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How Women Experience Addiction Services in Cork

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Taighde Éireann
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Contents

Executive Summary

The key finding of this report is that women with substance use disorder (SUD) are not a homogenous group. The women interviewed for this study had diverse backgrounds, experiences and needs, and provided different recommendations for improving addiction services. Services need to reflect this diversity, and provide a greater range of options, but all services should be trauma-informed and gender sensitive. While gender is an important consideration, it intersects with other identities, including class and age.

Official data

Illicit drugs: women accounted for 25% of overdose deaths (1998-2020) and 27% of demand for treatment (2013-2022) in Ireland.

Alcohol: women have traditionally engaged in less hazardous drinking than men, but the gap is narrowing. Women account for approximately 40% of people entering treatment in Ireland in 2023.

Caveat: as women are less likely than men to seek treatment or disclose problematic substance use, official data likely underestimates the prevalence of women needing treatment.

Method and sample

Semi-structured interviews were conducted with 15 women who have used addiction services. Half could be considered middle-class, based on educational attainment and employment at time of entering addiction services. Just under half were parents.

60% reported poli-drug use. The remainder reported using alcohol only. Alcohol was the most commonly reported substance, followed by cocaine and benzodiazepines.

Nearly 80% of participants reported one or more co-occurring **mental health condition.** Half reported at least one attempted suicide.

Experience of services

While participants reported diverse experiences of services, all expressed gratitude for the services they had received. That participants expressed an overall positive experience of services is important given the obstacles they needed to navigate in the current provision of treatment services.

- Most addiction services were identified as male spaces. The lack of women-only services means that women can either enter male-dominated spaces or search for less available women-only spaces. This presents additional costs on women's time and resources.
- Some participants felt emotionally and/or physically insecure within services. Some were critical of residential and community-based treatment services which employed 'tough love' models. Some had felt unsafe in mixed-gender residential houses, because abusive partners invaded their space or men in their group were intimidating. Services cannot be trauma-informed if people feel insecure.
- Participants identified the need for recovery to be fun and/or that recovery was fun.
- Participants reported that the development of pro-recovery relationships helped maintain recovery, but new relationships could be risky and some found it difficult to establish relationships with other women of a similar age.
- Most participants attended 12-step meetings (i.e. AA/NA) and found them useful. Some had struggled with the religious focus and misogyny of meetings, identified meetings as male spaces and/or wanted more women-only meetings.
- Participants identified mixed-gender and women-only services presenting different strengths and challenges, and different women need different services.

Barriers to recovery

Participants reported diverse barriers to recovery. Some reported few barriers. Others reported multiple overlapping barriers, revolving around intersecting inequalities.

- Many participants had not known what addiction services existed in Ireland, so relied on online searches and/or signposting from medical professionals. Most felt that front-line medical practitioners were unaware of services.
- Several participants reported flying under the radar of services because they maintained education, work and caring responsibilities. Some were linked-in with medical and/or social services, but felt that practitioners had not identified their problematic substance use and/or dismissed their concerns. This may have been because participants did not fit existing stereotypes.
- Some participants identified the double stigma faced by women with SUD. This often intersected with caring roles to prevent entry into recover.
- The fear that children would be taken into care was identified as a barrier to treatment, but participant's experience of social work was positive. This indicates a gap between perception and experience of social work.
- All parents found juggling treatment and childcare difficult.
- Participants had different experiences of waiting times for residential treatment. Those with caring responsibilities or without the financial resources for private care appeared to wait longer.
- Around 40% of participants reported intimidate partner violence. Abusive partners were identified as a barrier to recovery, and that the recovery process can place victims in risky and vulnerable positions.

Recommendations

Participants provided diverse recommendations. Not all recommendations were immediately gendered, although the double stigma attached to women with SUD was a thread running through many recommendations. Many proposed recommendations to help all men and women 'travelling the same path'.

1. There is a need for more, and better resourced, residential and community-based addiction services, and linked services (i.e. domestic violence and mental health services).
2. The financial costs of residential treatment should be reduced, as should the associated costs of travelling to appointments and arranging childcare.
3. Participants wanted the option of attending mixed-gender or women-only residential and community-based services, that women-only spaces be provided in residential services (i.e. recreation rooms, therapy groups), and all spaces be gender sensitive. Women should not have to navigate male-spaces.
4. Trauma-informed care is founded upon providing safe environments. Residential services should (re)design buildings to ensure residents feel safe and comfortable.
5. All community-based treatment should be timed around the school day, so both men and women can care for children. All parents need options for childcare support.
6. Front-line medical practitioners should be better informed. They need up-to-date lists of available addiction services and training on different options.

7. Addiction services should be advertised more widely and in spaces frequented by women with SUD.

8. A broader cultural shift is needed to challenge some of the stereotypes of the 'addict' and lessen the stigma around women with SUD.

9. All addiction services should screen for intimate partner violence and cooperate more closely with intimate partner violence services.

10. Recovery needs to be fun. This includes offering a range of pro-social activities and supporting the development of pro-recovery relationships.

Acknowledgements

This report emanated from research conducted with the financial support of Taighde Éireann (Research Ireland) under the New Foundations programme (grant number NF/2024/10896). The research was a collaboration with Tabor Group. The idea for the project came from a meeting with Colette Kelleher and Mick Devine, about how UCC and Tabor could collaborate. So, many thanks to Colette and Mick for their enthusiastic support. The involvement of Tabor Group in this research, from design to implementation, demonstrates Tabor Groups commitment to outcome studies that establishes evidence base for quality of service delivery and quality improvement initiatives, as per service level agreements with funders and under objective 3.1 of the Tabor Group Strategic Plan 2020-2029.

The first draft was reviewed by Tabor staff and their insights were very helpful. A big thank you to all the staff and residents at Tabor Fellowship House. We could not have completed this research without the support of staff and were aware of intruding upon residents' space, especially on weekends. But all staff and residents made us feel welcomed. Thanks to Dr Sinead Drew (HSE Clinical Psychology) for reviewing our consent form and information sheets. Most of all, we would like to thank the 15 women who participated for giving their time, sharing their experiences and being so reflective and kind.

A note on terminology

One of the findings of this report is that women who use addiction services are stigmatised. One of the ways we can counter this is by using non-stigmatising language, because the words we use influence how people treat, and mistreat, those who use drugs. We use person first language as this reminds us that participants are people first, and more than the sum of their substance use. As all participants in this study felt the need to engage in residential services for their substance use, we will refer to them as women with a substance use disorder (SUD).

We acknowledge that the extent of SUD ranges from mild to severe, and SUD cannot fully capture the complexity of some of our participants' experiences. The word addiction is also tricky. It's a specific term used to denote the most chronic form of SUD (Kleiman et al., 2011). The term addiction is, however, commonly used shorthand for any risky and habitual behaviour, and both Tabor Group and the HSE use the term addiction services. Following the anti-stigma network (nd) we have not called any individual an addict, but have not censored the words participants use themselves.

To cite this report:

Windle, J. and Cronin, J. (2026). How Women Experience Addiction Services in Cork. Cork: University College Cork.

1. Introduction

Several experts who spoke at the 2023 Citizens Assembly on Drugs highlighted the particular and unique needs of women who use drugs or have a substance use disorder (SUD). Two key themes emerged from two panel discussions. The first was the need to increase the number of treatment centres designed to address the 'complex needs' of women, including domestic violence and childcare (Citizens Assembly, 2024:65). The second was the observation that women who use drugs suffer 'additional stigma', especially if they are mothers (Citizens Assembly, 2024:74).

At the meeting, Jim Walsh, of the Department of Health, proposed that the next iteration of the National Drugs Strategy should take a more 'gendered perspective' which considered the unique needs of women. Gary Broderick, of SAOL (Women's Recovery and Education Project), told the Assembly how women experience addiction differently to men, and have different biological, psychological and social needs. This includes often having experienced greater levels of trauma, including domestic abuse, yet services are seldom tailored to their needs. The example was given of the need for childcare provision to be attached to harm reduction and treatment services. Pauline McKeown (Coolmine Therapeutic Community) explained how many women fear losing their children if they engage in treatment or harm reduction, and face multiple adversities, including homelessness, transactional sex, poverty and domestic abuse. Shannon Connors reported that traveller women face additional stigma, and have specific and additional challenges (Citizens Assembly, 2014).

While some experts invited to speak at the Citizens Assembly identified the gendered nature of substance use, and addiction services, the international and Irish research on this area is relatively slim. To the best of our knowledge, the Irish research literature is limited to four literature or policy reviews (Banka et al., 2022; Morton et al., 2020; Windle and Cronin, 2025; Women's Health Council, 2009), five qualitative studies on the experiences of women (Harris et al., 2024; Morton et al., 2015, 2023; Ivers and Barry, 2018; Ivers et al., 2021), and five quantitative studies on opioid use during pregnancy (Cleary et al., 2010, 2011, 2012; Corbett et al., 2023; Scully et al., 2004).

Two-thirds of these 14 studies were published after the 2017 national drug strategy. Before that time, 'women only really featured in government publications on drugs or alcohol as mothers, expectant mothers or sex workers' (Windle and Cronin, 2025). Reducing Harm, Supporting Recovery: A Health Led Response to Drug and Alcohol Use in Ireland 2017-2025 was a milestone, which provided greater acknowledgment that women have individual needs separate from men, included gender-specific recommendations and called for 'gender informed approaches' (Morton et al., 2020; Windle and Cronin, 2025). In short, before 2017, the voices of women who use substances have been seldom heard, or considered, in either research or policy.

Women-specific research is needed because women experience both substance use and services differently to men. Some studies have shown that women first use drugs and alcohol later than men, but often progress faster from first use to dependence. As such, those entering treatment may have 'used less of the substance and for a shorter period of time' while experiencing a more severe escalation and more rapid 'decline in functionality' (Fonseca et al., 2021:94; see Erol and Karpyak, 2015). Other studies, however, suggest that the 'telescoping course' (i.e. escalation from first use to dependence) found in the literature may be partly due to women presenting to treatment earlier than men (see Erol and Karpyak, 2015).

Several studies have found women's drug use is strongly influenced by relationships with men (Simpson and McNulty, 2008). Such studies often identified women, more so than men, being introduced to a drug, or a mode of ingestion, by a partner (Shand et al., 2011) and/or residing with a partner who uses drugs (Azim et al., 2015). Qualitative studies have, however, tended to show that, while romantic partnerships are important, many women are introduced to drugs/modes of ingestion by both male and female friends (Taylor, 1993; Tuchman, 2015). Some studies in North America have attributed higher rates of opioid (Mazure and Fiellin, 2018) and benzodiazepine (McHugh et al., 2021) dependence in women to higher rates of medical prescribing of these drug. Gender differences in prescribing of pharmaceutical drugs has also been found in Ireland (see Morton et al., 2023). A number of international studies have pointed to increased hazardous alcohol consumption by women to the alcohol industries targeted marketing towards women (see Atkinson et al., 2019; Lyons et al., 2024).

Substance use physiologically and emotionally impacts men and women differently. Two meta-analysis show that women are more likely than men to present psychological and medical comorbidity, including 'higher rates of liver problems, hypertension, diabetes, anaemia, and gastrointestinal disorders', depression and anxiety (Erol and Karpyak, 2015; Fonseca et al., 2021). It can, however, be difficult to untangle the extent by which these issues result from structural gender inequalities or physiology differences.

