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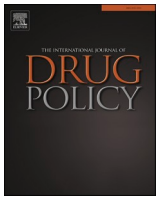

Review

Women and opioid use disorder treatment: A scoping review of experiences, use of patient-reported experience measures, and integration of person-centred care principles

Chloe J. Haynes *, Alison K. Beck, Megan Wells, Emma L. Hatton, Peter J. Kelly, Wan Jie Tan, Briony Larance

School of Psychology, University of Wollongong, Australia

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ABSTRACT

Background: Patient-reported experience measures (PREMs) are an important aspect of assessing and improving women's experiences of person-centred care during treatment for Opioid Use Disorder (OUD). This scoping review aimed to 1) examine the extent, type, and characteristics of evidence regarding women's OUD treatment experiences, and 2) describe the extent to which PREMs and person-centred care principles are incorporated within research methods.

Methods: Following Joanna Briggs Institute guidelines and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR), we conducted a scoping review to identify peer-reviewed articles on women's OUD treatment experiences. Data were extracted from 39 included studies and synthesised based on study design, method of assessment/analysis (including use of PREMs), key findings, and the integration of person-centred care principles.

Results: Analysis of included studies revealed a predominance of qualitative research focused on women's experiences of pharmacological OUD treatment (methadone and/or buprenorphine) in Western countries. Women in these studies reported predominantly negative or mixed experiences of treatment. Few studies used validated PREMs and there was a lack of direct assessment or focus on recognised person-centred care principles. However, common categories of outcomes/findings identified in results across studies broadly aligned with person-centred care principles (e.g., fast access to reliable healthcare, effective treatment by trusted professionals), emphasising their applicability to women's experiences of treatment.

Conclusions: Although there has been an increased focus on women's experiences of treatment for OUD in recent years, results highlighted room for improvement regarding the systematic and comprehensive assessment of women's experiences across different contexts. Given the often negative or mixed experiences reported by women, an increased focus on assessing service provision through a person-centred care lens (including utilising PREMs) may allow for service improvements or adaptations targeted towards the needs and experiences of women.

Introduction

Approximately 40.5 million people are dependent on opioids worldwide (Degenhardt et al., 2019), with the global opioid crisis being driven by consistently high pharmaceutical opioid use, as well as increased heroin and synthetic opioid (e.g., fentanyl) use (Barbosa-Leiker et al., 2021; Nolan et al., 2018; Quinones, 2015). The 'gold standard' treatment for Opioid Use Disorder (OUD) is pharmacological or opioid agonist treatment (OAT; i.e., methadone, buprenorphine), in combination with psychosocial support (Gowing et al., 2014). Other non-pharmacological treatment options include cognitive behavioural therapy and contingency management (Patel et al., 2021), residential treatment (Schuman-Olivier et al., 2014), and 12-step or other mutual support approaches (Kelly et al., 2019).

Since the late 1990's, opioid use and opioid-related harms among women have been increasing (Centres for Disease Control & Prevention,

* Corresponding author at: University of Wollongong, Northfields Avenue, Wollongong, NSW, 2500, Australia.
E-mail address: cjh893@uowmail.edu.au (C.J. Haynes).

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2015; Office on Women's Health, 2017). Despite this, the consideration of women-specific needs in substance use research and treatment is a relatively novel advancement, and is becoming particularly important as the number of women seeking treatment for opioid use continues to rise (Bawor et al., 2015). Research has demonstrated that women with OUD face complex and dynamic challenges (Springer et al., 2020), though it is difficult to adequately comprehend the nature and extent of these challenges without knowledge that is "grounded in practical lived experience" (Stanley & Wise, 1983, p. 33). Understanding the experiences of women who use opioids and seek treatment may facilitate treatment programs that are responsive to the needs of women (Rubio, 2013; United Nations Office on Drugs & Crime, 2004) and their treatment-related challenges (Springer et al., 2020). Consistent with the recognised importance of considering women's experience of substance use treatment, research in this area is growing. Existing literature is heterogenous, including a range of samples (e.g., women with current or historical OUD treatment experience, postpartum women, pregnant women, parenting women) within a variety of treatment modalities (e.g., methadone, buprenorphine, outpatient treatment, residential treatment, unspecified OAT, or general substance use treatment). This research, which has focused primarily on cisgender women, acknowledges that the experiences of women regarding opioid use and accessing treatment for OUD is generally associated with stigma, varying experiences of drug use and addiction, decisions to change, pathways to recovery, barriers to treatment (particularly for pregnant women), and varying perceptions of the specific treatment accessed (e.g., Chandler et al., 2013; Fallin-Bennett et al., 2020; Howard, 2015; Jackson & Shannon, 2012; Kelley et al., 2022; Mattocks et al., 2017; Morris et al., 2012; Ostrach & Leiner, 2019; Peacock-Chambers et al., 2019; Proulx & Fantasia, 2021; Radcliffe, 2011; Rubio, 2016; Schiff et al., 2022; Spector et al., 2021; Tsuda-McCaie & Kotera, 2022).

Research concerning experiences of health care has also started to shift towards the use of systematic and validated patient-reported experience measures, based on an increased emphasis on person-centred care within research and service provision (Jamieson Gilmore et al., 2023). However, it is unclear whether research regarding women's experiences of treatment for OUD reflects this shift. Person-centred care has been defined as "care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers" (Australian Commission on Safety & Quality in Health Care, 2011, p. 1) or "treating patients as individuals and as equal partners in the business of healing" (Coulter & Oldham, 2016, p. 114). The Picker Institute provides a useful framework for understanding and assessing person-centred care, involving eight principles (Picker Institute, 2023): 1) fast access to reliable healthcare advice; 2) effective treatment by trusted professionals, 3) continuity of care and smooth transitions; 4) involvement and support for families and carers; 5) clear information, communication, and support for self-care; 6) involvement in decisions and respect for preferences; 7) emotional support, empathy and respect; and 8) attention to physical and environmental needs. These principles are widely used to examine the degree to which health care services offer care that is inclusive, responsive, and person-centred (Picker Institute, 2023). A description of these principles is presented in Supplementary Table 1.

In research and service evaluation settings, measures which considerably aid in a comprehensive person-centred assessment include patient-reported experience measures (PREMs; (Davis et al., 2020). PREMs are surveys/questionnaires that gather important information on the person's experience across relational (e.g., experience of relationships during care) and/or functional (e.g., practical issues) aspects of treatment (Kingsley & Patel, 2017). This quantitative patient-level data can be used on individual (e.g., understanding perceived quality of care), service (e.g., monitoring effectiveness, benchmarking, evaluation) and system (e.g., improving continuity of care, transparency, and health literacy) levels (NSW Health, 2019). Another experience-related concept is satisfaction, which refers to the person's subjective views regarding the quality of their care (Kingsley & Patel, 2017). There is some debate regarding the conceptual and practical confusion between experience and satisfaction, with some arguing that PREMs are distinct from satisfaction measures due to their focus on objective views of what has or has not occurred during treatment (Bull et al., 2022; Kingsley & Patel, 2017), and others noting that satisfaction is an important component of assessing a person's overall experience of care (Sofaer & Firminger, 2004; Trujols et al., 2014). It is often difficult to disentangle one's subjective satisfaction with care from their overall experience of care and the two concepts are often related cyclically – with experiences of care impacting satisfaction, and satisfaction impacting perceptions or experience of care (Larson et al., 2019). It can therefore be argued that both objective experience and subjective satisfaction are important in increasing involvement in treatment and planning, identifying facilitators and barriers to treatment engagement, systematically increasing our understanding of people's experiences of treatment, and improving service provision (Bryant et al., 2008). As such, throughout this review, PREMs are noted to be inclusive of measures which assess treatment satisfaction.

Previous reviews have examined pregnant women's perceptions of OUD treatment (Tsuda-McCaie & Kotera, 2022), the accessibility of treatment among women (Khan et al., 2022), challenges for women entering treatment (Huhn & Dunn, 2020), the use of satisfaction surveys within opioid maintenance treatment (Trujols et al., 2014), and the use of PREMs (and outcome measures) within substance use treatment settings (Migchels et al., 2023). However, to our knowledge, there have been no reviews which synthesise the literature regarding women's experiences of engaging in treatment for OUD on a broad scale, including how PREMs have been used to draw conclusions regarding women's experiences. In addition, there have been no reviews which summarise the degree to which person-centred care principles have been integrated into research in this area. As such, the current scoping review aims to comprehensively examine the extent, type, and characteristics of evidence regarding women's experiences of treatment for OUD, and to determine the degree to which PREMs and person-centred care have been incorporated into this research. In doing so, this review aims to answer the following questions regarding women's experiences of treatment for OUD:

1. What types of evidence exist? What are the main study designs used?
2. What are the main populations and treatment modalities considered?
3. How has research assessed women's experiences of treatment? Have PREMs been used?
4. How has data been analysed and reported, particularly in the case of PREMs?
5. Does the evidence reflect a person-centred care approach or integrate recognised person-centred care principles (e.g., those described by the Picker Institute)?

