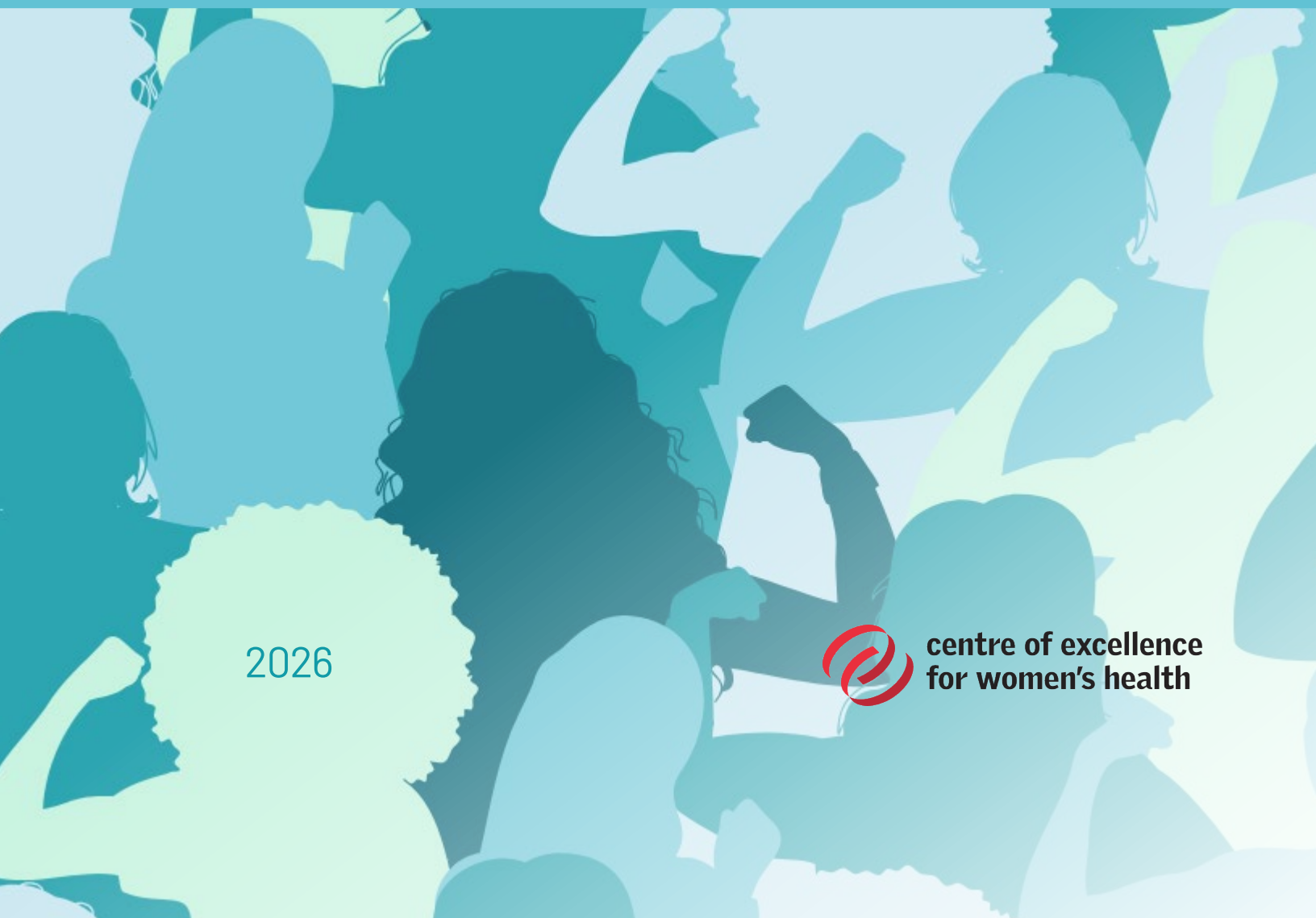
Clearing the Path to Recovery

A gender-transformative framework to act on structural factors impeding women's substance use treatment and recovery



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centre of excellence for women's health

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Executive Summary

Women who use substances and seek treatment and recovery often encounter barriers. Some barriers are social or economic while other are structural - meaning that they are systemic flaws or features that impede recovery such as funding, availability of services, or institutional policies. This report outlines a planning framework for Clearing the Path for Recovery (CPR) that assists in recognizing the drivers and barriers to recovery and offers routes to solutions in creating better services and policies for women seeking recovery. The CPR Framework was developed via extensive consultations, key informant interviews, focus groups and a cross sectoral Community of Inquiry.

Introduction

WHO IS THIS FRAMEWORK FOR?

The CPR Framework is a comprehensive tool for policy and practice analysis and action on upstream issues affecting treatment and recovery pathways for women who use substances in Canada. Using it in teams, or ideally, system wide will create coherent and unified planning that will benefit women who are seeking recovery, along with their children.

The CPR Framework can be used by policy makers, system planners, service providers and practitioners, community-based organizations, educators, researchers, advocates, and other parties involved in women's treatment and recovery.

Its use will facilitate visioning for removing barriers and clearing a path to recovery. It will strengthen multi-sectoral action, collaboration, and partnerships. It will shed needed light on under acknowledging, under researching and underfunding women's substance use. It will, if used consistently, support a synchronized approach to change in a jurisdiction, where initiatives at each level or in each sector positively reinforce each other. Sharing a vision for addressing the root causes of women's substance use and their barriers to recovery can be powerful and unifying. It not only points to changes but also offer hope to women who use substances that recovery can be achieved, and importantly, maintained.

KEY UNDERLYING QUESTIONS

Women who experience health and social issues due to substance use often have difficulty finding a route to treatment and recovery in Canada. Why is this so difficult?

Many interconnected influences, including gendered norms, institutional policies, entrenched systems, and a range of social processes create significant barriers to women's substance use treatment and recovery. In addition, as a society, we have often overlooked important sex based biological impacts of substance use, and a host of gendered recovery needs specific to women. Numerous gendered social and economic factors — such as caregiving burdens, gender-based violence, and income and employment inequities — directly influence women's substance use and shape their treatment and recovery pathways [1-5]. Taken together, this wide range of influences impacts women's routes to full recovery.

Women's substance use has long been ignored or under acknowledged in research [6] and practice. In part, this results from the ongoing higher prevalence of men's substance use, resulting in the "male norm" often serving as the default for designing substance use treatment and recovery paths, practice and policy. However, things are changing. Emerging sex and gender substance use science reveals that sex-related biological factors matter for both sexes, and in particular, contribute to relatively more damage to females from substance use, even with lower or less frequent use [7]. Further, there is increased concern that the historic gender gap in substance use may be beginning to close [8-13]. These trends underscore the urgent need for a closer look at women's substance use patterns, and their available routes to treatment and recovery.

What is the treatment landscape in Canada?

Using conservative estimates, 1 in 205 Canadians received treatment in publicly funded treatment centres for substance use. Between 2016 and 2018, 62% of those who received treatment in publicly funded treatment centres were males and 38% were females [14]. In part, this difference may reflect underlying sex differences in substance use prevalence rates or treatment needs, but also gender-related barriers to accessing treatment for women, such as difficulty finding childcare, fear of child apprehension [15, 16], guilt and shame [17, 18], and violence and trauma that require tailored interventions [16, 19-21]. For some subgroups of women in Canada, there are magnified barriers and concerns due to interacting racism, classism and other factors such as ability or age or mental health status.

These unique factors call for gender-responsive approaches that focus on providing services tailored to the specific needs of women [22]. However, while gender responsiveness may enhance initial access and support, and may even provide gendered programming, it does not always directly address the systemic or structural barriers. Only a gender-transformative solution goes further by actively addressing the underlying power dynamics and structural inequalities that contribute to these needs [23, 24] and proposing changes that improve gender equity for women, along with reducing substance use.

How can we address inequities in substance use treatment and recovery?