The international and Irish research literature has shown how women who use substances problematically are more likely than men to be stigmatised (Arpa, 2017; Azim et al., 2015; Harris et al., 2024; Simpson and McNulty, 2008; Mayock and Butler, 2022; Miller et al., 2025; Morton et al., 2023) and experience intimate partner violence (IPV) (Ivers et al., 2021). Banka and colleagues (2022:28) estimated that, in Ireland, 'at least' 11,000 women who use substances experienced domestic violence in 2020. Women are also less likely than men to access addiction services (Arpa, 2017; Simpson and McNulty, 2008) because of multiple, often interlinked, barriers to treatment, including:

- **Stigmatisation from family, community and healthcare practitioners**
  (Harris et al., 2024; Mayock and Butler, 2022; Miller et al., 2025; Morton et al., 2023);
- **Fear that children will be taken into care**
  (Banka et al., 2022; Harris et al., 2024; Ivers and Barry, 2018; Miller et al., 2025; Morton et al., 2023; Tuchman, 2010);
- **Sexual harassment within services**
  (Muel et al., 2025; Sered and Norton-Hawk, 2011);
- **Lack of services for women while pregnant**
  (Tuchman, 2010; Simpson and McNulty, 2008);
- **Lack of childcare or support for parents**
  (Morton et al., 2023; Simpson and McNulty, 2008);
- **Abusive partners preventing women from accessing or engaging in services, through physical, financial and/or emotional abuse**
  (Fox, 2020; Ivers et al., 2021; Pallatino et al., 2021)
- **and lack of integrated IPV/addiction services**
  (Morton et al., 2015, 2023).

Some studies have found women being blocked from accessing services by family members, because of IPV, the stigma attached to substance use by women and/or concern over children being taken into care (Pallatino et al., 2021; Tuchman, 2010).

Participants in a Dublin study, by Ivers and colleagues (2021:10), identified a number of barriers to accessing treatment services, notably: 'age, stigma, lack of childcare facilities and lack of information regarding available services', and recommended 'gender specific treatment services tailored to women's needs around pregnancy, childcare, domestic violence, sex work, co-occurring mental health issues and homelessness'. Participants in another Dublin-based study, by Morton and colleagues (2023:13), identified four barriers to treatment: insufficient childcare, having to travel long distances for services, lack of integrated services and lack of support from IPV services. Morton and colleagues (2020:1) have argued that Irish drug services have often been 'gender neutral' (i.e. designed for men) and 'not always considered women's substance use initiation, trajectories or intervention, often overlooking women's susceptibilities and gendered needs' (also Wincup, 2019). This said, and following the 2017 national drug strategy, more gender-specific services are being developed and there has been an increase in ancillary services (i.e. homeless and IPV services) supporting women who use substances problematically (Morton et al., 2020).

1.1. Summary – towards gender-sensitive services

Both the Irish and international literature shows that women with SUD face issues that vary in extent and nature compared with their male counterparts. They tend to experience greater levels of stigma, discrimination and internal shame, have fewer social supports than men and their roles as parents can orientate their substances use and recovery more so than men. They are also at a greater risk of being a victim of IPV than men and, more likely to suffer physical and psychological health issues.

Ettorre (2004:328) proposed that treatment services must be 'gender-sensitive'. Gender-sensitive services acknowledge that men and women experience drugs and services differently and, that men's needs and experiences have historically been privileged over women's. Wincup (2019) followed this by arguing that women should not be framed as a 'vulnerable' subsection of the general (i.e. male) drug using population but proposed integrating a 'gender sensitive approach' into all services, rather than just those aimed at women.

2. Context

Women, Substance Use and Treatment Demand in Ireland

Globally, women account for approximately one-quarter of people who use drugs problematically, 20% of people entering treatment (Arpa, 2017) and 20.4% of people who inject drugs, rising to 28.6% in Western Europe (Degenhardt et al., 2017). These numbers are likely underestimates as women are less likely than men to engage in treatment services or disclose drug use (Morton et al., 2023). UNODC (2025:15) estimated that, globally, just 1 in 18 women with SUD against 1 in 7 men, received treatment in 2023. Regardless of data accuracy, we know that women compose a sizable percentage of those entering treatment and, the 'differences in prevalence rates between genders are getting narrower' in many countries for currently illicit drugs (Fonseca et al., 2021) and alcohol (Erol and Karpyak, 2015).

2.1 Alcohol

Alcohol use in Ireland is 'characterised by high per capita consumption and a high level of problematic drinking patterns' (Mongan et al., 2020). While alcohol use declined somewhat between 2011 and 2021, and litres consumed per capita is close to the OECD average, Ireland ranked eighth of 33 OECD countries for the proportion of adults who reported heavy episodic alcohol use in 2019 (OECD, 2023).

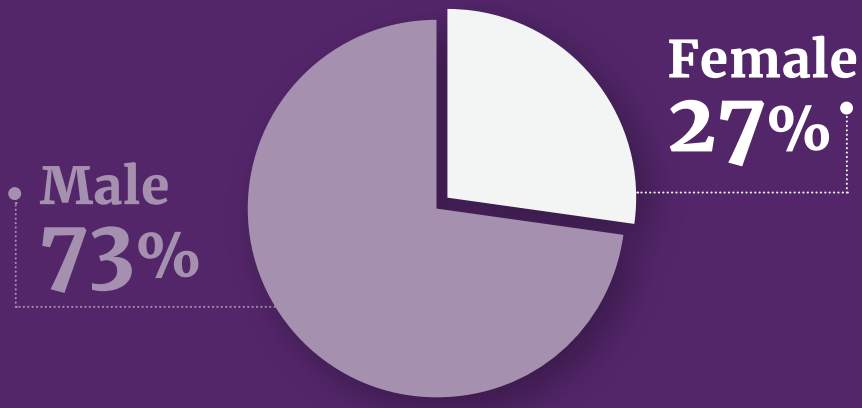
Hazardous drinking is more common in men than women. Of respondents to the Healthy Ireland Survey, 42% of men 'binge drink on a typical drinking occasion' against 14% of women. Accounting for age, 50% of men aged 15-24 binge drink against 26% of women in the same age bracket; and 45% of men aged 25-64 years against 13% of women in that age bracket (Ipsos, 2024). An earlier survey of 7,005 individuals aged over 15 found that 73% of men and 41% of women 'met the criteria for hazardous drinking' (Mongan et al., 2020). Other research has shown the gender gap to be smaller and narrowing. A cross-sectional survey of 2,275 Irish university students found that 65.2% of male and 67.3% of female respondents reported hazardous alcohol consumption (Davoren et al., 2015).

Women accounted for 27.3% of alcohol-related deaths in 2022 (Doyle et al., 2024). In terms of treatment demand, of the 8,163 new cases of people receiving treatment for problematic alcohol use in 2023, 63.7% were men (Health Research Board, 2024), suggesting that 36% were women. Furthermore, just under a quarter of all people in treatment for alcohol use reported poly-drug use; and the number reporting cocaine as an 'additional problem' increased by 115.8% between 2017 and 2023 (Health Research Board, 2024).

2.2 Currently illicit drugs

The EUDA database was searched. The only data broken down by gender are treatment demand and overdose deaths. The results of these two fields are similar with both showing that women have accounted for around one-quarter of all treatment demand (Figure 1) and overdose deaths (Figure 2 and 3). Female demand for treatment and deaths from overdose have also been rising (Figure 3 and 4). Lynn and colleagues (2021) found that, in 2004 and 2017, the main drugs implicated in female poisoning deaths were prescription opioids (often methadone), benzodiazepines and antidepressants.

Figure 1: Demand for Treatment, Average (2013-2022)

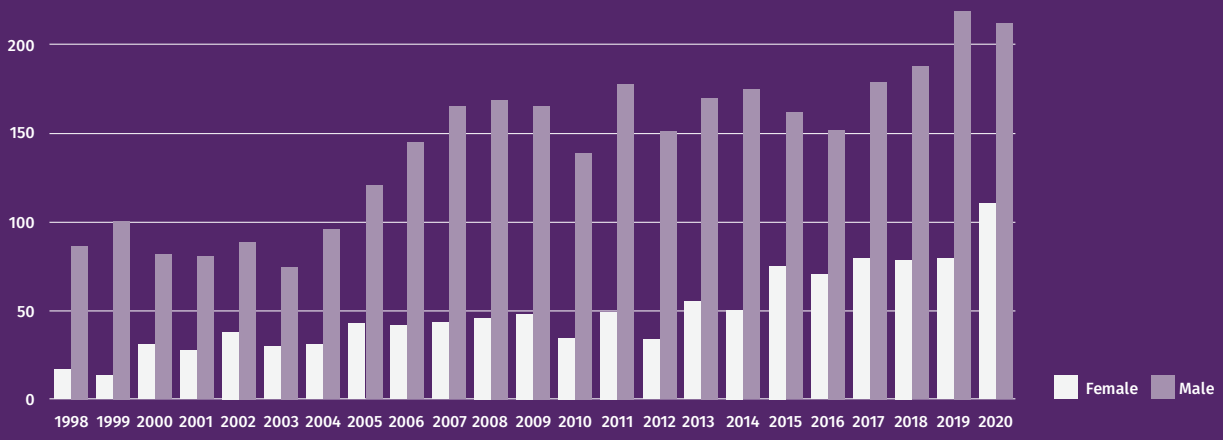


Source: European Union Drugs Agency (2024). Statistical Bulletin 2024 — Treatment Demand: https://www.euda.europa.eu/datastats2024/tdi_en

Figure 2: Overdose Deaths, Average (1998-2020)

Source: European Union Drugs Agency (2024). Statistical Bulletin 2024 — Drug-Induced Deaths: https://www.euda.europa.eu/datastats2024/drd_en

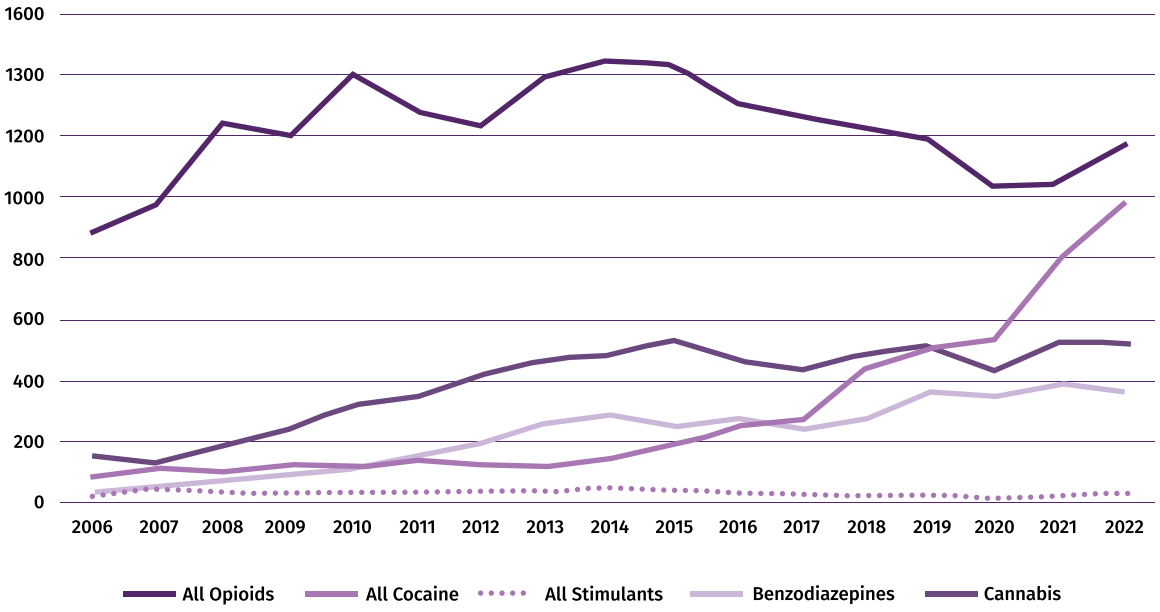
Figure 3: Overdose Deaths (1998-2020)



