Clinical Quicknotes
on Substance Use Disorders

Substance Use Disorders
Center of Excellence

Women and Substance Use Disorder: Treatment Success and Barriers for Care

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Quick Takes

- Treatment for women with substance use disorders (SUDs) was historically based on programs developed for men, leading to gaps that failed to acknowledge or address women-specific treatment needs that are needed for successful outcomes.
- Women with substance use disorders experience specific barriers to treatment, including childcare, housing, financial support and stigma.
- Addressing treatment barriers promotes treatment entry, treatment retention, and positive treatment outcomes.
- Trauma histories are ubiquitous in women with SUD. Women with SUDs should always be evaluated for current and previous traumatic experiences such as interpersonal violence, adverse childhood experiences (ACEs), sexual assault, and homelessness. Trauma-informed care is foundational.
- Trauma treatment should be integrated with treatment for SUDs. Non-integrated approaches are associated with premature departure from treatment and poor outcomes.

This Clinical QuickNote discusses various barriers women with substance use disorders experience when entering treatment, particularly when intimate partner violence (IPV) is present, and suggests pathways to more comprehensively meet women's treatment needs and help them live better and more rewarding lives in recovery. The case study examines the treatment journey of a woman with opioid use disorder (OUD) who is trying to enter a life of recovery while simultaneously navigating an abusive relationship. In this QuickNote, we discuss current research on gender responsive care, trauma informed practice, and the systemic and structural barriers that impede treatment and suggest approaches that can help provide the coordinated, interdisciplinary interventions that support safety, recovery, and long term stability for women in treatment.

Background on Women's Treatment:

The original forms of SUD treatment were developed for men with alcohol use disorder (AUD). Treatment for women developed as an extension of male-focused treatment, and not surprisingly, did not effectively address the needs that women with SUD experience. Not only did men consume more alcohol and other substances, but the entire treatment approach ignored female-specific issues, creating a path of policy, services, and research practices that was based on the needs of men,

or at best was gender neutral.[1,2] Globally, while women comprise around one-third of people with SUDs, they comprise only about one-fifth of the individuals in treatment, indicating a substantial treatment gap.[1,3,4] To better meet women's treatment needs, providers must account for higher rates and severity of psychiatric disorders, trauma, medical issues, and social complications in women when compared to men.[1,5]

> *"Increasing retention for women in treatment for success is imperative for positive and effective outcomes, and the aspects of women's lives need to be incorporated into the plan of care."*
>
> -"Substance Abuse Treatment: Addressing the Specific Needs of Women"[6]

Case History:

Maria, a 34 year old woman and mother of two, presents to a community health clinic after a panic episode at work. She reports daily opioid use that began after a prescription for pain management following a work-related accident. Over the next several years, her pain required increasing doses of prescription opioids, and she began to use illicit opioids when her prescription ran out. Illicit opioid use has continued to escalate, and she expresses concern to her provider that she can't stop or even cut down on her use. She is concerned she might overdose with her children at home. She has been without opioids for a day and is displaying signs of withdrawal including sweating, gooseflesh, severe stomach upset and is having cravings to use. She lives with her partner, who is increasingly emotionally, physically, sexually, and financially abusive. Maria would like help but feels ashamed and is concerned that if she enters treatment, her partner will retaliate against her or her children and is concerned that she may lose her children.

Women have a higher risk of experiencing a co-occurring disorder (coexistence of an SUD and mental illness) than men[7-9] and frequently experience a triad of mental illness, SUD, and trauma, all of which interact and may exacerbate each other.[1,9] This combination of factors in women with SUDs makes them significantly more likely to experience domestic violence, rape, incest, and childhood physical, sexual, and emotional abuse. These factors, along with heightened levels of stigma related to motherhood (as well as gender itself), all serve to deter treatment entry.[1,10,11]

Along with the increased rates of psychiatric disorders and trauma, the risk of suicidal thoughts and behaviors is also increased in women with SUD (Table 1).[9,12] These all emphasize the importance of mental health, trauma, and safety screening in all women with SUD.

