here, pour out all my problems and when I leave, I feel relaxed and well informed. Then I know where my life is going to go from there on."

Patient 4: "Really positive, informative, welcoming and it helped me through personal issues and all the other things that go along with my addiction pain killer."

Patient 8: "I feel that it's worked very well actually. It's not just for my script. They helped me out with numerous things."

Link with other services

Participants had favourable opinions on the combined service with the sexual health clinic. Five women who had used the sexual

health clinic and found it helpful to have it combined with the service as they felt that it was easier to have appointments at the same location so sexual health needs are addressed.

Patient 1: "I think it does. Personally, I had implant that used to cause me problems. So when I was coming to the service, I could use that as well and got it removed. So, I think it made a lot of difference especially when you are using and not in right frame of mind, have unprotected sex, some people use needles, sharing and all the stuff. So I think it's a good connection with the service."

Patient 2: "It's useful having it. I was due to have a smear test. If you go there to do anything, personally, I get really nervous. Sometimes, you may not want to go."

Patient 7: "I didn't use it myself [sexual health clinic]. But I think it will be a good idea to have it in the same building here. While you are here, you can make appointment to do that. That will be a good idea."

Similarly easy access and guidance on domestic violence and relevant services, advice on parenting and on other women related issues was considered useful by most women.

Patient 1: "not from this clinic...I was working closely with probation, so they will help me in that department. I won't really need to ask for help. They have offered me help here, but I've already had it elsewhere from probation."

Patient 6: "When I first started, key-worker got me in contact with NSPC. They do family activities. I got a good support."

Women only or combined service

Nonetheless, some women felt they could not compare their experience in women only service to the mixed service since it was their first experience whereas others felt the difference was due to key-worker engagement and the quality of the relationship developed.

Patient 5: "no difference. I suppose it would for some people but not for me."

Patient 1: "it doesn't make any difference to me if it is mixed or women only service. It just depends on the worker. My worker, they've personally been through it. So I feel I've had a connection with them because they know what I'm going through. I feel that makes a big difference."

Patient 4: "My husband and I were having a lot of problems. I find the normal sort of counselling quite irritating. So I thought it was best if I maintained contact with key-workers and they have been very supportive to me and I'm happy with that."

Location away from main specialist service

When participants were asked on how they perceive the separate location from the main drug and alcohol service building, most of them expressed quite strong views on the matter. They reported that one of the advantages of the separate location was less contact with service users who are still using drugs. They also appreciated the discreetness of the present premises rather than the main building.

Patient 1: "me personally, I find it better because I've been clean for so long. For people to be clean, you have to dissociate yourself

from anybody...anyone that uses drugs, whether its family or friend. It does not matter, you have to dissociate yourself."

Patient 2: "People that go there want to stay clean and they bump into people that aren't really bothered if they are clean. Obviously, they have clinics that they run, courses and things like that, which are very good."

Location within primary care

Although they expressed their satisfaction towards the current location of the service, the results were mixed when they were asked if the service were to be moved to a GP surgery. Some were negative towards this move as they felt that they would be judged in the awaiting area and lose their privacy.

Patient 1: "If I went to the GP surgery with people there with all sorts of problems which are not drug related, you tend to feel more judged than isolated I suppose. So I think that will be negative."

Patient 3: "GP surgery- I think it won't be a nice idea. It will be small and the other people there waiting, you won't know what they are there for. You will feel obliged to talk to them. But this place is like people know why you are here because it's a women's group and you won't need to talk to them."

On the other hand, others felt it did not make a difference and thought it will be more convenient to consult the GP if they needed.

Patient 2: "I came from a GP surgery. If it goes back, it is better for me because it is closer to home"

Patient 6: "I don't mind a GP surgery"

Patient 9: "I think that will be a good idea because the doctor will be next door, and be able to speak to the doctor."

Discussion

This study had used a small opportunistic sample; therefore findings might not be generalizable neither to the rest of the group nor to the population in treatment. Findings should only be considered as indications about "truth" and should be read with caution and only in conjunction with existing evidence.

The results of the study suggest that overall service users reported to have had positive experiences during their engagement with service; formed therapeutic relationships especially with their key worker and the clinic helped them to address their opioid dependence by being supportive and informative. These women appreciated the discreetness of the service and the one to one support. Therapeutic relationships established and further individual support from key-workers place emphasis on the need to focus on women's biopsychosocial needs to improve treatment engagement and retention. This is consistent with previous recommendation that women-only programmes should be centred on the social model and peer based treatment approaches [5,12]. Most of them felt though that it was not necessarily the fact of being in a women only service but having an empathic keyworker was an important factor to their recovery.

