Sexual and reproductive healthcare provided onsite in an inner-city community drug and alcohol service

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BACKGROUND

People with substance dependence problems are at increased risk of poor sexual and reproductive health. They are known to be at high risk of sexually transmitted infections (STIs) and women have an increased risk of sexual violence, unplanned pregnancy, poorer pregnancy outcomes as well as having their children taken into care.[1–7] They are therefore a target group for specialist sexual and reproductive healthcare (SRH). However, take up of services is not meeting the existing need in this patient group. Delivering this care has always been challenging as clients who use addiction treatment centres do not readily engage with mainstream SRH services. This is not only related to ease of access of conventional SRH services but also to barriers such as internalised stigma or perceived infertility by drug-dependent women.[8]

WHY WAS CHANGE NEEDED?

Attempts to provide effective services for people with severe drug and alcohol addiction are often based on more effective signposting and advertising of existing services and the provision of priority care pathways. Our experience showed that this approach did not work even with a clinic within close geographical proximity. We believe that the main reasons for this were lack of trust in unfamiliar services and internalised stigma by drug users. Other barriers that have been identified are the demands of a drug-using lifestyle, altered perception of risk around sexual health, and practical problems. Drug users are within their comfort zone in the drug treatment centre and often have a very good relationship with health workers. In addition, The Hidden Harm Report has recommended the establishment of sexual health services within drug treatment centres.[9]

HOW DID WE GO ABOUT IMPLEMENTING CHANGE?

A needs assessment, completed by 104 potentially fertile women of reproductive age at the drug and alcohol treatment centre, revealed a high level of unmet contraceptive need as well as an interest in onsite service provision. Of the 104 women assessed, 80 (77%) said contraception was relevant to them and 57 (71%) wanted those services to be available in the drug and alcohol service. We set out to improve the SRH of patients attending a Tier 3 drug and alcohol treatment centre [run by the Southwark community drug and alcohol team (SCDAT)] in central London, UK. The local commissioner was crucial to all parts of the project not only for providing the initial funding (£50 000, of which £32 000 was used in the first year) but also for enforcing regular management team meetings and arranging follow-on funding through social services. Longer-term funding of the service has been agreed between children and family services and drug and alcohol commissioning dependent upon satisfactory reviews and recommissioning of services.

The intention was to open a SRH service within the community drug and alcohol team (CDAT), linked to and with support from the Department of SRH at Guy's and St Thomas' Hospital NHS Foundation Trust (GSTT). This was however not immediately possible as the consultant leading the project (RP) was delayed taking up post due to administrative reasons. Whilst awaiting contracts a care pathway was developed and optimised between SCDAT and a brand new state of the art sexual health clinic at

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Burrell Street, a mere 10 minutes' walk from the centre. Despite intensive advertising to patients and SCDAT staff, the care pathway was used by only seven patients over a 7.5-month trial period.

The initial plan was to 'export' a SRH clinic into SCDAT using SRH reception, nursing and medical staff, but staff shortages forced us to improvise and provide the service using the SCDAT reception, the blood-borne virus (BBV) nurse at SCDAT (SB) and a consultant from SRH (RP). The clinic was run parallel to a busy drug and alcohol service where many patients attended either for on-site substitute opiate dispensing or to see their keyworker or doctor. The clinic was delivered using counselling rooms and the clinic room with a multipurpose medical couch. The only new additional items purchased were an examination light and a mobile modesty screen. Drugs and medical records were stored on site at SCDAT.

Sexual health clinics were advertised to potential patients through their keyworkers and by means of posters in the waiting area. To avoid the stigma of sexual health the clinic was advertised on two different posters and promotional flyers either as a men's clinic or a woman's clinic. Clients registered themselves for the clinic by telling the receptionist that they wanted to be seen in the men's or women's clinic and were seen on a 'first come, first served' basis. Clients were called to the clinic in the same way as they would be called to see their keyworker or psychiatrist. On the days of the clinic the SRH consultant (RP) attended the morning multidisciplinary team meetings.

The clinic operated for 4 hours a week and offered nearly the full range of services of a Level 3 SRH clinic, including infertility and incontinence advice, sexual dysfunction and menopause management and STI care for men and women, including condom distribution and sexual health promotion and advice. However, our primary objectives were the prevention of unplanned pregnancies and the preservation of fertility to help women to have their pregnancies when it was right for them and when they had optimised their chance of a healthy pregnancy with a child that could remain with them.

