

Getting it right for women

Ignoring women's specific needs can leave them highly vulnerable to relapse.

Maggie Semmens and **Claire Clarke** describe how the team at Clouds House set about becoming more responsive to the women in their mixed-sex treatment centre.



There is ongoing debate about whether treatment services are sufficiently well organised to respond appropriately and effectively to the needs of women. Research evidence supports women-only treatment models and mixed gender programmes. It is clear that not all women need to be treated in female-only environments – some do not want to, and some will positively benefit from mixed sex units. But whatever their treatment setting, we need to ensure we are responding as effectively as possible to their particular needs.

Clouds House has been treating men and women in a mixed-sex facility for nearly 25 years. As part of our organisation's commitment to the continuous improvement of all of our services, we undertook a project to evaluate how responsive our treatment programme is to its female clients. We wanted to learn directly from women who had used the service whether we were being as helpful as we might be. We formed a working party of nurse team deputy managers, Rowena Barnett and Louise Black; and the two of us (Maggie Semmens, senior counsellor, and Claire Clarke, head of treatment services at Clouds House).

We held in mind that women have a number of issues specific to them which relate closely to their vulnerability to relapse. We were also aware of the evidence that many women can benefit from mixed-gender treatment if adequate attention is given to female specific issues. We included abuse, eating disorders and self-harm in this category.

A questionnaire was devised which covered seven areas: pre-treatment experience; therapeutic care; medical care; the treatment environment; family issues and visiting arrangements; post-treatment arrangements; and suggestions for improvement. There were four questions in each section, with room for additional comments. We intended for the questionnaire to take an average of 30 minutes to complete.

Since the start of the project in December 2006, questionnaires were sent through the post to 90 of the women who had been admitted into treatment in the last two years and were easily contactable. Some were living at home while others were still in secondary residential treatment. Just over half of the questionnaires (49) were

returned. Some women felt unable to fill out the forms by themselves and we spoke to them over the telephone to collect their responses. In addition we gave out questionnaires to women currently in treatment, and continue to collect feedback via this questionnaire, but this article covers the findings of a survey conducted over one year.

The respondents reflected the usual mix of clients to be found in treatment at Clouds House – women ranging from 18 to 65 from different socio-economic and cultural backgrounds. Some of these were pregnant women (the subject of a previous article by our medical consultant, Dr Gordon Morse, in *DDN*, 6 December, page 6) and the questionnaires suggested that they appreciated the sensitive and professional way that their detox was handled. We also received praise from an elderly blind lady who successfully completed her treatment with us.

In collating the responses to the questionnaire, it was gratifying to record satisfaction with much in our established approach. However, one theme in particular emerged that indicated a need for improvement: the women wanted their single-sex groups to be held more frequently and to be longer. At the time the questionnaire was issued, the women's group was held once a week and for one hour only. Feedback showed their strong appreciation of the time allocated for them to talk specifically with other women about the problems they have encountered throughout their lives. Many of them reported that residential treatment was the first place where they felt safe enough to talk openly. There were comments from some women about how much they had learned about humility from each other in this setting.

Taking this feedback on board, the time allotted to women's group therapy was increased in June 2007. The group was divided into two and the time extended to one and a half hours, ensuring that each of the women had much more time in which to make use of the group.

One of the female clients commented: 'When we asked the counsellors to reduce the size of women's group by splitting into two, this was agreed and dealt with in a week's time. The result was fantastic.' Our current female clients report that these groups are very empowering in terms of the installation of hope and the opportunity to change 'old behaviour'.

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We recorded the following comments from female clients on this subject: 'Women in addiction don't ever really relate well together and generally mix mainly with men or tend to be alone'; 'women are less likely to be able to manipulate each other'; and 'women are under pressure to please men and miss out on communications and friendships with women'.

We were interested to note that despite such comments, none of the women responding said that they would have preferred to have been in a single sex

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unit. In fact 68 per cent of those responding said they rated the experience as good and 30 per cent said it was excellent. Some of the comments were about the age difference between women, particularly where some had had problems with their mothers. There was a view that the mixed unit provided an opportunity for women to build back their trust of men and for men and women to learn to be around each other in a non-sexual way.

Some women said that although it was somewhat unusual for them to be 'sharing a bedroom at my age', they actually gained a lot from this by developing the kind of close friendship that many of them had not experienced before. An alcohol-dependent woman said she 'wouldn't like to share with an (drug) addict'. This prejudice was challenged when she experienced the support of her roommates (who were addicted to drugs) in resolving some of her problems in treatment – something she had previously felt she would never be able to do.

Some women told us that they appreciated the support and understanding offered to them around the issues of sexual abuse and self-harm. These issues are principally addressed in one-to-one counselling, mini-groups and in the women's group. As part of our ongoing training programme for the treatment team, we have revisited these areas with recent one-day workshops on addressing the issue of self-injury and of working with survivors of childhood abuse in residential treatment. We are holding another training day on eating disorders for members of the counselling and nurse teams.

Sunday visiting is an important part of the treatment timetable. There is an opportunity to have family meetings, and some children will be invited to take part in one or more of these sessions. On a practical level and as a result of the feedback, we have now improved our facilities for visiting children and we have a baby changing area and a stock of toys and games at hand.

In terms of their relationships with their children, the main source of the women's guilt appears to be around the lack of parenting skills and the behaviour that the children may have witnessed. Feedback from the questionnaire told us that coming face-to-face with family and friends for the first time when

not under the influence of drugs or alcohol was a frightening experience for some women. They felt grateful to be in a safe place where they could process their thoughts and feelings after the visitors had left. Some of the women told us that they set up their own groups on a Sunday evening following these visits, and they can also access the in-house AA meeting held the same night. We now check in with them about this on a Monday morning and may follow this up with a meeting with a family counsellor to clarify the direction they would like to take in working with their families. They have reported that this has allowed them the chance to offer support to each other in coping with any difficult feelings and emotions they had felt. Again, this experience appears to have brought the women closer together.

One woman stated that she was very lucky that she had the support of parents who were able to look after her child while she was in treatment – if she had not had their help she would not have been able to go on to further treatment. It seems that funding is not always available for these women to consolidate their recovery as they are expected to return home to take up their child care, and this can be a major stumbling block in the provision of drug and alcohol treatment for women. Since the formation of Action on Addiction through merger, we now have the opportunity to offer a care plan that includes referral to Hope House, a women only service in London. We also work closely with the Nelson Trust as part of our co-operative 'Treatment Link' project.

In working on this project the wide range of support we do offer our female clients at Clouds House has come more sharply into focus and it is reassuring to find from client responses that we have generally been on the right track. We have watched the ratio of men to women in treatment shift from 2:1 to almost equal numbers in the past year, and we welcome this shift – part of which we believe may be the result of our increased sensitivity and responsiveness to women's needs. We have started off this year with the firm intention of continuing to collect the views and suggestions of our female patients, and hope to be able to respond to their feedback by making the changes needed to keep actively improving our service.