TABLE 1. SUICIDAL THOUGHTS AND BEHAVIORS IN WOMEN WITH SUD AND ALL WOMEN IN U.S.[9,12]

	Women with SUD	All U.S. Women
Suicidal thoughts in the past year	22.5%	4.1%
Suicidal plans	7.7%	0.5%
Suicide attempt	3.2%	0.5%

Maria fears being labeled an "unfit mother" and feels "frozen" to move forward and obtain treatment for her illicit drug use, even though she knows that she needs it. She initially avoids even discussing treatment options as she is concerned that her provider will report her to Child Protective Services (CPS) leading to potential for removal of her children from her home. She and her provider discuss her concerns, and Maria is placed in immediate contact with an interpersonal violence (IPV) advocate via telehealth. They establish a safety plan which includes options for emergency shelters, safe communication strategies, and a plan for adequately securing documents for herself and her children.

SAMSHA recommends that, if during the assessment, the patient feels that she is in imminent danger from the batterer, the treatment provider should immediately respond to this issue, even if it means deferring the remainder of the assessment until later. The provider should take steps to assure the woman's safety by immediately connecting her with a domestic violence program, and if necessary, arranging for admission to a women's shelter and referring for legal services. Services for psychotherapy and counseling with a safety/trauma focus is essential, but the first step should always be assuring safety. All staff dealing with such issues should be able to respond promptly and effectively, and should receive training to be able to do so.[13]

Once her safety is established, her provider completes the assessment, identifying anxiety, depression, and trauma symptoms, in addition to OUD. She does not have any suicidal ideation but has an elevated Clinical Opioid Withdrawal Scale (COWS) score of 15. She is immediately started on buprenorphine, an evidence based medication that improves treatment retention and outcomes for women with opioid use disorder. After receiving an initial dose of 4 mg, the dose is increased rapidly to 16 mg, resulting in elimination of withdrawal symptoms and drug craving.

Intensive outpatient programming (IOP) that includes daycare for her children is arranged three mornings per week. Maria receives evidence-based treatment including trauma-focused cognitive behavioral therapy (TF-CBT) and Motivational Interviewing (MI).

She continues to take buprenorphine 16 mg daily and receives a naloxone kit with instructions in its use in the case of overdose. She maintains regular contact with her IPV advocate. Intensive outpatient treatment program displays a gender-responsive, trauma-informed, and integrated model of care, consistent with best practices for women experiencing SUD and IPV. The IOP team understands the priority of safety planning in addressing immediate danger.

Some of the most profound issues affecting treatment entry and retention with women are socioeconomic. Understanding and addressing treatment in the context of women's lives throughout the treatment experience is essential for good outcomes. While some of these issues are common to most women, many are unique to an individual, and all must be addressed for best results. Some of the specific aspects that must be considered include the roles and significance of family relationships and support systems, the impact of culture and gender, economic realities, and issues such as parenting, pregnancy, and childcare needs that predominantly fall upon women.[6]

Barriers to women seeking and receiving care are many, including fear of losing a child or partner, relationship difficulties, shame and stigma, pregnancy, sexual harassment, difficulties with poverty/unemployment, and inadequate insurance.[1,13–16] These barriers are even more profound among black, indigenous, and other women of color.[2] Regrettably, many programs often fail to address the very services that would mitigate these barriers and do not offer services such as childcare, obstetric care, other medical services, mental healthcare, or trauma treatment, either directly or through collaboration with other treatment providers, decreasing the likelihood of treatment entry and participation.[1,4]

"Women's risks for substance use disorders are best understood in the context in which the influences of gender, race and ethnicity, culture, education, economic status, age, geographic location, sexual orientation, and other factors converge. Understanding group differences across segments of the women's population is critical to designing and implementing effective substance abuse treatment programs for women"

-"Substance Abuse Treatment: Addressing the Specific Needs of Women"[6]

Clinician self-awareness is important during assessment and throughout treatment.[1,5] Clinicians may wish to consider that they can be perceived as "authority figures" whose approach, language and attitudes may have profound effect on the patient. Special effort should be made to avoid language that might be stigmatizing. A patient-centered approach that allows more time for assessment is valuable in identifying issues that may be involved in the development and persistence of substance use, especially trauma.[1,5,18]

Trauma affects almost all women with SUD, especially those who have experienced homelessness.[9] Chronic trauma is demonstrated to cause aberrations in brain function and structure, leading to difficulties retaining and processing information and making SUD assessment and treatment more challenging.[18] Additionally, substances may have been utilized to cope with the distress of the violence or to "numb" post-traumatic stress disorder symptoms, emphasizing the importance of understanding the different roles that substances may hold in the women's lives.[19,20]

The patient who has experienced trauma in the past may feel re-traumatized if the clinician interaction seems rushed or authoritative, or if the provider uses insensitive or stigmatizing language. Women with SUD are less likely to enter treatment in general, and when they experience language that reflects stigma, they are even less likely to do so. Many treatment-seeking women are already experiencing guilt and shame as a result of their SUDs, often due to self-perceived failure to fulfill gender-stereotyped "role obligations." A trauma-informed approach that is empathetic, expresses hope for the future, and integrates gender-specific approaches and supports addresses this gap.[1,5,21] Multiple treatments have been developed specifically for individuals with SUDs who have experienced trauma (Table 2).

