WOMEN AND OPIOID DEPENDENCE TREATMENT

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Foreword

Following publication of the *'Women and Opioid Dependence'* brochure in March 2022 and as part of its continuing support for women with opioid dependence, Camurus has collaborated with a group of experts from Australia, Europe and the United States to examine some of the barriers that women may face in accessing opioid dependence treatment (ODT) and to propose potential solutions to overcome these barriers. This brochure provides information on some of these issues as well as key observations from the expert group meeting to help raise public awareness about of some issues associated with women and ODT.

Preface

The World Health Organization states that the highest attainable standard of health is a fundamental right, which means that countries have a legal obligation to ensure access to timely, acceptable and affordable healthcare.[1] However, at a General Assembly meeting of the United Nations held in January 2023, the Secretary-General António Guterres stated that many women and girls still face enormous challenges to their health, wellbeing and human rights.[2] The Pompidou Group Council of Europe International Co-operation Group on Drugs and Addiction has produced a handbook *'Implementing A Gender Approach In Drug Policies'*, which provides policy makers and healthcare professionals with recommendations for policies and practices that address specific gender needs.[3]

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Introduction

The prevalence of the non-medical use of opioids and tranquillizers in women is comparable to or higher than that in men.[4] Although women usually start using opioids later than men, their rate of consumption tends to increase more rapidly.[4] Mental health issues, such as depression, anxiety and post-traumatic stress disorder, are much more common among women.[4] In addition, female drug users are at greater risk of gender-based violence than non-drug users in the general population.[4]

Women are under served by drug treatment programs and services, which tend to be male focused as they are mainly designed, implemented and assessed according to men's needs.[3] A male focus can also be explained by the fact that 80% of patients in drug treatment are men.[3] Treatment services are likely to reflect society's gender inequalities, which is why, historically, women have been under-represented.[3] Although 30% of people with drug dependence are women, they represent only 20% of patients in treatment centres.[3] Women have some unique challenges and experiences, which need to be specifically addressed in any treatment program so they can achieve and maintain long-term recovery.[5]

Worldwide[3]

3 in 10

drug-dependent people
are women

2 in 10

patients in drug treatment centers
are women

Europe[6]

18%

of patients entering treatment
are women

28%

of patients entering drug treatment
did so for opioid dependence

74%

of fatal overdoses are
due to opioids

21%

of drug-induced deaths
are in women

Women and opioid dependence treatment (ODT)

Women with opioid dependence have unique care needs that require a broad range of medical, behavioral health and social services to meet these needs.[7,8] Without a coordinated approach to manage the different services women require, they may face difficulties in accessing these.[7,8] Furthermore, women with children may face challenges in accessing treatment services because of childcare needs.[7,9] Family responsibilities and finances may limit a woman's ability to access ODT, especially if therapy entails daily visits.[9] If a woman with opioid dependence and her healthcare providers understand all the available treatment options and work together, she is more likely to choose the most suitable option.[7,8] Inadequate provision of ODT services may result in a lack of help and may even lead to death in some cases.[10]