Source: European Union Drugs Agency (2024). Statistical Bulletin 2024 — Drug-Induced Deaths: https://www.euda.europa.eu/data/stats2024/drd_en

There are some differences when broken down by drug type. Women's treatment demand for opioids has declined since a 2014 peak; cannabis increased steadily from 2007, plateauing from around 2014; cocaine rose rapidly from 2017; while benzodiazepines steadily increased from around 2010 (Figure 4). These trends are reflected in a study monitoring pregnant women attending the Coombe Hospital (Dublin) which found that the number of women presenting with opiate use disorder had declined by 50%, but rates of cocaine and cannabis use during pregnancy had increased (Corbett et al., 2023).

Figure 4: Female Treatment Demand by Drug (2006-2022)



2.3 Summary

Official data and research literature show that women account for around one-quarter, or more, of problematic drug use, treatment demand and overdose. While men have traditionally engaged in more hazardous alcohol use than women, the gap is narrowing and, just under 40% of people entering treatment for problematic alcohol use are women, and women account for just under one-third of alcohol-related deaths.

This data may, however, underestimate the true figure as women are less likely than men to seek treatment or disclose problematic substance use.

3. Methodology

The key objective of the research was to support addiction services to uncover what is different and unique about the needs of women service users and, to gain an understanding of how women experiences services.

The research aimed to:

1. Provide insight into how women with SUD issues in Ireland have experienced drug/ alcohol harm reduction and treatment services;
2. Identify what supports have helped women with SUD, and what additional supports may be useful;
3. Identify barriers to accessing supports, harm reduction and treatment services.

Semi-structured interviews were conducted with 15 women with SUD (licit or illicit substances) and have used, or currently using, Tabor Group services (residential or community-based). The interviews were designed to gain an understanding of participant's experiences of treatment services in Cork. To participate individuals had to be female, aged over 18 years old, English speakers and a current or former service user of Tabor Group (residential or community) for drug or alcohol addiction. Non-English speakers were excluded because our limited resources could not pay interpreters.

3.1 Interview procedure

Employing purposive sampling, posters were placed in Tabor buildings asking for participants. Tabor staff then sent a group email to those fitting the involvement criteria, inviting them to participate. The research and informed consent were explained to potential participants at this stage, and potential participants could speak with one of the research team over the telephone in advance of interview. Most participants responded to Tabor, but some emailed us directly, to arrange an interview. Interviews were conducted at Tabor Fellowship House. No Tabor employees were present in the confidential interviews, although they were onsite to support or stabilise participants if needed. The interview schedule was short. Most interviews took place over three days in mid-June, with the remainder conducted at the start of July. Participants were given the choice of being interviewed by a male or female researcher. Two participants requested to be interviewed by the male researcher, but most did not specify a preferred gender.

Semi-structured interviews were organised around general themes designed to elicit in-depth and contextualised experiences of harm reduction and treatment services. Questions were open ended, and lasted around one hour. Participant were offered a €20 voucher in recognition of the time given to the research. Interview were digitally recorded, transcribed and analysed using reflexive thematic analysis (Braun and Clarke, 2021). All names and other identifying information were anonymised. Participants were first given a number, this was changed to a name in the coding sheet and then changed again to a letter of the alphabet in this report.

3.2 Ethics

The study was granted ethical approval from University College Cork Social Research Ethics Committee. Participants were provided an information sheet and informed consent form, prior to interview and then again on the day. A clinical psychologist reviewed these forms to ensure those with lower reading ages could comprehend. Participants were reminded at interview that they could choose to not answer questions, stop any time, and withdraw within two weeks. It was made clear that we are independent of Tabor and participation was completely voluntary, but that Tabor could provide follow-up services to support participants who become distressed or upset during or after interviews. Participants were fully debriefed at the end of the interview by re-iterating information provided to them in the participant information sheet and at the beginning of the interview. They were given time to reflect on the session and how they were feeling.

3.3. Limitations

This time-limited study has several limitations. First, this is a small sample of women who have engaged in addiction services in Cork, and is unlikely representative. Second, Tabor's involvement in recruitment, and interviews being conducted at Fellowship House, may have had some influence on the sample. Third, there may have been a positivity bias. Ms. W confessed a 'blind loyalty' to one residential service, and most expressed similar feelings towards 12-step meetings, 'because it did change my life like. I'm sitting here as a sober person' We tried to reassure participants that we were not journalists trying to uncover a juicy story but looking for their experiences of all services in Cork that they had engaged in, and all institutional names would be anonymised. Fourth, some participants had abstained from substances for several years; others had only recently left residential treatment services. This presented a challenge to analysis as some participants experienced discontinued therapies. This has been acknowledged in the results where possible. Finally, all participants were in recovery, and those in active addiction would likely have different perspectives on services than those in the recovery process. Further research should interview those in active addiction.

4. Results

4.1 Background and demographics

The women in this study had diverse backgrounds and experiences. Family is a good example of this diversity. For some, family was a barrier to recovery, and they had to distance from abusive partners or siblings and/or parents with SUDs (see Section 4.4.8). For others, family was a source of support and encouragement. Ms. D's husband supported her when she felt too physically and emotionally unwell to attend an assessment with a residential service. Ms. K's family provided childcare and decorated her room while she attended a residential service. Ms. J felt her family were initially unhelpful but became more helpful after learning about addiction.

Participants were aged between early-20s and late-50s, with just over half aged over 40. All but one were white Irish. At time of interview, 40% (N=6) were married or had partners, and 46% (N=7) were parents. The number of children ranged from one to four. Just under half of participants may be considered middle-class. Six (40%) reported having completed third-level education and a further four (26%) had entered university during their recovery. Two (13%) did not declare educational status and three (20%) had no third-level education. Six (40%) had worked in professional careers, five (33%) had been employed in semi-skilled or unskilled jobs and two (13%) had been on social welfare during much of their addiction. Three (20%) had trained to become addiction councillors during their recovery. Of course, this assessment of class is blunt. For example, some participants had left professional careers to care for family members and/or as their addiction progressed.

Sixty percent (N=9) reported poli-drug use; 40% (N=6) reported use of alcohol only. All but one participant said they used alcohol. Cocaine (N=8, 53%) was the second most commonly reported substance, followed by benzodiazepines (N=5, 33%), heroin (N=4, 26%), crack cocaine (N=3, 20%) and cannabis (N=2, 13%). Some seemed to very quickly enter into active addiction, while others reported a more steady progression. Some reported beginning to consume substances problematically as teenagers. Others reported increased use after a period of stress, including family illness and IPV.

There is an extensive literature showing dual diagnosis as common, but 'underestimated, under-diagnosed and often poorly treated' (Fantuzzi and Mezzina, 2020). Nearly 80% (N=11) of participants reported having one or more co-occurring mental health conditions. This was most commonly depression (N=6, 42%), including post-natal depression, and anxiety. Three participants reported PTSD (21%), two resulting from IPV, and three reported eating disorders (21%). All participants described being depressed during their active addiction, even if they did not use the exact word. Some described mental health difficulties preceding addiction, and had sought treatment for depression, anxiety or an eating disorder before entering recovery. Half (N=7, 50%) reported at least one attempted suicide, and three (21%) reported self-harming.

The research literature often points to higher rates of adverse childhood adversity (ACEs) within women who use substances problematically, compared to male counterparts and the general population (Morton et al., 2022, 2023; Ivers et al., 2021; Shand et al., 2011; Shin et al., 2018). Half (N=7, 50%) of the sample reported having experienced one or more ACEs. Participants were not specifically asked questions about childhood trauma, so some may not have disclosed ACEs. Exploring this would have required a longer life-history interview (see Cambridge et al., 2022) or administration of an ACEs questionnaire (see Morton et al., 2022). While ACEs were important for some of the women, and helped them explain their behaviour, Ms. J and Ms. Y felt there was a stigma attached to not having childhood trauma.

Trauma does not, however, stop at childhood. While not all reported childhood traumas, all had been traumatised by events in their adult lives. One participant reported being raped, another physically assaulted, and another had received death threats. Several reported grieving the death of friends or family members, or close family members becoming ill. All had incurred physical injuries because of their problematic substance use.

4.2 Experience of treatment services

We did not define treatment during interviews and acknowledge the broad range of available treatment services. Participants tended, however, to primarily focus on two types of talking therapy: 12-step meetings and residential recovery services. Some discussed other services (i.e. mental health, fitness) but these were less frequent. We asked participants about harm reduction but few had experienced these services, likely due to substances used and demographics. For most participants, the narratives jumped between 12-step and residential services, sometimes making it difficult to navigate what was being discussed, and possibly indicating continuity between the two. As such, we have split this section into general themes around treatment and recovery, including residential and 12-step, and then a separate section focused narrowly on 12-step programmes.

