We recognise and pay respect to the Elders and communities – past, present, and emerging – of the lands that the University of Sydney's campuses stand on. For thousands of years they have shared and exchanged knowledges across innumerable generations for the benefit of all.

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Acknowledgement of Lived Experience

We honor the lived and living experience of our community members. By respecting your unique journeys, we are able to learn, grow, and work collaboratively to achieve better outcomes and foster a more inclusive environment.

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Working with NGOs

How they can support women with substance use disorders and their children

Prof Carolyn Day
Faculty of Medicine and Health
Edith Collins Centre, Sydney Local Health District
Alcohol and Drug Foundation NSW (operating Kathleen York House)
Sydney Medically Supervised Injecting Centre

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ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

ADDICTION DEBATE

doi:10.1111/add.14131

Do women with complex alcohol and other drug use histories want women-only residential treatment?

Joanne Neale[1,2]*, Charlotte N. E. Tompkins[1]*, Alison D. Marshall[3], Carla Treloar[2] & John Strang[1]

National Addiction Centre, King's College London, London, UK,[1] Centre for Social Research in Health, University of New South Wales, Sydney, Australia[2] and The Kirby Institute, University of New South Wales, Sydney, Australia[3]

No one size fits all

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

1752 *Letters to the Editor*

THE NEED FOR MORE RESEARCH AND CONSIDERED DEBATE REGARDING WOMEN-ONLY TREATMENT SERVICES: A COMMENT ON NEALE *ET AL.* (2018)

We were surprised to read Neale and colleagues' conclusions in their recent work on women-only services, which stated: 'Women who have complex histories of alcohol and other drug use do not necessarily want or perceive benefit in women-only residential treatment' (Abstract conclusion, p. 989) [1] and that women were 'routinely fearful and negative about entering women-only treatment' (p. 994) [1]. These conclusions and interpretations appear to misrepresent the findings based on the data presented and are at odds with the study's qualitative methodology. The authors report that some women were initially apprehensive or fearful but, based on our reading of the data presented, this was neither universal nor necessarily specific to the same-sex environment. Many of the challenges described were perhaps more attributable to the residential and therapeutic environment and there-

in their field, the authors are no doubt aware that qualitative research can provide rich and detailed insight into the experience of research participants, but it is rarely generalizable beyond the cases to the extent the authors suggest [1]. Although these limitations were identified in the Discussion, the authors failed to couch their conclusions within the context of these limitations.

We agree that it is both important and necessary to explore women's expectations and experiences of services and applaud the call for more research and critical discussion of research findings [6]. However, the interpretation and conclusions of any qualitative research should reflect the data adequately and reveal the lived experiences of participants and the contexts in which they are created.

Declaration of interests

C.D. is a Director of a non-governmental organization which provides residential treatment for drug-dependent women and their children. This is a voluntary, non-renumerated role.

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Why we need women only services

GUIDELINES FOR
THE TREATMENT OF
ALCOHOL PROBLEMS

GENDER ISSUES IN THE IDENTIFICATION AND MANAGEMENT OF AUD

AUD is more likely to be under-detected in women than men. As such, greater attention to routine and opportunistic screening of women is important. Where an AUD has been identified, gender should be considered when both screening for and treating AUD. Key gender-related issues when screening for and managing alcohol-related problems are:

1. Screening both women and men for domestic violence (victim and/or perpetrator);
2. Screening for alcohol-related violence in men;
3. Screening for and managing alcohol-related problems for parents and caregivers of children;
4. Screening of and advice for about contraception for women; and
5. Gender-specific treatment programs.

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ORIGINAL PAPER

Drug and Alcohol REVIEW APSAD WILEY

Unmet treatment need: The size of the gap for alcohol and other drugs in Australia

Alison Ritter | Keelin O'Reilly

"AOD treatment is significantly underfunded and under-resourced. In 2022/2023, less than half of the people suitable for AOD treatment received it."