A location of the service away from the main drug and alcohol building was considered a positive element and a contributor to their engagement in the service. The finding agrees with Knight et

al., [7] study who found peer deviance as a predictor to treatment completion and in this study participants mentioned that what aid their recovery was the fact that the service did not took place in the main drug and alcohol building therefore prevented them from interacting with others still on drugs.

The provision of sexual health clinic in the same building was beneficial and nearly half of women interviewed had used it at some point. Links with services providing support for domestic violence, parenting skills and other women related issues was considered useful by these users. This is considered necessary given that women report more psychiatric symptoms and increased history of experiencing violence compared to men [15,16]. However moving the location to primary care received mixed responses. Some preferred this approach for its convenience, whereas others have expressed strong fears of being judged and having no privacy.

The results also argue that having the women-only service does not necessarily impact treatment outcomes as suggested [9], rather addressing socioeconomic, emotional and psychological issues focusing on women leads to the satisfaction of the service. It appears that gender-related topics which were addressed aided to their recovery [11] and the approach of combined services (sexual health service) was preferred since it provided further support to women.

Despite the major limitation of the small and convenience sample, this study implies that just having a women-focused treatment facility does not necessarily contribute into achieving Key Performance Indicators (KPIs) related to treatment completion. It rather increases service satisfaction, places emphasis on addressing the gender-specific needs of women on ORT and provides them with resources tailored to their needs. Furthermore this study suggests that the location of the women only service could have an impact on retention in treatment as women seemed to prefer discreetness and a non- judgemental environment, away from other chaotic substance misuse service users.

References

1. Copeland J, Hall W. A comparison of women seeking drug and alcohol treatment in a specialist women's and two traditional mixed-sex treatment services. *British Journal of Addiction*. 1992; 87: 1293-1302.
2. Henderson C, Smith S, Smith C, et al. *Women and psychiatric treatment: A comprehensive text and practical guide*. East Sussex, England: Routledge. 2006; 352.
3. Mynatt S. "A model of contributing risk factors to chemical dependency in nurses". *Journal of Psychosocial Nursing*, 1996; 34: 13-22.
4. Nelson-Zlupko, Lani, Kauffman Eda, et al. *Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women*. *Social Work*. 1995; 40: 45-54.
5. Prendergast ML, Messina NP, Hall EA, et al. The relative effectiveness of women-only and mixed-gender treatment for substance-abusing women. *Journal of Substance Abuse Treatment*. 2011; 40: 336-348.
6. Rockville. *Substance Abuse Treatment: Addressing the Specific Needs of Women*. *Treatment Improvement Protocol*. 2009; 51.
7. Knight DK, Logan SM, Simpson DD. Predictors of program completion for women in residential substance abuse treatment. *American Journal of Drug and Alcohol Abuse*, 2001; 27: 1-18.
8. Greaves L, Poole N. Bringing Sex and Gender into Women's Substance Use Treatment Programs. *Substance Use Misuse*. 2008; 43: 1271-1273.
9. Greenfield SF, Trucco EM, McHugh K, et al. The Women's Recovery Group Study: A Stage I trial of women focused group therapy for substance use disorders versus mixed-gender group drug counselling. *Drug and Alcohol Dependency*. 2007; 90: 39-47.
10. Messina N, Grella CE, Cartier J, et al. Randomized Experimental Study of Gender-Responsive Substance Abuse Treatment for Women in Prison. *Journal of Substance Abuse Treatment*. 2010; 38: 97.
11. Greenfield SF, Cummings AM, Kuper LE, et al. A Qualitative Analysis of Women's Experiences in Single- Gender versus Mixed-Gender Substance Abuse Group Therapy. *Substance Use Misuse*. 2013; 48: 772-782.
12. Grella CE, Greenwell L. Substance Abuse Treatment for Women: Changes in the Settings Where Women Received Treatment and Types of Services Provided, 1987-1998. *Journal of Behavioral Health Services Research*. 31: 367-383.
13. Grella CE. Women in residential drug treatment: differences by program type and pregnancy. *Journal of Health Care for the Poor and Underserved*. 1999; 10: 216-229.
14. Greenfield SF, Brooks AJ, Gordon SM, et al. Substance Abuse Treatment Entry, Retention, and Outcome in Women: A Review of the Literature. *Drug and Alcohol Dependency*, 2007; 86: 1-21.
15. Covington SS, Bloom BE. *Gender-Responsive Treatment and Services in Correctional Settings*. *Women and Therapy*. 2006; 29: 9-33.
16. Greenfield Shelly F, Grella Christine E. What Is "Women-Focused" Treatment for substance Use Disorders? *Psychiatry Service*. 2009; 60: 880-882.