

HOLLYWOOD, HEALTH & SOCIETY

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Tip Sheet: Opioid Addiction in Women

What is the Problem?

Opioid addiction has increased at alarming rates for both men and women in the United States. Opioids include both illicit drugs, such as heroin and street fentanyl, and prescription medications such as oxycodone, codeine and morphine. They work by dulling emotional and physical pain signals to the brain, giving their user an immense sense of both emotional and physical relief, calm and pleasure. After the first dose, it takes higher and higher doses to replicate this sensation, and over time, it is harder to achieve a “high.” At the same time, stopping after long-term opioid use results in overwhelming sensations of craving and intolerable withdrawal symptoms or “dope sickness”: pain, vomiting, diarrhea, sweats, and emotional suffering. These withdrawal symptoms are severe enough that people with addiction will go to extreme means to continue using opioids to avoid feeling dope sick, even though they no longer get “high.”

Addiction is a chronic disease of the brain. People with addiction continue to use despite substantial physical and social harms, like life-threatening overdose, loss of jobs, housing, and family.

Like other chronic diseases (diabetes, for example), opioid addiction is influenced by genetics and behavior, and involves cycles of getting worse and improving, commonly known as “relapse” and “remission.” Like other chronic diseases, the most effective treatments for opioid addiction involve medication and changes in lifestyle. Without medication-based treatment, addiction is progressive and can result in disability or death.

Is opioid addiction treatable?

Yes. Opioid addiction is best treated with medications long-term.

There are three FDA-approved medications to treat opioid use disorder: methadone, buprenorphine, and naltrexone; all of which dramatically reduce the craving for opioids. Methadone and buprenorphine (Suboxone) cut death rates in half, and ideally are combined with counseling, job training and other services to help people recover. Unfortunately, stigma prevents many parts of the country from embracing these

effective medications (see Vox: [There's a highly successful treatment for opioid addiction. But stigma is holding it back.](#))

Only about 1 in 10 people who quit “cold turkey” without medications stay sober at one year, and people quitting without medications have two to three times the death rate compared to those on treatment. This is why “detox” and “rehab” without ongoing maintenance medication are dangerous and not recommended for opioid addiction.

Harm reduction means making sure people can get help and services even if they aren't quite ready for treatment, since many people quit many times before they are ready to stop drugs completely (just like quitting smoking). Naloxone (Narcan) can be given by lay people to save people from an overdose. Syringe services (needle exchanges) prevent people from getting HIV and Hep C while they are using drugs.

How is opioid addiction and treatment different in women?

Addiction to opioids is less common among women than in men, but it has rapidly increased over the last twenty years. From 1999 to 2017, the rate of overdose deaths involving opioids in women increased almost five-fold. The increase was largely driven by increased exposure through the medical system, as women are more likely to report chronic pain and to be prescribed opioids, which can lead to addiction in some people.

75% of women with addiction have a history of sexual abuse, compared to 27% of men. Women who are victims of domestic violence have higher risks of addiction, as are women that have experienced divorce, loss of child custody, or the death of a partner or child. Women are more likely than men to start drugs with a boyfriend or husband than on their own, and they tend to progress more quickly than men from first use to addiction (called telescoping). Women tend to seek treatment earlier than men, but they have suffered more severe consequences of their addiction when they get treated.

Moms, babies and addiction

Pregnant women with untreated opioid addiction are more likely to die, deliver prematurely, and have babies with complications or die of sudden infant death syndrome. However, pregnancy is a powerful motivator for change — women are willing to do things to help their baby that they would not do to help themselves. Importantly, “detoxification” (stopping all opioids during pregnancy) actually increases the risk to the baby, compared to using buprenorphine or methadone. Pregnant women should be referred to medication treatment as early as possible in the pregnancy, since buprenorphine and methadone are proven safe, they increase the likelihood of a healthy baby and a healthy mother, and they lower overdose death rates. Neither drug causes long-term effects on the baby. On the other hand, when women continue to use drugs, the baby is much more likely to go into foster care, which causes real long-term harm to the child.