With the need to address structural drivers in mind, we developed the CPR Framework that highlights a gender-transformative approach to solutions. It contextualizes, highlights and helps to dismantle the root causes of discrimination and inequity and fosters an environment where women can not only begin to acquire appropriate treatment and recover, but maybe even influence the systems that serve them. Gender-transformative approaches to programs, policies, and research focus on reducing gender inequity alongside addressing the specific issues of substance use among women [23]. This can include engaging women in action and advocacy that is effective in making changes to policy and programmes that help.

What is a Gender-Transformative Approach?

Improving gender equity is particularly important for girls' and women's health. This is because gender inequities such as socioeconomic status, literacy, pay gaps, or discriminatory cultural attitudes and practices are often key contributors to women's health. Some prevention, programs and policies may be gender-specific (created for women) or gender-sensitive (designed to accommodate childcare or low income), but do not necessarily strive to improve gender equity. Improving gender equity is the basis of a gender-transformative approach as it deliberately and actively strives to change power distribution, roles, values, or decision-making authority at the same time as addressing a health issue [23, 24].

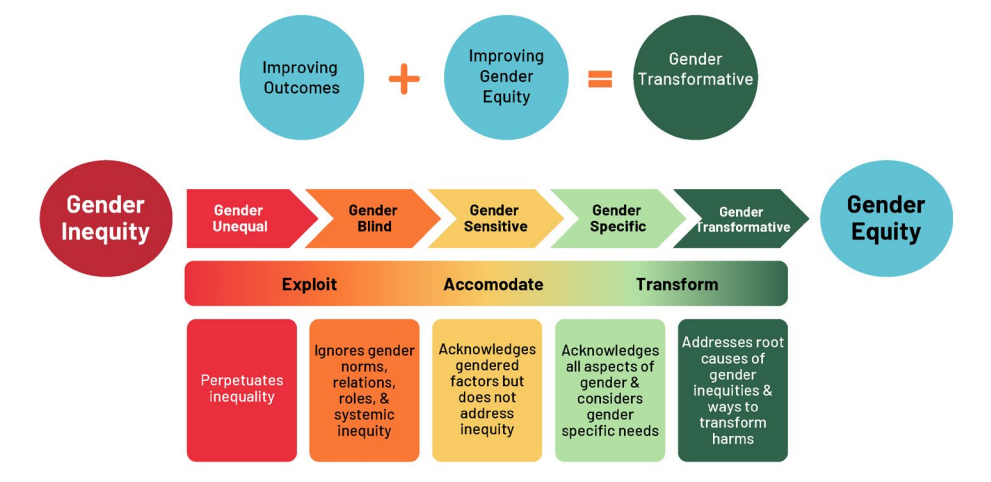


Figure source: Greaves, L., Pederson, A., & Poole, N. (2014). Making it Better: Gender-Transformative Health Promotion. Canadian Scholars' Press/ Women's Press.

Across society as well as in the substance use field, we often focus on individual behaviour change or at best, the more proximal social determinants of health, such as income, education and age. But a clear focus on upstream structural determinants of health (see box below) is crucial to enhancing recovery but not typically applied to the issue of women's substance use despite long standing observations of their impacts on women's paths to recovery [25-28].

Upstream Structural Determinants of Health

"Upstream" (distal) structural determinants of health and health equity relate to how our society is organized, while "downstream" (proximal) determwinants of health relate to individual health behaviours and health outcomes [3]. Examples of structural determinants of health include [29, 30]:

- Colonialism, racism, sexism, classism, ableism and other forms and processes of oppression and discrimination
- Cultural and societal norms and values
- Political, social, commercial and economic policies, laws, regulations and budgets
- Governance and self-determination

Action on upstream structural determinants focuses on shifting norms and policies, improving conditions of daily life, and strengthening community capacity to influence governance systems, policies, and norms and values.

How will using the Clearing the Path to Recovery Framework help?

The CPR Framework guides analysis and action around important "upstream" structural factors impeding women's substance use treatment and recovery. Using it to create and critique policies, programs and institutional practices is a great first step in clearing the path to women's recovery.

It will help to focus on more distal social processes such as sexism, racism, classism and colonialism and their impacts on women's treatment and recovery. Getting clarity on these big factors will ultimately assist in improving advocacy, programming and policy making.

For example, sexism profoundly impacts women's mental health and substance use patterns [31]. Research consistently indicates that women often turn to alcohol and drug use as a coping mechanism for the heightened stress resulting from the cumulative effects of sexism, such as sexual objectification and its ramifications such as sexual violence [32, 33].

Sexism also affects our societal response to women's substance use, by creating and maintaining the many gendered stereotypes about women, pregnant women, and mothers who use substances that increase stigma. These stereotypes often imply that mothering and substance use are entirely incompatible, and mothers who use substances are automatically uncaring or unsafe. Such stereotypes often underpin punitive responses such as child apprehension practices, intrusive monitoring, and unrealistic recovery demands, often in the absence of accessible appropriate treatment options [34, 35].

Sexism, racism, and classism intersect in unique ways that impact substance use and recovery for women. For example, Black women have lower retention rates in substance use treatment compared to Black men and women from other racial backgrounds [36]. Young Indigenous women face higher mortality rates from substance use than men or other groups [37], with First Nations women experiencing eight times more overdose events and five times more overdose deaths than non-Indigenous women [38]. The roles of racism and colonialism in these trends manifest in expanded scrutiny and over policing, racial stereotyping and persistent differential pay gaps. These more structural problems are often ignored in devising treatment or policy changes and prevent acknowledgment of some key drivers and barriers.

Women with lower socioeconomic status face multiple barriers to substance use treatment, such as financial and insurance limitations, transportation, housing, childcare, and stigma [16]. For example, economic stress, coupled with lack of access to healthcare and experiences of intimate partner violence, exacerbates mental health issues and pre-existing traumas, often leading women to use substances such as tobacco or alcohol 'to cope' [39]. The distal drivers of such patterns include ineffective policies and institutional practices regarding epidemic levels of violence against women, underfunded mental health systems, and persistent gendered income gaps.

In short, as a society we often overlook the root causes and structural drivers of women's substance use, and the subsequent barriers to treatment and recovery. In failing to recognize their links to structural sexism, racism, classism and colonialism, for example, societal institutions help perpetuate the negative practices that create barriers to recovery.

HOW WAS THE FRAMEWORK DEVELOPED?

The CPR Framework development process had multiple stages. A previous project brought together women's treatment providers across Canada to articulate what key content was required to improve treatment programmes. The providers identified four main areas: a focus on physical health, being trauma and violence informed, social support and empowerment and crucially, support of the mother-child dyad as a unit [4, 5].

Building upon this important base, the framework development process focused on identifying the deep reasons, root causes, and distal drivers that continue to block the development of effective accessible treatment that cultivates smooth recovery pathways to women.

To foster deeper thinking on structural issues, we held focus groups with treatment providers to focus on the four areas and elicit experiences of structural and social determinants of health affecting recovery. In addition, we held a multisectoral Community of Inquiry with service providers, researchers, women with lived and living experience, and policymakers to generate ideas for the CPR Framework. We then consulted with key informants with policy and system design expertise to comment on feasibility issues in addressing structural determinants that impact women's recovery and reflect on system remedies.