TABLE 2. INTEGRATED, TRAUMA-INFORMED, GENDER-RESPONSIVE MODELS OF CARE[1]

Model of Care	Format/Focus of Treatment
• Women's Recovery Group (WRG) • Population: Gender Specific	• 12 sessions of manualized relapse-prevention; skill-based • Focus: Consequences and outcomes
• Breaking the Cycle (BTC) • Population: SUD, MH, DV	• Weekly counseling • Focus: Maternal connections, trauma, and basic needs
• Boston Consortium Model Modified Trauma and Empowerment Model (TREM) • Population: Women with co-occurring mental health	• Focus: Trauma/SUD, gender identity, sexuality boundaries, self-esteem, family, relationships, harmful behaviors, and abuse
• Seeking Safety • Population: Women's SUD, PTSD	• 24 structured sessions addressing cognitive, behavioral, interpersonal coping skills, and safety • Focus: Abstinence and protection
• Helping Women Recover (HWC) • Population: Women's SUD, trauma	• Four recovery modules • Focus: Self, relationships, sexuality, spirituality
• Beyond Trauma (adjunct-HWC) • Population: Trauma Specific	• Focus: Coping skills and the impact of abuse
• Woman's Path to Recovery (WPR • Population: Women's Addiction SUD with Co-occurring MH	• 12 sessions on addiction and co-occurring disorders • Focus: Gender-based, psychoeducation
• Understanding and Overcoming Substance Misuse (UOSM) • Population: Women's SUD, PTSD	• Interventions assisting women with serious mental Illness in forensic care with motivation, change, trauma awareness, and impact on use • Focus: Forensics
• Female-Specific Cognitive-Behavioral Therapy (FS-CBT) • Population: Gender-specific AUD	• Manualized core CBT, motivational enhancement therapy, and relapse prevention • Focus: Self-confidence, autonomy, and interpersonal functioning
• Moment by Moment in Women's Recovery (MMWR) • Population: Black women	• Mindfulness-based for residential programs (coping with cravings), application to parenting roles, trauma and mental health issues, interpersonal conflict, and reducing treatment dropout rates • Focus: Gender-responsive approach

As part of her assessment, Maria receives a complete medical history, physical examination, and laboratory assessment. Medical history is positive for mild hypertension during pregnancy, which resolved after delivery, but is otherwise not significant. The current physical exam is not remarkable, with normal vital signs, including normal blood pressure. Lab assessment finds slightly increased liver enzymes, though testing for viral hepatitis was negative. Urine drug screen is positive for fentanyl and cannabis; she indicates she occasionally smokes cannabis with her partner. The pregnancy test is negative. She reveals that she is sexually active and is not using regular contraception. She does not want to become pregnant anytime soon and requests Depo-Provera, which she utilized previously without difficulty.

The physical impacts of substances are also more pronounced in women than in men. Women progress from first use of a potentially addictive substance to a diagnosable SUD more rapidly than men due to an increase in drug-induced dysregulation of neural pathways, a phenomenon known as "telescoping."[1,22] Additionally, women exhibit differences in substance absorption, distribution, and metabolism compared to men, leading to more damaging physiological responses and advanced disease, including cirrhosis, breast/cervical cancer, and reproductive issues.[1,15,22,23,24] In short, women experience more physiological harm from substances than men, even with lesser amounts consumed and shorter durations of exposure. Additionally, women with SUDs are twice as likely as women without an SUD to have an unplanned pregnancy and are less likely to utilize contraception. The American College of Obstetrics and Gynecology recommends that family planning be discussed with all women of reproductive age who are diagnosed with SUD.[25]

Maria is adherent to attendance at IOP and buprenorphine treatment. She also commences trauma-focused CBT and starts attending 12-step meetings on days when not in IOP. Her participation in treatment and psychoeducation groups helps her identify emotional regulation skills to manage her life.