In answering these questions, this scoping review aims to illuminate the current state of research regarding women's experiences of treatment for OUD, and to provide a critical analysis of the integration of person-centred care and related research methods in this area. A scoping review was chosen as the most appropriate type of review due to the complex and heterogenous nature of research in this area, and the importance of mapping and summarising the literature and identifying opportunities for future research (Peters et al., 2020b).

Methods

Protocol

This review adhered to the Joanna Briggs Institute Manual for Evidence Synthesis (Aromataris & Munn, 2020) for Scoping Reviews (Peters et al., 2020a). The Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR)

Checklist (Tricco et al., 2018) is presented in Supplementary Table 2. A protocol for the review was registered with the Open Science Framework prior to conducting database searches (access here: https://osf.io/3bg9e).

Search strategy

The search strategy for the current review, completed on 15th December 2022, aimed to locate published, peer-reviewed studies regarding women's experiences of treatment for OUD. An initial limited search of Medline and CINAHL was undertaken to identify articles on the topic. The title and abstract content of relevant articles and the index terms used to describe the articles were used to develop a full search strategy for Medline, Scopus, Web of Science, PsycINFO and CINAHL (see Supplementary Table 3 for search strategy and results of database searches).

The search strategy, including all identified key words and index terms, required minimal to no adaption for each included database and/or information source. All searches were conducted to identify key words and index terms within article titles or abstracts only to limit results to relevant sources. Studies published in any language were included, and there were no restrictions based on date of publication. Studies that were not in English were translated using Google Translate. The reference list of all included sources of evidence was also screened for additional potentially eligible studies.

Eligibility criteria for studies

A full description of the inclusion and exclusion criteria for the current review is presented in Supplementary Table 4. Studies were included if at least 80 % of participants identified as a woman (based on identified gender or assigned sex at birth if gender is not reported) and had current or historical experiences of accessing OUD treatment. Mixed-gender samples with less than 80 % women were also included where women's experiences of or satisfaction with treatment were reported/analysed separately. Similarly, studies were included if at least 80 % of the sample reported opioids as their primary substance of concern (McKenzie et al., 2019), or if less than 80 % reported opioids as their primary substance of concern but any opioid-specific findings were reported/analysed separately.

Studies were included in the current review if they examined women's experiences, perceptions, or satisfaction regarding engaging in treatment for their own opioid use (referred to generally as 'experiences of treatment' throughout this review). This included inpatient settings, residential or outpatient treatment, community or office based opioid treatment, and opioid treatment programs (e.g., methadone, buprenorphine). Community, clinician, private, and peer-led treatments were considered. Studies were excluded if they only reported on treatment outcomes (e.g., treatment retention, reductions in substance use). Treatments or interventions needed to be targeted towards OUD alone, or OUD alongside co-occurring conditions. Studies were excluded if they primarily focused on women's experiences of accessing other healthcare or social support services whilst receiving OUD treatment (e.g., difficulties accessing prenatal hospital care due to methadone treatment status).

As this review aimed to scope the study designs used to examine experiences, perceptions or satisfaction with treatment, few restrictions were placed on study design. All experimental, quasi-experimental, observational, and qualitative study designs were considered for inclusion. Review articles and other non-peer reviewed sources (e.g., grey literature, theses) were not included.

Study selection

Based on the initial search strategy, a total of 8440 articles were identified. After removing duplicates, 3083 articles were imported into Covidence. Titles and abstracts were then screened by two independent reviewers for assessment against the inclusion criteria for the review. The full texts of selected citations were imported into Covidence and assessed in detail against the inclusion criteria by two independent reviewers, with thirteen studies requiring translation (original languages of these studies included French, German, Greek, Hungarian, Iranian, and Spanish). Reasons for exclusion of sources of evidence at full text that did not meet the inclusion criteria were recorded. An additional four studies were retrieved and included through scanning of included studies' references lists. Any disagreements that arose between the reviewers at each stage of the selection process were resolved through discussion, or with an additional reviewer/s.

Data extraction

A specifically developed data extraction tool was used to extract data from included papers (see Supplementary Table 5). This data extraction tool was developed collaboratively with discussion among authors. Once a final tool was agreed upon, all data extraction regarding study information, sample, design/procedure, results, and discussion was completed by one reviewer, with any queries or concerns discussed with other authors.

Synthesis of results

Following extraction, frequency counts and narrative descriptions were used to synthesise the study designs, sample characteristics, methods of assessment and analysis, and use of PREMs in included studies. Consistent with the procedure described by Pollock et al. (2023), basic content analysis was conducted to identify common categories in the experience-related results extracted from included studies. Within each category, individual study findings were classified according to whether they reflected predominantly negative, positive, or mixed treatment experiences. An independent reviewer then checked the appropriateness of individual findings within each category, as well as the classification of results as negative, positive, or mixed. Any disagreements that arose were discussed between reviewers. This data is presented in Supplementary Table 6. Each individual study was then examined against the Picker Institute (2023) person-centred care principles to assess any focus on each principle either directly (explicit reference within the article), or indirectly (clearly able to be inferred from findings presented). Finally, the overall content of each experience-related category was examined and matched to the corresponding Picker Institute person-centred care principle(s) to provide an understanding of how these principles are represented in included studies. All findings are reported in tables, figures, and in-text discussions.

Results

Study selection

The results of the search and the study inclusion process are presented in a PRISMA-ScR flow diagram (see Fig. 1). A total of 39 articles were included in the current review.

Study characteristics

Table 1 provides an overview of included studies. Research was conducted across 13 countries, though predominantly in the United States ($k = 23$, 59.0 %). Despite no restrictions on publication language, almost all included studies were published in English, with only one study in Spanish requiring translation (Díaz, 2013).

There were 33 (84.6 %) cross-sectional and 6 (15.4 %) longitudinal studies, with longitudinal follow up periods ranging from four weeks (Lander et al., 2015) to 12-months (Marchand et al., 2011). Studies

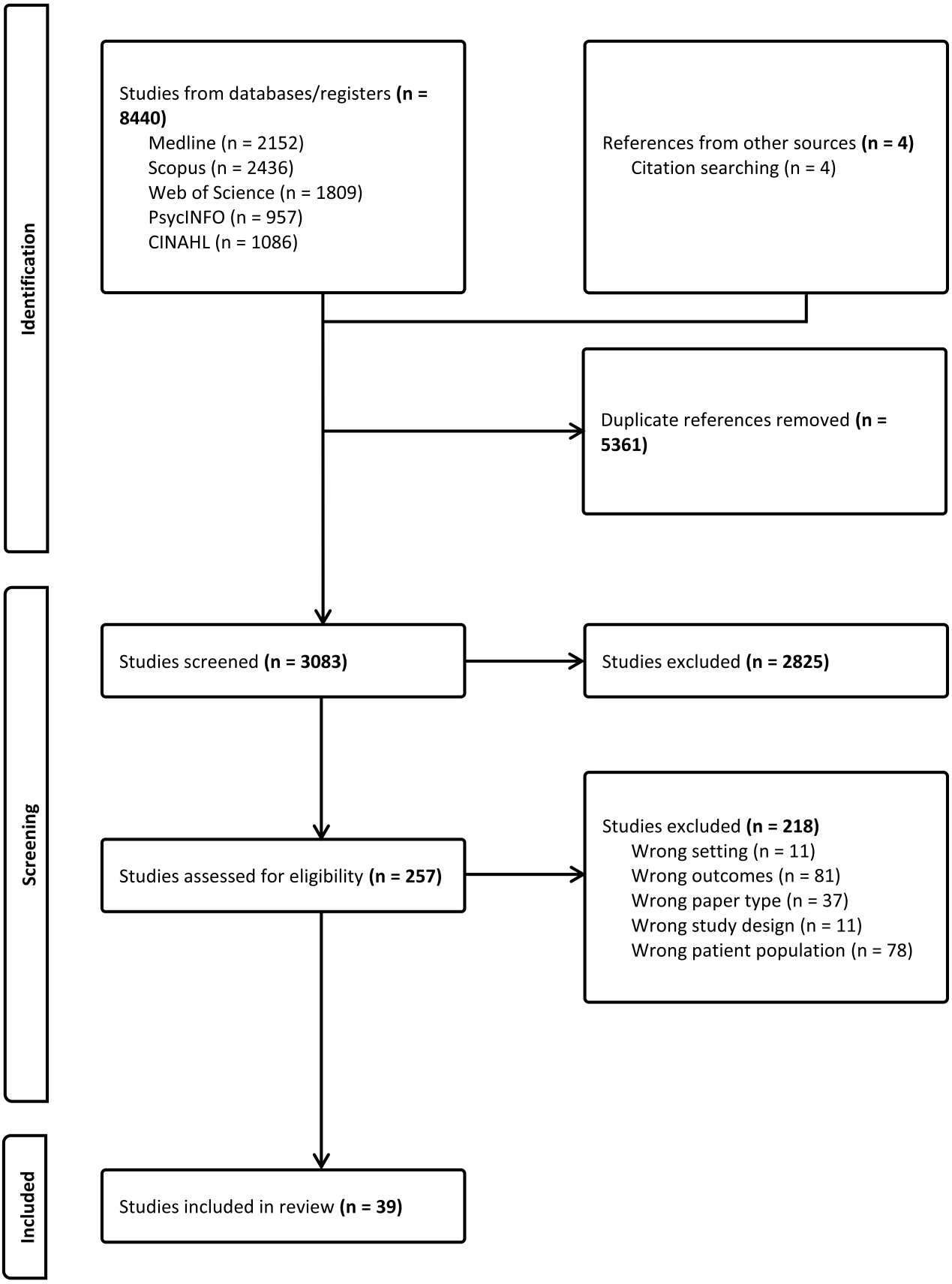

Fig. 1. Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for scoping review (PRISMA-ScR) flow diagram.