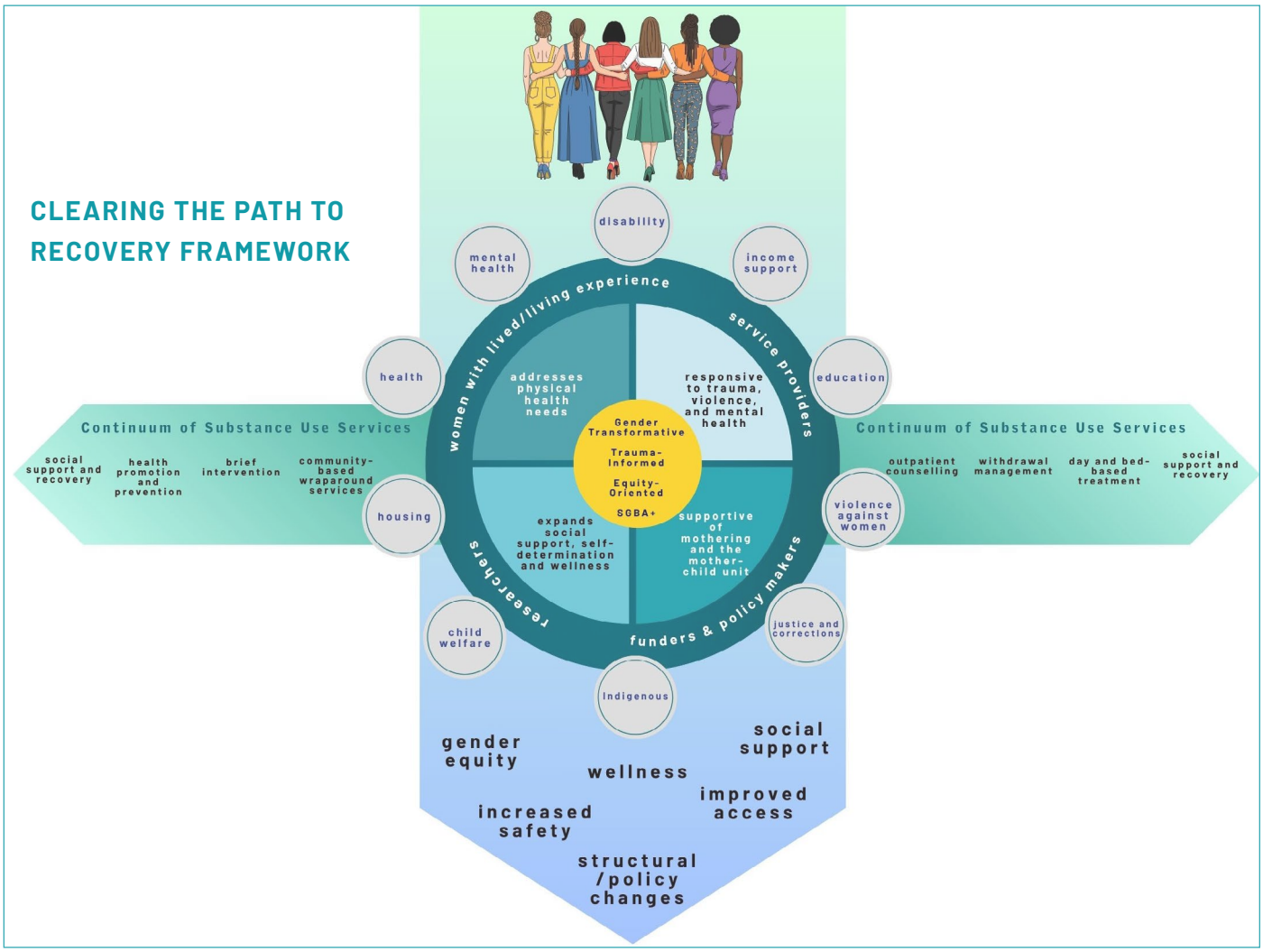
Ultimately, providing recovery support services that are sex and gender informed, trauma-informed, equity oriented, culturally sensitive, and harm reduction oriented is essential but still an elusive reality in Canada. Some specific improvement suggestions include:

1. Addressing gender-based violence and supporting women's dual recovery from substance use and violence by providing merged recovery from violence and substance use in both anti-violence and substance use services
2. Providing integrated, family-centered supports for pregnant and parenting women by creating accessible opportunities for pregnant women and mothers to seek recovery in supportive child-inclusive programs
3. Making community based wraparound programming that address the challenges for pregnant and parenting women facing challenges related to multiple determinants of health
4. Supporting the socioeconomic conditions necessary for recovery by creating income, welfare and housing policy changes that support women and their children throughout recovery
5. Addressing multi-level, structural and compounding sources of stigma by rooting out the sources and manifestations of institutional and social stigma that perpetuate substance use and prevent recovery
6. Improving collective agency by ensuring opportunities for women in recovery to enact self and collective advocacy and learn from and with each other about recovery
7. Using Two-Eyed Seeing (Etuaptmumk) to weave together the strengths of both Indigenous and Western ways of knowing in service and policy improvement.

These seven areas were a starting point for developing the CPR Framework as they not only identified immediate needed program and policy changes but also prompted discussion and thinking about key structural and social determinants to clear the path to recovery. They informed the design of the CPR Framework and helped identify the selection of the examples of priority policy shifts and actions in this document.

But crucially, these needed improvements are also indicators of root causes, reflections of gender inequality and entrenched biases, and indicative of systemic barriers to treatment and recovery. It is these deep structural barriers that the CPR Framework was developed to highlight and aims to ameliorate to clear the path to women's recovery.

The Clearing the Path to Recovery Framework

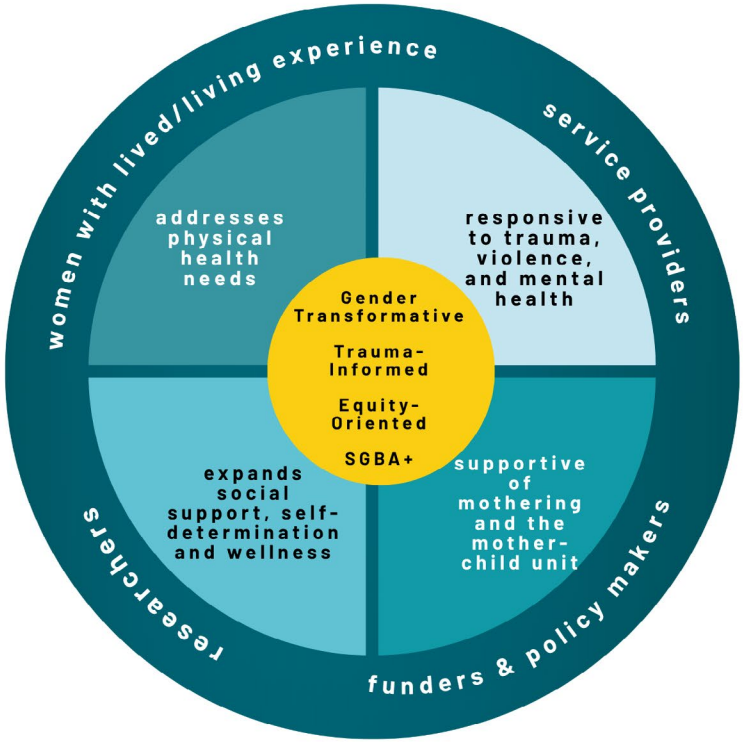


The CPR Framework is a tool for discussion, planning, analysis, and advocacy. It helps guide and facilitate action on improving the options for recovery for women who use substances.

It can be used by any group or individual, interested in analyzing and improving women's recovery paths in Canada. It can be used by individuals or teams working on program development, service and system planning, policy makers or advocacy. It helps to clarify areas of importance in removing barriers and indicates areas for improvement and action.

It depicts various components for consideration in our collective efforts to remove barriers for women who use substances in seeking treatment and recovery. Taken together, the CPR Framework identifies the elements that need to be considered as actions, programs or policies are developed.

Let's start at the centre.



FOUR KEY APPROACHES

At the very centre of the CPR Framework are four key approaches that we must either learn about or use and evolve in order to hone our analyses of social and structural determinants of women's recovery. These approaches are dynamic, and must reflect current realities, regional contexts and specific features of various groups of women in Canada. They include asking four basic questions when assessing the situations of women using substances and their hopes for recovery. They are also useful questions for assessing proposed solutions and improvements.

