Sex and Gender Differences in Substance Use: Policy and Practice Responses to Improve the Care of Women

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Outline Day 1
- Sex and gender differences in substance use and addiction
- Models of care
- Pregnancy, mothering and substance use: Overview
- Pregnancy, mothering and substance use: Connecting with women

Self-reflection exercise: Three messages you remember receiving (explicitly or implicitly) about how girls/boys should be or act

True or False: Questions about women and substance use

What do we mean by sex and gender differences?

Differences in health and illness are influenced by both:
- individual genetic and physiological constitutions including anatomy, physiology, genes and hormones (sex), and by
- the socially prescribed and experienced dimensions of “femaleness” and “maleness” in a society (gender)

Implications of sex and gender differences

There are sex and gendered aspects of substance use and addiction, including:

- Different mechanisms
- Different origins - risk factors, pathways, contexts of use
- Different courses, consequences, impacts
- Different access to and responses to treatment

AND THEREFORE LEAD US TO RESPOND IN 'GENDER INFORMED' WAYS

Gender-informed service principles

1. Equality: power used openly and fairly
2. Knowledge and commitment: staff able and willing to bring a gender informed perspective to their work
3. Relationships: staff authorised and supported to place relationships with patients at the centre of services

WHO on integrating a gender focus into programs to improve outcomes

- Gender integration refers to strategies that take gender norms into account and compensate for gender-based inequalities
- 2 of the approaches to gender integration:
  1. accommodation of gender differences or
  2. Interventions that seek to transform gender relations

Addressing sex differences

- Little has been published describing how service providers and health system planners might address sex differences in the experience of addiction

Differences in prevalence of drug use

Level of illicit drug use in past year by those age 15+

- Cannabis: females: 10.2% males: 18.2%
- Illicit drugs other than cannabis f: 1.9% m: 4.3%

So what are these sex and gender differences?

Some members of the GENACIS research team studying Gender, Alcohol and Culture in over 30 countries, (in Victoria in 2008)

**Difference in prevalence – Convergence?**

- MA is a highly addictive synthetic central nervous system stimulant, both readily accessible and very inexpensive.
- Of 1484 admissions to community addictions services for amphetamine misuse in 2003, 53% were male and 47% female.
- In Victoria's inner city youth clinic, 70% of methamphetamine admissions in 2003 were girls (personal communication).


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**Differences in prevalence**

- Women are more likely than men to use prescribed psychoactive drugs of all categories (eg pain relievers 24% vs 20%).
- Benzodiazepines - Health professionals have known for twenty-five years that benzodiazepines are addictive—even at standard doses— if taken for more than several weeks, yet these drugs are still prescribed for much longer periods. Neither health care providers nor women are generally aware of the wide range of withdrawal symptoms associated with stopping tranquilizer use.


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**Gender differences in motivations for use**

- Although youth of both sexes seek specific effects of methamphetamine use such as increased energy and productivity:
  - females are 5 times more likely than males to report weight loss as a motivation for initiation of use (36% vs. 7%).
  - However males were more likely to report better sex as a motivator (23% vs. 14%).


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**Gender differences in pathways to use**

- Younger injection drug users (N = 232) were more likely to be female, work in the sex trade, report condom use, inject heroin daily; smoke crack cocaine daily; and need help injecting.
- HIV prevalence was associated with female sex; history of sexual abuse; engaging in survival sex; injecting heroin daily; injecting speedballs (a mixture of heroin and cocaine) daily; and having numerous lifetime sexual partners.

Differences in pathways/impacts

- High concurrence of MH concerns in student populations e.g. hazardous drinking & psychological distress: 11.6% vs. m- 5.7%


- In recent CAMH study of concurrent disorders in 196 clients aged 12-25 years:
  - PTSD – 50.3% (f-62%; m- 39%)
  - OCD – 75.5% (f-83%; m-66%)

Substance use in pregnancy - a unique difference

- The risk of alcohol use during pregnancy causing birth defects and developmental disabilities in offspring – is often considered the most profound sex/gender difference in alcohol use.

Sex differences in impact of use

- Women are more likely than men to develop cirrhosis after consuming lower levels of alcohol over a shorter period of time.
- Women are more likely to develop brain shrinkage and impairment, gastric ulcers and alcoholic hepatitis with heavy alcohol use.
- Heavy alcohol use compromises bone health in girls and bones do not overcome the damaging effects of early chronic alcohol exposure


Sex differences in impact of cocaine

- Cocaine-dependent men have perfusion deficits previously associated with cocaine withdrawal and impaired response inhibition, whereas,
- Cocaine-dependent women demonstrated perfusion abnormalities consistent with heightened stress responsivity and worse treatment outcome.