Table 1
Overview of included studies ($K = 39$).

Reference	Country	Study design	Target population	Treatment setting	Treatment type	N (total)	n (women)	Outcomes related to experience of treatment	Method of assessment	Method of analysis
Barry et al. (2007)	US	Cross-sectional, quantitative	Men and women participating in larger 24-week RCT	Primary care	Buprenorphine-naloxone	142	28	Satisfaction with treatment	Questionnaire developed by authors – *Primary Care Buprenorphine Satisfaction Scale*	Simultaneous multiple regression to assess predictors of satisfaction, including gender
Boeri et al. (2021)	US	Cross-sectional, qualitative	Pregnant or parenting women with current and/or historical treatment experience	Outpatient OAT Residential rehabilitation Community treatment	OAT Residential 12-step	58	58	Experiences of treatment (e.g., stigma, staff attitudes, perception of OAT, pharmacological effects, clinic operating hours, access for females, cost, location)	Semi-structured interview, field notes	Modified grounded theory; mixed methods and theoretical triangulation
Carrera et al. (2016)	Spain	Mixed methods: Longitudinal with 3 month follow up + focus groups (note: no women specific reporting of findings from focus group)	Men and women opioid users	Opiate Derivatives Treatment Program utilised by the Galician Network of Addictive Disorders	Multimodal, integrated care. Two treatment groups: 1) methadone + transfer to buprenorphine/naloxone maintenance 2) methadone only	Group 1 = 83 Group 2 = 52	Group 1 = 20 Group 2 = 19	Satisfaction with treatment	*Verona Service Satisfaction Scale for Methadone Treatment*	Multivariate logistic regression to assess predictors of satisfaction, including gender
Chandler et al. (2013)	Scotland	Longitudinal with follow up period up to 1 year postnatal, qualitative	Parents with drug dependency	General practice Specialist drug treatment services	Methadone Buprenorphine Dihydrocodeine	19	14	Structures surrounding engagement with OST (e.g., prescribing practices, relationships with health care and social workers)	Semi-structured interview	Sociologically informed narrative approach; comparative analysis
Chou et al. (2022)	US	Cross-sectional, qualitative	Women participating in mixed methods study developing behavioural intervention for OAT	Outpatient treatment centre	Interdisciplinary treatment (including counselling, buprenorphine - naloxone, methadone, and case management)	23	23	Experiences of OAT, stigma, and treatment needs	6 x focus groups	Thematic analysis; Lincoln and Guba's guide for trustworthiness, reliability, and validity
Deering et al. (2012)	New Zealand	Cross-sectional, mixed methods	Māori and non-Māori opioid users	Outpatient OAT	Methadone	93	42	Satisfaction with treatment	*Treatment Perceptions Questionnaire*	Descriptive statistics, *t*-tests to examine gender differences in satisfaction
Díaz (2013)	Puerto Rico	Cross-sectional, qualitative	Mothers with current/historical heroin use and treatment experience	Not defined	Not defined	5	5	Experience of stigma within treatment	Semi-structured interview	Discourse analysis
Fallin-Bennett et al. (2020)	US	Cross-sectional, qualitative	Postpartum women parenting a child under 5	Comprehensive care clinic	OAT Counselling Peer support	9	9	Experiences of peer support during OAT	2 x focus groups, semi-structured interview	Content analysis
Fiddian-Green et al. (2022)	US	Cross-sectional, qualitative	Women enrolled in treatment for at least 90 days	Outpatient OAT	Methadone Buprenorphine-naloxone	20	20	Fear, perceptions, and experiences with OAT pharmacotherapies	2x focus groups, semi-structured interview	Constructivist grounded theory, narrative content analysis, contextual analysis
Friedman and Alicea (1995)	US	Cross-sectional, qualitative	Women enrolled in methadone clinic (parent study also	Outpatient OAT	Methadone	30	30	Past and present experiences with	Semi-structured interview	Not defined

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Table 1 (*continued*)

Reference	Country	Study design	Target population	Treatment setting	Treatment type	N (total)	n (women)	Outcomes related to experience of treatment	Method of assessment	Method of analysis
			collected data from men, though this study reports women-specific findings)					treatment programs and staff		
Gallagher et al. (2022)	US	Cross-sectional, qualitative	Female drug court participants	Outpatient OAT	OAT	14	14	Experiences, benefits, and challenges of OAT	Focus group, semi-structured interview	Phenomenological analysis
Hanke and Faupel (1993)	US	Cross-sectional, mixed methods	Women opioid users	Outpatient OAT Residential rehabilitation	Methadone Residential	208	208	Experience of treatment, including female-sensitive services access/ availability	Interview with forced-choice responses	Chi square analyses to examine ratio of female to total clients and female counsellor availability by treatment modality
Higgs et al. (2008)	Australia	Cross-sectional, qualitative	Vietnamese women who use heroin	Outpatient OAT	Methadone	24	24	Attitudes towards treatment	Semi-structured interview	Iterative grounded theory
Hoff et al. (2017)	Ukraine	Mixed methods, secondary analysis (examining women data only)	Women with OUD and current injecting drug use	Outpatient OAT	OAT	380	380 (Qual sample = 67)	Treatment exposure/ access and experiences, attitudes towards extended-release naltrexone as alternative medication	Questionnaire incorporating established measures + 5 x focus groups	Quantitative: Descriptives and multivariate predictors of OAT utilisation. Qualitative: modified grounded theory
Kontautaite et al. (2018)	Estonia	Cross-sectional, qualitative	Women with current or past drug use, some also receiving HIV treatment	Outpatient OAT	OAT	38	38	Experience of OAT (particularly in terms of 'human rights violations' e.g., discrimination, criminalisation and stigmatisation of drug use)	Semi-structured interview	Method unclear, though "local activists" engaged in interpreting research results
Kramlich et al. (2018)	US	Cross-sectional, qualitative	Pregnant or postpartum women with past or current opioid use	Not defined	General treatment	13	13	Care experiences encountered throughout their treatment for substance use	Semi-structured interview	Framework analysis
Ledingham et al. (2022)	US	Cross-sectional, qualitative	Men and women who self-identified as having lived experience with disability and opioid use	Outpatient OAT or general SUD treatment	OAT, general treatment	28	15	Experiences initiating and engaging in treatment	Semi-structured interview	Thematic analysis
Lander et al. (2015)	US	Longitudinal with follow up until 4 weeks post-partum, randomised to treatment group upon entry to treatment	Pregnant women with OUD seeking treatment with buprenorphine	Randomised control trial	Pregnancy only buprenorphine + group therapy vs mixed-gender treatment as usual	45 (27 pregnant group; 18 TAU)	45	Satisfaction with treatment	Survey developed by authors	Satisfaction scores compared between treatment groups at 4-, 8- and 12-weeks post-enrolment (exact analyses not defined)
Lockard et al. (2022)	US	Cross-sectional, qualitative	Men and women with OUD who utilised virtual care visits during COVID-19 pandemic	General practice telemedicine	OAT	19	9	Experiences of treatment during COVID-19 pandemic	Semi-structured interview	Thematic analysis
Mallow and Steiker (2010)	US	Case study	Woman in recovery from heroin use	Not defined	General treatment	1	1	Experience of treatment/recovery	Not defined	Not defined

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Table 1 (*continued*)