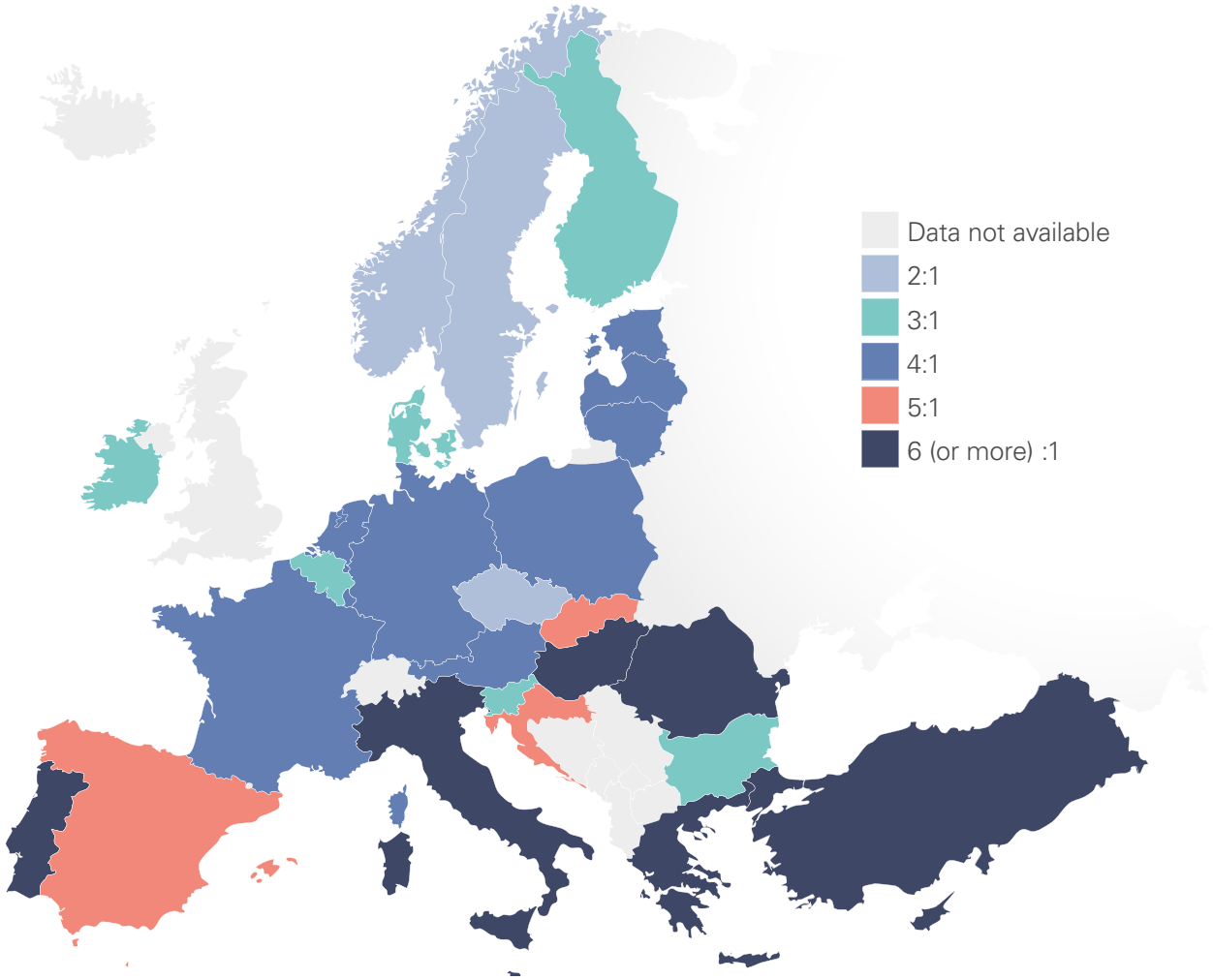