Women's Health
Volume 19, 2023

https://doi.org/10.1177/17455057231200133

Sage Journals

Original Research Article

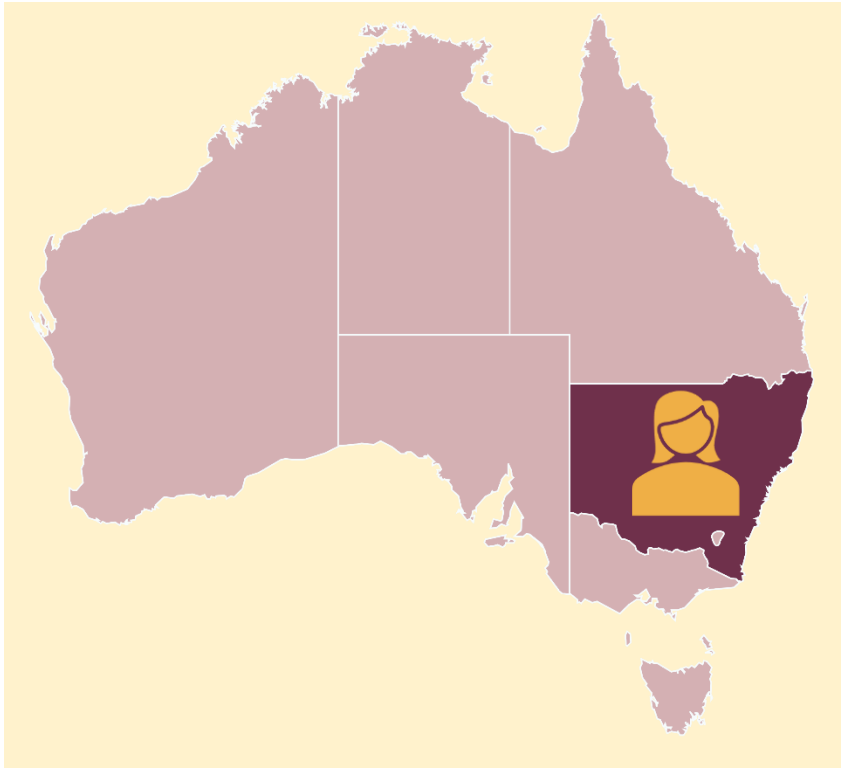
Characteristics of clients entering women-only substance use treatment services in New South Wales

Natalia Uthurralt [1,2], Felicia Miao Cao [1], Sharon E Reid [1,2], Latha Nithyanandam [3], Lucy Burns [4], and Carolyn A Day [1,2]

Who is entering women only treatment in NSW

- Six women-only NGO AoD treatment services, 2014-2018

- 1,357 women, mostly entering residential services (91%)
- Median age 33.8 years (range 17-67)
- 11% lived alone with children
- 45% self-referred to treatment
- 89% on temporary benefit



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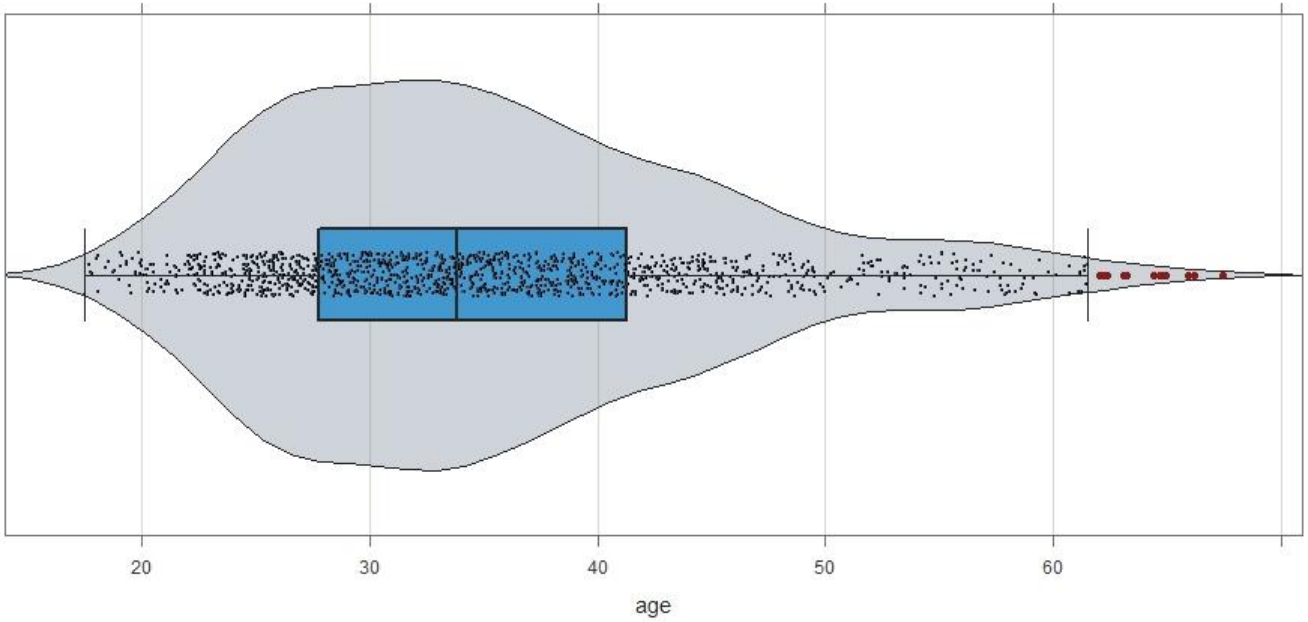
Median age at treatment entry 33.8 years, (range 17-67)