  The possibility of different neural mechanisms underlying relapse in men and women exists, and there are implications for utilizing specialized treatments.


Intersections of substances and their sex specific impacts

- Women who use alcohol also smoke, and women who are poor also smoke and women with abuse histories are more likely to drink alcohol and smoke.
- Health risks are heightened for women who are multi users.

Diversity, sex and gender

- CTUMS data shows that in 2003 approximately 23% of men (aged 15+) in Canada were current smokers, higher than for women (18%)
  
  but
  
  A recent study of high school students in Vancouver, found:
  - 45.5% of Aboriginal/First Nations youth were smokers:
  - 42.7% of Aboriginal boys and
  - 48.5% of Aboriginal girls

Gender differences in influences on use

Dr. Jean Kilbourne has written extensively on media influences on girls and women's drinking, smoking, dieting and identity and made a number of influential videos.

Spin the Bottle: Sex Lies and Alcohol is a recent video which offers a critique of the role that contemporary popular culture plays in glamorizing excessive drinking and high-risk behaviors. Critics Jackson Katz and Jean Kilbourne decode the power and influence these seductive media images have in shaping gender identity, linked to the use of alcohol.

Source: http://www.jeankilbourne.com/video.html

Gender influences as they play out in media and policy - The myth of “crack babies”

- Flawed research and bias in peer reviewed journal article selection in the 1980s and 90s created a false understanding of the impact of cocaine/crack use in pregnancy
- Political and media forces turned this into a war on poor (usually black) women in the US – and this continues today with legal actions such as that against a woman who used cocaine in pregnancy in Texas charged with for delivering drugs to a minor


Differences in operation of stigma - affecting access to care

- It is well documented in Canada that pregnant women and mothers need non-judgmental information and support related to the use of alcohol, tobacco and other substances in pregnancy and while breastfeeding
- While we have known about Fetal Alcohol Syndrome since the 1970s, this awareness is only now being translated into information, education, and action, so that effective health promotion, prevention, harm reduction, treatment and maternity care programming for pregnant women and new mothers who have substance use problems and addictions is embedded in provincial and territorial health systems.

Stigma – Mothering and substance use

Representation of women’s responsibility

<table>
<thead>
<tr>
<th>Mental illness</th>
<th>Woman abuse</th>
<th>Substance use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of woman’s control</td>
<td>Within her control</td>
<td>Deliberate</td>
</tr>
</tbody>
</table>

Representation of the system’s responsibility in the 3 ‘cases’

<table>
<thead>
<tr>
<th>Mental illness</th>
<th>Woman abuse</th>
<th>Substance use</th>
</tr>
</thead>
<tbody>
<tr>
<td>System failing</td>
<td>Limited system failure</td>
<td>Not system’s fault</td>
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Gender differences at treatment entry

- Women experienced fewer years of regular use of opioids and cannabis, and fewer years of regular alcohol drinking before entering treatment.
- Although the severity of drug and alcohol dependence did not differ by gender, women reported more severe psychiatric, medical and employment complications.

Gender differences in the course/response to treatment

When we look at the dynamic process of change that occurs following referral and entry into substance abuse treatment:

- Self-help participation was more strongly associated with moving from using to recovery for women.
- More prior treatment episodes increased the likelihood of moving from recovery to using for women but reduced the likelihood for men.


Women’s voices on impact of gender-specific treatment

- “With the help of staff and my peers, I have learned more truth about myself than I have in 41 years. This info I will use and continue to add to and build upon. I have found so much joy being in the company of women. I’m so grateful for that. I have a whole new outlook in that regard and that will affect all aspects of my life. Thank you for these experiences and the opportunity to know myself better, as the person I truly am, or will be. I’m leaving here uplifted, inspired, and very hopeful.”
- “This is the greatest gift I have ever given myself / allowed myself to receive. I love myself and I am so excited about reintroducing myself to my daughter and teaching and raising her in a healthy environment that I didn’t have the opportunity to be raised in! I am the solution!”

Source: Aurora Centre client feedback, 2003

Intervention is not a specialist problem but a broad social responsibility that should be shared by many public and private sectors.