Is the solution or improvement gender-transformative? Will the proposed change improve recovery pathways, as well as gender equity?

Is the solution trauma-informed? Does the improvement or solution account for broad experiences of trauma among women who use substances, and will it prevent re-traumatization?

Is the change equity-oriented? Does the proposed change address and account for differences among women, by age or ability, or income or region or ethnicity?

Has there been a comprehensive sex and gender-based analysis plus (SGBA+)? Does the proposed change reflect evidence, content and consideration of the sex-based and gender-based elements of diverse women's substance use and recovery?

Using all four of these approaches in analyzing and improving women's substance use and recovery pathways is essential to moving forward. These approaches will combine evidence and understanding of sex and gender considerations in women's substance use and treatment and recovery with tailored solutions that improve gender equity for various groups of women, along with providing trauma-informed care. A key approach embedded in being equity oriented is integrating Indigenous cultural approaches into recovery from substance use and addiction [40-42]. All of these elements are important.

FOUR IMPORTANT ELEMENTS OF WOMEN'S RECOVERY SERVICES

Surrounding these key approaches are the four important elements of women's substance use treatment and recovery identified by a pan-Canadian group of women's treatment providers and researchers [4, 5]. These are essential improvements for creating accessible women's treatment systems, and that, if present and robust, will enhance entrance to and ongoing recovery for women [43].

Considers physical health - Addressing the sex-specific effects of substance use on female bodies and integrating comprehensive health care into treatment and recovery.

Responds to violence and trauma - Recognizing the epidemic level of violence against women and incorporating tailored, trauma-informed support to address its physical and mental health impacts.

Supports consideration of mothers and children together - Acknowledging persistent barriers for pregnant and parenting women and addressing the interconnected needs of women and their children, including attachment and parenting support.

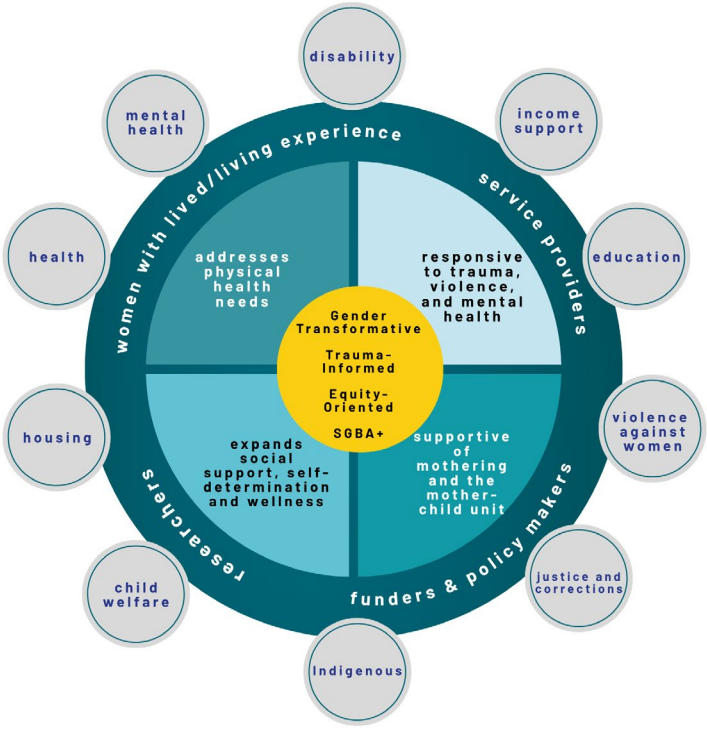
Improves social support and self-determination - Promoting women's empowerment and connection by strengthening social support, addressing stigma, and honouring women's agency in recovery.

Echoing these, European researchers identified several gender-related factors influencing the women's recovery journey, "such as the importance of empowerment, the dual challenge of motherhood and personal healing, supportive relationships, and resilience against societal doubt" [43]. But reaching a state where these elements are present, consistent and strong, requires consideration of structural barriers and drivers and requires multiple actors.

The final ring of this inner circle is about engagement — reflecting the essential involvement of four broad categories: women with lived experience, service providers, researchers, and policy makers. These categories overlap. It is important to recognize the lived experiences of community activists and service providers, the wisdom of Indigenous Knowledge Keepers along with researchers, and the decision making of service and system planners along with policy makers. Respectful, comprehensive involvement leads to feasible and realistic solutions.

KEY POLICY AREAS

Surrounding the central section of the CPR Framework are some key policy areas that matter in analyzing and acting to address the barriers to women's recovery. These include housing, child welfare, income assistance, mental health, health, corrections, labour, disability, Indigenous relations and education. In each of these areas, there are significant structural barriers or impediments to women's recovery pathways that ultimately need concerted, coordinated change.

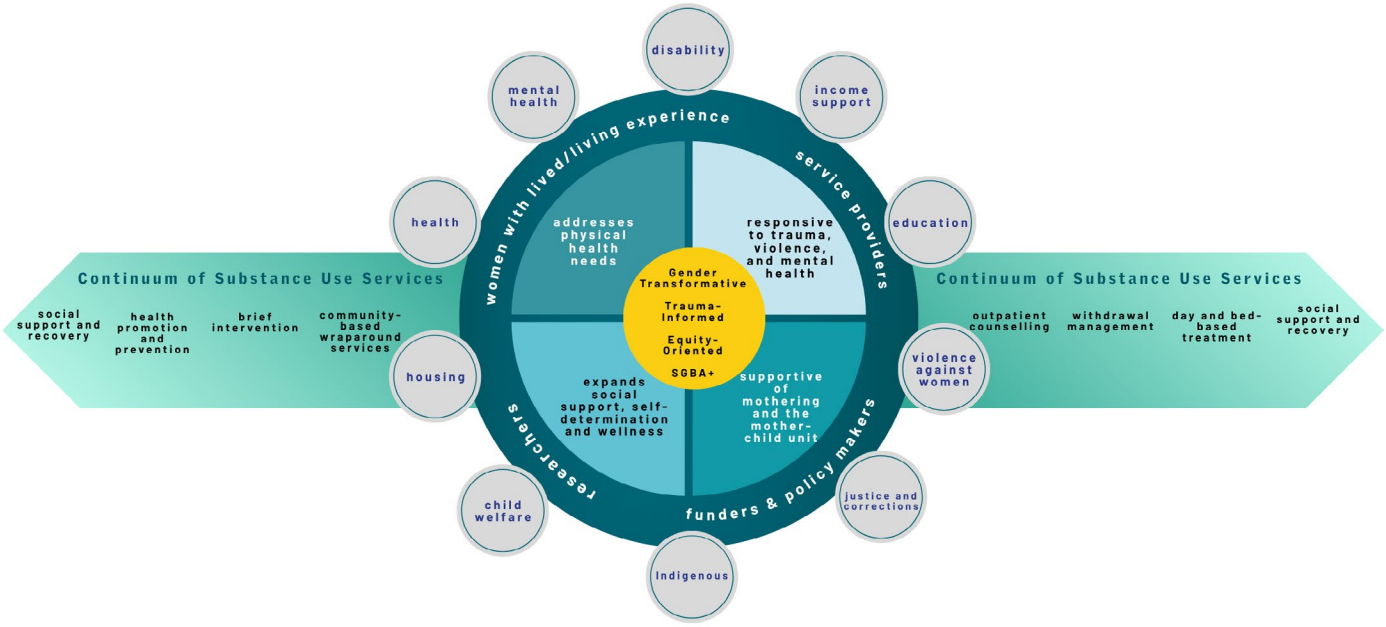


This circle reminds us of the range of issues that will prompt us to consider barriers to joined-up action in our own geographic regions and jurisdictions, pertinent to specific populations of women, in different social and cultural contexts or experiencing different kinds of substance use. Using this as a basis for forming a unified vision gets us started on using the CPR Framework for our own purposes in our own settings.

The following policy issues directly affect the growth and development of women's treatment, and women's access to recovery pathways.