When we asked participants how they experienced recovery, the overwhelming response was one of gratitude to services which had supported their recovery process. Some participants initially said they had no negative experiences to report but became more critical as the interview progressed. Every participant had a different experience of recovery. For example, some found residential treatment difficult, but worthwhile, while others enjoyed their time:

> **It was the best thing I ever done in my life [...] it was a lovely peaceful bubble (Ms. V)**

> **I had a bad first impression but that, that, slowly faded away. Everyone else like, the ladies at reception, the chefs that I met on the first day, all the peers on the first day were all so like welcoming [...] I'd give it 9 out of 10 (Ms. Y)**

4.2.1 Male and female spaces

Several participants identified some addiction services as male spaces. Ms. S, who worked as an addiction counsellor, said that mixed-gender residential services were 'definitely more male dominated', but they try to place women in groups with other women, so they can support each other. Ms. V described:

> **There was only three women, including myself, and there were sixteen men [...] it was a small bit annoying because men would take over the TV and the sports [...] that was the only difference. I wasn't, I didn't really care that they were a group and stuff to be honest [...] but like I'd see one or two girls who did have issues with it. But the only thing that annoyed me a bit, a small bit, was the soccer things. Like we wanted to watch PS I Love You one night and there was chaos. (Ms. V)**

Ms. N found both 12-step programmes and residential services to be overly male spaces. This impeded the development of pro-recovery female relationships, and she felt lonely. She later attended an education-based community service, which had a more equal gender split, and her peer network grew. Ms. N also highlighted age as another important consideration, suggesting the utility of an intersectional approach beyond gender:

> **I was in treatment at 24 with men that were in their 40s and their 50s [...] I was on my own down there as well. Like I would have been isolated. The women that were in there were older as well. (Ms. N)**

Ms. V was aware of a women-only AA meeting, but had yet to attend, and felt that while AA was 'men orientated' she enjoyed the mix of genders:

> **I know there is women's only on a Sunday [...] but I haven't gone to that yet actually. I might go tomorrow. So, there is that option but [...] you want to be able to mix with both genders as well so there's, there's pros and cons [...] I definitely find that all the meetings are men orientated. (Ms. V)**

Ms. W talked of balancing the challenges of attending male dominated AA meetings with time constraints and convenience. She also identified that men have more choice than women around meetings, but reluctantly accepted that she must 'deal with it' by navigating this male space:

> **Interviewer: How did you feel being the only woman in the [AA] room?**
>
> **Ms. W: its daunting [...] If I went into an AA meeting and it was mostly women and the odd few men here and there, like how much more comfortable would I feel sharing, you know how much easier would it be to identify? I would often say it to the lads like "ye don't realize how lucky ye have it like do you know". Now I've just decided that I'll [...] try and be sober on a daily basis despite the fact that it's mostly men and try and look at the bright side of it all and deal with it best way I can like. Keeping in mind like the AA meeting that I personally chose to go to is all old men and [...] I could change that and I could go to a room with a bit more balance [...] but I decided to go with the room that was most convenient to me time wise and just ignore the whole gender thing and just get over it and there's nothing I can do about it. (Ms. W)**

4.2.2 Fun

Ms. N felt that 'if you don't enjoy recovery it's not sustainable' and maintaining recovery required meeting new friends and doing 'pro-social' events together – 'fishing, walking groups, coffee, swimming, crochet, art classes' (also Brennan and Wright, 2024). Ms. V felt that part of recovery was learning how to have fun without substances. Others hinted at this by emphasizing how much fun they were having in recovery with new friends:

> **We laughed and we done karaoke, and we colored. I got them all to art class, childish laugh [...] we were in our element out playing football. (Ms. K)**
>
> **Some laughs we had, some blast. (Ms. V)**

Ms. Y preferred one aftercare meeting because it was fun:

> **I do enjoy that hour and a half on Tuesday and the facilitator is very good as well. I enjoy him [be]cause he's a recovering alcoholic too but he's not too serious. Like he'll make a joke now and then. (Ms. Y)**

Ms. G enjoyed an aftercare programme which provided pro-social activities, including day trips:

> **we have a bus driver, we have a little van. (Ms. G)**

Some identified how boredom can derail recovery. Ms. J spoke about finding an overly strict women-only religious residential service very difficult:

> **There was nothing to do [...] weren't even allowed to walk unaccompanied [...] all the people did was knitting and crochet [...] very restricted, no talking [...] you don't put 24 women on their own in a room with nothing to do and various age groups as well [...] On occasion it was dangerous. Now I don't mean safety wise, it was just dangerous to the health like and little clicks forming. (Ms. J)**

Ms. N avoided 12-step meetings which were too serious and frowned upon laughter. Ms. Y actively searched for meetings which were fun, and found more serious ones risky:

> **I enjoy meetings when there's a bit more lighthearted. There's some meetings I have been in, and you'd come out and you'd nearly want to have a drink like their very depressing. (Ms. Y)**

4.2.3 Pro-recovery networks

> **The friendships I made there were great (Ms. S).**

One of the most frequently arising themes was the need for new social networks. The importance of developing a new network, consisting of what Timpson and colleagues (2016) call 'pro-recovery relationships', to support recovery is well documented in the research literature. Studies show that many in recovery feel lonely and isolated, and developing pro-recovery relationships increases the chance of successful recovery (Best et al., 2016; Brennan and Wright, 2024; Cambridge et al., 2022; Timpson et al., 2016). Some participants did, however, suggest it can be more difficult for women to find such networks.

Ms. V had left residential treatment with three women who became close friends:

> **The three of us are in the same area so we are really close now [be]cause we spend our time together and we know each other so well. There's only very limited girls in here at the time. (Ms. V)**

Ms. B reported how a group of women had supported each other to reduce their felt shame:

> **I was blessed. I had a really nice group and there was a couple of women on it [...] There was three of us that were very similar and it was hearing their story of like "that is me too", and I was like "oh my God ok", and I didn't think they were shit mothers or terrible people, so maybe I wasn't that bad. Maybe I wasn't an awful person. (Ms. B)**

Ms. A had been afraid of men, so was surprised that she developed a close network of male friends:

> **I suppose got to know these people like and do you know like some of them became like family to me like. I still have the closest relationships with them people today, so, yeah it really just kind of gave me, gave me a push. (Ms. A)**

Ms. K also described forming a close bond with two younger men in a residential service, and then other women in NA, and:

> **I thought how long since the last time I had a real friend do you know. So, it was just I had a safeness. (Ms. K)**

Ms. K described going with friends to an exercise class, followed by an NA meeting. She valued the company as she found meetings intimidating:

> **I had great craic and then I walked from [fitness class] over to a meeting. My friend, it was the biggest meeting I ever sat down [...] I was on air for the night. We went to McDonalds but I don't care about that part myself and my friend from treatment, we just had a giddy, great night. The two of us were on air, he even said it was one of the best days he had in a long time. (Ms. K)**

Ms. J described how her first attempt at residential treatment failed because 'the groups were so big and I just got lost in the group'. She clicked with a smaller group during a later residential treatment. Once a week they went into Cork City. The quote below indicates the importance of building pro-recovery relationships with those who can hold boundaries without stigma:

> **[We would] go out on a Saturday [...] we all kind of looked after each other as well in that group and I guess that kind of bond then you make with your peers, and because it's a small group its viable [...] we have peer groups like, and the floor is open for us to [...] call each other's bullshit but otherwise its actually being a mirror to someone and someone being a mirror to you. You're sharing your stories and [...] we get a place to, no judgement (Ms. J).**

Some participants, however, found that relationships could derail recovery. Ms. Y had developed close friendships in a residential service but had to distance from those who had relapsed as it became 'dangerous' to be around them. Four of the women identified being attracted to men, or forming romantic relationships with men, in residential services as a distraction which could act as a barrier:

> **I'm attracted to you. I'm not going to be my real self. I'm vulnerable. I'm not going to be vulnerable in front of you because you're a man (Ms. N).**

Of course, this was not as simple as separating males and females. Ms. S had been recommended to attend a women's-only residential service because she had been addicted to relationships, but 'ended up obsessing over women'. Ms. S observed, however, that unhelpful relationships must be reconciled with the positive aspects of reducing loneliness:

> **People will hook up with other people [...] unhealthy relationships. But the Fellowship, it was, it kept me safe a lot like. Even in my loneliness there was always somebody (Ms. S).**

Ms. W showed how the development of new relationships can be beneficial but risky, and involves a combination of luck and judgement:

> **You need to be very selective with who you keep around because you are very impressionable at the start [...] if you keep bad company you just can't help but to soak-up [...] When I came into my first treatment [...] I had this crush [...] I left my second treatment with a good core group and I went to meetings with them and that helped [...] Whereas when I left the first treatment I left very much alone and doing the AA thing alone was so hard (Ms. W).**

The final part of this quote points to an element of 12-step programmes that many participants highlighted. It's difficult to walk into meetings alone, especially younger women waking into a room of older men. As such, residential treatment can help develop networks which support community-based recovery:

> **I met great people there [residential service]. I'm still in touch with a few friends [...] there was a few of us came out from [residential service] around the same time so we continued on that aftercare programme then for 12 months (Ms. I).**

Those who lived away from Cork City felt lonely when they returned home. Ms. L returned to another county:

> **Everything was gone [...] all my sober friends [...] a lot of people that were in the programme with me were from Cork. They left here and all went to meetings together. So, I'm jealous (Ms. L).**

Ms. L had, however, maintained friendships in Cork and visited often. Ms. K lived in Cork City but found it lonely because the friends she had made in residential treatment lived in different parts of the city, and so attended different meetings and aftercare.

This section has shown the importance of developing pro-recover relationships. While the importance of relationships is well covered in the research literature, this section has shown how it can be more difficult for some women to develop relationships if they are unable to find other women, or women their age. Furthermore, while relationships are important, it can be challenging to manage the potential risks found in new relationship.

4.2.4 12-step programmes

Twelve-step programmes (i.e. AA/NA) are common and cost effective forms of treatment. There is evidence to support the utility of such self-help communities, in some circumstances, and especially as aftercare (see Cambridge et al., 2022; Gossop et al., 2008; Manning et al., 2012; Marsh, 2011). However, a study in North America, by Sered and Norton-Hawk (2011:310), found women being coerced during meetings to disclose histories of trauma, unwanted sexual behaviour from men in meetings and that 12-step programmes focus too much on personal responsibility.

Most participants were attending 12-step meetings, usually AA and/or NA. Many spoke of meetings as pivotal to their recovery:

> **I found the Fellowship extremely helpful. I suppose it's a lot of sick people trying to get well in the same space. (Ms. S)**

> **I do go to regular meetings, and I have a sponsor now as well through AA [...] it's about learning how to live without any mind-altering substance. (Ms. D)**

> **[My] first AA meeting in [residential service] - I realized I was in the right place, and I was "God I, I really am an alcoholic". (Ms. G)**

> **I couldn't go a week without one [a meeting], and I would never have [just] one ever. Like since I've left treatment if I'd gone to one meeting a week that would fuck me up. (Ms. L)**

Attending a 12-step meeting was sometimes the first step towards recovery, even if participants initially felt too uncomfortable to fully participate in the meeting.

Ms. W described her approach to AA changing at different stages of her recovery process. She initially 'hated' AA, felt very 'lonely', and was unable to speak in-front of the older men she felt disconnected from: 'It's very male heavy, there was no women' and 'I think like my social anxiety and my fear of people and groups and interacting in groups, that really made AA difficult'. She continued meetings and, at the time of interview, identified it as a core element in recovery:

> **You don't have to like everyone in there, but you know you're there for yourself. I just went enough like I, I think that going to a meeting every day for three months saved my life. (Ms. W)**

Ms. S's anxiety prevented her from speaking in 12-step meetings for two years but she found meetings 'extremely helpful', 'safe' and that they reduced the loneliness of early recovery.