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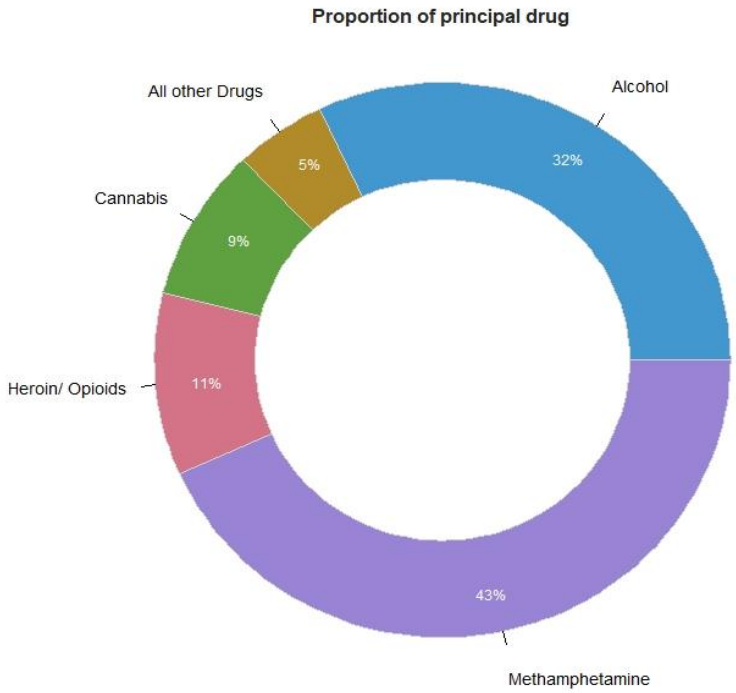
Principal drug of concern

- 43% methamphetamine
- 32% alcohol



Principal drug of concern

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Key findings

Women's only services **need** to ensure their programs can **respond** to a **high volume** of **younger women** presenting with **methamphetamine** use disorder, whilst also providing care for **older women** with **alcohol** use disorder experiencing **high levels of psychological distress.**

Case study

Residential Service

- 6+ month residential treatment program to women from diverse backgrounds wanting to overcome their substance use disorder
- Residential support to pregnant women during their pregnancy and after delivery to both the mother and child
- Supporting children up to the age of 11-years by providing them accommodation along with their mothers
- Parenting support
- Residential support to the visiting children during the weekends or during their school holidays
- Providing a physically and emotionally safe environment free from alcohol and other drugs

- Comprehensive assessments before admission and further assessments including mental health assessments on admission
- Holistic evidence-based interventions
- Medical assessment, including medication review
- Individualized treatment plans
- Case management and Counselling
- Group sessions
- Family assessments and meetings
- Psycho-education to the family about the nature, cause and management of SUD and relapse
- Assessment of children when needed and advocacy

More than AoD treatment

- Importance of these programs in terms of **prevention** – FASD, DV, **contraception**, other health needs (e.g., HCV treatment)
- Parenting programs – Tresillian, Brighter Futures, local services (schools, day care etc)
    - Limited long-term data on outcomes for children of women who attend these services
- **Legal support**
- Current gaps
    - Withdrawal management

Making pregnancy a choice

Process

1. Partner with local GPs (or other services) willing and able to provide LARC
2. Educate staff on effective contraception, including LARC
3. Develop policy and procedures around contraception discussion
4. Include LARC uptake as service outcome

Risk management

Trauma management	Careful prior assessment and therapeutic work; timing; method
Mistrust of healthcare services	Support and attendance; timing
Guilt, denial and embarrassment	Support and counselling; timing
Inadvertent coercion	GP (or service) responsible for prescription, consent and procedure
Costs	Partnership with services that bulk bill or provide subsidised care

Policy development

CONTRACEPTIVE POLICY

1. PURPOSE

The women's contraceptive policy (WCP) has been designed to aid KYH caseworkers in effective and informative contraceptive delivery to clients, advocating personal health and wellbeing to maximize the uptake of long-acting reversible contraception (LARC).