Reference	Country	Study design	Target population	Treatment setting	Treatment type	N (total)	n (women)	Outcomes related to experience of treatment	Method of assessment	Method of analysis
Marchand et al. (2015)	Canada	Cross-sectional, mixed methods	Men and women with long term opioid dependence (at least 5 years)	Outpatient OAT	OAT	160	74	Satisfaction with treatment	*Client Satisfaction Questionnaire* Open-ended feedback regarding treatment	Multivariate linear regression; thematic analysis of open-ended comments
Marchand et al. (2011)	Canada	Longitudinal with 3 and 12 month follow ups, quantitative	North American Opiate Medication Initiative (NAOMI) participants – 25 years or older, at least 5 years opioid dependence, current daily injection of opioids and minimum of 2 prior treatment attempts	Randomised control trial	Injectable diacetylmorphine versus oral methadone	251	88 (3 months 91 (12 months)	Satisfaction with treatment	*Client Satisfaction Questionnaire* Open-ended feedback regarding treatment	Multivariate proportional odds model to determine predictors of treatment satisfaction
Morse et al. (2022)	US	Cross-sectional, qualitative	Women who participated in the opioid intervention court	Opioid Intervention court	General treatment	31	31	Experience of treatment and the opioid court	Semi-structured interview	Consensual qualitative research analysis (integrative approach incorporating elements from phenomenological, grounded theory and comprehensive process analysis)
Najavits et al. (2007)	US	Longitudinal with follow up 1 and 2 months after study intake, mixed methods	Women with OUD waiting for admission to methadone maintenance treatment	Pilot study of group therapy	A Woman's Addiction Workbook - 12 group sessions in 8 weeks, also 2 one-hour methadone-related individual sessions	8	8	Satisfaction with treatment	*Client Satisfaction Questionnaire Helping Alliance Questionnaire* Exit interview	Scores on measures scaled from 1 to 4, mean scores reported at months 1 and 2
Ndimbii et al. (2021)	Kenya	Cross-sectional, qualitative	Men and women accessing treatment for at least one month	Outpatient OAT	Methadone	30	9	Process of initial engagement and daily experiences of engaging with methadone	Semi-structured interview	Thematic analysis
Nelson-Zlupko et al. (1996)	US	Cross-sectional, Mixed methods	Women with at least 1 month sobriety	Specialist and non-specialist drug treatment	General treatment	24	24	Helpfulness of services and impact on recovery and overall life functioning	Survey developed by authors to rate helpfulness of services to recovery Semi-structured interview	Quant: frequency distributions of responses Qual: not defined
Noori et al. (2019)	Iran	Cross-sectional, qualitative	Women with opioid dependence	Outpatient OAT	Methadone	20	20	Experience of treatment, side effects of methadone	Semi-structured interview	Qualitative content analysis with conventional approach
Ostrach and Leiner (2019)	US	Cross-sectional + 4-month observation, qualitative	Women opioid users	Women in combined perinatal substance use treatment program	Buprenorphine or buprenorphine-naloxone alongside prenatal care	27	27	Benefits and challenges of treatment, additional treatment needs, barriers to treatment, effectiveness of treatment in meeting goals	Semi-structured interview	Modified grounded theory
Palis et al. (2017)	Canada	Part of larger RCT Cross-sectional, mixed methods	Men and women with long term opioid dependence who were not benefitting from available treatments	Randomised control trial (6-month treatment period delivered	Hydromorphone versus diacetylmorphine (Could also add oral methadone if desired)	202	62	Perceptions of treatment efficacy	Short interviewer-administered survey regarding experiences of first 6 months of treatment	Thematic analysis

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Table 1 (*continued*)

Reference	Country	Study design	Target population	Treatment setting	Treatment type	N (total)	n (women)	Outcomes related to experience of treatment	Method of assessment	Method of analysis
				under supervised model of care)						
Pérez de Los Cobos et al. (2005)	Spain	Cross-sectional, quantitative	Men and women with opioid dependence receiving treatment for at least 3 months	Outpatient OAT	Methadone	165	38	Satisfaction with treatment	*Verona Service Satisfaction Scale for Methadone Treatment* plus general question about perceptions of methadone	Descriptive statistics
Proulx and Fantasia (2021)	US	Cross-sectional, qualitative	Postpartum women within six months of birth with self-reported use of opiates or heroin	Outpatient OAT	Methadone Buprenorphine-naloxone	10	10	Experience of being mother receiving treatment	Semi-structured interview	Transcendental phenomenology
Rubio (2016)	US	Cross-sectional, qualitative	Women entering treatment with at least 12 months of opioid use	Outpatient OAT	Methadone + regular counselling and medical appointments as part of comprehensive treatment plan	13	13	Experience of treatment	Semi-structured interview	Interpretative phenomenological analysis
Schiff et al. (2022)	US	Cross-sectional, qualitative	Women diagnosed with OUD who had delivered live birth in last three years	Outpatient OAT	Methadone Buprenorphine	26	26	Beliefs, attitudes, and structural factors that impede or support treatment	Semi-structured interview	Constant comparative method
Syvertsen et al. (2021)	US	*Re*-analysis of qualitative data from study originally focused on NAS incidence	Women currently misusing opioids and/or enrolled in treatment who are either pregnant and at risk of delivering infant with NAS or had recently given birth to infant with NAS	Outpatient OAT	Methadone Buprenorphine	28	28	Experiences of treatment and stigma within treatment	Semi-structured interview	Content analysis
Tuchman and Drucker (2008)	US	Longitudinal pilot study with 1 year follow up, case study of subsample of participants	Women who had not completed treatment (i.e., became clinically unstable or returned to outpatient methadone)	Office-based treatment	Methadone	3	3	Experience of treatment, satisfaction with treatment	Eligibility screening form, methadone clinic counsellor referral, social work case notes, contact with client's medical team, clinical case conference notes reviewing patients monthly care, pharmacy, and social work visits	Triangulation and co-coding/auditing
Varty and Alwyn (2011)	UK	Cross-sectional, qualitative	Pregnant women taking prescribed opiate medication for treatment of heroin dependence for at least 2 weeks during pregnancy	Outpatient OAT	Methadone Buprenorphine	6	6	Experiences of treatment	Semi-structured interview	Constant comparative method
Welle-Strand et al. (2020)	Norway	Follow-up study of participants in	Women receiving treatment who	Outpatient OAT	Methadone Buprenorphine	67	67	Satisfaction with treatment	Survey developed by authors	Descriptive statistics of satisfaction rates

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Table 1 (*continued*)

Reference	Country	Study design	Target population	Treatment setting	Treatment type	N (total)	n (women)	Outcomes related to experience of treatment	Method of assessment	Method of analysis
		prior pregnancy cohort study, quantitative	delivered children between 2004 and 2009							
Williams and Privott (2018)	US	Cross-sectional, qualitative case study	Women no more than 12 months postpartum	Residential treatment	Integrated residential treatment facility	2	2	Experiences of treatment	Semi-structured interview	Codes drawn from Social Stress Model of Substance Abuse
Yona et al. (2021)	Indonesia	Cross-sectional, qualitative	Women with HIV and history of drug use but abstinent for at least 2 months	Outpatient OAT	Methadone	22	22	Experience of treatment	Semi-structured interview	Grounded theory

Note. General treatment = unspecified SUD treatment. Integrated treatment = combination of OAT plus psychosocial treatment. NAS = neonatal abstinence syndrome. OAT = opioid agonist therapy. TAU = treatment as usual.

primarily used qualitative methods ($k = 26$, 66.7 %), followed by mixed ($k = 7$, 17.9 %) or quantitative ($k = 6$, 15.4 %) methods. Primary data collection and analysis was conducted by 34 (87.2 %) studies. The remaining studies involved secondary analyses of women-specific data ($k = 3$, 7.7 %) or experience-related outcomes ($k = 2$, 5.1 %) collected during larger parent studies.

The publication year of included studies ranged from 1993 to 2022, with just under one-third ($k = 12$, 30.8 %) being conducted since 2021 (see Fig. 2).

Target populations

Eleven studies (28.2 %) assessed experiences of treatment among both men and women and provided women-specific analysis/reporting of results (Barry et al., 2007; Carrera et al., 2016; Chandler et al., 2013; Deering et al., 2012; Ledingham et al., 2022; Lockard et al., 2022; Marchand et al., 2015, 2011; Ndimbii et al., 2021; Palis et al., 2017; Pérez de Los Cobos et al., 2005). The remaining studies examined treatment experiences among women only. Among these studies, there was a large degree of heterogeneity in terms of the specific sub-population of women involved. Just under one-third ($k = 12$, 30.8 %) of included studies focused primarily on pregnant or parenting women, specifically: women with children (Díaz, 2013; Fallin-Bennett et al., 2020; Proulx & Fantasia, 2021; Schiff et al., 2022; Williams & Privott, 2018), pregnant women (Lander et al., 2015; Ostrach & Leiner, 2019; Syvertsen et al., 2021; Varty & Alwyn, 2011; Welle-Strand et al., 2020), pregnant or postpartum women (including in suburban areas only: Boeri et al., 2021; Kramlich et al., 2018). Other sub-populations included women reporting current opioid use and/or currently attending treatment for opioid use (Chou et al., 2022; Fiddian-Green et al., 2022; Friedman & Alicea, 1995; Hanke & Faupel, 1993; Kontautaite et al., 2018; Najavits et al., 2007; Noori et al., 2019; Rubio, 2016), women participating in some form of drug court intervention (Gallagher et al., 2022; Morse et al., 2022), women 'in recovery' or maintaining sobriety (Mallow & Steiker, 2010; Nelson-Zlupko et al., 1996), and women who did not complete treatment (Tuchman & Drucker, 2008). While most studies considered the experiences of treatment of White/-Caucasian women, some studies addressed additional complexities surrounding treatment experiences for racially or ethnically diverse populations, including women of Vietnamese ethnicity living in Australia (Higgs et al., 2008), women who inject drugs in Ukraine (Hoff et al., 2017), women who use drugs in Estonia (Kontautaite et al., 2018), women accessing methadone in Kenya (Ndimbii et al., 2021), Iranian women reporting substance dependence (Noori et al., 2019), and Indonesian women living with HIV (Yona et al., 2021).