- The removal of babies or children from mothers with substance use issues by child welfare authorities is a significant barrier to women approaching treatment and recovery services.
- The underfunding of women's mental health support systems that precludes access to gender responsive care is a barrier to recovery.
- Income, welfare or tax policies that fail to rectify or reflect persistent gender pay gaps are a structural barrier to recovery.
- Precarious housing that does not support women, families or women fleeing violence are barriers to change for women.

COMPONENTS OF A RESPONSE CONTINUUM



The horizontal arrow depicts the components of a comprehensive response to substance use, with both ends of the arrow culminating in increasing social support and changes of successful recovery. On the left, prevention and health promotion can contribute to early recovery or even avoidance of substance use problems. On the right, more intensive treatment options such as bed-based withdrawal and treatment services play a key role. At either end, the importance of creating socially supportive environments that not only assist in recovery, but also sustain health and facilitate thriving, is the critical component.

What does recovery support for women using substances include? In each of these components, barrier free access to care that addresses the four key areas in the centre of the CPR Framework diagram is essential. For example, sex specific information about both the impacts of substances and treatment options on women needs to be readily available, with appropriately tailored information, trained staff, and specific services provided. Substance use services that incorporate a response to gender-based violence and gendered trauma and accept and accommodate both mothers and children are critical. Finally, building women's empowerment and agency and increasing gender equity during recovery, is a crucial element of recovery support.

Creating and maintaining services like these requires policy shifts, and comprehensive planning in a joined-up manner. Funding that ensures success, attention to dismantling stigmatizing processes and obliterating punitive exclusionary policies for mothers who use substances are examples of long overdue policy steps.

This section of the CPR Framework is important to planning and delivering on this vision. It assists in isolating exactly how structural barriers can be addressed within and by the various components of the prevention, treatment and recovery system. It can reflect the four important approaches in the centre of the CPR Framework as well as call attention to all the possible policy areas that could impact each component. This section focuses our collective gaze on designing services to increase accessibility, relevance and impact for women who use substances as they work toward recovery.

OUTCOMES TO BE ACHIEVED

Taken together, these framework elements (the core approaches, the four essential elements of women's treatment and recovery, the engagement model, key policy areas, and the continuum of substance use care) are essential for creating policy and program action to remove structural barriers to women's treatment and recovery pathways in Canada. If we coordinate our approach using the CPR Framework, it will lead to increased gender equity, enhanced wellness, stronger social support, improved access, and even ongoing structural and policy improvements in response to emerging needs and contexts.

Using the Clearing the Path to Recovery Framework as a tool for action

Action and advocacy are necessary to eliminate, change or weaken the structural barriers to recovery. Given a diminishing gender gap in substance use, and a growing need for more appropriate, accessible and effective services, concerted attention to the structural as well as the social determinants of health is now essential. There is a need for a conceptual realignment of many existing policies and programs to meet this challenge.

SOME EXAMPLES IN POLICY AND PRACTICE

We present four examples of using the CPR Framework to not only assist in analyzing the barriers, but also to identify ways of rectifying them. These examples emerged from Community of Inquiry discussions, focus groups and interviews undertaken in developing the CPR Framework. All of these examples of policy and practice address both social and structural determinants of women's health and substance use, reflect both sex and gender considerations, and are gender-transformative in their approach.

1) Addressing the need for women-centred policy that focuses on the mother-child unit and reduces stigma and stereotyping

Women's sex-based reproductive roles have an important impact on their substance use and recovery trajectories and are often a preoccupation of providers and policy makers. However, they are often not considered in developing programs or policies, or in encouraging shifts in public opinion and stigma. A long-standing barrier to recovery for women is a lack of treatment options that reflect their reproductive needs and life stages.

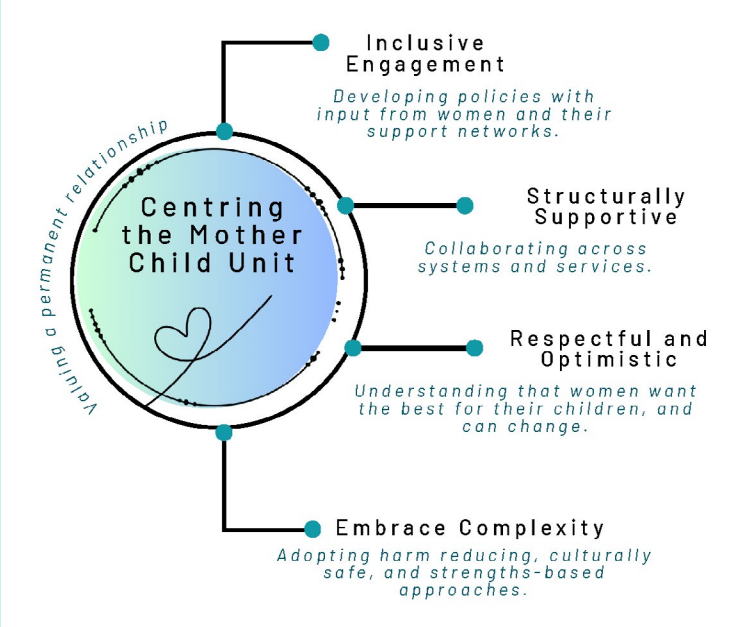
For example, treatment that serves mothers and children together is rare. Indeed, all too often child welfare and women's recovery are considered separately, creating programs and policies that set women and children on different pathways, dealt with by different departments using different principles. And, when children are apprehended, sometimes at birth, mothers experience further trauma that often escalates substance use. The fear of loss of child custody is one of the most important barriers to treatment and recovery. This fear is often mixed with maternal guilt, stemming from gendered stigma attached disproportionately to mothers, setting up complex and difficult barriers to recovery.

What could help? Approaches that serve women across the continuum of support and treatment which facilitate the health and recovery of the mother without fear of apprehension or loss of custody are required as a standard approach.

There are some examples of such approaches [4, 35, 44]. They include:

- Respite options
- Home visiting programs - e.g. FIRST (Families In Recovery SupporT) Steps Together in Massachusetts, USA
- Day treatment programs with parallel programming for children - e.g. Mom and Kids Too Program, Jean Tweed Treatment Centre in Toronto, Ontario
- Wraparound, community-based programs that combine substance use programming for mothers with infant and child mental health programming - e.g., Mothercraft's Breaking the Cycle in Toronto
- Mother-child programming within correctional facilities - e.g., Correctional Services Canada's Institutional Mother-Child Program
- Affordable, supportive housing for mothers and children - e.g., Karis Support Society's semi-independent and independent living in Kelowna, British Columbia

This diagram depicts four approaches that can be adopted when developing, implementing, and assessing mothering-related policy. A version of it was first published in 2002 in A Motherhood Issue: Discourses On Mothering Under Duress.



However, these types of programs remain hard to access. Child welfare policy making must develop clear collaboration with the substance use field to confront and change deep-seated barriers to recovery for women who are pregnant or mothering.

This requires a deliberate joined-up effort between sectors and departments, or even among government ministries, an acknowledgment of both sex and gender related factors affecting women's health and substance use, and a commitment to reducing gendered stigma and re-traumatization of pregnant women and mothers.

Such a shift can bring results in program offerings. It can be manifested in co-planning with families [45] and between services offered to children and to women. For example, the FIR Unit in Vancouver where social workers work with medical professionals and parents in an acute maternity care context. Such coordinated policy supports early attachment in the context of exposure to substances for infants and can help coordinate pregnancy and postpartum care. It also can address the impacts of racism and colonialism that results in the over-representation of Indigenous mothers in the child welfare system. Such recovery co-planning can also involve assessing and supporting safe, wanted connections with fathers, partners, and extended or chosen family. In parallel, men's recovery programs can support parenting by fathers with substance use problems.