2. BACKGROUND

There is a consensus, Australia wide, that increased access and uptake of LARC is needed (Black, Bateson & Harvey, 2013). Australia has a high rate of unintended pregnancy and abortion (19.7 per 1000 aged 15-44 years) (Black et al., 2013) with the rate often higher for women with substance abuse problems. Women account for approximately 30–40% of clients attending alcohol and drug treatment services, yet their sexual and reproductive health is characteristically overlooked by health services (Sherman, Kamarulzaman, Spittal, 2008). Women are often subjected to added challenges concerning sexual relations with men, contraception, pregnancy and childbearing responsibilities (Cornford, Close, Bray, Beere & Mason, 2015). Pregnant women with substance abuse issues brings a multitude of both legal and ethical issues, often resulting in prejudicial and judgmental treatment from medical services and acts as a deterrent for women seeking help (Jones & Kaltenbach, 2013). It is reported that 1.3% to 2% of Australian women use illicit drugs during pregnancy (Abdel-Latif, Bajuk, Lui, & Oei, 2007), with data showing detrimental affects for those who do (Turnbull & Osborn, 2011). Children of women who use drugs are considered to be at risk of neglect and abuse (Abdel-Latif et al. 2007) and parental drug use are increasingly seen as a factor in child protective service provision (Abdel-Latif et al. 2007; Dawe et al. 2007). Amid the health needs of these women and the barriers associated with availability, accessibility and approachability of contraceptive health services, a clear gap is evident. The benefits for the women, children, families and governments are significant with effective uptake of LARC, as the implications of unintended pregnancies impact the economic, social, psychological and physical elements of both a woman and child's life.

3. PRINCIPLES

While women at KYH are participating in their six-month rehabilitation program, though before they commence transition, caseworkers have the opportunity to discuss, educate, inform and encourage women to select a suitable long-acting reversible contraception (LARC). This policy applies to all staff that delivers contraceptive education to clients.

4. OUTCOMES

Contraception is currently taught in Stage 5 of the NSW PDHPE curriculum. However, adolescents is often a turbulent time, and may involve risk taking behavior such as truanting. If women at KYH missed the opportunity during school and/or have forgotten, it is likely their understanding of effective LARC is limited. Through effective contraceptive education, clients are provided with the tools to strengthen their independence, feel empowered and have control over their bodies and their reproductive choices. At the completion of this meeting clients will understand the risks associated with not using contraception; will have an understanding of the available methods of contraception, in particular LARC; and will know the health services they can access, both while at KYH, during transition and into the future.

1. Economic Empowerment Objectives

- To enable women to engage in LARC and improve long-term livelihood opportunities.

2. Social Empowerment Objectives

- To change current mindset that limits their active participation in reproductive decision-making by raising awareness of sexual health and contraceptive methods, educating women on their options and available choices.

3. Health and Wellness Objectives

- To strengthen their independence and self-confidence, improving their physical, mental and social health through effective uptake of LARC.

5. FUNCTIONS AND DELEGATIONS

A range of LARC contraceptive devices are currently available in Australia, with several providing highly effective contraception for up to 5 and 10 years, (Black et al 2013, p. 317), however we are still seeing high rates of terminations and unplanned pregnancies among drug users. The response needed from caseworkers, is to work on improving clients understanding of contraceptive options through non-discriminatory discussions; raise awareness of the current health services available; and improve the overall contraceptive up-take of LARC and reproductive advice for women. As a caseworker it may be beneficial to assess:

1. How, if at all, does substance abuse affect their thoughts on LARC?
2. What restrictions and obstacles currently exist for the client when accessing LARC?
3. Does the client prioritize contraception?

It is the responsibility of the caseworker to deliver the contraceptive information clearly and ensure clients have the opportunity to ask for clarification if need be.