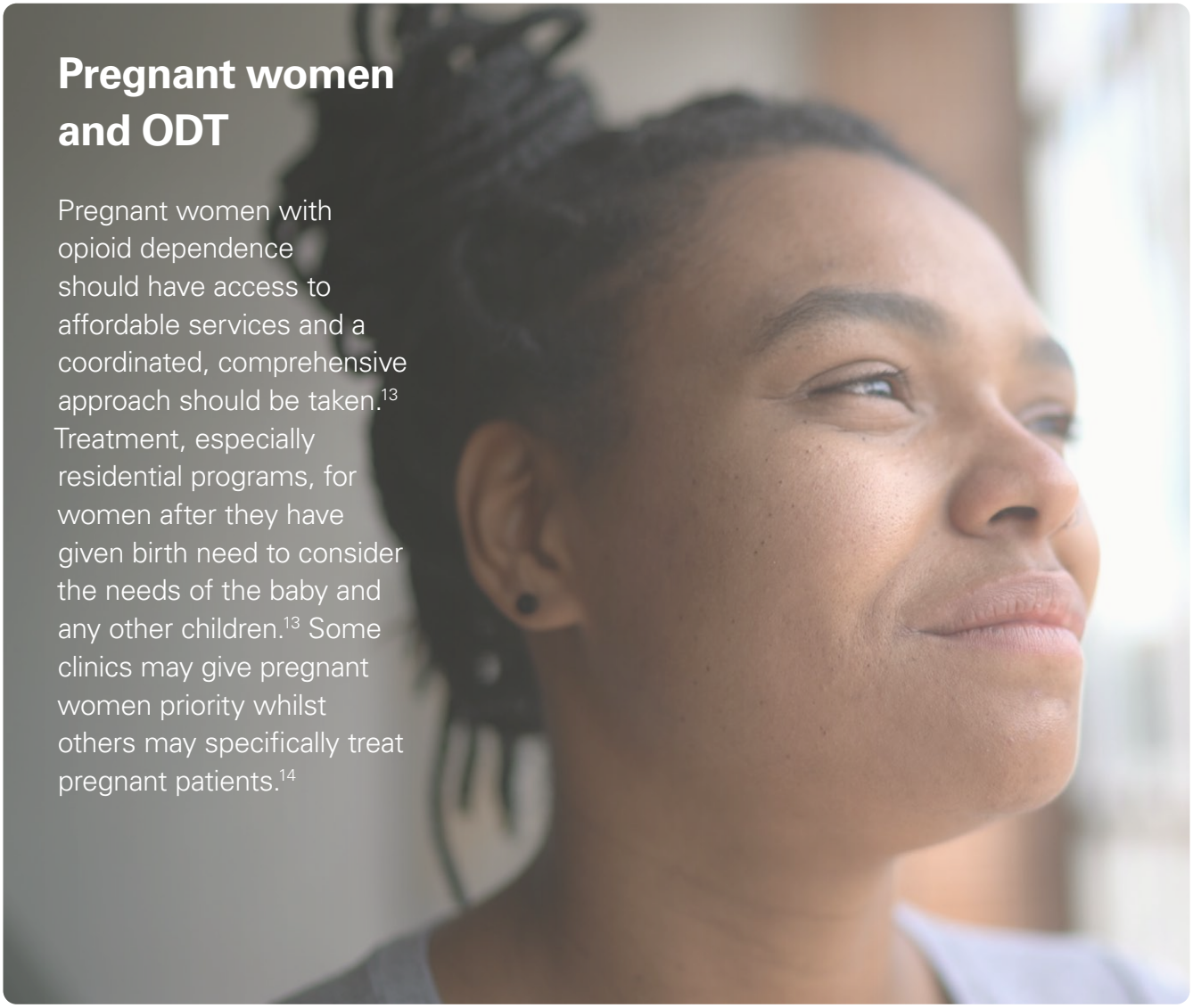