There are other deep seated structural barriers that need to be addressed to ease the load of mothers with substance use issues seeking recovery. It is essential to break down gendered caretaking roles and assumptions that have not only overburdened mothers, but simultaneously relieved fathers of responsibilities. Using a gender-transformative approach, both substance use and child welfare policy would aim to bring more equity to parenting responsibilities by addressing underlying sexism with a gender-transformative lens. This would reduce isolation and fear among women by developing support for fathering, non-violent relationships, less conflict-based custody decision-making, and kin care and community supports to actively encircle mothers and their children during recovery.

2) Addressing sexism as a structural barrier by creating integrated approaches for women facing substance use, mental health and/or gender-based violence experiences

Sexism often manifests in women's poorer health [31-33]. It is evident in the overmedicalization of women experiencing depression and anxiety, the stigma aimed at women with substance use concerns, and a virtually complete lack of systemic attention to the complex overlaps of gender-based violence and substance use.

Sexism also contributes to a lack of funding for women's health research and care, insufficient recovery and treatment options for women, and a lack of wraparound programming. The lack of integration of services addressing the overlapping issues affecting women who use substances ultimately can be traced back to the undervaluing of women's health. Addressing these root causes is increasingly important to reconstructing systems of response and form options to women seeking recovery.

What would be different if an ideal set of options were available? There are many policy and programming remedies that can be seen through the lens of the CPR Framework. By working through the various steps of the CPR Framework, we are collectively inspired to consider a wide range of contributors to women's health, or conversely, barriers to health.

The provision of integrated mental health responses, access and support could be improved by policy and practice changes that address biases in health research and clinical practice that fundamentally devalue or ignore female bodies and women. This can be in many forms, such as providing accessible, sex-informed and gender-informed supports for issues related to substance use such as tapering from anti-anxiety and anti-depressant medications, including benzodiazepines and selective seratonin-reuptake inhibitors (SSRIs), clinical education on stigma reduction, or simply promoting sex-specific public information and advice on the differential and deleterious impacts of ingesting substances for women.

Or, similarly, in understanding the value of social support for women seeking recovery, or the importance of providing non-stigmatizing day treatment for mental health, violence and substance use issues simultaneously. Or the relevance and necessity to provide options for recovery that include childcare, inclusion of children, and aligned infant/child mental health services. Such approaches indicate a strong, integrated multi- sectoral response that is reflective of the complexity of substance use recovery for women.

For example:

- Can a bed-based service expand to include children, so that mothers can attend more easily?
- Can prevention education highlight root causes of substance use and gendered and intimate partner violence, and include information and techniques for reducing both?
- Can sex-segregated detoxification and withdrawal services reduce re-traumatization?
- Can social support be a key element throughout the substance use response system, generating connections between women as a source of strength?
- Can wraparound services include opportunities for supporting collective action and advocacy on issues such as funding for women's services, gendered income gaps and precarious housing?

Siloed care can often leave women wanting. Using the CPR Framework can illuminate the exact places where merging services and instituting joined up policy making could change everything. For example, the major overlap between women's experiences of substance use and intimate partner violence calls for the widespread provision of integrated violence and substance use services [46, 47]. The increased incidence among women of traumatic brain injury and chronic health conditions associated with substance use and violence against women further support a merged approach [48]. Finally, the differential sex-based negative impacts of substances on female bodies and women's health, including cancers and chronic diseases [7] needs wide publicity and integration into clinical care, guidance, and public education.

Building Connections is a "two-generation", trauma-informed, 6-week group intervention designed and offered for mothers and children who have experienced violence and are accessing community-based programs such as Canada Prenatal Nutrition programs and Aboriginal Head Start in Urban and Northern Communities (AHSUNC) Program. It addresses the mother's needs, the child's needs, and their relationship needs [30, 49].

Strong Women is a dual-focused intervention designed to address IPV and substance use (alcohol and/or tobacco) together for women accessing anti-violence and substance use services. The program has been piloted and tested across seven substance use and anti-violence services in Canada. It is based on a virtual social support curriculum, a self-paced workbook for women, and a facilitation guide [47, 50, 51].

3) Creating joined-up policy development that links recovery to housing, income and food security

Key determinants of health are stable housing, food security and adequate income. But these basics are often either unaffordable or unavailable. Access to supportive housing for women is even less likely. Supportive housing for women and families that includes treatment, health care and recovery support is direly needed. For example, the Housing First model [52] as an approach to homelessness has shown how supportive services can be brought to people where they live, as an alternative to requiring abstinence as a condition for housing. For women with substance use problems, the provision of assistance to keep them in stable housing can support a health improvement and recovery path that offers stability for accessing treatment and recovery pathways, without loss of housing, friends, or child custody.

There are many options for programming when housing is stable for those needing and wanting substance use treatment or recovery.

Atira Women's Resource Society in British Columbia provides in-reach services to women living in Single Room Occupancy (SRO) hotels, to bridge gaps in services for those with limited connections to resources.

Atira also developed SheROes, a peer-led outreach program that engages women living in SROs by offering practical assistance, social support, and connections to community resources. It was developed in response to the isolation many of these women experienced and the gaps in meeting their needs. Peer support workers with lived experience foster social connection, distribute food and essential supplies, and help women navigate health and social services, including substance use supports [55].

Home-based programming approaches include early interventions such as home visiting programs with a mother-child unit, provision of home detox when desired, and in-reach services by nurses to provide substance use services and support for related conditions such as chronic pain [53, 54].

Policies related to income support are a similarly important structural determinant of recovery and access to treatment for women. In some jurisdictions, rent allowance from women's income support is often required to be reallocated to supplement treatment program funding. Changing such a policy can help retain housing stability for women who may need temporary bed-based treatment services. Overall, provision of basic income needs is an important step in removing income related barriers to recovery, along with housing and food security. Considering these policies in relation to each other, along with community supports is a perspective promoted by using the CPR Framework in planning and policy making.

Examples of mechanisms that illustrate a joined-up approach:

- Pooled or braided funding across ministries, so a woman does not have to separately qualify for housing, income assistance, and treatment funding that each run on different rules and timelines.
- Flexible and portable wraparound supports. Supports and a case manager are attached to the woman herself rather than to the housing program, moving with her if she changes housing, and scaling up or down as her and her children's needs change over time. [56]
- A single point of entry or navigator role, so the complexity of the system is absorbed by that role rather than by the woman having to find her own way through it.
- Data-sharing agreements between child welfare, health, and justice, so a woman isn't forced to retell her story to each part of the system with the risk of re-traumatization or triggering different responses.
- Shared outcomes frameworks, so that different sectors understand that they are contributing to common outcomes for women and children and are held collectively accountable.

4) Promoting a social model of health that strengthens a wide range of community supports

Social connections and community belonging and engagement are key to mental and physical wellbeing and can make the difference in attempting or sustaining recovery. It is important that women who use substances have access to circles of support, virtual care, and local resource centres for social support. These supports are extremely important to individual wellbeing and provide a context for women to experience the benefits of contributing collectively to the wellbeing of others and their community. This commitment to a social model ensures that women feel less isolated and are better able to shift their pathways and sustain recovery goals. Addressing the structures that foster or maintain social support is crucial.

For example, community support and social connection are direly needed immediately following release from correctional facilities, which is a time of high-risk for substance use relapse and loss of custody for women [58-60].

A sense of cultural identity, agency and community connection are central to an Indigenous Wellness worldview. The Indigenous Wellness Framework [57] describes the benefit of:

- Hope for our future and the future of our families that is grounded in a sense of identity, unique values and a belief in spirit;
- A sense of belonging and connectedness within our families, our community and our culture;
- A sense of meaning and an understanding of how our lives and the lives of our families and communities are part of Creation and a rich history; and
- Purpose in our daily lives, whether it is through education, employment, caregiving activities or cultural ways of being and doing.

It is a key policy moment for integrated policy and clear collaboration between corrections and community-based housing, health, and child welfare services. It is key to make connections to peer social support in women's recovery groups in this period.