Ms. Y was initially discouraged by the religious element of AA, and the misogyny of 'the book'. This said, she applied for residential treatment after her third AA meeting, so does credit it with increasing her awareness of her need to enter recovery, and later returned with friends she had made in residential services:

> **I had been to a few AA meetings actually before I came into treatment. It was another kind of "oh I'll go to AA meetings, tick the box" and it was very much inside again, "I fell to my knees and God changed my life" and it just turned me off straight away because I just said no matter what that won't be me because like nothing's going to change my mind on religion (Ms. Y).**

Ms. J spoke about how there are around '100 meetings a week [in Cork], in nearly 50 different places' but there's an element of luck in finding one that suits individual needs:

> **sometimes you could walk into those meetings, and you could get a lunatic one day and someone fantastic the next. (Ms. J)**

Ms. N was very critical of 12-step programmes, which she felt were male spaces, but spoke highly of Smart Recovery (now Connect Recover) as more women were present and because it helped her build pro-recover relationship:

> **It's not listening to somebody older telling you war stories about their drinking. It's about where we are now. It's solution focused. It's educating yourself about why you are where you are and how to move forward. Its recovery capital [...] It was really kind of what I needed at the time rather than going away saying a few prayers and you'll be ok. I needed to learn about it rather than Fellowship the way they do it [...] There was a little bit more women in the meetings with Smart Recovery [...] I had a bit of support, and I had the chats with the women and the coffees and you know the clothes conversations and the light conversations and the deep ones. (Ms. N)**

Ms. L valued mixed-gender services, but reported 'loving' women only 12-step meetings, and had seen sexual harassment from men in 12-step meetings, but no more than in other realms of life:

> **First meeting I ever went to [...] I remember this really nice older woman coming up to me after the meeting. She was like "be careful of the creeps", she was like "the older men, you know like don't go for coffee with them, not until your stronger" [...] I said I wouldn't let that happen to me. It has happened, I've heard about it [...] I don't find men say inappropriate things in meetings more so than women. I think that we're all there, we're all fucked up with our own problems and if you put a mosaic of people together, there's a clown at every circus [...] I don't like being stared at by any means, that happens, but that's just people. Men are staring at me my whole life so I don't know [...] it's just another gathering of people. (Ms. L)**

Ms. Y was critical of the misogyny of the AA Big Book, and its influence on the culture of the 12-step programme. The book was first published in 1939 and:

> **It always refers to males [...] it's not modernized. It's like the housewife, a chapter on the housewife [...] it kind of normalizes, the alcoholic is the man, it's never the woman, and if it is its "oh my God it's a woman" you know and so I think maybe the mind-set has come from that. (Ms. Y)**

We asked Ms. Y how reading the Big Book made her feel:

> **I don't enjoy the book. I really don't. I think it's very old fashioned and I suppose it, it, it links in with God a lot and I'm an atheist [...] It's very male focused and there's a very huge religious thing to it and that's just the so opposite of me but then there's like the stories, I relate to stuff in it even though it's not my cup of tea. (Ms. Y)**

Several participants identified age as equally as important a barrier as gender to engaging in 12-step meetings:

> **I went to my first AA meeting. I was the youngest person there and I was like "I'm not as bad as these people". (Ms. L)**

> **I was going to these meetings, and I was like "these people are fucking, like I'm not like them" [older men]. (Ms. W)**

> **Ms. V identified AA and NA as very 'men orientated', with most meetings having around three women to 20 or 30 men. She found comfort in attending with a group of women she had met during residential treatment. Ms. Y had found a meeting she regularly attended which was a 'good mix' of ages and genders, but found other meetings 'full of' older men and 'whilst I related to the stories I just didn't feel like I fitted in there'. (Ms. Y)**

Several lamented the lack of women-only meetings. Three participants spoke about how, while women-only meetings are beneficial, they are uncommon and difficult to find:

> **I have a women's meeting I go to. There is not very many of them. They are not advertised online. I understand why, it's a safety thing I'd imagine. So you need to find out by word of mouth, by another woman saying it to you. My home group had women's meetings the entire time and I only found out in April. I love it. I try to go every week but man I could have used that information earlier, but they can't put it online [...] they would be in the 1% you know. They're not the majority; there's not very many men's meetings either. (Ms. L)**

> **I think it's harder maybe for females definitely than males [to first approach AA]. I know there was kind of a female group [be]cause a friend of mine was facilitating it and to the best of my knowledge that has stopped [...] I think a female group is lovely and to the best of my knowledge I don't think there is one in the city. I could be corrected on that now, but I don't know is there one in the city at night time, there was one during the day, but not at night. (Ms. I)**

Ms. K said there was one women-only 12-step meeting in the city, but it does not always run due to low numbers. She described this as a major barrier for a friend who could not speak in front of men:

> **I was supposed to be going to a women's only meeting, it wasn't on anyway [...] I reckon it wasn't on because the numbers [...] [the last time] there was only four of us [...] I think that's the only women's one in the whole of Cork that I am aware of anyway and it just, its shitty [be]cause I think its brilliant. [a friend] finds it hard talking in front of men [...] and she wants to, she's a good few months in and she is due a badge but she is finding the meetings hard so. (Ms. K)**

The experiences of 12-step meetings varied. There appears to have been an element of luck in finding meetings that were convenient, suited participant's needs and with people they could connect with. Several participants identified some 12-step meetings as overly male spaces. The number of women in a meeting was an important factor, but so too was age. Several women noted the lack of women-only meetings, and the difficulty they had finding these.

The discussion around 12-step meetings opened a question that we do not have the data to answer. All participants identified men heavily outnumbering women in 12-step meeting. Ms. V felt that women accounted for around 10% of those attending fellowship meetings (3 women to 20 to 30 men). Official data on treatment demand, however, shows that women account for 27% of treatment demand for illicit drugs (EUDA, 2024), and 36% of treatment demand for alcohol (Health Research Board, 2024), and demand data likely underestimates the number of women who need treatment (Morton et al., 2023; UNODC, 2025).

As such, women should account for over one-quarter of meetings rather than 10%. It's possible that our participants were unlucky in finding male-heavy meetings or exhibited some form of bias in their assessment of male/female ratios. It's also possible that women find it more difficult to maintain 12-step meetings when juggling caring responsibilities or find the overtly masculine subculture off-putting. Both of these scenarios would appear plausible based on participant testimonies.

4.3 Preference for mixed-gender or women-only services

We tried to provide participants space to reflect and talk, keeping prompts and questions to a minimum. We did this so participants would tell us what was important to them. Towards the end of the interview, however, participants were reminded that we were interested in how women experienced services. Participants often had to be nudged back to discuss the experience of women. Some studies have found that men and women interact differently in group treatment settings, and that some women are unwilling or unable to fully engage and interact in mixed-gender settings (Muel et al., 2025; Tuchman, 2010). Our participants, however, had diverse views on the utility of mixed-gender services, with the overarching view being that some women need mixed-gender and others women-only, and most women could benefit from both mixed and women-only.

> **Ms. V and Ms. N had seen some women 'hold back' (Ms. V), or avoid being vulnerable (Ms. N), in mixed-gender group sessions, especially when talking about 'sexual experiences or past trauma with miscarriages'. This said, Ms. V identified every woman as different. That she was mostly comfortable around men, but 'wouldn't be inclined to talk' during a meeting if there was 'a good-looking fella', but other women were uncomfortable around men, especially those who had been 'abused all their life by a man' (Ms. V).**

Some felt that mixed-gender treatment could be disruptive for both men and women. That people only want to share certain things with those of the same gender, and people can be distracted by members of the opposite sex they find attractive:

> **I'd like women to be in treatment separate even if it's for two weeks [...] it's very very important because you need self-nurturing, you need self-compassion. We're coming in riddled in guilt, riddled in shame and then you have to front-up because there's a man there [...] You don't know what experience they've had with men and vice versa for men with women. They'll speak more freely when there's no women in the room, yes they will [be]cause they don't want to offend anyone, and they don't want to upset anyone. The majority of men in here are very compassionate about women (Ms. N).**

Some participants had negative experiences with women-only services. Two participants had attended an all-women residential service in Cork, and found the restrictive regime caused friction between residents, although Ms. A found it 'very beneficial' in the end:

> **I think in a house full of women first off like we're very bitchy [...] like I would have thought I'd feel more comfortable but actually no [...] there was lots of jealousy between everyone and bitching [but ...] it was very beneficial [...] I suppose, you know they [women] have that kind of depth [...] and everyone had the same kind of situations. But yeah I would have preferred the mixture [of genders] over that anytime (Ms. A).**

> **Very restricted, no talking [...] you don't put 24 women on their own in a room with nothing to do and various age groups [...] On occasion it was dangerous now I don't mean safety wise, it was just dangerous to the health like and little cliques forming (Ms. J).**

These two quotes demonstrate that it is not just the gender of the group, but the level of care extended to them. That is, if a more secure therapeutic relationship had formed, built upon a trauma-informed framework, then inter-personal frictions may have lessened. The next residential service Ms. J attended 'worked' partly because it was a smaller mixed-gender group:

> **I do see the benefit of having it mixed because when I was in a very female place a lot of times you know "men are bad", "men are bad", "men are this, that and the other" and there are good men out there. It's nice to be able to see there are good men. You can see the other side of their struggle and stuff so, I firmly believe in mixing, for the lads as well (Ms. J).**

Ms. A had come into residential treatment afraid of men, but found the mixed-gender setting to be therapeutic and she developed close bonds with men:

> **Through my addiction I would have had some negative encounters with men [...] even growing up I suppose in the home that I was in like I would have. I didn't really like men [...] I was really put off by the whole thing and I didn't think I'd be able to be social. Like I thought it would be more traumatic than anything, but it actually turned out to be quite the opposite for me. I think it was what I needed really [...] it actually humanized them for me to be honest [...] some of them became like family to me like. I still have the closest relationships with them people today. (Ms. A)**

Ms. L and Ms. K felt that gender had little impact on their experience of residential treatment:

> **When I got here the ratio was actually more women to men. By the time I left that had completely flipped. That's the kind of thing that makes no difference to me. I don't feel that my gender had anything to do with my experience here [...] I don't think I was treated differently or had different experience from anyone else [...] we were really all in the same boat. We were all just trying to fucking get through the day. (Ms. L)**

> **There was eight in there when I came [...] there was three women at the time, one was leaving the day I came, and they said that was a big [number] for women at one time. It's never like that. By the time I was leaving I was there two weeks by myself with just boys but that didn't weigh, shape or make. I had a better time actually [...] I was with boys that were a lot younger than me, and it was like a comfort thing, I got a bond with them. (Ms. K)**

Ms. L opposed women-only services, describing them as 'not normal' while acknowledging some women need them:

> **I feel the way about mixed meetings the way I feel about mixed secondary schools [...] I don't think it's normal to separate gender because that's not how life is. Every other aspect of life we're all mixed together [...] there are circumstances where it does make sense. [In] women's meetings there are women who confess to domestic abuse and stuff, and they need a safe space to share but like I don't go for that reason. It's nice to be among women but in general unless it's for a specific reason we're all there for the same thing you know, we're all just there to get better [...] Not everybody is just like an object [...] you're all going to have to work in an office with it someday. (Ms. L)**

Ms. K felt that it was more down to personality than gender - 'you're either going to be comfortable with who's with you or you're not' – and was initially resistant to women-only groups taking place during residential therapy, but eventually found them useful:

> **They separated the women and the men and everything would come out in the women's group [...] I didn't like the first one because the first one it was like, "that's the boys kind of club" [...] I loved the next one, I started off the next one, Mother's Day was coming up and we went into it about my own mam and stuff like that [...] the women's group were amazing [...] the boys used say things in the boys group and talk about stuff when we were not here do you know. (Ms. K)**

Several identified the utility of creating networks of women peers:

> **I do think women connecting with women should be really fostered. I was afraid of women when I came into treatment [...] all my friends growing up were male [...] Jesus now in recovery I have, I have women in my life [...] part of my inner circle are men but now I have really strong women by my side as well and I think we really need to foster that because women empower women. (Ms. B)**

Many of the women were 'on the fence' (Ms. B) about the utility of women-only services. Most pointed to the need for a combination of women-only and mixed-gender services, and that different women needed different approaches. For example, Ms. B had made positive connections with men, and benefited from hearing their experiences, but felt she might have developed in a 'nurturing' women-only environment. She concluded by recommending a mixed-gender setting with women-only sessions, and that both men and women be provided a choice of mixed-gender or gender-specific:

> **I'm on the fence with this one [...] I love the all-female environment [in an women-only residential service] and I can see how that would really have been beneficial for me. But I also can appreciate that [treatment ...] gave me a chance to see what nice men are like, what safe men are like. I sat in rooms, I heard these men talk on an emotional level. I heard some men who had been horrible to their wives and saying it and I was like "oh my God, that's abuse really" [...] hearing it from safe men was good for me [...] did I need exposure to see these men or did I need a nurturing female environment I wonder? I don't know the answer to that, and I suspect a mix. A mix might be good. I think having an all-female [group] would work a couple of times a week in treatment where there's a space for women just to be with women [...] that we can have that space to be safe and to talk but also mix with the men and see men eating and see men crying and see men getting better. (Ms. B)**

Ms. Y spoke often about the need for women to be in groups, but when asked if she would have attended a women-only centre she replied: 'No, I don't think I would':

> **Just because you're a man it doesn't mean your different to me [...] their experiences might be different but [...] any guy that's [in AA] even though their male I can relate to something they say, and I think 20 women together would be a nightmare [...] I think women can be very bitchy, even when the three of us were together like we'd go for walks, and we'd be like "that fecking ejit now" or "God he's so annoying" [...] if you say something to a guy he'll forget about it. Women don't forget things, they can remember what you said last Tuesday at two o'clock [...] It wouldn't be for me, but it might be for other people. (Ms. Y)**

Ms. V also displayed ambivalence. A victim of IPV, she spent much of the interview saying that she socialised and worked with men, and was 'confident' around men, but that women who were 'fairly quiet' could be intimidated by men. When we directly asked her if she would have taken a women-only options she replied:

> **Yeah, definitely, yeah. (Ms. V)**

In a balanced assessment, Ms. S felt that both mixed-gender and women-only services had different challenges:

> **There is a lot of vulnerable people in the rooms [...] It's hard for a woman with the men [...] But it's hard for a woman with other women as well. For me, my experience was I experienced a lot of jealousy, it's like "oh you're really quiet talk more", "oh you're talking too much, quieten down". This kind of thing or "who does she think she is like with her nice clothes on" or "getting attention from the guys she loves that" [...] it can be tough to experience [...] it triggers old stuff in me then that I'm not good enough or they don't like me. I get very hurt. (Ms. S)**

Similarly, Ms. W identified that she would like women-only, and might have taken that, but had learnt much from mixed-gender settings, and that her recovery was her responsibility:

Interviewer: Would you prefer a woman's only option?

> **Ms. W: No, option, maybe the option but [...] I don't know [...] my first time going to treatment I'd have opted for an all-girls one, maybe my second one having being in AA seeing the mix [...] I don't know actually how I would have chosen [...] hindsight like I'm glad that it, it went the way it did but an option would be good [...] there is like a private facility for all women and I wonder actually if that turns women off coming to treatment now that we are talking about it. I wonder are there ladies that, that just, they would go to that particular treatment centre [...] but if there had been an all-female do you know yeah, yeah, probably [I would have gone]. (Ms. W)**

Ms. W described AA being a male-space and, when asked if she would have liked women-only, she replied:

> **Obviously, I have a preference to more ladies in the room but what can I do, I have to accept the AA room as it is, you know and just wish everyone well that they are there and get sober you know and just try and pull wisdom from people. (Ms. W)**

Ms. W, as with other participants, indicated that women have less control over their recovery but also an ambivalence about mixed-gender treatment. Participants wanted the option of women-only groups, but 'what can I do, I have to accept the AA room as it is' (Ms. W). The lack of women-only services means that women can either enter male-dominated spaces, which are more frequent and available, or find women-only space, which are less frequent and available. Services which are less frequent and available require women to spend more time searching for them and then traveling to them. This places additional costs on women's time and resources.

Overall, few participants expressed an interest in attending women-only spaces. The ambivalence around the benefits of women-only services captured the complexity of service user's needs.

> **All participants, however, asked for spaces be more sensitive to the needs of women.**

This aligns with Wincup's (2019) proposition that 'gender sensitive approaches' should be integrated into all services, rather than just those aimed at women.

4.4 Barriers to entry and barriers to engagement

Ms. N felt women often had more challenges and barriers than men. More 'struggles on top of recovery':

> **I know the struggles on top of recovery, on top of domestic violence, on top of trauma, on top of relationships. I just think the stresses and the trauma are a lot more and there's an awful lot more men in recovery as well that can build each other up and their going on pro-socials together and you know they don't have to worry so much about childcare, money, stigma. (Ms. N)**

While some participants identified psychological barriers (i.e. insufficient readiness to engage in the recovery process), all identified some form of structural or institutional barrier which made it difficult to enter treatment and/or engage in the recovery process. Some of these barriers were gendered, others were not. Some participants experienced more barriers than others, and gender often intersected with social class and age.

4.4.1 Flying under the radar and functionality

> **Our [women's] drinking styles are different, we are much more behind closed doors, we're high functioning. (Ms. B)**

Some participants reported hiding their substance use from all but their closest family and friends. They reported functioning well, for a time, and upholding work, study and caring responsibilities. Even when their substance use began impacting careers and family life, and their own health, they presented an image of coping:

> **I was a functioning alcoholic, in that I never missed work [...] I suppose they [employers] wouldn't have any reason [to suspect alcoholism]. (Ms. I)**

> **I was drinking 3 bottles during the day and then I'd have the vodka just to keep it steady [...] I'd still thought I'm alright because I was still functioning. I was at work, still good mum. (Ms. B)**

> **I've got an honours degree, I have my own apartment, I have my own car. Everything looks great from the outside. (Ms. V)**

> **I had a great job you know. I had my own apartment [...] from the outset it looked like I had this brilliant life but [...] away from eyes I was like really struggling. (Ms. Y)**

Several participants spoke of flying under the radar of healthcare, social work and other services. Several reported being dismissed when they sought help from professionals, often GPs, or disclosed their substance use:

> **I did go to some alcohol support worker in [name of town]. I remember going in telling her what I was doing and she was like "I don't think you're an alcoholic but definitely like you could do with reducing your drink" [...] I was reaching out for help and it was like "no you're a fully functioning woman" [...] I think women can really fly under the radar. (Ms. B)**

Ms. S had been hospitalised after an overdose and was attending mental health services:

> **All the time nobody ever said anything about addiction, when I was in the hospital, when I was in the services. It was just, I didn't feel supported. (Ms. S)**

Ms. G had frequently attended the hospital emergency department and psychiatry services because of self-harm and suicide attempts, and was only once signposted to addiction services:

> **I'd become such a frequent flyer the last couple of years for self-harm [...] there was only once I got talked to about doing rehab. (Ms. G)**

It's possible that practitioners did not recognise problematic substance use because of the profile of the women (older, more middle-class), that they were otherwise coping on the surface and because they did not fit the stereotype of 'the addict'.

4.4.2 Referral

Many participants had not known what addiction services existed in Ireland, so relied on signposting from medical professionals or online searches. Ms. J felt that website content was a significant barrier because, as costing plans were unclear, she assumed residential services were too expensive. She had been unaware people could pay installments or apply for subsidies, as the websites only gave information for private patients (Ms. J). Conversely, Ms. G had not known about residential treatment until she had searched the internet and found an 'affordable service' that suited her needs.

Participants often spoke of medical professionals being unaware of services and/or dismissing their concerns (see Section 4.1.1). That almost all participants mentioned their GPs is indicative of this services centrality in supporting those with substance use issues. Some reported positive experiences. Others were less positive. Some studies have shown that referral by, and the encouragement of, a medical professional can increase attendance in addiction services (Manning et al., 2012).

Ms. G's GP was very supportive. They spoke regularly; he listened to her concerns and advised her on available services. She also, however, felt he 'didn't have a lot of knowledge about what was available'. He initially signposted her to a community-based service, which helped for a time and set a foundation for later entering residential treatment. He then recommended a religious-based women-only residential service. This was the most significant barrier Ms. G faced. Not only was she cautious about attending a religious programme but found the women who answered the phone at that service to be rude and unhelpful. She eventually found an alternative residential service through an online search.

Two participants reported long waiting lists as a challenge to securing a referral, while several felt there was an element of luck in finding helpful and informed GPs. Ms. N acknowledged that many practitioners, especially nurses and social workers, were suffering burn-out from overwork, but people were 'lucky' if their GP, or other practitioners, were educated about addiction and empathetic to their needs. Ms. J had heard 'horror stories' about GPs unwilling to support clients due to the stigma attached to SUD, so felt 'lucky' she had a 'good GP' who cared, was educated about available services and did not stigmatize her:

> **I am so lucky with the doctor I have. She's young, she's clued in and what she doesn't know she goes and finds out [...] I know of horror stories out there. Doctors don't even look people in the eye when their looking at them. (Ms. J)**

Ms. L felt her GP was supportive, but when asked if they had signposted her to treatment, she replied:

> **'No, that was on me [...] I don't think it's within her realm of skill, her area of expertise'.**

This reply suggests a low-bar whereby GPs are not expected to signpost people to addiction services, let alone offer support.

Ms. W disclosed to her GP that she was drinking 70cl of vodka every second night, was 'really dependent on it' and it was 'really affecting me'. He recommended AA, but without signposting to alternative services:

> **He was like vague [...] he was like you know "just go to AA". It was like you know there wasn't much more to it. I don't remember coming out of there feeling like I had been helped that much. (Ms. W)**

Ms. W later searched for residential services online, and asked her GP for a referral letter:

> **He said, "best of luck [Ms. W] I'm very confident that you will achieve the goal that you wish to achieve whether that be abstaining from alcohol for the rest of your life or bringing your alcohol consumption back to a manageable place". Now, straight away that shows like my doctor doesn't have an understanding of, you know, the fact that if you're an alcoholic abstinence is the only way. For him to say that to me like I really held onto. (Ms. W)**

While some people who use substances problematically can bring their consumption to a manageable level (Kleiman et al., 2011), Ms. W felt that her GP was ill-informed, undertrained and dismissive. The GP surgery is the most front facing of all medical staff and should be able to signpost individuals to the most appropriate services. Our participants together suggested that some GPs are skilled listeners and communicators and educated about which services are available. Others are not.