Figure 1. Male to female ratio among clients entering drug treatment in 2020.[11]

ODT services should take into consideration that women:[12]

- **Have greater functional impairment**
- **Have greater psychiatric severity**
- **Are more likely to use opioids to cope with negative emotions and pain**
- **Are more likely to first use prescription opioids via the intended route of administration**

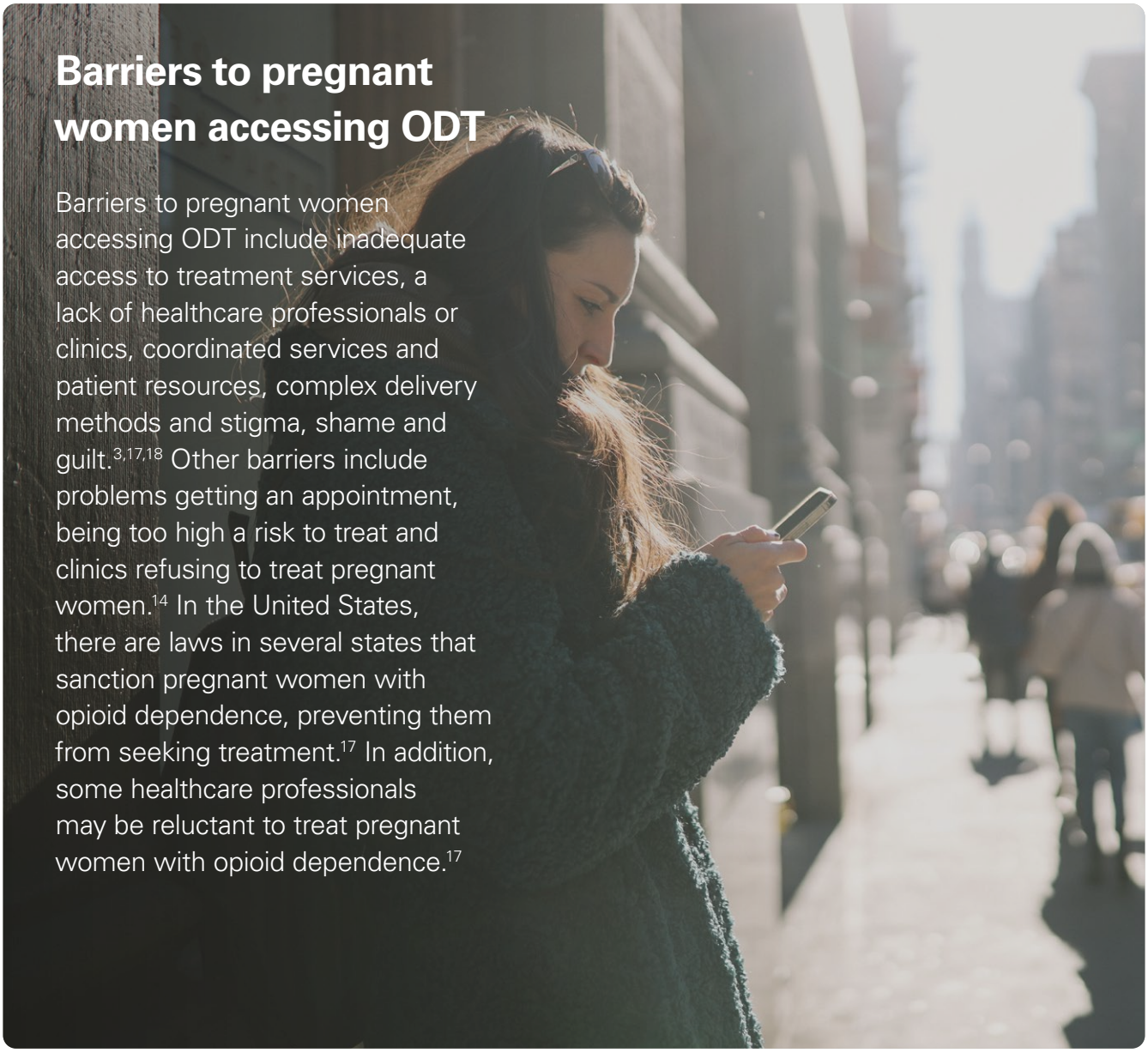


Pregnant women and ODT

Pregnant women with opioid dependence should have access to affordable services and a coordinated, comprehensive approach should be taken.[13] Treatment, especially residential programs, for women after they have given birth need to consider the needs of the baby and any other children.[13] Some clinics may give pregnant women priority whilst others may specifically treat pregnant patients.[14]

Barriers to women accessing ODT

At the expert group meeting held in November 2022, the expert panel proposed that the barriers to women accessing ODT could be divided into three categories: systemic, cultural and individual (Table 1).[15] An alternative classification is systemic, structural, social, cultural and personal.[4] Examples of structural barriers include a lack of childcare facilities and access to public transport, strict admission requirements and schedules, negative attitudes towards mothers and pregnant women with substance dependence.[3–5,16] Cultural barriers include the stigma associated with substance dependence and its treatment.[3–5,16] Examples of personal barriers include a history of emotional or physical abuse, limited finances or social support and fear of losing custody of their children.[2,4,16]



Barriers to pregnant women accessing ODT

Barriers to pregnant women accessing ODT include inadequate access to treatment services, a lack of healthcare professionals or clinics, coordinated services and patient resources, complex delivery methods and stigma, shame and guilt.[3,17,18] Other barriers include problems getting an appointment, being too high a risk to treat and clinics refusing to treat pregnant women.[14] In the United States, there are laws in several states that sanction pregnant women with opioid dependence, preventing them from seeking treatment.[17] In addition, some healthcare professionals may be reluctant to treat pregnant women with opioid dependence.[17]

Systemic barriers	Cultural barriers	Individual barriers
Lack of gender-specific data except in pregnant women.[19,20]	Religious and traditional beliefs,[20] including the persecution of women on the grounds of witchcraft.	Fear of judgement, fear of losing custody of their children and lack of understanding and acceptance from others.[4,21]
Stigma and the poor treatment of patients with opioid dependence,[3–5,16,22,23] particularly for pregnant women and those with infectious diseases.	Dependency on religious communities among some women.[20]	Patients denying their need for treatment – only 50% of people with opioid dependence are in treatment in EU.[6]
The lack of ODT supply in some countries.[24]	Fear and shame of speaking about opioid dependence among some religions.	Fear of treatment centres,[25] which are often filled with men, as many women are victims of domestic and/or sexual violence.[19]
The requirement for patients to have written permission from the government to bring opioids, including opioids for treatment, into some countries,[26] which can make travel for recovering patients very challenging.	Controlling relationships,[19] the lack of freedom and the feeling of isolation.	Lack of financial control and money.[19,26]
Bias of government funding towards men over women in certain countries,[20] such as the UK, due to male patients with opioid dependence being perceived as a public nuisance and threat, while female patients are less likely to draw public attention.	Poor standards of gender equality in the drug-using population.[27]	Distrust towards treatment providers.[13,28]
		Doubts over treatment efficacy.[29]