Treatment settings

Two-thirds ($k = 26$, 66.7 %) of included studies were concerned with women's experiences of pharmacological treatment (i.e., OAT). Although OAT often involves adjunct psychosocial treatment, these studies reported on women's experiences with OAT only. Of these studies, the majority examined experiences with methadone (Boeri et al., 2021; Chandler et al., 2013; Deering et al., 2012; Fiddian-Green et al., 2022; Friedman & Alicea, 1995; Gallagher et al., 2022; Hanke & Faupel, 1993; Higgs et al., 2008; Hoff et al., 2017; Ndimbii et al., 2021; Nelson-Zlupko et al., 1996; Noori et al., 2019; Pérez de Los Cobos et al., 2005; Proulx & Fantasia, 2021; Schiff et al., 2022; Tuchman & Drucker, 2008; Varty & Alwyn, 2011; Yona et al., 2021). Additional pharmacotherapy treatments included unspecified OAT (Kontautaite et al., 2018; Lockard et al., 2022; Marchand et al., 2015; Syvertsen et al., 2021), buprenorphine (Fiddian-Green et al., 2022; Schiff et al., 2022; Varty & Alwyn, 2011), buprenorphine-naloxone (Barry et al., 2007; Proulx & Fantasia, 2021), methadone plus transfer to buprenorphine-naloxone maintenance (Carrera et al., 2016), injectable diacetylmorphine versus oral methadone (Marchand et al., 2011), and hydromorphone versus

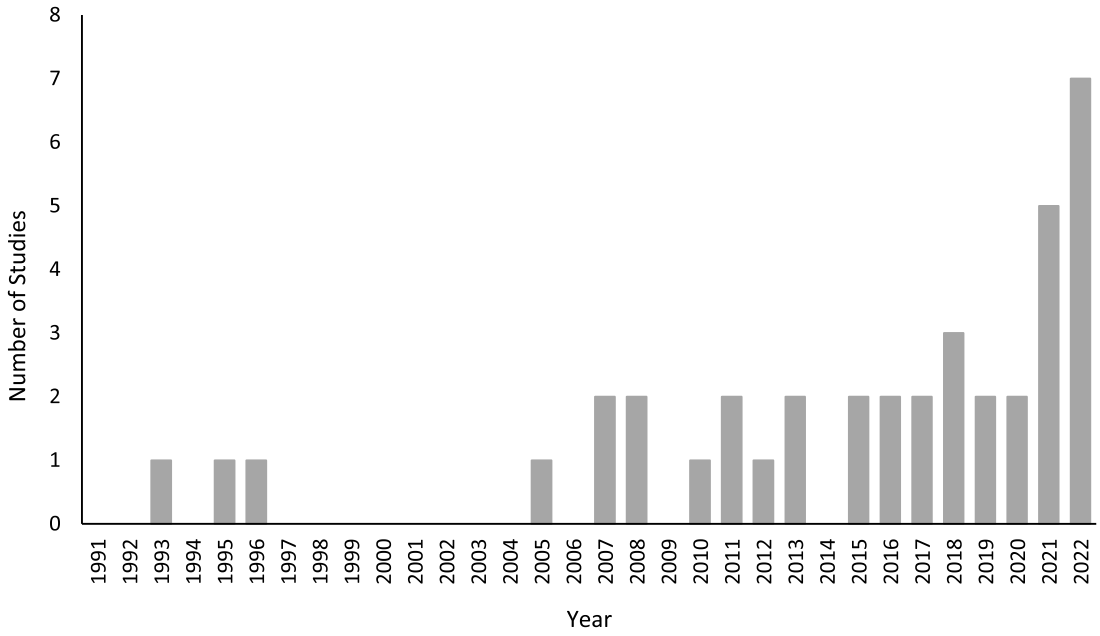


Fig. 2. Year of publication of included studies.

diacetylmorphine (Palis et al., 2017).

Six studies (15.4 %) examined women's experiences with pharmacotherapy plus integrated treatment services, which typically involved some combination of OAT plus counselling, peer support, and case management. Most of these integrated care services also provided prenatal/perinatal care or parenting support (Fallin-Bennett et al., 2020; Kramlich et al., 2018; Ostrach & Leiner, 2019; Welle-Strand et al., 2020). Three studies (Boeri et al., 2021; Hanke & Faupel, 1993; Williams & Privott, 2018) examined experiences with residential treatment services. Two studies assessed experiences with group therapy – Najavits et al. (2007) examined women's experiences with 'A Woman's Addiction Workbook' which involved 12-sessions across an eight-week period, while Lander et al. (2015) compared women's experiences and satisfaction with treatment in pregnancy-only group therapy versus mixed-gender treatment as usual. Other treatment settings considered included 12-step programs (Boeri et al., 2021) and generalised substance use treatments (Díaz, 2013; Ledingham et al., 2022; Mallow & Steiker, 2010; Morse et al., 2022).

Patient-reported experience measures

All quantitative and mixed-methods studies ($k = 13$) utilised surveys or questionnaires that can be considered PREMs due to their collection of numerical experience or satisfaction data. Of these studies, six (46.2 %) used PREMs that had been previously validated in the literature (Carrera et al., 2016; Deering et al., 2012; Marchand et al., 2015, 2011; Najavits et al., 2007; Pérez de Los Cobos et al., 2005), and one study involved both the development of a measure and the completion of validation procedures (Barry et al., 2007). Six studies used purposefully developed measures or single questions to assess a range of participant's treatment experiences or satisfaction with certain aspects of treatment. The validated and purposefully developed measures are discussed in turn below.

Validated measures

A description of the validated PREMs utilised by included studies is presented in Supplementary Table 7, including how these PREMs were used to assess and report women's experiences or satisfaction with treatment. This varied across studies, but typically relied on reporting average 'satisfaction' scores without additional contextual information. The most common PREM was the *Client Satisfaction Questionnaire* (CSQ-8; Larsen et al., 1979) used by three studies (Marchand et al., 2015, 2011; Najavits et al., 2007). Other validated PREMs included the *Verona Service Satisfaction Scale for Methadone Treatment* (VSSS-MT; de los Cobos et al., 2002) used by Carrera et al. (2016) and Pérez de Los Cobos et al. (2005), the *Treatment Perceptions Questionnaire* (TPQ; Marsden et al., 2000) used by Deering et al. (2012), and the *Helping Alliance Questionnaire* (HAQ; Luborsky et al., 1983) used by Najavits et al. (2007). Barry et al. (2007) developed the *Primary Care Buprenorphine Satisfaction Scale* (PCBSS), which was validated by the authors as part of their study.

Four of these studies analysed the relationship between gender and total treatment satisfaction scores, finding that women reported significantly higher satisfaction scores compared to men (Barry et al., 2007; Carrera et al., 2016; Marchand et al., 2011; Pérez de Los Cobos et al., 2005), though these studies generally did not provide any additional detail regarding women's specific satisfaction scores or experiences of treatment. One study found no gender differences in satisfaction scores (Deering et al., 2012). Remaining studies analysed women's overall satisfaction scores, concluding that women were largely satisfied with treatment (Marchand et al., 2015; Najavits et al., 2007).

Purposefully developed measures

A description of the purposefully developed PREMs is presented in Supplementary Table 8. Seven studies utilised measures which involved specific questions regarding women's experience of and/or satisfaction with treatment, including: satisfaction with group therapy (Lander et al., 2015), experience of pregnancy and satisfaction with treatment (Welle-Strand et al., 2020), the availability of female-identifying counsellors and women-specific treatment services (Hanke & Faupel, 1993), exposure to and experience of OAT (Hoff et al., 2017), the helpfulness of treatment to recovery (Nelson-Zlupko et al., 1996), and the perceived effectiveness of treatment (Palis et al., 2017). There was considerable variability across studies in the information provided regarding how these measures were developed and the questions and scoring methods utilised. However, these studies often provided more detailed results regarding women's experiences of treatment, rather than relying on overall 'satisfaction' scores. For example, Nelson-Zlupko et al. (1996) asked women to rate both the availability and perceived helpfulness of a variety of services. It was found that the services rated as most available (i.e., individual counselling, therapeutic medication, health care

monitoring, psychological evaluation, and addiction education) were not often perceived as the most helpful services for recovery. Instead, women rated services such as transportation assistance, help attaining food and housing, recreational activities, onsite health care and 12-step meetings as the most helpful services. Similarly, Hanke and Faupel (1993) concluded that many women did not perceive a lack of accessibility of female counsellors, but that the female sensitivity of services varied by treatment modality (with residential treatment being the most 'friendly to women' in terms of availability of female counsellors and access to different kinds of counselling). Palis et al. (2017) further outlined women's reasons for considering treatment to be effective, which included health and quality of life, stopping/reducing drug use or non-legal activity, reducing craving and withdrawal symptoms, allowing for money to be spent on other things, and the specific model of care used. Welle-Strand et al. (2020) concluded that women were satisfied with treatment, and Hoff et al. (2017) concluded that current OAT use for women is protective against a multitude of risks including risky sex, violence, and injection and depression severity.