4.4.3 Initial contact

Three participants spoke of feeling dismissed or unheard during their initial phone-call to arrange residential or community-based treatment. Ms. B called a religious-based residential service. They dismissed her childcare needs, including concerns about leaving children with an abusive father. She phoned another service who were more compassionate and helpful. The quote below shows the importance of that first phone-call. Ms. B was motivated and resilient enough to not be deterred by one un-empathetic reaction from one service. However, if she had been in another space, the dismissive phone-call could have been a major setback:

> **I'd rang [a residential service] and I, I, I had something in me that was like able to say "I can't leave my child for 12 weeks with their father" and I didn't want to say why. But they were like "don't worry, they can go into foster care, like a lot of moms put their kids into foster care and then when you come out you buy them a present and they'll be grand, they'll be delighted, they won't remember anything else" [...] I was appalled and I was like I'm never going fucking there anyway and I rang [another residential service] and whoever I got to speak to thank God were much more humane. (Ms. B)**

4.4.4 Waiting times and cost (residential service)

The wait between first assessment and being admitted to residential services seemed to range quite dramatically. Ms. N said that, in the past, people had to wait with minimal support, but most residential services now provide education and one-to-one support while waiting for a bed, which takes an average of four to eight weeks (Ms. N). Some talked of securing a bed in a matter of days (Ms. G) others felt 'lucky' to secure a bed in seven weeks (Ms. J). Longer wait times were consistently identified as problematic:

> **I would have been waiting an awful long time, and it was only that I begged and pleaded with [residential services] to take me [...] I actually wrote an email to the CEO [of residential service] because I was so desperate. (Ms. D)**

This quote speaks to Ms. D's social capital. She had the capacity and confidence to email the CEO. Ms. K seemed to wait several weeks, during which time she went on a destructive binge of heroin and crack cocaine. Her children were taken into care, and she was admitted to hospital for drug-induced psychosis. She detoxed in hospital and stayed there until a bed was available in the residential service. Ms. A had relapsed to wait months for the Probation Service to arrange a bed, and relapsed during this time:

> **The wait is massive yeah. Like there is some pre-entries, I know they have started doing a new one now [...] where you go in there. I think it is two or three times a week and then there's [...] community-based and like community-based can work for people. [But] like for me in particular, that wouldn't have worked for me. (Ms. A)**

Ms. A did not have health insurance and could not pay privately, so had to wait while applying for state funding, and needed the support of the Probation Service, who were reluctant because she had previously relapsed four times. Ms. J described first securing a bed in a residential service, in another county, because 'I was a local, it was within the catchment, and they knew the family name'. She later had to 'work hard' to get a place in another residential service, in Cork, after having already relapsed there previously:

> **I had to call kind of once a week and check in. Tell them [...] that I was sober, those kind of things [...] I had to earn coming back, at least that's how I understand it [...] and that kind of was a bit motivating for me. (Ms. J)**

Several participants noted the difficulties of having to be substance-free when entering residential treatment, and how that slowed the process:

> **They were ready to take me the next day but when I came the next day, I still had cocaine inside me – tested positive so they sent me to my sister's house for a week and I came back a week after. (Ms. P)**

Ms. P and Ms. I felt that they had been fast-tracked because they were financially secure:

> **I had health insurance, and I think maybe that's probably what made it more accessible for me, quite quickly at the time. I'm not sure if it's as accessible if you're on a waiting list. Maybe not [...] I wasn't waiting too long [...] I'm sure being a private patient helped as well you know. Listening to people that are trying to access beds you know they are talking about 12 weeks, they are talking about 16 weeks, it's a long wait yeah. (Ms. I)**

> **I am so grateful and lucky that my sister is an alcoholic and anorexic, she is in recovery for 27 years with alcohol, so they paid €24,000. (Ms. P)**

We asked Ms. P if she experienced any barriers. She replied:

> **No, because I was paying in cash [...] I think I would be dead now because I could not wait 6 months [...] it's so hard to keep, to do it on your own [....] It's what you need to do, meeting after meeting until you get to the treatment center. (Ms. P)**

While Ms. P was talking of six-month waiting lists in the UK, it points to a common perception that wealthier individuals can access treatment faster than those under financial strain, and that it can be slower to access beds through the HSE than with insurance or by paying directly.

Ms. N, who has worked for a residential service, said that residential treatment centres do not prioritise people with health insurance, but:

> **The funding takes longer if you're looking for it. Yeah, I think it is a bit of a pain of a process. Private medical insurance is a phone call [...] it does take longer to get the paperwork side of things yeah. Now I would like to think it doesn't [prioritize] but do you know you can have rose tinted glasses as well like do you know and if somebody rocks up with €10,000. (Ms. N)**

The experiences discussed here point to the intersectionality of drug treatment. A middle-class woman, with private medical insurance and good supports at home, can find it easier to access treatment than a working-class woman with minimal social support.

While participants did not identify costs as gendered inequality, in 2022, on average men earned 9.6% more than women (CSO, 2024; see Walsh, 2019) and have fewer childcare and household responsibilities (McGinnity and Russel, 2008; Russell et al., 2019). As such, social class and gender can intersect, especially when women have caring responsibilities.

4.4.5 Caring roles

Most of the women reported some form of a caring role. This was often caring for children, but also parents and partners. Several interviews drifted between discussions about addiction services to the lack of services available for children, and it was often difficult to differentiate whether participants were discussing their service needs or their children's. This suggests you cannot divorce the needs of the parent from the needs of the child.

Parents who were able to enter treatment quickly had social supports. Ms. N, however, had left her violent husband and family, who were in active addiction. Having no childcare meant she could not engage in residential therapy. This experience shows that, for women with children, treatment requires a pre-existing network able to provide childcare:

> **I didn't go [to residential service] since then because I had children [...] I had no-one to mind them and I remember I needed it and I wanted to go in and I couldn't go in and I had the three of them, and I had an extremely violent relationship and I needed to get out of it and I couldn't [be]cause I had no childcare. I don't have support from family. (Ms. N)**

Five participants spoke about having to plan treatment and recovery around childcare:

> **[at a residential service assessment] she said, "can you come in on the Monday" [...] this was the Thursday and I said "could you leave me maybe another few days just to get myself organized you know and the kids and everything". (Ms. D)**

> **A lot of women turn [residential treatment] down because at the start of the year you have you know New Years, Christmas. After that then you have communions and confirmations so they can't come in then because they have to be here for three weeks. Then after that it's the summer holidays, so they can't get out and there is no interim for them except to go for a [12-step] meeting. (Ms. J)**

> **My twins were doing the Leaving Cert that year. That June. So, I waited until they had the Leaving Cert done and I came in [to residential service]. (Ms. I)**

This was particularly important when there was IPV in the household:

> **I rang [residential service] [...] they were like "don't worry we'll get a plan, you will work it out if you want to, it will work out" and actually they did help me. I lined up like my mom, my sister, the two girls now were older [...] I had literally a schedule on the wall of like who was spending time with [name of son] and the only time he was with [ex-partner] was when he was asleep at night. So, like they did help me kind of figure out that. (Ms. B)**

4.4.6 Stigma

The international and Irish literature often find that women experience greater levels of stigma than men, and this presents a barrier to recovery (Arpa, 2017; Miller et al., 2025; Morton et al., 2023; Simpson and McNulty, 2008). Many participants discussed feeling shame at past behaviour, or that family members had been ashamed, and felt stigma. Almost all participants spoke of stigma at some stage.

Some participants identified the double stigma faced by women with SUD, and explored the interplay between shame and stigma:

> **You carry the Catholic guilt then. He'll find out so now I can't go for the job, yeah and you're a woman then on top of it all, "you should be ashamed of yourself". (Ms. J)**

> **Do you know if women have children it's reported to Tusla? Do you know if the man has children "oh my God you're amazing, you're on your own with the kids". She's on her own with the kids and she's reported. That's what you're dealing with. It's a stigma thing [...] [Men] don't have to worry so much about childcare, money, stigma, all that kind of thing. (Ms. N)**

For Ms. D, stigma intersected with the caring roles assigned women in society:

> **The men will get help quicker because the women will push them, whereas the mammies and the women will still stay because there's a huge stigma attached to it. (Ms. D)**

Some felt that the stigma of being a woman in recovery acted as a barrier to entry. Ms. V felt that the 'mortifying shame of going to rehab' as a woman was a barrier to accessing treatment. She was worried about asking her manager, who did not drink alcohol, for leave. Ultimately, her manager was understanding and supportive, but the internalised shame of admitting alcoholism, and stigma around women who use alcohol problematically, was a significant barrier.

Some participants felt stigmatised by medical professionals. This often revolved around visits to the hospital. Ms. D, a middle-class woman, described being hospitalised after a suicide attempt. While in the emergency department, she felt like one amongst a mass of 'addicts' who security were closely monitoring, and staff did not care. The first quote conjures image of 'addicts' treated like cattle:

> **I was out in the corridor, kind of back where the ambulances come in and I was looking around and what I could see was we were all either, it was all either overdoses or alcohol [...] there was a security guard walking up and down. So, it was nearly like "God help us we'll put them out there and we'll keep the real patients in here" (Ms. D). I felt like the druggie in the hospital [...] I asked to do an AA meeting up there and they said they don't do it anymore and there's signs everywhere they just don't care. (Ms. K)**

Some participants identified the fear of being seen entering treatment as a significant barrier to recovery. Ms. J reflected on not wanting to attend local services in a small town because 'everyone will know me':

> **The meetings are there like. But there's still a bit of a stigma and if you grow up in a small county and there's only a couple of meetings and the same meetings every week that's quite challenging. (Ms. J)**

Ms. I's fear that someone might see her attending AA lessoned as she became more comfortable with her recovery, however, the final part of the following quote shows how destabilising stigma can be:

> **My big concern going into AA was, you know was, would somebody recognize me, and you know anonymity to me was kind of [important] [...] I'm not as concerned about that now as what I was a number of years ago. I suppose I have more acceptance around it now [...] It's an illness, I have to treat it and part of that is going to meetings. If I became very concerned about that I'd stop going. (Ms. I)**

Some participants reported initial reluctance to engage with 12-step meetings because they were not like 'them'. The women had internalised the 'addict' stereotype (see Radcliffe and Stevens, 2008) – whether the working-class older male alcoholic or working-class homeless heroin user – and felt that their substance use did not map onto this image:

> **I was like I'll go [to AA] and I went, and I was in the fucking horrors. "I'm nothing like those people". (Ms. B)**

> **It's the frame of mind I think in society. It's you're male and you're older and [...] on the street with a paper bag. (Ms. Y)**

Ms. D felt that internalised shame, and 'the addict' stereotype, was a barrier to opening up during her recovery:

> **I was very guarded in the sense of what I would say because I didn't want people to think, to think less of me [...] I thought if I was an alcoholic and an addict, I was scum on the floor you know. I was the man or woman down the side-alley shooting up heroin or you know homeless. (Ms. D)**

Some participants identified how such stereotypes are perpetuated by the media.

> **They always seem to find the big, bald hard man. Nationwide did it there last year and I was laughing and I'm thinking as a 45-year-old single woman [...] I think tattoos are cool, but that would put me off going cause I'd be like I'm going to sit next to him now when I go to a meeting (Ms. J). If the government are doing an ad like on alcohol, like 9 times out of 10 they probably have an older male, like they'll never have a young female playing sport. (Ms. Y)**

An associated element of this is that two participants reported how they had not experienced trauma as children, and popular psychological books and podcasts frame all addiction as founded in trauma. For these women, they initially felt that they could not be addicted because they did not have multiple ACEs, and then later as they went through the recovery process felt shame at their lack of childhood trauma. This shame limited their capacity to be open in group therapies.

