Small incentives, big gains….does low level contingency management increase attendance and uptake of long-acting reversible contraception and cervical screening in a weekly sexual health clinic held at a community drugs and alcohol service?

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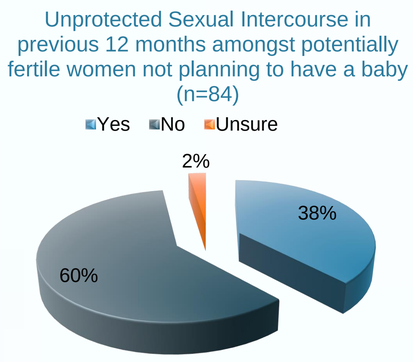
Introduction

Women using drugs and alcohol services are at higher risk of:

- unplanned pregnancies
- poorer pregnancy outcomes and having their children taken into care
- sexually transmitted infections
- sexual violence

A contraceptive needs assessment in the local community drugs and alcohol services confirmed high levels of unmet needs.



Recent studies have identified several barriers that prevent drug and alcohol users from accessing mainstream sexual health services.

Signposting clients to local sexual and reproductive health (SRH) service for rapid access was ineffective and the pilot in-reach service was implemented.

Aims

- improve the SRH of men and women attending an inner city tier 3 drugs and alcohol service
- reduce the number of unplanned pregnancies
- preserve future fertility

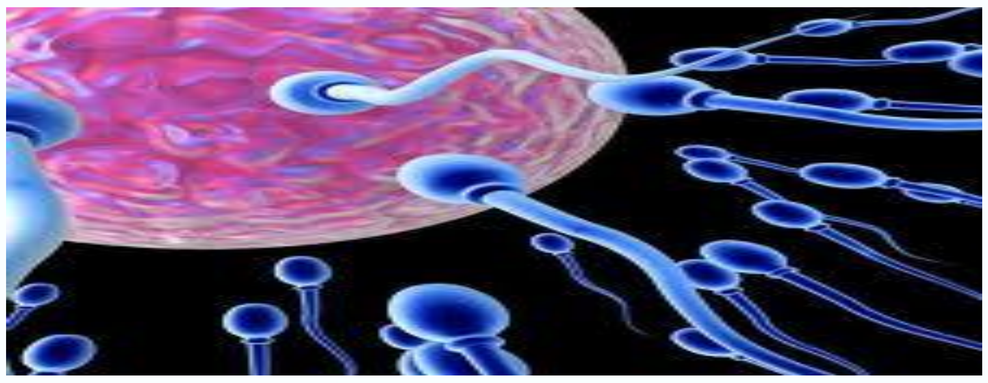
Methods

- evaluation of the first 46 weeks of a weekly SRH clinic provided for men and women within a tier 3 drugs and alcohol service.
    - **primary outcome measure**
    - initiation and continuation of long-acting reversible contraception (LARC)
    - **secondary outcome measures**
    - identification and treatment of sexually transmitted disease
    - provision of cervical smear tests
    - provision of other contraception methods
    - provision of other health advice/treatment/referral as necessary
- The clinic was advertised through face-to-face contact with staff, fliers and posters.
- after 6 months, we introduced incentives (supermarket gift cards) with ethics approval:
    - £2 for a full STI/BBV screen
    - £5 for a cervical smear test
    - £5 for intrauterine (coil) or sub-dermal (implant) contraception.
- The service was provided by “our” BBV nurse and a consultant in community sexual health at a cost of £38,000/year.

Results

	Without incentive	With incentive
Number of clinics	23	23
Mean consultations/clinic	3.6	3.4
Subdermal implants	6	10
IUD	0	2
IUS	2	1
DMPA	3	4
Years of LARC provided	28.75	56
Mean LARC years/clinic	1.25	2.4
Cervical smears	10	10

As part of this initiative, a further 8 SDIs were provided on postnatal ward (STH) during the 2nd period, 2 of whom were substance users, but no incentives were offered so have not been included above.
Other conditions managed included: HIV (1 new, 2 re-engaged care), PID, early and late syphilis, complete abortion, subfertility, urinary incontinence



Discussion

Unplanned pregnancies among women attending drug and alcohol services are common and can be preventable.

Utilisation of effective contraception remains low as clients / addiction services often have poor “SRH literacy” and clients feel stigmatised in conventional SRH services.

Addiction treatment services are increasingly performance managed. SRH is not an outcome that is currently measured with resultant reduced priority. Neglecting this area of health care can be costly.

Introduction of low level incentives (contingency management) initially appeared to increase service uptake and provision of effective LARC but latterly was not shown to be statistically significant. The time necessary to establish a new treatment initiative and embedding it within local “culture” (staff and clients) is likely to also be important. Further monitoring will be required with measures taken to ensure that the clinic is working to capacity.

Accurate cost / benefit analysis of an in-reach SRH service is complex with need to account for:

- immediate and long term emotional costs of separation for both parent and child
- financial costs including complex births, extended hospital stay for mother / child, future treatment needs, care proceedings and short/long term child support needs

Local C&F SSD and published reports suggest the following estimated costs:

- £25K care proceedings
- £35K annual cost of fostering a child
- £700K lifetime costs of a child in care

A conservative estimate of preventing 2 children going through care proceedings (£50K) makes the service financially viable with savings of £12K pa.

Effective SRH provision can support clients in managing substance misuse, optimising health, preparing for pregnancy / parenthood with reduced risk of child removal. Future funding requires careful planning and engagement of all stakeholders.

Other areas to be addressed include ensuring sustainability of the model (SRH staff; training addictions staff) and exploration of it’s application amongst other vulnerable patient groups.

Conclusions

A cost-effective in-reach sexual and reproductive health service has been established through:

- **identification of need**
- **multi-organisational and multi-disciplinary engagement including addiction treatment providers, sexual health providers, commissioners, children and families social services**
- **innovation and creative commissioning**
- **contingency management - patient attitudes changed from “I’ll think about it” to “Ok, I’ll do it now”**
- **further research into SRH provision for addiction clients is necessary**

Benefits for service users

- **choice and empowerment**
- **avoidance of unplanned pregnancy**
- **preservation of fertility until underlying difficulties addressed with realistic opportunity to parent**