Babies born to women with opioid addiction are born dependent (meaning their bodies are used to having drugs on board). Babies can never be addicted, since addiction means compulsive use of drugs despite harm.

Babies born with exposure to opioids, methamphetamines or other drugs may have a period of withdrawal symptoms, including tremors and excessive crying. The risk of this neonatal abstinence syndrome (NAS) is highest among women who continue to smoke or use illicit substances (opioids or other drugs) and lower for women on buprenorphine or methadone. Many hospitals treat NAS by separating a baby from its mother, putting the baby in a neonatal intensive care unit and giving opioids, tapered over a month. However, most babies do not need medication and intensive medical treatment if they are kept in constant contact with the mother, using the same techniques used for all crying babies: holding, rocking, swaddling, and breastfeeding, with nurses or other staff helping the mother learn to console the baby. Children born to women maintained on buprenorphine or methadone appear to have no long-term side effects.

Many health systems and jails still equate medication treatment with addiction, and women continue to lose custody of their infants because they are using buprenorphine or methadone to stay sober. Some state laws make it a crime to use drugs while pregnant and put women in jail instead of treatment. As a result, many women are afraid to get help during or after pregnancy.

Women behind bars

Women with opioid use disorder are at high risk of criminal justice involvement due to addictive behaviors: arrest for possession of illegal substances, or arrest for behaviors related to sustaining the addiction, such as theft or prostitution. Incarcerated women are particularly vulnerable because most jails and prisons do not provide medication-based addiction treatment. People released from jail have a lower tolerance to opioids due to prolonged abstinence, and because most jails and prisons do not connect inmates to medication treatment at release, opioid use after release can easily result in overdose. Opioid overdose is a major cause of death for people recently released from prison, with death rates 12 to 40 times higher than the general population.

There is a new movement to provide medications in jails and prisons, endorsed by the National Sheriff's Association and other national correctional health organizations. There are also efforts to give naloxone (Narcan) at release, an opioid antidote that reverses the effects of opioids and prevents death from overdose.

Case Study:

Jenna's addiction started in 2007 when she was in a violent relationship and she was repeatedly beat up by her boyfriend. She suffered severe depression and daily headaches and got Percocet from her doctor to manage the pain. She found herself taking Percocet to deal with stress, and then needed more and more of it just to feel okay. She lost her job, ran out of money, and couldn't afford Norco anymore, so a friend connected her to heroin. Her life revolved around getting her fix, because without it, the withdrawal symptoms were unbearable – "so bad I feel like I am going to die." She got pregnant, and since she had heard that hospitals take away babies from addicts like her, she stayed away from doctors and got no prenatal care.

She tried to quit cold turkey several times, but the withdrawal was too overwhelming. Once in the middle of being “dope sick” she got contractions and got scared. Since she had heard women can lose babies with bad withdrawal, she got another fix. When she delivered her baby, the boy was taken by CPS – “I wasn’t even given a chance. They treated me like a criminal.”

A year later, her friend told her about Suboxone and she bought a dose on the street. “I felt normal for the first time in years. My whole day wasn’t about just survival.” She couldn’t find a doctor to prescribe it, other than a doctor who charged hundreds of dollars per week. So, she went back to heroin. She was arrested for shoplifting and was sent to residential treatment – they didn’t allow her to use any medications in the facility. She finished 30 days and was motivated to stay sober. She went to daily NA meetings. But the cravings became overwhelming – she remembers getting in a fight with a friend and then finding herself with a needle in the arm: “it was that automatic. I couldn’t stop myself.” Even though she used half her normal dose, she had lost her tolerance in treatment, and she stopped breathing. A friend had Narcan and brought her back, and she decided to go back to treatment.

Since the residential program still wouldn’t let her have Suboxone, she snuck it in and used it without being caught. “It seems crazy to me that the one place you go for help won’t let you use what works.” This time she graduated from the program, was able to stay clean, and over time, was reunited with her son. She continues Suboxone treatment and goes to a support group for women with addiction.

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