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A Call To Action To Combat the Opioid Epidemic among Women

Sandra A. Springer, MD[1], **Breanne E. Biondi, MPH**[1], **Cynthia Frank, PhD**[1], **Nabila El-Bassel, PhD**[2]

[1]Yale AIDS Program, Department of Internal Medicine, Section of Infectious Diseases, Yale School of Medicine, 135 College Street, Suite 323, New Haven, CT

[2]Columbia University School of Social Work, New York, NY

Abstract

Acknowledging the needs and challenges of women with opioid use disorder is an essential step in order to reduce the opioid epidemic in the United States. Efforts that can help women include increasing psychosocial services to address trauma, increasing access to medication treatment for opioid use disorder, reducing barriers and stigma that impede access to and retention on treatment, and addressing structural and policy barriers. This commentary discusses the reasons why women-focused treatment for opioid use disorder is necessary and makes specific recommendations for interventions, treatment, services, and policies that can reduce barriers to care and improve treatment and retention among women.

Keywords

women; opioid; epidemic; treatment; criminal justice; overdose

Commentary

Overdose deaths have steadily increased for both men and women over the last two decades with men having a 225% increase from 1999–2017 and women having a 270% increase over the same time period[1]. Opioid overdose deaths are increasing for both men and women, however, the opioid epidemic has affected women differently The CDC has reported a startling 492% increase in opioid overdose deaths among women aged 30–64 between 1999 and 2017.[2] Further, among women aged 55–64, overdoses were found to be primarily due to prescription opioids, with the highest rates of death occurring among women aged 50–54 in 2017 when the age group most affected was a decade younger in 1999. This current trend is significant given the decline in opioids prescribed by clinicians since 2010[2]. For reasons that are not fully clear, women are prescribed prescription opioids at higher doses and are more likely to develop opioid use disorder (OUD) compared to men. Further, women have more negative consequences from OUD[3]. Research shows that due to differences in body mass and metabolism, women have lower tolerance to opioids, overdose with smaller doses compared to men, and develop to physical dependence with smaller amounts[4]. Despite these gender-specific impacts and burgeoning epidemic, few women with OUD are accessing

Contact Author: Sandra A. Springer, MD, Fax; 203-737-4051, Phone: 203-687-6680, Sandra.springer@yale.edu.

FDA-approved medication treatments for opioid addiction such as buprenorphine, methadone, and extended-release naltrexone[5].

The challenges that women with OUD face are complex, multi-factorial and differ across the life span. Women are more likely to begin opioid use with prescription opioids.[6] If they move from prescription opioids to heroin or other illicit opioids or begin injecting drugs, they are suddenly engaged in new, unfamiliar social networks and must rapidly learn new navigation approaches to obtain drugs, how to inject safely, and how to protect themselves from gender-based violence. These new environments and context may increase their risk for physical and sexual abuse as well as exploitation, which can further perpetuate drug use and put them at risk for acquiring infectious diseases, exposure to gender-based violence, trauma, stigma, and laws that punish women who use drugs, etc. These women may also lack the knowledge and skills to access and navigate health care services and treatment, which if exposed to such care, may ensure their safety and survival[5].

Even if women are aware of services, only half of programs that provide medications for OUD (MOUD) in the U.S. provide women-specific programming. Studies have shown that targeted woman-specific services have advantages, including greater retention in treatment, a safer environment for women, and better psychological well-being, as well as improved pregnancy and substance use outcomes[5]. Trauma and violence are common occurrences in the lives of women with OUD, yet services for intimate partner violence (IPV) are provided by only 24% of programs and less than 25% provide specific interventions for sexual abuse[7]. Untreated psychological trauma is a major risk factor for relapse, overdose and suicide, yet only 35% of MOUD programs offer trauma-specific counseling[7].