Qualitative accounts of women's experiences

Two-thirds (k = 26, 66.7 %) of included studies utilised semi-structured qualitative interviews to assess participant's experiences of treatment, including four studies which conducted interviews in focus group formats (Chou et al., 2022; Fallin-Bennett et al., 2020; Fiddian--Green et al., 2022; Gallagher et al., 2022). While these studies did report on women's experiences of treatment, they did not utilise quantitative measures and are therefore not described as using a PREM. However, in addition to quantitative measures, seven studies also analysed qualitative participant experience data collected via comments made during the completion of a PREM (Deering et al., 2012; Marchand et al., 2015; Nelson-Zlupko et al., 1996; Palis et al., 2017), supplementary focus groups (Carrera et al., 2016; Hoff et al., 2017), or study exit interviews (Najavits et al., 2007). An additional two studies were case studies – Mallow and Steiker (2010) involved an analysis of the treatment experiences of a 'recovering woman', while Tuchman and Drucker (2008) involved a review of treatment documents, clinician case notes and monthly patient care check-ins to explore a woman's non-completion of office-based methadone treatment.

Basic content analysis was used to group key findings reported across these studies into 12 overarching experience-related categories: 1) *stigma* (e.g., stigma as a result of opioid use and/or OAT use, internalised stigma, stigma from community or health care services), 2) *perceptions of staff* (e.g., experiences of compassion, communication, information sharing, trust, safety, respect for preferences, regularity of contact), 3) *perceptions of efficacy and engaging in treatment* (e.g., beliefs regarding efficacy of treatment, sense of community, quality of treatment, access to different kinds of supports), 4) *experiences regarding pharmacological dosing* (e.g., control over dose reductions or changes, feeling "stuck" on pharmacotherapy), 5) *operational or logistic considerations* (e.g., strict treatment protocols, operating hours of clinics, managing daily demands of treatment), 6) *side effects of pharmacotherapy* (e.g., experience of physical and emotional side effects, concerns around side effects during pregnancy), 7) *experiences of women-specific services* (e.g., availability of services, preference for women-only treatments and more gender-responsive care), 8) *cost* (e.g., financial burden, insurance coverage, impact of employment), 9) *location* (e.g., travel time to treatment, transportation issues), 10) *fear of consequences or potentially negative implications of treatment* (e.g., involvement of child protective services and potential loss of child custody, fear of services reporting treatment status to potential employers, impacts on access to housing), 11) *considerations regarding pregnancy* (e.g., pregnancy as a motivator or barrier for treatment access, concerns about welfare and health of baby, coordination of substance use treatment and prenatal/postnatal health care), and 12) *impacts of treatment* (e.g., contribution to recovery, access to other treatment or support due to OAT treatment status, improvements in quality of life). The individual study results associated with each theme are presented in Supplementary Table 6. Table 2 shows the number of studies discussing each theme, as well as categorisations based on whether individual study findings within each theme reflected primarily negative, positive, or mixed experiences for women. Table 2 also includes a category of 'overall satisfaction' to reflect any quantitative or mixed-methods studies reporting women's overall satisfaction scores only.

As shown in Table 2, most experiences reported by women across categories were negative or mixed, particularly for categories relating to stigma, perceptions of staff, efficacy and engaging in treatment, dosing, operational/logistic considerations, availability of women-specific services, cost, and location. Though it was rarely discussed in included studies, when it was mentioned, women tended to reflect positively on the impact of treatment on their life and/or functioning.

Integration of person-centred care principles

Studies were examined to determine whether person-centred care generally, or recognised person-centred care principles, were present in the evaluation, presentation and/or discussion of women's experiences of OUD treatment. Where person-centred care was mentioned, it was often in the discussion or conclusion sections, where authors highlighted the importance of their results in further researching and improving person-centred care for women. It was rare for studies to acknowledge recognised person-centred care principles from the outset of study design. Despite studies' lack of explicit focus on person-centred care principles, there is a great deal of overlap between the Picker Institute person-centred care principles and reported findings regarding women's experiences of OUD treatment (see Fig. 3).

The commonly discussed experience-related categories (i.e., perceptions of efficacy and engaging in treatment, perceptions of staff, operational/logistic considerations, stigma) could be captured by the person-centred care principle *'effective treatment by trusted professionals'*. This demonstrates that majority of the literature regarding women's experiences of treatment for OUD tends to focus on practical experiences regarding access to treatment, efficacy of treatment, and relationships with staff. In comparison, experience-related categories that were less commonly discussed among studies (e.g., fear of consequences, considerations regarding pregnancy) can be mapped onto the person-centred care principles regarding continuity of care and smooth transitions, or involvement and support for family/carers. For example, the principle '*continuity of care and smooth transitions*' was noted to be primarily related to discussions of pregnancy, as pregnant women often require the integration of additional health and pregnancy-related services during their care. Similarly, the principle '*involvement and support for families/carers*' primarily appeared to be discussed in the context of women's fears of consequences of treatment, particularly in relation to their care of children, as well as concerns regarding limited childcare support during treatment.

Discussion

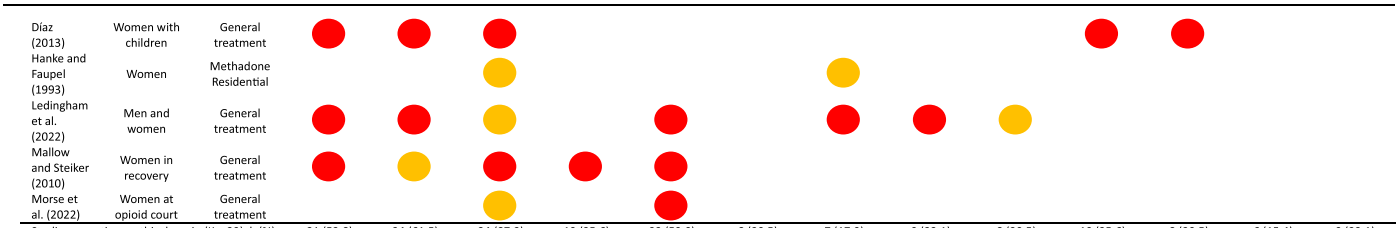
This review demonstrates that research regarding women's experiences of treatment for OUD is predominantly focused on experiences of pharmacological treatment in Western contexts. It also highlights that while studies relying on overall 'satisfaction' scores tend to conclude that women are largely satisfied with treatment, qualitative or mixed-methods studies demonstrate that women who access treatment for OUD, particularly pharmacological treatments, report mostly negative or mixed experiences. Women are often identified as a particularly vulnerable group in opioid treatment guidelines and policies, including the Australian National Guidelines for Medication-Assisted Treatment of Opioid Dependence (Gowing et al., 2014), the American Society of Addiction Medicine National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (Kampman &

Table 2
Nature of findings reported across key outcome categories identified in studies.