Similarly, for newcomer, refugee, and undocumented women, immigration status itself functions as a barrier to needed supports for health and wellbeing, especially given the fear that disclosure of substance use could affect immigration status. Coordinating service and policy for these groups of women is clearly a need.

In 2023, Community Foundations of Canada released its national Vital Signs report, Reconnecting Communities, drawing on results of the 2022 Social Capital in Canada Study [61]. According to the national report, a strong sense of belonging has dropped 12% over the 10 years since 2013 and 29% of people do not have close friends in their community [61]. At the same time, non-profits are grappling with soaring demand, skyrocketing costs, and decreases in revenue sources [62].

Support by governments and foundations for local community centres, women's resource centres, immigrant and refugee organizations, community kitchens, supportive housing, and Indigenous agencies is key to providing prevention and recovery routes for women with substance use concerns.

Organizations such as the SHE RECOVERS® Foundation provide both online and local opportunities for women to "increase their recovery capital, heal themselves and help other women to do the same." Below are two of their intentions and guiding principles, which reflect the importance of social and community connection, empowerment, and agency in women's recovery:





The provision of community in all of its forms is a collective responsibility, easily aided by good planning and sound policy. Adopting a social model of health is a step in removing the barriers to recovery that stem from isolation such as loneliness and shame by providing a social safety net for women.

Conclusion

Women who use substances continue to face many significant barriers to treatment and recovery. The barriers reflect both program availability and suitability, policy designs and funding mechanisms, all of which are ultimately affected by political decisions and ideology. They are rooted in sexism, reflected in longstanding lack of action on women's health, safety and equity. To reduce these barriers in a sustainable way, fundamental shifts are required. The CPR Framework can assist in identifying barriers, as well as solutions.

The solutions are many. It is necessary to shift systems at meso and macro levels, and to identify the specific social and structural determinants of health that stand in the way of individual women, or groups of women, seeking change. There are immediate, proximal issues such as lack of appropriate, accessible treatment or housing or food precarity that add complexity to women's journeys as they consider the major life changes required to address their substance use. In addition, there are significant social and economic factors that impact women's opportunities for recovery such as stigma and poverty.

The immediacy of these concerns can preoccupy us all as we try to plan or design more effective responses to women who use substances in Canada. Despite their importance, these concerns also serve to divert our collective attention from the root causes of inadequate responses, or the underlying issues that prevent effective solutions or pathways to recovery from being formulated, funded, coordinated, and maintained.

Using the CPR Framework can focus our collective attention on the impacts of social attitudes and practices and the structures that support and perpetuate them. It can draw our attention to root causes such as sexism that prevent equal resource allocation to women, treatment services or related housing and income needs. It can surface the impacts of racism and colonialism that feed on and perpetuate stereotyping via over policing and culturally inappropriate care.

It can highlight the shortsighted approaches that fail to consider mothers and children as a unit, preventing progress for many women in choosing recovery. It can also help suggest solutions that require an about face in thinking about current responses and lack of options, such as providing housing first, generating basic income security and equal pay for women, and instituting trauma informed child welfare policies.

There are powerful social processes and structural problems and solutions that determine the shape of change for women who use substances as they seek recovery. Making changes in the context of dependence or addiction is already an extremely difficult mental and physical journey, without facing insidious manifestations of sexism, racism, classism and colonialism, in contexts of siloed care, amid gendered stigma about substance use, women and mothers. It is time to confront some of these basic, but powerful factors that limit women's opportunities for recovery and health. Using the CPR Framework in groups, or work teams, in ministries, or in systems, can assist in illuminating opportunities for more radical solutions, more humane and women-centred policies and better health for women.

References

1. Government of Canada. *Federal actions on the overdose crisis*. 2024; Available from: https://www.canada.ca/en/health-canada/services/opioids/federal-actions/overview.html
2. Greaves, L., et al., *Integrating Sex and Gender Informed Evidence into Your Practices: Ten Key Questions on Sex, Gender & Substance Use*. Centre of Excellence for Women's Health, 2020.
3. Public Health of Canada. *Key Health Inequalities in Canada: A National Portrait*. 2018; Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf.
4. Poole, N., et al., *Women's Substance Use Treatment and Recovery: What do we know and what are research and evaluation priorities for Canada*. 2024, Centre of Excellence for Women's Health: Vancouver, BC.
5. Poole, N., *Bridging the gaps for women in substance use treatment.* Frontiers in Psychiatry, 2026. **Volume 16 - 2025**.
6. Greaves, L., *Missing in Action: Sex and Gender in Substance Use Research*. International Journal of Environmental Research And Public Health, 2020. **17**(7): p. 2352.
7. Substance Abuse and Mental Health Services Administration, *Substance Abuse Treatment: Addressing the Specific Needs of Women*. Treatment Improvement Protocol (TIP) Series No. 51. HHS Publication No. (SMA) 13-4426. 2009, Rockville, MD: Substance Abuse and Mental Health Services Administration.
8. Greaves, L. and N. Hemsing, *Sex and Gender Interactions on the Use and Impact of Recreational Cannabis*. International Journal of Environmental Research and Public Health, 2020. **17**(2): p. 509.
9. Keyes, K.M., et al., *Is There a Recent Epidemic of Women's Drinking? A Critical Review of National Studies.* Alcohol Clin Exp Res, 2019. **43**(7): p. 1344-1359.
10. White, A.M., *Gender Differences in the Epidemiology of Alcohol Use and Related Harms in the United States*. Alcohol Res, 2020. **40**(2): p. 01.
11. Alam, F. and P. Silveyra, *Sex Differences in E-Cigarette Use and Related Health Effects*. Int J Environ Res Public Health, 2023. **20**(22).
12. World Health Organization, *WHO global report on trends in prevalence of tobacco use 2000-2025*. 2020: World Health Organization.
13. Johnson, R.M., et al., *Past 15-year trends in adolescent marijuana use: Differences by race/ethnicity and sex*. Drug Alcohol Depend, 2015. **155**: p. 8-15.
14. Konefal, S., et al., *National Treatment Indicators Report: 2016-2018 Data*. 2020, Canadian Centre on Substance Use and Addiction.
15. Greaves, L., et al., *Mothering Under Duress: Women Caught in a Web of Discourses*. Journal of the Motherhood Initiative for Research and Community Involvement, 2004. **6**(1).
16. Wolfson, L., et al., *Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework*. Health Soc Care Community, 2021. **29**(3): p. 589-601.
17. Bakos-Block, C., et al. *"My Addiction Doesn't Define Me"—Experiences of Stigma among Mothers with Opioid Use Disorder*. Pharmacoepidemiology, 2024. **3**, 57-68 DOI: 10.3390/pharma3010004.
18. Poole, N. and B. Isaac, *Barriers to treatment for substance-using mothers*. 2001, British Columbia Centre of Excellence for Women's Health: Vancouver, BC.
19. Elms, N., et al., *Need for women-centered treatment for substance use disorders: results from focus group discussions*. Harm Reduction Journal, 2018. **15**(1): p. 40.
20. Motz, M., et al., *Addressing the Impact of Interpersonal Violence in Women Who Struggle with Substance Use Through Developmental-Relational Strategies in a Community Program*. International Journal of Environmental Research and Public Health, 2019. **16**(21): p. 4197.
21. Rutman, D., et al., *Multi-service prevention programs for pregnant and parenting women with substance use and multiple vulnerabilities: Program structure and clients' perspectives on wraparound programming*. BMC Pregnancy and Childbirth, 2020. **20**(1): p. 441.
22. Harris, M.T.H., et al., *Gender Dynamics in Substance Use and Treatment: A Women's Focused Approach*. Medical Clinics of North America, 2022. **106**(1): p. 219-234.
23. Greaves, L., *How could a gender transformative lens foster the integration of sex/gender into more equitable policy and practice?* , in *Ernst Strüngmann Forum on Sex and Gender Transforming Scientific Practice*. Forthcoming 2024, MIT Press.
24. Greaves, L., A. Pederson, and N. Poole, *Making it Better: Gender Transformative Health Promotion*. 2014, Toronto, ON: Canadian Scholars Press.
25. Shahram, S., *The social determinants of substance use for aboriginal women: A systematic review*. Women & Health, 2016. **56**(2): p. 157-176.
26. Greenfield, S.F., et al., *Substance abuse treatment entry, retention, and outcome in women: A review of the literature*. Drug