Among women who are admitted to drug treatment facilities in the U.S., approximately 7% are pregnant[8]. Pregnant women report several barriers to entering treatment, including fear of testing positive for illicit substances which could result in losing custody of their newborn or other children, or cause them to be reported to child protective services[9]. In some areas providers are less likely to treat pregnant women[10], which increases their risk of overdose and relapse. Despite the increase in the number of pregnant women with OUD entering treatment programs, only 50% receive MOUD, even though it is considered the standard of care for pregnant women[11], and only one-quarter of MOUD programs offer specific programming for pregnant or post-partum women[8]. Although more than 70% of women in drug treatment have at least one child, only 6% of outpatient programs provide childcare[7]. Of the inpatient drug treatment programs that allow mothers to have their children with them, only 2.6% provide ancillary beds for their children, even though having ancillary beds for children has been shown to increase retention for women in drug treatment programs[5]. Additionally, women may not seek treatment due to fear of losing custody of their children, or they are punished for treatment noncompliance when clinics are unable to meet their childcare needs.

Also complicating this situation for women is an increased potential for arrest, prosecution, and incarceration in those who use illicit substances. Many women of childbearing age or those who are pregnant and found to have used illicit opioids and other drugs are not offered medication treatment but are punished with arrest and incarceration[12]. In some states, illicit

drug use during pregnancy is considered a crime, and can lead to prosecution, and in 23 states, substance use during pregnancy is considered child abuse.[13] Children of women in these circumstances can be removed from their care. Compared to men, women are more likely to be arrested for drug-related crimes and are less likely to be able to post bond[14]. A recent article in the New York Times (NYT) reported on a woman who was arrested because of a positive urine drug test, which was mandated by the Illinois probation office after she violated probation.[15] Instead of seizing the opportunity to help her through linkage to drug treatment, she was placed in a mandatory "7-day lockdown" and died from a perforated ulcer. The NYT reported that the officers in charge during this period refused to provide medical attention despite her multiple requests for medical assistance. Her requests for help were thought to be either unnecessary or due to opioid withdrawal, and the determination was made that she did not require medical treatment.[15]

Most approaches to addressing the opioid epidemic in women are focused on informing those of child-bearing age about the risks posed by neonatal abstinence syndrome, a result of opioid use during pregnancy, however, this largely ignores personal and structural barriers to accessing and staying retained on treatment for all women with OUD. Women with OUD face many challenges to engaging in treatment, which range from individual issues such as arranging childcare, to larger structural issues (e.g., stigma, legal and/or economic constraints, including threats of child protective services interventions).[16] Additionally, these experiences are not fully understood because research has had few women participate in medication treatment engagement and retention studies, thus the reasons for not engaging or retaining in treatment is unknown. In addition, despite the growing overdose epidemic in women over 50 years of age, little research has focused on understanding substance use and challenges to treatment engagement among this age group, as most research has been focused on women of childbearing age.

Summarized below are suggestions, interventions and steps that can be taken to reduce barriers to care among women, including:

1. Research to better understand the causes for this intensifying epidemic in women and the barriers and challenges to accessing and maintaining substance use treatment, particularly medications to treat OUD. This is especially important for women of childbearing potential and women over 50 years of age;
2. Removing laws that punish women who use drugs, and finding non-punitive ways to foster entry into treatment for OUD and other substance use disorders;
3. Providing wrap-around services that address women's needs related to treatment engagement and retention, including acknowledging and addressing the impact of violence and trauma afflicted on women;
4. Assistance with child-care and transportation to attend substance use treatment, particularly for women who have sole or primary responsibility for child care;
5. Providing access to financial literacy, asset building programs, and employment opportunities, given that this will decrease power differentials for those in relationships. Providing such opportunities has been shown to empower women

to better care for themselves and their children through better access to healthcare services and affordable and safe housing.

All of these services can maximize access to and retention to life-saving opioid medication treatment and entry into treatment for other substance use disorders if they are provided in non-stigmatizing ways to women.

In order to reduce the opioid and other substance use epidemics in the U.S., there needs to be a focus on caring for women in ways that acknowledge their needs as well as their challenges related to treatment. We can make an impact through increasing psychosocial services to address trauma, increasing access to medication treatment for OUD, reducing barriers and stigma that impede access to and retention on treatment, and addressing structural and policy barriers. More state-directed funding is required to provide MOUD and to educate community and clinical providers about the specific needs of women with OUD across their lifespan. It is critical that we understand, acknowledge, and address the specific needs of women with OUD in order to end this epidemic.

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