Ref.	Population	Treatment setting	Experience-related outcome categories											
			Stigma	Staff	Efficacy and engaging in treatment	Dosing	Operational or logistic considerations	Side effects	Female specific services	Cost	Location	Fear of consequences	Considerations regarding pregnancy	Impacts of treatment	Overall satisfaction
Pharmacotherapy only															
Barry et al (2007)	Men and women	Buprenorpine													🟢
Carrerra et al (2016)	Men and women	Methadone													🟢
Chandler et al. (2013)	Drug dependent parents	Methadone	🟡		🟡	🔴	🔴					🔴	🔴	🟢	
Deering et al. (2012)	Men and women	Methadone		🟡	🟡		🔴								🟢
Fiddian-Green et al. (2022)	Women receiving treatment for 90 days	Methadone Buprenorphine Naloxone	🔴	🟡	🔴	🔴	🔴	🔴							
Friedman and Alicea (1995)	Women	Methadone	🔴	🔴	🟡	🔴	🔴					🔴			
Gallagher et al. (2022)	Women in drug court	Methadone	🔴		🟡		🟡					🔴		🔴	
Higgs et al. (2008)	Women with Vietnamese ethnicity	Methadone	🔴		🟡					🔴					
Hoff et al. (2017)	Women who inject drugs	OAT: primarily methadone	🟡	🟢										🟢	
Kontautaite et al. (2018)	Women	OAT	🔴	🔴	🔴							🔴			
Lockard et al. (2022)	Men and women	OAT: tele-medicine		🟢	🟡		🟢								
Marchand et al. (2011)	Men and women	Injectable diacetylmorphine Oral methadone			🟢										🟢
Marchand et al. (2015)	Men and women	Methadone		🟢	🔴	🔴	🟢	🔴						🟢	🟢
Ndimbii et al. (2021)	Men and women	Methadone	🔴		🟢		🔴				🔴				
Nelson-Zlupko et al. (1996)	Women maintaining sobriety for ≥ 1 months	Methadone	🔴	🟡	🟡		🔴		🟡		🟢		🔴		
Noori et al. (2019)	Women	Methadone		🔴				🔴	🔴	🔴	🔴				
Palis et al. (2017)	Men and women	Hydromorphone Diacetylmorphine	🟢	🟢	🟢										
Perez de los Cobos (2005)	Men and women	Methadone													🟢
Proulx and Fantasia (2021)	Postpartum women	Methadone Buprenorphine	🔴		🟢		🔴			🔴		🔴			
Schiff et al. (2022)	Women with live birth in last 3 years	Methadone Buprenorphine		🟡	🟢	🔴	🔴	🔴	🔴			🔴	🔴		
Syvertsen et al. (2021)	Pregnant women	OAT	🔴	🔴	🟡		🔴			🔴		🔴	🔴		
Tuchman and Drucker (2008)	Women who did not complete treatment	Office-based methadone	🔴	🟡	🔴	🔴		🔴		🔴	🔴				
Varty and Alwyn (2011)	Pregnant women	Methadone Buprenorphine	🔴	🔴	🔴		🔴	🔴					🔴		
Welle-Strand et al (2020)	Women	Methadone Buprenorphine				🟡		🔴							🟢
Yona et al. (2021)	Women in recovery	Methadone			🟡	🔴	🔴				🔴			🟢	
Integrated treatment															
Chou et al. (2022)	Women	Integrated treatment	🔴	🟡	🟢		🔴								
Fallin-Bennett et al. (2020)	Postpartum women with child < 5	Integrated treatment		🟡	🟢		🔴								
Kramlich et al. (2018)	Pregnant or postpartum women	Integrated treatment	🔴	🟡	🟡	🟡	🔴				🔴		🟡		
Ostrach and Leiner (2019)	Perinatal women	Integrated treatment	🔴	🟡	🔴					🔴		🔴			
Rubio (2016)	Women	Integrated treatment		🟢	🟡					🟡				🟢	
Residential treatment															
Williams and Privott (2018)	Postpartum women	Residential treatment		🟢	🟡		🟡								
Group treatment															
Najavits et al. (2007)	Women	Group therapy			🟢		🟡		🟢						🟢
Lander et al (2015)	Pregnant women	Pregnant-specific group therapy vs TAU		🟢	🟢										🟢
General treatment or combinations of different treatment types															
Boeri et al. (2021)	Pregnant or parenting women in suburban areas	Methadone Residential 12-step	🔴	🔴	🔴		🔴	🔴	🔴	🔴	🔴	🔴	🟡		

(continued on next page)

Table 2 (*continued*)



Díaz (2013)	Women with children	General treatment												
Hanke and Faupel (1993)	Women	Methadone Residential												
Ledingham et al. (2022)	Men and women	General treatment												
Mallow and Steiker (2010)	Women in recovery	General treatment												
Morse et al. (2022)	Women at opioid court	General treatment												
Studies reporting on this domain (K = 39), k (%)			21 (53.8)	24 (61.5)	34 (87.2)	19 (25.6)	23 (59.0)	8 (20.5)	7 (17.9)	9 (23.1)	8 (20.5)	10 (25.6)	8 (20.5)	6 (15.4)	9 (23.1)
Nature of findings (k, %)															
Mostly positive			1 (4.8)	7 (29.2)	9 (26.5)	0 (0.0)	2 (8.7)	0 (0.0)	1 (14.3)	0 (0.0)	1 (12.5)	0 (0.0)	0 (0.0)	5 (83.3)	9 (100.0)
Mixed findings			2 (9.5)	10 (41.7)	15 (44.1)	2 (20.0)	3 (13.0)	0 (0.0)	2 (28.6)	1 (11.1)	1 (12.5)	0 (0.0)	2 (25.0)	0 (0.0)	0 (0.0)
Mostly negative			18 (85.7)	7 (29.2)	10 (29.4)	8 (80.0)	18 (78.3)	8 (100.0)	4 (57.1)	8 (88.9)	6 (75.0)	10 (100.0)	8 (75.0)	1 (16.7)	0 (0.0)

Note. General treatment = unspecified SUD treatment. Integrated treatment = combination of OAT plus psychosocial treatment. OAT = opioid agonist therapy. TAU = treatment as usual. Colour indicates nature of experiences reported by women in each study within each key theme (red = mostly negative, yellow = mixed experiences, green = mostly positive).

Jarvis, 2015), and the Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (World Health Organization, 2009). As such, responding to the needs of women is an important clinical, research and policy priority – this includes the importance of improving how women's experiences are measured and described, and how these experiences can be used to inform targeted service recommendations or policy adaptations to improve the experiences of women on a broad scale.

Despite much of the research regarding women's OUD treatment experiences being related to pharmacological treatment, it is important to note that this does not occur in isolation. Whilst it is important to understand how women experience pharmacological treatment due to its standing as the 'gold standard' treatment for opioid use (Gowing et al., 2014), in order to ascertain a comprehensive understanding of women's treatment experiences it is important to acknowledge that this treatment requires a complex and individualised combination of supports. Assessing women's experiences of how well these supports are delivered, integrated, and coordinated is important in understanding women's general experiences of navigating multifaceted treatment systems and how services may be streamlined or adapted to improve women's experiences.

The current literature on women's experiences of treatment for opioid use demonstrated some focus on pregnant or postnatal women, which is consistent with concerns regarding the potential complications of opioid use for developing foetuses (Centers for Disease Control & Prevention, 2022) and the increased prevalence of neonatal abstinence syndrome worldwide (Zyoud et al., 2022). Many included studies considered the experiences of women more generally, rather than specifically related to pregnancy or parenting, highlighting the importance of understanding the diversity of women's experiences. In order to improve service access and provision for all women, continued research regarding the myriad of difficulties women who use opioids face, regardless of pregnancy or parenting status, is warranted. Additionally, there was a general conflation of sex and gender across included studies, as well as a focus on cisgender women, which limits our understanding of the experiences of non-binary, transgender, or gender diverse populations.

The current literature also demonstrates a predominantly Western-centric view of treatment, as almost all studies were conducted in the United States or other high-income nations. While the US is noted to have the highest prevalence of illicit opioid use globally, high rates of opioid dependence have also been observed in the Middle East and East Asia (Degenhardt et al., 2019) and women accessing treatment in these countries are under-represented in the literature. There is also evidence of considerable geographical variations in treatment availability and delivery (Degenhardt et al., 2019; Mathers et al., 2010; Wu & Clark, 2013). However, it is acknowledged that this geographic disparity in the literature may be due to the stigmatised nature of women's substance use across socio-geographic contexts. Research has demonstrated that recruiting women who use substances can be difficult in some settings (e.g., Razani et al., 2007). This can be compounded by varying laws, policies and structural-level stigma surrounding substance use, particularly in developing or low-income nations (e.g., Myers et al., 2009; Slabbert et al., 2020). Understanding how women who use opioids experience treatment and navigation of treatment systems in this context of limited treatment availability, and broader structural level barriers to care, is an important consideration for future research, particularly given the calls for scaling up and improving the coverage and quality of treatment for opioid use globally (Degenhardt et al., 2019).

Use of patient-reported experience measures

Across 39 studies included in this review, only seven used validated PREMs to assess women's experiences of, or satisfaction with, treatment (see Supplementary Table 7) and six used measures which could be considered PREMs, but which were purposefully developed and not validated (see Supplementary Table 8). While this is consistent with the large degree of heterogeneity observed in terms of the specific research aims across studies, it demonstrates how the literature has room for improvement in terms of the systematic and reliable collection of data regarding women's treatment experiences. However, it is also noted that this lack of use of PREMS may reflect the general lack of specific substance use treatment PREMs that have been developed and validated across the literature more generally. It has been suggested that using PREMs that are specifically developed for the context in which they are to be used is vital in ensuring the reliable collection of data regarding treatment experiences (Kingsley & Patel, 2017). As such, a focus on PREMs which are specifically developed to assess women's experiences of treatment for opioid use may be the first step in improving the integration of person-centred care and validated data collection in this area.