Tiered System

Tier 5
- Intensive residential tx

Tier 4
- Structured outpatient treatment

Tier 3
- Acute, outreach and harm reduction services

Tier 2
- Brief support and referral by a range of professionals

Tier 1
- Community-based outreach, prevention and peer support


Old “special population” view

New “population-informed” view

Source:
Low risk drinking guidelines

In British Columbia, the Centre for Addiction Research (www.carbc.ca) recommends the following:

Guideline 1
- Avoid intoxication.
- Don't drink more than the daily limit (4 standard drinks for men, 3 for women).

Guideline 2
- To avoid long-term harms to your health, don't exceed the weekly limit.
- At least one or two days of the week should be drink-free, and you should never consume more than 20 standard drinks for men, and 10 for women.

Guideline 3
- Never consume alcohol when it will put you or others at increased risk.
- For example, don't drink when you:
  - Are pregnant or breastfeeding
  - Use other substances like painkillers
  - Drive or operate machinery
  - Need to be alert, like at work
  - Have a mental illness or health problem

Models / Frameworks

- Women-centred
- Harm reduction oriented
- Bio-psycho-social spiritual
- Culturally informed / safe
- Relational

Continuum of Substance Use

- Non-Problematic - recreational, casual or other use that has negligible health or social impact
- Beneficial - use that has positive health, spiritual or social impact, e.g., pharmaceuticals, coffee/tea to increase alertness, moderate consumption of red wine, ceremonial use of tobacco
- Problematic - use that begins to have negative health consequences for individual, friends/family, or society: e.g., impaired driving, binge consumption, routes of administration that increase harm
- Substance Use Disorders - Clinical disorders as per DSM-IV criteria

Principles of Harm Reduction

- Pragmatism
- Human rights
- Focus on harms not only the substance
- Provide a variety of options, doors and support
- Priority of immediate goals
- Involvement of women who use substances
Sheway Program: Reducing Harms on Key Determinants of Health

- Support to build networks - both friendship and ongoing service support networks
- Pre and postnatal Medical Care and Nursing Services
- Nutritional Support and Services
- Advocacy and Support on Access, Custody and other Legal issues
- Support/Counselling on Substance Use/Misuse issues
- Support on Housing & Parenting issues
- Support in reducing exposure to violence and building supportive relationships
- Healthy Babies, Infant/Child Development
- Drop In Out Reach
- Crisis Intervention
- Advocacy Support
- Connecting with other services
- Support to build networks - both friendship and ongoing service support networks

Substance-informed Approach

Support is provided to women based on:
- An understanding of a continuum of substance use and a continuum of harm reducing options for safety, change and growth
- Awareness that brief, minimal and multi faceted support is helpful

Biopsychosocial Spiritual Model

- Biological
  - Possible genetic or physiological predispositions
  - Physiological effects of addiction on the body, brain & nervous system
- Psychological
  - Psychological history
  - Family History
  - Past traumas
- Social
  - Influence of family members/friends/peers/society in the development of attitudes/values
  - How people relate and interact
- Spiritual
  - Meaningful connection with life
  - Sense of purpose

Relational Model

- Proposes that the primary motivation for women throughout their lives is building relationships and connection with others (Jean Baker Miller, 1976)
- Problems arise from disconnection or violations within relationships from personal to societal levels (Covington & Surrey, 1997)

Benefits of a Relational Approach

- Increased understanding of how trauma, mental illness & substance abuse have impacted her life — and a complex new identity integrating all three
- Increased empowerment, agency, self-esteem and quality of life (N. Finkelstein)
- Increased capacity for mutuality, empathy, authenticity in relationships

Mutual Help Groups

- Reflect relational model in their design
- Importance of women only groups that emphasize strengths
- Women able to share more openly (trauma, abuse, oppression, body image concerns)
- In mixed groups it has been shown that women help facilitate men sharing while women share less than they would in an all female group


16 Steps for Discovery and Empowerment

- Created by Charlotte Kasl
- Began questioning the 12 Step model as the only way to overcome substance use problems
- Encourages women connecting with one another through mutual celebration, creativity and support
- www.charlottekasl.com

Substance Use Treatment for Women: Guiding Principles

- Driven by women and individualized
- Empowerment and strengths-based
- Women-centred - address all aspect of a woman’s life
- Support a harm reduction approach
- Relational - support connections between women