When Maria's partner finds out that she has accessed services, he is enraged and demands that she stop. He begins to restrict her access to money, transportation, and childcare support. He monitors her movements and threatens harm if she discloses that he is violent toward her. Maria struggles with leaving her relationship and fears that she and the children will be homeless if she leaves her current situation. She finds this especially frightening because she was homeless in the past and was physically, emotionally, and sexually traumatized.

Women in unstable living conditions, including those who have been victims of human trafficking, are at increased risk of violence and economic insecurity.[20] These risks often escalate when she enters treatment, and threats or physically violent acts could drive her out of treatment.[13] Additionally, abuse and human trafficking may increase the stigma already faced by women with SUDs, making them even more reticent to seek services and rendering them vulnerable to the continuing cycle of addiction and revictimization. Specialized programs and outreach by community and social support to these women could be highly impactful.[20,26] Integration of IPV and SUD services for women is the ideal scenario, but all too infrequent.

Maria does NOT stop treatment, but treads lightly with her partner to avoid confrontation and potential for violence directed at her or her children. However, when he discovers that she also is interacting with an IPV advocate, he becomes irate and escalates his violence. Using her safety plan, she contacts her advocate through a friend and enters a domestic violence shelter with her children. This transition is supported by coordinated services that assist her with housing applications, childcare vouchers, legal advocacy, and financial assistance, providing a foundation that encourages positive outcomes for her sobriety and marking a critical shift toward long term recovery. She continues to receive buprenorphine and actively participates in relapse prevention, trauma-focused therapy, and self-help support group meetings.

Maria transitions from shelter to supportive housing and eventually to independent living. She completes a job readiness program and secures part time employment. She reports to her provider that her mental health is stabilizing, and her anxiety and depression symptoms are decreasing with the support of integrated care. Her social support is strengthened through reconnecting with her family and building a supportive recovery network. Eventually, Maria obtains a protective order and seeks full child custody with legal support. She describes her recovery as "the first time I've felt like I'm living my own life." Maria gains awareness that peer support increases empowerment and reduces the isolation she experienced before entering treatment and is optimistic about the future.

The needs of women experiencing SUDs are many, and all need to be addressed for the best chance of recovery. Trauma is almost universal in women with SUDs, and mental illness and physical problems are also quite common. The additional stresses of childcare, transportation, financial stresses, and others complicate women's ability to enter treatment and sustain participation. Fortunately, good treatment does exist and can yield positive results. Such treatment needs to be comprehensive and include integration of trauma-informed care, interpersonal violence resources, treatment for co-occurring disorders, childcare resources, and transportation in addition to the usual psychosocial and pharmacological treatments. Providers need to be aware of the issues that women with SUDs may be facing and be prepared to help them in a holistic, stigma-free, empathetic, and caring manner. The rewards for the patient (and often her family) are great, as is the professional satisfaction experienced by those who help her on the path to recovery.

Treatment for co-occurring trauma, intimate partner violence (IPV), and substance use is an act of profound bravery. This journey honors the courage required to heal, rebuild self-worth, and reclaim one's narrative from past adversity.

For Additional Information on This Topic

Resources for SUD and women in Ohio:

- Recovery Rachel: Interactive tool to find treatment resources (from RecoveryOhio)
- Addiction Resource. Lists women-specific recovery programs (not all-inclusive)
- FindTreatment.gov. Interactive tool to find treatment resources.
- National Center on Substance Abuse and Child Welfare. Multiple resources relating to women with substance use disorders

Free helpful general references:

- Substance Abuse Treatment: Addressing the Specific Needs of Women. Substance Abuse and Mental Health Services Administration
- Substance Abuse Treatment and Domestic Violence. Substance Abuse and Mental Health Services Administration
- Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. Substance Abuse and Mental Health Services Administration

Training Resources on Substance Use Disorders

- Ohio Substance Use Disorders Center of Excellence.
- American Academy of Addiction Psychiatry.
- American Society of Addiction Medicine.
- The Providers Clinical Support System-Medications for Opioid Use Disorders (PCSS-MOUD).

At the SUD COE, we are committed to bringing you resources and trainings that meet your needs in providing care to patients with substance use disorders. Please let us know what suggestions you have for improving Clinical QuickNotes, or topics that you would like addressed by clicking here: QuickNotes Feedback Survey.

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This QuickNote is an overview only and is not intended to be the sole resource about treatment of women with substance use disorders. The reader is encouraged to seek additional information from sources listed in "For Additional Information on This Topic."

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