Consistent with the debate within the literature regarding the relative utility and often concurrent use of PREMs and satisfaction measures, the current literature also shows large variability in terms of the specific measures used and the reporting of findings. Despite the ability of validated measures to highlight specific aspects of a person's treatment experience, and satisfaction with these aspects, many studies reported only single overall satisfaction scores. These results were often used to conclude that women are highly satisfied with treatment, and report higher treatment satisfaction than men. However, consistent with Trujols et al. (2014), these generally high satisfaction scores were often not aligned with women's experiences or perceptions of treatment where qualitative or mixed methods were used. This could also reflect the context in which satisfaction data is collected – for example, satisfaction surveys completed at the request of clinicians may be more positively skewed, whereas data collected externally (e.g., through anonymous

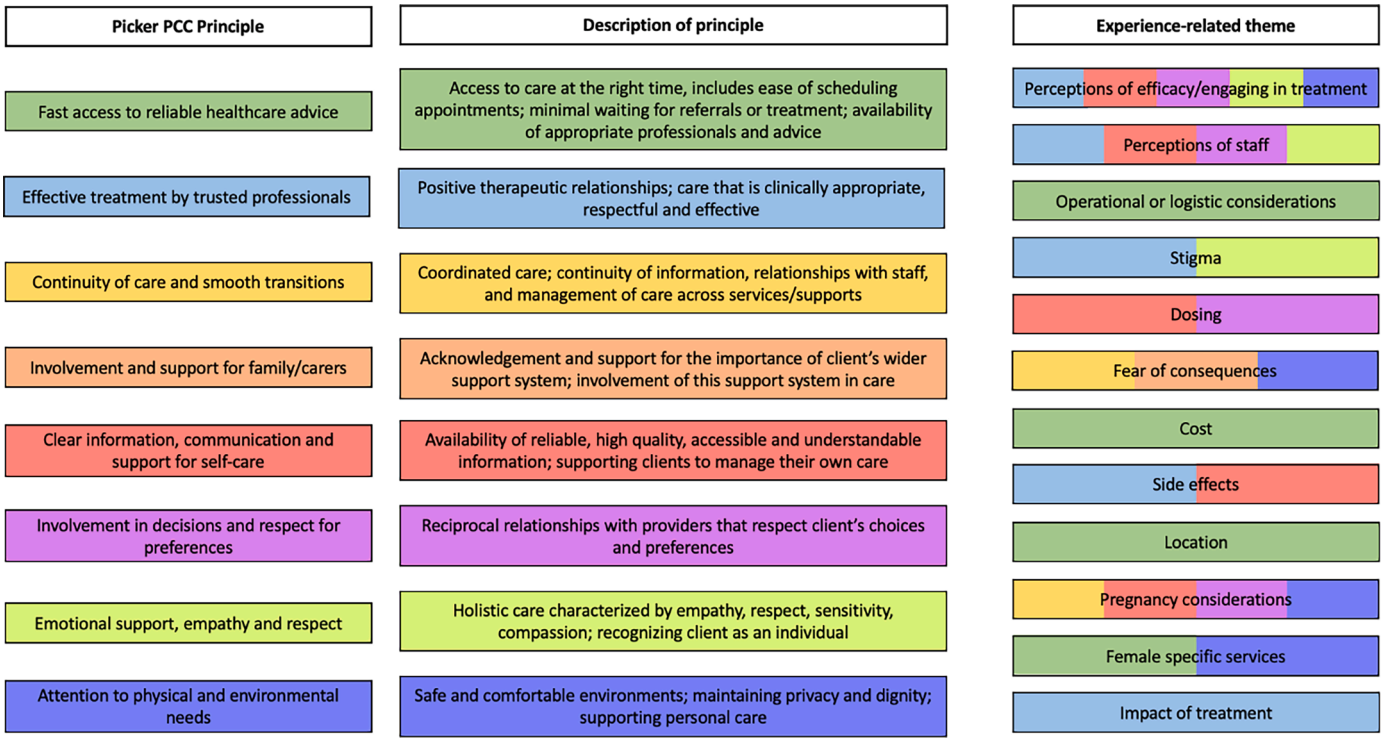


Fig. 3. Mapping of twelve experience categories identified across studies onto person-centred care principles.
Note. Description of principles obtained from Picker Institute (2023). Mapping based on principles which best apply to content of results and experiences identified by women within each key outcome/theme. Outcomes reported are listed based on frequency of reporting across studies, from most to least frequent.

questionnaires or external research) may highlight more negative opinions or perceptions of the treatment received.

This dichotomy reflects an important consideration for the future development and use of PREMs – while assessing satisfaction remains an important component of a comprehensive assessment of treatment experiences, it is important that PREMs are utilised in a way that provides meaningful data which can be used to inform and improve service provision. Therefore, to ensure that the experiences of women are meaningfully reflected in clinical practice and policy, it is important for future research to consider how PREMs can be used to capture a) overall treatment satisfaction, and b) experiences with, or perceptions of, specific aspects of treatment which may impact this overall satisfaction.

Integration of person-centred care principles

Across studies included in this review, there was a lack of explicit assessment of women's experiences of treatment in the context of established person-centred care principles (e.g., those defined by Picker Institute, 2023). Despite this, almost all studies reported on outcomes that have been identified as important to person-centred care treatment approaches. Fig. 3 provides an indication of the utility of the current literature in informing how these principles have been experienced by women during treatment, and further emphasises the applicability of the Picker Institute principles in the study of women's experiences of treatment. However, it also demonstrates that drawing broad conclusions regarding women's experiences of specific person-centred care principles is difficult due to the large heterogeneity in outcomes measured and reported, and the difficulty in retrospectively fitting these outcomes into person-centred care principles.

As such, a systematic assessment of these recognised principles may be useful in synthesising findings regarding women's experiences of treatment and person-centred care. For example, rather than broadly enquiring about women's experiences with staff during treatment, it may be pertinent to separately enquire about women's experience of a) trustworthy staff, b) effective communication and support for self-care, c) involvement in treatment decisions and staff member's respect for individual preferences, and d) empathy and respect during interactions with staff. Structuring the assessment of women's treatment experiences in this way may provide more meaningful data regarding the specific aspects of staff relationships and involvement women are satisfied with, or which areas may require improvement. Specific assessment of these recognised person-centred care principles may also aid in making targeted recommendations for clinical practice and service provision based on identified shortcomings both within individual services, and across treatment modalities.

Additionally, the person-centred care principles which seemed to attract the most indirect attention within the current literature are those directed towards treatment access and efficacy. Whilst these principles are important in developing an understanding of the efficiency of current treatment services, an increased focus on all aspects of person-centred care (especially involvement and support for family/carers and continuity of care and smooth transitions, which are currently underrepresented) is important in gaining a comprehensive understanding of the complex situations of women and their experiences of treatment.

Strengths and limitations

This review provides a comprehensive overview of women's experiences of treatment for OUD and used a reproducible and clear procedure for identifying and synthesising studies. Included studies were analysed and reported in depth, allowing for a comprehensive understanding of the characteristics of published literature in this area, as well as potential gaps in the literature and areas for future research.

The review is limited to peer-reviewed articles indexed in five databases (Medline, Scopus, Web of Science, PsycINFO and CINAHL) and is subject to publication bias. Some limitations also exist regarding the nature of studies included in this review. Studies which primarily focused on treatment barriers were not included, as the review was

primarily concerned with women's experiences during a treatment episode. Despite this, women experience significant and unique barriers to treatment access and engagement, and this remains an important area for future research. Similarly, this review did not include studies which considered women's experiences of general health care access based on their OUD-treatment status. For example, many studies identified in full-text review involved women who were accessing treatment (mostly OAT) during pregnancy and their resulting experiences of accessing general health care services related to their pregnancy or childbirth. This reflects a specific, albeit incredibly important, area for future research, particularly in the context of improving integration of services and person-centred care across all areas of women's care. While the current review endeavoured to include non-English articles to reduce bias, all non-English articles were translated using Google Translate. Research has demonstrated that Google Translate is a viable tool for translating non-English articles for the purpose of abstracting data for systematic and scoping reviews (Jackson et al., 2019). However, it is possible that potentially eligible non-English articles may have been excluded due to translation errors, and that some conclusions drawn from the included Spanish article may have been misinterpreted.

Finally, it is acknowledged that there is additional complexity that may have been missed in this review due to the intricacies surrounding sex and gender. Consistent with Rebić et al. (2023), there was a general conflation of sex and gender within the literature regarding women's experiences of OUD treatment, which may result in some oversight regarding the additional treatment related challenges experienced by transgender people or people who identify outside the binary conception of gender. As suggested by the National Academies of Sciences Engineering and Medicine (2022), clearer conceptualisation of sex and gender and improved measurement of these constructs may aid in identifying minority populations and better understanding the unique challenges they experience.

Conclusion

This scoping review demonstrated that the research regarding women's experiences of treatment for opioid use is developing, though several important opportunities for future research have emerged. This literature provides insight into the often negative or mixed experiences of women who receive treatment for opioid use, particularly pharmacological treatment. However, our understanding of women's treatment experiences across situational and geographical contexts remains relatively limited. In addition, the literature shows room for improvement regarding the meaningful use of validated PREMs, and the comprehensive assessment of women's experiences of person-centred care during treatment.

Continued research regarding women's experience of treatment in the context of complex gender-specific needs and circumstances is vital to improving service provision for women who use opioids. An increased focus on person-centred care, as well as the development, validation, and meaningful use and reporting of PREMs may provide important insights into the shortcomings of current treatment settings, and how services may be improved to better accommodate the needs of women.

CRediT authorship contribution statement

Chloe J. Haynes: Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing – original draft, Visualization, Project administration. **Alison K. Beck:** Methodology, Writing – review & editing, Supervision. **Megan Wells:** Writing – review & editing, Investigation. **Emma L. Hatton:** Writing – review & editing, Investigation. **Peter J. Kelly:** Writing – review & editing, Supervision, Methodology. **Wan Jie Tan:** Writing – review & editing, Investigation. **Briony Larance:** Writing – review & editing, Supervision, Methodology.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethics approval

The authors declare that the work reported herein did not require ethics approval because it did not involve animal or human participation.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2024.104520.

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