Integrated Principles

<table>
<thead>
<tr>
<th>Women-Centred</th>
<th>Harm Reduction</th>
<th>Relational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership/Equality</td>
<td>Women actively involved</td>
<td>Connection</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Human rights – self determination</td>
<td>Autonomy</td>
</tr>
<tr>
<td>Self-determination</td>
<td>Start where she is at</td>
<td>Strengths-based</td>
</tr>
<tr>
<td>Respect</td>
<td>Focus on overall harms</td>
<td>Integration of experiences</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Empowerment</td>
<td>Empowerment</td>
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<tr>
<td>Pragmatism</td>
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“Gender responsive” programs are those that consider the needs of women in all aspects of their design and delivery, including location, staffing, programme development, programme content and programme materials.

Gender Responsive Treatment: Guiding Principles

1. Gender – acknowledge that gender makes a difference
2. Environment – create an environment based on safety, respect and dignity
3. Relationships – develop policies, practices and programmes that are relational and promote health connections to children, family, significant others and community


Gender Responsive Treatment: Guiding Principles

4. Services – Address the issues of substance abuse, trauma and mental health through comprehensive, integrated, culturally relevant services
5. Economic and social status – provide women with opportunities to improve their socio-economic conditions
6. Community - Establish a system of community care with comprehensive collaborative services


Small group exercise

Choose one model and record on flip chart paper community specific examples of that model in action. Highlight what is working and areas to build on.

PREGNANCY, MOTHERING & SUBSTANCE USE: OVERVIEW

Alcohol use by women in childbearing years

- In the 2004 Canadian Addiction Survey 13% of young women 18-19 yr & 11% of women 20-24 yr reported heavy, frequent drinking
- 12-14% of mothers indicated they used alcohol during their last pregnancy in Canadian Community Health Survey 2001

Alcohol use by women in childbearing years

- Women of highest income more likely to be drinkers (86% vs 67% for lower) and women of highest income more likely to drink 1 to 3 times a week (33% vs 21.6%)
Impact of alcohol use in pregnancy - Fetal Alcohol Spectrum Disorder

- FASD is an umbrella term used to refer to the spectrum of birth defects and developmental disabilities related to prenatal alcohol exposure.
- It includes FAS, Partial FAS (pFAS), Alcohol Related Neurodevelopmental Disorder (ARND) and Alcohol related Birth Defects (ARBD).

Tobacco-related risks for pregnant women

- Increased risk of:
  - placental abnormalities
  - premature labour and delivery
  - miscarriage
  - stillbirth
  - SIDS
  - range of problems associated with low birth weight

Second-hand smoke

- Women exposed to significant amounts of second-hand smoke during pregnancy are more likely to give birth to low-birth-weight babies.
- Low-birth-weight infants who are exposed to ETS after birth have an increased risk of developing respiratory illnesses.
- Incidence of sudden infant death syndrome (SIDS) is higher among infants who are exposed to ETS after birth.

Risks of other substances in pregnancy

- Increased risk of miscarriage, still birth and premature delivery
- Women who use street drugs in pregnancy may not be getting enough sleep, have poor nutrition, and be at risk of diseases such as Hepatitis and HIV.
- Babies born to mothers who use street drugs during pregnancy often need specialized medical support to relieve withdrawal symptoms at birth.

Punitive Approaches and Stigma

Judge rejects lawyers’ advice, sends pregnant woman to jail

A 22-year-old pregnant woman is appealing a three-month jail sentence given to her by an Ottawa judge who decided she needed a “wake-up call” and overruled lawyers’ recommendations she be given six months of house arrest.

Judge Lajoie pointed out that Ms. XX had smoked marijuana in the first three months of her pregnancy, and that she had re-offended while still on probation.

April 2nd 2006 Ottawa Citizen

“Rescuing infants from the depths of Victoria’s crystal meth crisis”

“Often the babies’ mothers won’t accept what their addiction has done to another human being. They’re almost always in denial about any impact to the baby.”

Globe and Mail, Friday, January 19, 2007
Mothering Policy

Study of barriers to accessing treatment by mothers

• Shame (66%)
• Fear of losing children (62%)
• Fear of prejudicial treatment on the basis of their motherhood status (60%)

Source: Apprehensions: Barriers to Treatment for Substance Using Mothers, BC Centre of Excellence for Women’s Health (2001). Researchers: Nancy Poole and Barbara Isaac.