6. RISK MANAGEMENT

There are several factors that should be considered before discussing contraception options with clients and taken into consideration during the meeting. Women have identified several reasons for not utilizing the existing health care services (Howell & Chasnoff, 1999; Curet & His, 2002):

- Mistrust of healthcare services
- Fear of forced treatment or fear of losing custody of children
- Guilt, denial or embarrassment regarding their substance use
- Stigma
- Costs and difficulty of accessing services

CHECK LIST [APPENIX 1]

Caseworker: _____ Date commenced: _____

Client: _____ Date completed: _____

TO-DO	NOTES	COMPLETED
Read policy document		
If unfamiliar with contraceptive content, conduct further readings [appendix 2]		
Organise a one-on-one meeting with client [schedule 30 minutes]		
Discuss clients personal history with contraception		
Discuss methods of contraception and what might work best		
Provide information sheets regarding contraception and dispel any myths surrounding LARC		
Highlight the benefits of LARC		
Discuss suitable options for the client to adopt, try to come to a concrete conclusion whilst the meeting is in process		
Discuss health services available and book appointments for the client		
Client chooses method		
Client is fitted with a LARC device: please provide date and location		

Additional comments:

Approximately half of the residents each year make a choice about pregnancy

Legal issues – what can NGOs do?

Key issues for drug and alcohol clients

- Financial stress
- Health related (cost of medicines, access etc)
- Other external financial stresses e.g. credit card debt, predatory lending
- Family-related issues
- Domestic violence and child protection
- Housing problems
- Homelessness, access to stable housing, eviction

- Legal remedies, can address some of these issues, especially in the acute phase

Key issues for drug and alcohol clients

Financial stress

- Health related
- Other external financial stresses e.g. credit card, predatory lending

Family-related issues

- Domestic violence and child protection

Housing problems

- Homelessness, access to stable housing, eviction

Legal remedies, can address some of these issues, especially in the acute phase

Health Justice Partnerships

- Health Justice Partnerships (HJPs) involve the provision of legal services within a health service
- HJP may help address social determinants of health, which heavily influence outcomes for substance users, via legal remedies
- A HJP was established between a NGO legal service and a public drug treatment service within a tertiary hospital in Sydney, Australia

Legal problem	N (n=427)	%
Child protection	117	27
Family law	73	17
Tenancy	63	15
Fines and debt	49	12
Other legal issues	44	10
Family or domestic violence	36	8
Issues related to government (incl benefits, excl police)	19	4
Injury compensation	16	4
Government /administrative complaint against police	10	2

Key themes

“And that’s a big thing for me to say because of what happened to me, that I trust [solicitor], because trust is out the window and like, I didn’t trust the staff here, any other staff member here, even the nursing staff I didn’t trust, but I trusted [solicitor].”

"To be honest, I wouldn’t even – like, how can I put it? I just sort of left it up to [Social Services] to do it and they just didn’t do it for you, and when [the solicitor] come along, she made sure, you know, there was a visit four times a year. Like I missed five years, six years straight, all because no-one done it for me, and I didn’t really know how."

Legal privilege - seeking help without risk of mandatory reporting

Conclusions

- Women's only AOD services are essential – provided predominantly by the NGO sector
- They provide services which extend beyond traditional AOD services
- More resourcing is necessary for these services to operate effectively and expand to improve overall outcomes for women and children beyond traditional metrics
- More withdrawal management services needed!!

Acknowledgments

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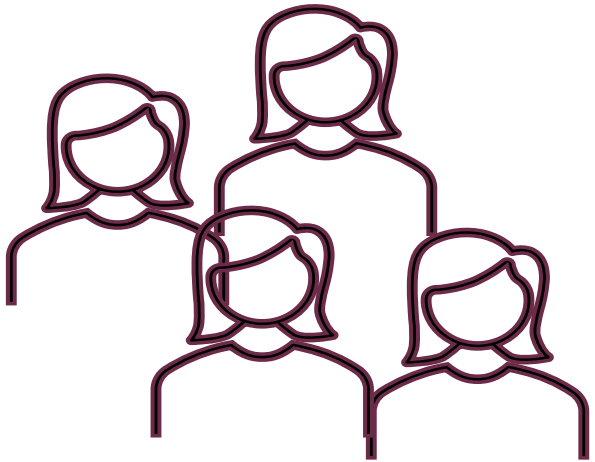
- All the clinical and service staff who have contributed to the research, especially Dr Latha Nithyanandan and the staff of KYH
- Sydney Women and Drugs Research (SWaDR) group



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