Table 1. Barriers to women accessing ODT.[15]

Potential solutions for overcoming barriers to women accessing ODT

Treatment services that provide social services and accommodate women's specific needs can contribute to better engagement and improved treatment outcomes.[4] Long-acting or prolonged-release formulations, which enable fewer visits to a healthcare provider and less frequent administration, can reduce the burden and stigma associated with ODT,[30] improve treatment retention by making it easier for patients to combine treatment with work and family life and to live a more 'normal life.[28] Potential solutions that were suggested by the expert group to help overcome some of the barriers identified in Table 1 are shown in Table 2.[15]

Potential solutions for overcoming barriers to pregnant women accessing ODT

Variations in the supply of and access to treatment service for pregnant women could be improved by using healthcare professionals perceptions, experiences and recommendations to build an integrated team-based, patient-centered approach to care provision.[18] Other potential solutions include improving patient education and access to resources, an integrated team-based patient-centered approach as the ideal model for treating pregnant women, providing education and training for healthcare professionals and reducing the stigma associated with opioid dependence.[18]

Potential solution	Potential effects
Integrated medical services could improve ODT access.[13,17,31]	This would reduce the burden for patients with dual disorders and prevent patients from having to queue for their ODT, which is associated with significant stigma.
Women-only treatment centers or a women-only clinic one day per week could improve ODT access among women.[16,19]	This could encourage patients usually too ashamed or too scared to go for treatment to seek help and provide them with a safe environment. Many female patients prefer to be seen by female healthcare professionals. Physician assistants, who are often women, could be more involved in ODT, e.g. by increasing their ability to support women.
Flexibility in treatment schedules is particularly important for women,[31] e.g. providing drop-in sessions and extended service hours.	Telephone or video appointments could also improve treatment flexibility and enable gender-specific interventions to be provided. It is considered a safe way for women to receive treatment and/or psychosocial support.
Group consultations may improve ODT access.	These sessions could provide patients with prescriptions and/or information and patients could also share their experiences. This would help women suffering from loneliness and isolation and women could be encouraged to join these sessions by their peers.
More data on psychosocial care are needed to provide evidence-based treatments for women.[32]	More adapted psychosocial care could lead to better treatment access and success.
More female role models are needed to encourage women with opioid dependence into treatment and to tackle the assumption that opioid dependence is a choice.	Celebrity role models could influence the general public and policy makers and former patients could influence current patients.
Gender budgeting and specific gender goals are needed to implement changes.[20]	Funding towards gender-specific programs need to be improved, although gender-specific treatment may not be the right approach for every woman.

Table 2. Potential solutions to overcoming barriers to women accessing ODT.[16]

Summary

Women with opioid dependence have unique treatment needs which require specific, tailored services. These services can be offered in mixed or female-only programs and should be integrated, needs-based, patient-centered, welcoming, non-judgmental, supportive and safe, both physically and emotionally, to address the stigma and trauma associated with opioid dependence.[16,33] Services for pregnant and parenting women need to address childcare and family support issues as well as the needs of the mother.[13,33] Categories for barriers to women accessing ODT proposed by the expert group are systemic, cultural and individual.[15] Providing necessary solutions to overcome these barriers is important to ensure that women with opioid dependence are able to find, engage with and remain in treatment services.[4]

Camurus would like to thank the expert group for their assistance in identifying some of the barriers that women face in accessing ODT and proposing potential solutions to overcome these barriers. Camurus will continue to focus efforts on improving the lives of women with opioid dependence.

Camurus is committed to improving treatment outcomes and quality of life for people with severe and chronic diseases. We focus on diseases of the central nervous system, rare diseases, endocrine disorders, oncology and supportive care.