and Alcohol Dependence, 2007. **86**(1): p. 1-21.
27. Shahram, S.Z., et al., *The Cedar Project: Using Indigenous-Specific Determinants of Health to Predict Substance use among Young Pregnant-Involved Indigenous Women In Canada.* BMC Women's Health, 2017. **17**(1): p. 84.
28. United Nations Office on Drugs and Crime, *Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned*. 2004, United Nations Office on Drugs and Crime: Vienna, Austria.
29. BC Ministry of Health, *British Columbia's Population and Public Health Framework: Strengthening Public Health*. 2024, BC Ministry of Health: Victoria, BC.
30. Andrews, N.C.Z., M. Motz, and D.J. Pepler, *A national implementation of a community-based intervention for mothers experiencing violence in relationships.* J Fam Psychol, 2021. **35**(1): p. 92-102.
31. Scheer, J.R., et al., *Mental Health, Alcohol Use, and Substance Use Correlates of Sexism in a Sample of Gender-Diverse Sexual Minority Women.* Psychol Sex Orientat Gend Divers, 2022. **9**(2): p. 222-235.
32. Carr, E.R. and D.M. Szymanski, *Sexual objectification and substance abuse in young adult women.* The Counseling Psychologist, 2011. **39**(1): p. 39-66.
33. Petzel, Z.W. and B.J. Casad, *Sexism predicts alcohol use and motivations among college women with stronger alcohol identity*. Social Cognition, 2019. **37**(3): p. 341-354.
34. Meyers, S.A., et al., *The intersection of gender and drug use-related stigma: A mixed methods systematic review and synthesis of the literature.* Drug Alcohol Depend, 2021. **223**: p. 108706.
35. Centre of Excellence for Women's Health, *Mothering and opioids: Addressing stigma and acting collaboratively*. 2019, Centre of Excellence for Women's Health: Vancouver, BC.
36. Davis, T.A. and J. Ancis, *Look to the relationship: a review of African American women substance users' poor treatment retention and working alliance development*. Subst Use Misuse, 2012. **47**(6): p. 662-72.
37. Jongbloed, K., et al., *The Cedar Project: mortality among young Indigenous people who use drugs in British Columbia.* Cmaj, 2017. **189**(44): p. E1352-e1359.
38. First Nations Health Authority, *Overdose Data and First Nations in BC: Preliminary Findings*. 2017, First Nations Health Authority: Vancouver.
39. Mehr, J.B., et al., *Intimate partner violence, substance use, and health comorbidities among women: A narrative review.* Front Psychol, 2022. **13**: p. 1028375.
40. Rowan, M., et al., *Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study.* Substance Abuse Treatment, Prevention, and Policy, 2014. **9**(34).
41. Wolfson, L., et al., *Revitalizing Culture and Healing: Indigenous Approaches to FASD Prevention.* 2019, Centre of Excellence for Women's Health: Vancouver, British Columbia.
42. Dell, C., et al., *Turtle Finding Fact Sheet: The Role of the Treatment Provider in Aboriginal Women's Healing from Illicit Drug Abuse*. 2010: CES4healthinfo.
43. Nisic, M., et al., *What constitutes a women's recovery from addiction? Examining lived experiences and recovery capital of women from diverse European backgrounds.* Addiction Research & Theory, 2025. **33**(4): p. 322-339.
44. Nota Bene Consulting Group and Centre of Excellence for Women's Health, *Digital Handbook on Wraparound Programs for Pregnant and Parenting Women with Substances Use and Other Concerns*. 2022, Nota Bene Consulting Group: Victoria, British Columbia, Canada.
45. Turnell, A. and S. Edwards, *Aspiring to Partnership. The Signs of Safety approach to child protection*. Child Abuse Review, 1997. **6**(3): p. 179-190.
46. Brabete, A.C., Greaves, L., Poole, N., Wolfson, L., Whittaker, D., Cole, C., *Examining Interventions for Intimate Partner Violence and Substance Use: Results from a Scoping Review*. 2024, Centre of Excellence for Women's Health: Vancouver, British Columbia, Canada.
47. Centre of Excellence for Women's Health. *Strong Women: Resources to Support Women with Intimate Partner Violence and Substance Use Concerns [Webinar]*. 2026; Available from: https://www.youtube.com/watch?v=1R022NR6YcE&feature=youtu.be.
48. Lalonde, D., Baker, L., & Nonomura, R., *Traumatic Brain Injury and Violence Against Women*, in *Learning Network Issue 28*. 2019, Centre for Research & Education on Violence Against Women & Children: London, Ontario, Canada.
49. Leslie, M., et al., *Building Connections: Supporting Community-Based Programs to Address Interpersonal Violence and Child Maltreatment*. 2016, Mothercraft Press: Toronto, Ontario.
50. Centre of Excellence for Women's Health, *Strong Women: Social Support Workbook*. 2026, Centre of Excellence for Women's Health: Vancouver, BC.
51. Centre of Excellence for Women's Health. *Strong Women: Reducing the impact of intimate partner violence and substance use on women's health*. [cited 2026 April 28]; Available from: https://cewh.ca/current-projects/strong-women/.
52. Nelson, G., et al., *Systems change in the context of an initiative to scale up Housing First in Canada*. Journal of Community Psychology, 2019. **47**(1): p. 7-20.

53. Catherine, N.L.A., et al., *Effectiveness of nurse-home visiting in improving child and maternal outcomes prenatally to age two years: a randomised controlled trial (British Columbia Healthy Connections Project).* Journal of Child Psychology and Psychiatry, 2024. **65**(5): p. 644-655.
54. Mussared, J., et al., *An In-Home Withdrawal Service for individuals with low-to-moderate substance dependence: implementation and program evaluation.* Australian journal of primary health, 2024. **30**.
55. Flattery, S., et al., *SheROes Peer Support Pilot Program: Three-Month Developmental Evaluation*. 2026, Atira Women's Resource Society: Vancouver, British Columbia.
56. Provincial Perinatal Substance Use Program, *Perinatal Substance Use Housing - Planning, Design and Implementation Report*. 2024, Provincial Perinatal Substance Use Program, BC Women's Hospital MHSU Programs + Initiatives.
57. Thunderbird Partnership Foundation, *Indigenous wellness framework reference guide*. 2020, National Native Addictions Partnership Foundation. Retrieved from: https://www.thunderbirdpf.org/IWF.
58. Janssen, P.A., et al., *Factors that support successful transition to the community among women leaving prison in British Columbia: a prospective cohort study using participatory action research.* CMAJ Open, 2017. **5**(3): p. E717-e723.
59. Matheson, F.I., S. Doherty, and B.A. Grant, *Community-based aftercare and return to custody in a national sample of substance-abusing women offenders.* Am J Public Health, 2011. **101**(6): p. 1126-32.
60. McLeod, K.E., et al., *Use of community healthcare and overdose in the 30 days following release from provincial correctional facilities in British Columbia.* Drug Alcohol Depend, 2021. **229**(Pt A): p. 109113.
61. Community Foundations of Canada, *Reconnecting Communitis: Belonging, Engagement and Well-being*, in *National Vital Signs Report*. 2023, Community Foundations of Canada.
62. BC Non-Profit Network & Vantage Point, *Stretched Thin: 2025 State of BC's Non-Profit Sector*. Vantage Point: Vancouver, British Columbia, Canada.



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