“We’re slipping through the cracks and everything else, and when you push and shove and take away the children and stuff, I mean, we’re losing mothers in droves here, you know, so there’s a flaw in the system.”

Voice of mother in treatment from Mothering Under Duress study

Integrated Framework

✓ Mother-centred
✓ Harm reduction oriented
✓ Collaborative

What do we mean by woman- or mother-centred?

- Focus on the woman’s own health pre, during and post-pregnancy and encourage internal motivation for change
- Acknowledge the negative social responses to pregnant women’s substance use and assist in dealing with stigma, punishment and blame


It’s Not Only About Alcohol

Poverty

Policy on Mothering

Exposure to Violence

Racial Discrimination

Mother’s nutrition

Mother’s stress level

Mother’s use of other drugs

Mother’s overall health

Resilience

Genetics

Age

Experience of Loss

It’s Not Only About Alcohol

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Mother’s nutrition

Mother’s stress level

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Mother’s overall health

Resilience

Genetics

Age

Experience of Loss

It's Not Only About Alcohol

The story of the highest risk mothers

Study of Birth Mothers of 160 children with FAS. Of the 80 interviewed:

• 100% seriously sexually, physically or emotionally abused
• 80% had a major mental illness
• 80% lived with men who did not want them to quit drinking


It's Not Only About Alcohol
Harm Reduction Principles in Pregnancy

- Provide a variety of options and support
- Prioritize immediate goals - focus on harms, not only the substance – be pragmatic
- Recognize that health care is a right
- Involve women who use substances in defining the level and type of change they wish to make

Need to recognize that addiction can be “a way of adapting to desperately difficult situations. People cannot be ‘cured’ of adaptive strategies unless better alternatives are available to them.”

ALEXANDER, B. K. (1991)

Evidence for Collaborative Approaches

- Project Choices – RCT on benefits of 4 brief motivational sessions focused on reducing drinking and using contraception
- Those in intervention group 2 times more likely not at risk for alcohol exposed pregnancy after 3, 6 and 9 months than those in the control group


Research on Motivational Interviewing

- Effective in brief interactions
- Shown to outperform traditional advice giving
- Effect not necessarily related to the practitioner’s educational background


Case Scenario: Talking with Beth

Beth has been coming to your prenatal program sporadically for about two months. She is four months pregnant. Her first baby was taken into care about a year ago because she was drinking heavily. She comes to your program because she has heard good things about it in the community and she really needs the milk coupons you provide. She is also very interested in the food and clothing your program provides. Beth’s partner is not that supportive because of Beth’s previous experience with professionals. Beth reports seeing her doctor regularly, she has attended most prenatal classes and has started to purchase things she needs for the baby. She is willing to discuss some life issues, but not others. Beth has never had any treatment for alcohol use. Beth says she is not interested in addictions “treatment” but would like more parenting supports. Because of Beth’s history, you are wondering about her current alcohol use, possible need for treatment, and safety of her children.

Canadian Centre on Substance Abuse. (2005). Nurturing Change: Working effectively with high-risk women and affected children to prevent and reduce harms associated with FASD.
4 Levels of FASD Prevention

Level 1 - Broad awareness building and health promotion efforts
Level 2 - Discussion of alcohol use and related risks with all women of childbearing years and their support networks
Level 3 - Specialized, holistic support of pregnant women with alcohol and other health/social problems
Level 4 - Postpartum support for new mothers assisting them to maintain/initiate changes in their health and social networks and to support the development of their children

Level 1 Prevention

Is about:
- raising awareness through campaigns and other broad strategies
- linking to public policy and health promotion activities supportive of girls’ and women’s health
- involves a broad range of people at the community level

Key Elements for Effective Messaging

<table>
<thead>
<tr>
<th>Level of Threat</th>
<th>Efficacy Response</th>
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<tbody>
<tr>
<td>Threat is low</td>
<td>No response – individuals do not feel concerned</td>
</tr>
<tr>
<td>Threat is higher than</td>
<td>Defensive response – individuals respond with</td>
</tr>
<tr>
<td>efficacy</td>
<td>avoidance, denial, anger, rationalizing (it won’t happen to me)</td>
</tr>
<tr>
<td>Efficacy is higher than</td>
<td>Positive response – increases in awareness, etc.</td>
</tr>
<tr>
<td>threat</td>
<td></td>
</tr>
</tbody>
</table>

Council for Tobacco-free Ontario et al., 2000; Witte and Allen, 2000