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References
1. World Health Organization (WHO). 2022. Available at: https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health. **2.** United Nations (UN) News. 2023. Available at: https://www.devdiscourse.com/article/education/2335406-25-years-after-population-conference-women-still-face-challenges-to-well-being-and-human-rights-says-un-chief. **3.** Mutatayi C, et al. 2022. Available at: https://rm.coe.int/2022-ppg-implementing-a-gender-approach-in-drug-policies-a-pg-handbook/1680a66835. **4.** United Nations Office on Drugs and Crime (UNODC). 2018. Available at: https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_5_WOMEN.pdf. **5.** Recovery Research Institute. Available at: https://www.recoveryanswers.org/resource/women-in-recovery/. **6.** European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2022. Available at: https://www.emcdda.europa.eu/system/files/publications/14644/TDAT22001ENN.pdf. **7.** US Department of Health and Human Services (DHSS), Health Resources and Services Administration (HRSA). 2020. Available at: https://www.hrsa.gov/sites/default/files/hrsa/owh/caring-women-opioid-disorder.pdf. **8.** US Department of Health and Human Services (DHSS), Health Resources and Services Administration (HRSA). 2020. Available at: https://www.hrsa.gov/sites/default/files/hrsa/owh/reg-opioid-consult-initiative-508.pdf. **9.** Ait-Daoud N, et al. Med Clin North Am 2019;103:699–711. **10.** Macleod ER, et al. Subst Abuse Treat Prev Policy 2021;16:26. **11.** Matias J. Oral presentation at EMCDDA symposium 22 November 2022. **12.** McHugh RK, et al. J Subst Abuse Treat 2013;45:38–43. **13.** Substance Abuse and Mental Health Services Administration (SAMHSA). 2016. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4978.pdf. **14.** Phillippi JC, et al. Womens Health Issues 2021;31:455–61. **15.** Camurus expert group meeting. November 2022. **16.** Harm Reduction International (HRI). 2022. Available at: https://hri.global/wp-content/uploads/2022/11/HRI_RCF_briefing_FINAL-1.pdf. **17.** Substance Abuse and Mental Health Services Administration (SAMHSA). 2018. Available at: https://www.drugsandalcohol.ie/28957/1/Samsha_Clinical_guidance_for_treating-pregnant_and_parenting_women-with-opioid.pdf. **18.** Titus-Glover D, et al. BMC Health Serv Res 2021;21:215. **19.** Tuchman E. J Addict Dis 2010;29:127–38. **20.** European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2017. Available at: https://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Women-who-use-drugs.pdf. **21.** European Institute of Studies on Prevention (IREFREA). 2000. Available at: http://www.irefrea.eu/uploads/PDF/Stocco%20et%20al_2000_Women%20Drug%20Abuse.pdf. **22.** Patel K, et al. Cureus 2021;13:e13173. **23.** Hall NY, et al. Drug Alcohol Depend 2021;221:108651. **24.** Harm Reduction International (HRI). 2022. Available at: https://hri.global/wp-content/uploads/2022/11/HRI_GSHR-2022_Full-Report_Final-1.pdf. **25.** United Nations Office on Drugs and Crime (UNODC). 2019. Available at: https://www.unodc.org/documents/southernafrica//Publications/Health/WWUD_In_our_own_words_2019_web.pdf. **26.** National Health Service (NHS). 2021. Available at: https://www.nhs.uk/common-health-questions/medicines/can-i-take-my-medicine-abroad/#:~:text=Some%20countries%20such%20as%20India%2C%20Pakistan,will%20not%20allow%20into%20the%20country.&text=Some%20countries%20such%20as,allow%20into%20the%20country.&text=such%20as%20India%2C%20Pakistan,will%20not%20allow%20into. **27.** Motyka MA, et al. Int J Environ Res Public Health 2022;19:14039. **28.** Johnson B, et al. Subst Abuse Treat Prev Policy 2022;17:40. **29.** Neale J, et al. Exp Clin Psychopharmacol 2018;26:570–81. **30.** Gilman M, et al. Patient Prefer Adherence 2018;12:2123–9. **31.** United Nations Office on Drugs and Crime (UNODC). 2020. Available at: https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders. **32.** United Nations Office on Drugs and Crime (UNODC), World Health Organization (WHO). 2022. Available at: https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_65/01.Statements/17.03/ISN_statement.pdf. **33.** European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Available at: https://www.emcdda.europa.eu/best-practice/briefings/women-drug-problems_en.