In the planning phase of the service, incentivising for service use had been approved by the local ethics committee as there was initial uncertainty amongst the team whether incentivising would be ethical as we are dealing with a highly vulnerable but competent client group. The local ethics committee felt that the huge potential benefits of using low-level incentivisation outweighed the risks. The Clinical Ethics Advisory Committee at GSTT agreed and supported low-level financial incentives in the form of vouchers as they recognised the huge potential benefits that outweighed the risks (personal correspondence with the Chair of the Clinical Ethics Advisory Group by RP) Incentivising, also known as contingency management, is a standard intervention in drug and alcohol services and recommended by National Institute for Care and Clinical Excellence (NICE) guidelines to motivate clients more effectively.[10] The NICE guidelines state that "material incentives such as shopping vouchers up to £10 in value should be considered to encourage harm reduction for people at risk of physical health problems, including transmittable diseases, resulting from their drug misuse".[10]

Table 1 Summary of clinic activity

Activity	Without incentive (*n*)	With incentive (*n*)
Number of clinics	23	23
Mean number of consultations/clinic	3.6	3.4
Subdermal contraceptive implants	6	10
Intrauterine devices	0	1
Intrauterine systems	2	1
Depot medroxyprogesterone acetate	3	4
LARC years	28.75	46
Mean LARC years/clinic	1.25	2
Cervical smears	10	10

LARC, long-acting reversible contraception.

After the first 23 clinics we started incentivising using supermarket vouchers: a £2 voucher for everyone who attended the clinic for a full STI/BBV screen and a £5voucher for those who had a cervical smear, a subdermal contraceptive implant, a depot medroxyprogesterone acetate injection or an intrauterine device/system inserted (see Table 1).

Informal feedback received from SCDAT patients and SCDAT staff indicates that this service is appreciated and a formal evaluation is planned. Training of SCDAT staff is planned to increase their knowledge and interest and enable them to practise with more independence. So far one Faculty of Sexual & Reproductive Health (FSRH) SRH trainee has had the opportunity to experience working in a CDAT, thus gaining an understanding of working with people with mental health problems, the socially disadvantaged and those with complex contraceptive needs.

The service has been selected to receive the FSRH's 2014 David Bromham Award and has been rolled out to the Drug and Alcohol Service (Lambeth). We hope to offer similar care soon to other parts of the mental health trust. The service has broken down barriers for patients, providers and commissioners and other sectors of the mental health trust.

WHAT ARE THE KEY POINTS FOR OTHERS LOOKING AT REPLICATING THIS SERVICE?

1 Understand the needs of your client group and the needs of the services looking after them. The delay in obtaining a contract for the SRH consultant (RP) meant that he

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had a chance to spend the first 2 months learning about the clients and the SCDAT service. The SRH in-reach was then designed around clients' needs and those of SCDAT rather than simply exporting an existing model. Clients were given the chance to attend a SRH clinic in a familiar environment.

2 Work with service providers, particularly keyworkers and nurses. They will signpost patients and where needed 'hand-deliver' clients to the SRH clinic. Working with the BBV nurse, who is well respected within the client group of SCDAT, provided a 'celebrity endorsement' for RP and credibility by proxy.

3 Engage with the drug and alcohol team and do not just do your clinics. Attending morning briefings and communicating with keyworkers lowers the bar for them to address SRH issues with their clients and to refer them if need be.

4 Adapt tools used in the drugs service such as incentivising to increase uptake. Clients who would have replied with "I will think about it and come back next week" are more likely to make the decision immediately if offered incentives.

5 Make your commissioner your ally. Conduct a needs assessment showing the need for the service and work very closely with them. In our case the drug and alcohol commissioner lobbied the children's services commissioner to pick up the future costs of the service. This model of funding (by social service commissioning) is most appropriate as over half the children born to CDAT patients do not live with a biological parent, and taking a child into care is associated with costs in excess of £50 000 in the first year alone.

6 Enjoy the service. The clients are very grateful to be treated with respect and kindness and do not abuse the service. The service is not overrun by patients and every patient has complex problems that make the work challenging and interesting. The most rewarding part is preventing difficult and unplanned pregnancies with children needing to go into care, surely the most expensive and heart-breaking outcome of unsafe sex.

Competing interests None declared.

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