4.4.7 Social workers and children

Some of the women spoke of the fear that social workers would take children into care if they disclosed problematic substance use. Ms. N felt that the perception that children will be taken into care is a major barrier for many women:

> **[Women need to know] it's not going to be reported to Tusla, because that is going to stop 9 times out of 10. I'm not going [be]cause my children will be taken off me [...] I understand it [be]cause I was one of them as well. It's a huge block, huge block for women. (Ms. N)**

Ms. D felt the primary barrier was the unwarranted fear surrounding social workers:

> **I do think for mothers it's a fear [...] if I admitted that I was struggling or that things weren't good my kids might be taken you know, and that social workers would get involved and there's a huge stigma in and around social workers as well. In the sense of like "oh sure their only there to take your kids" you know and that's another stigma. They're there to help you know and do you know what my kids were never in jeopardy. (Ms. D)**

It's possible that our participant's class position influenced interaction with social services (for an alternative account see Harris et al., 2024). As many of the women were middle-class, and appeared to be functioning, they may have received less intervention than if they had been unemployed and/or leading more chaotic lives.

Ms. K's story was, however, one of chaotic heroin and crack cocaine use. She was separated from the father of her two children, who was also in active addiction, and one child was autistic. She reported being 'sent by a social worker' to a residential service after her child had been signed into her parents' care. She quickly relapsed. Tusla and the school later intervened after her child wrote in his school copy-book 'my mam's missing again, I don't know if she's OK'. Tusla signed one child into the care of a friend and the other to a family member. Ms. K did not seem annoyed at this, understood it was because she was 'so unpredictable', and described a meeting with teachers and a social worker as 'brilliant'. She seemed pleased they were caring for her children's needs and identified Tusla's intervention as the 'push I needed'.

Useful services are less useful if

people's perceptions of them are skewed

Addiction services need to help people manage their expectations of Tusla and reduce the stigma surrounding this service.

4.4.8 Intimate Partner Violence (IPV)

The experience of IPV amongst women who use substances problematically is a common theme in the research literature (see Banka et al., 2022; Cafferky et al., 2018; Devries et al., 2014; Morton et al., 2015, 2023). Just over 40% (N=6) of participants reported IPV. Some briefly mentioned IPV for context; framing it as something they had experienced earlier in their lives. For others, IPV was central to their process into andout of substance use. It was both a cause of their addiction and a barrier to recovery.

Ms. V had begun heavy and habitual alcohol consumption when a physically and emotionally abusive relationship ended. Diagnosed with PTSD she used alcohol to soothe the trauma and avoid loneliness. Her experience of IPV was initially a barrier to engagement in therapy because she had learned to avoid expressing emotions to avoid abuse ('I knew the consequences of speaking my mind'). She also felt that her alcoholism had prevented her from engaging with mental health services and IPV supports, so had needed to treat her addiction first.

Ms. N was unable to attend residential services because of ongoing IPV and caring responsibilities. As she could not leave her children with her partner (see section 4.4.5), a community-based educational programme was the only viable option, at that time.

Ms. B described how abusive partners can erect barriers to recovery, and that the recovery process places victims of IPV in vulnerable positions. Her husband had disliked how she had changed after returning home from a residential service, so assaulted her and gave her a bottle of vodka:

> **we had a big row one day and it was really nasty, really nasty interaction and he was like you fucking need to drink [...] he went and he bought me a bottle of vodka and I took it so gladly [...] it just didn't suit him for me to be sober [...] for a woman coming out of treatment it's almost as dangerous as the time she leaves the house in the first place because you are going back into an environment. You've changed; they haven't. They feel it and their world is fucking rattling. I had no idea what was going on and that just escalated the violence, and I wish I'd known this was a possibility because they you'd be prepared for it like or I'd have support. (Ms. B)**

Ms. K described how an abusive ex-partner, and one of his friends, entered the same service as her, invading her space:

> **We were down at the NA meetings. He was starting to come around to all the meetings I was going to [...] and at that meeting I was able to completely pullback but not be rude. That's what I was struggling with [be]cause I didn't want to affect his recovery, but there's 500 meetings, you don't need to be at the ones I'm going to, and he knew these meetings [be]cause he'd been through this treatment center before. (Ms. K)**

Ms. B had experienced coercive control and physical violence from her husband. She felt that the residential service she attended provided no supports for IPV victims, and failed to protect her from her husband, who was allowed to enter the facility and attend family therapy. He invaded her space. She also felt that, because much therapy revolves around personal responsibility, it can make women feel responsible for their own victimisation, increasing their vulnerability:

> **The first time I came in here I would not have mentioned violence. The second time I definitely was more open about it and not one support service was offered. You're still the problem, in fact [ex-partner] turned up three times during treatment, while I was at the [residential] treatment center. He came to drop fags one day. I didn't ask for fags. He came with pajama's another day. I didn't ask for a pajama's [...] there was no one to say to him do not turn up and I was fucking rattling after it because now my safe space [...] now he can land in any time and then I have to sit in a family meeting with him while my counsellor tells him what progress I've made. So now he's getting an even bigger insight into my vulnerabilities. You are told that family meetings are part of it like. If you want to work the programme you have to engage with your family [...] we don't need to have the partner in here and I wasn't the only client that came out of here with the same experience and the same difficulties on the other side. (Ms. B)**

4.4.9 Insecurity and trauma-informed care

> **Security is everything, security is everything. (Ms. E)**

While the above quote is about the security of therapeutic relationships, security has diverse meaning and participants often spoke of the necessity of feeling emotionally and physically secure during the treatment and recovery process. Few participants actively mentioned trauma-informed care, but many pointed to its essence. Elliott and colleagues (2005) identified 10 principles upon which trauma-informed services are founded, including that all services empower women, maximise the 'women's choices and control over her recovery' and support the need for safety. The responses in this section show that some services have fallen short of these three principles. The lack of choice, relative to men, is highlighted throughout this report, so this section focuses on felt security.

Several participants were critical of residential and community-based treatment services which employed 'tough love' models. This often revolved around participants' identification that people who have had traumatic experiences need care and support. The following quote points to the essence of trauma-informed care, as Ms. P understood that her history of childhood trauma meant that 'tough love' models would have been re-traumatising:

> **There is some [residential] treatment center where its tough love you know and that was not going to be good for me because I had tough love when I was young [...] I needed love and I got that here and I got that unconditional love that I did not know. (Ms. P)**

Several women reported feeling uncomfortable attending religious-based residential services. Ms. G, for example, felt many women could not attend residential service run by the Catholic Church because they had experienced clerical abuse:

> **I heard horror stories [...] They said the nuns were quite harsh on them and they ended up leaving [...] for me if somebody said to me I have to go and say 10 Hail Mary's and a novena in the morning I'd be like "I'm a bit of a hypocrite now because I have no faith in the Catholic Church anymore" [...] Men found it fine but women they specifically said "what do you mean its run by nuns", so that would be a big thing. (Ms. G)**

Ms. S was in recovery around eight years ago and described how services have changed and are now moving towards more trauma-informed approaches. She had attended a women-only residential service:

> **If I had to clean that carpet, they might make me do it on my knees with a brush and the hoover could be sitting there in the hallway. I painted the whole place down there. Do you know it was tough going like. Even, you'd make your bed in the morning. It has to be made, envelope corners etc., and a counsellor came in one day [...] stripped all the blankets and threw the pillows, "make it again then". I went mad then, made it, it took me about 10 minutes [...] She came in, same thing again. Stripped it to the ground, she goes "make it again" [...] I think it was the third time I was "ok yeah no hassle" and once I didn't get angry it was like that was my lesson [...] I wouldn't say its trauma-informed. (Ms. S)**

Ms. S then participated in aftercare, in a women-only programme which included 'hot seat' therapy. This approach, which has since been discontinued, was traumatic:

> **My experience of hot seats was counsellors saying to me "it's no wonder your family don't want you, you're always going to be by yourself [be]cause you won't even talk about it". Like horrible, horrible things said. I did not find it helpful [...] it was re-traumatized [...] I shared something confidential with her, and she brought it to the group and shamed me in front of all the girls. (Ms. S)**

While these are historical examples, they are in the very recent past and, spotlight the lack of safety and security some women have felt during recovery.

Four women reported feeling unsafe in mixed-gender residential houses. Ms. B, a victim of IPV, had been in a residential service twice. The first time she found it 'very safe, very nurturing, very kind, a lot of compassion'. The second time she reported being threatened by male residents after she discovered one of the support workers was viewing pornographic images with male residents and had begun a sexual relationship with a female resident. She felt that her life was in danger. Ms. B left treatment early because she felt the residential services management had not taken her concerns seriously. She returned to the service for aftercare after the support worker had left. While Ms. B felt unsafe in the service, the service had repaired the relationship and she felt they had been 'incredibly good to me since, like really now I got incredible support':

> **It was appalling the stuff that went on while I was in treatment [...] there was you know five or six people that were really quite intimidating and I was coming out shaking and rattling between [IPV] and my relapse. I was already on high alert and then there were people in there that were quite aggressive and [...] there was no locks on the doors and there was threats to life [...] it was really unsafe for me [...] it's not like you can sleep at night [...] I felt, I'm going to die here. (Ms. B)**

Both Ms. B and Ms. K reported abusive partners invading their spaces. Ms. K's ex-partner came into the service as a client, while Ms. B's visited her and attended family therapy. Ms. K had developed a friendship with two men during a stay in a residential service. They 'were very protective' and asked the ex-partner to give her space. She did not, however, mention residential staff intervening in the situation.

Ms. W and Ms. Y found some men 'intimidating'. Ms. Y reported arguments erupting into near 'physical fights' between some 'immature' men in her residential group. Ms. W described being scared of some men and emphasised the need for assertive staff:

> **I was scared of some people do you know, scared of their past [...] I think it's important to have male staff in the treatment centre [...] I always felt safer with the stronger male staff presence. That if the guys who would be inclined to get out of line were to do that, that there was that strong alpha male there, and I see a lack of that in support weekend support staff. (Ms. W)**

4.4.10 Section summary

This section has shown how difficult it can be to find addiction services, begin recovery and engage with treatment. Intersecting inequality ensures some experience more barriers than others. Wealthier women with existing social networks of support do seem to have somewhat less barriers than those who are less financially secure, and with less support.

The section also identified multiple institutional barriers, ranging from medical practitioners lack of knowledge to stigma and, insufficient emotional and physical security. While some barriers identified by participants apply to both men and women, issues such as stigma, IPV and lack of private healthcare may be more prominent for women than men.

5. Recommendations

We asked participants how they would improve addiction services. Most were, overall, quite happy with the services they had received, with the caveats discussed above. They often pointed less to the need for significant overhauls but for more services, more options, and improved communication about available services. Few recommendations focused on gender. They were often more general recommendations to support all entering treatment. Some participants did not appear to have thought about the distinct needs of women, until prompted by the interviewer. Once provided a space to reflect, however, most participants wanted the option of attending mixed-gender or women-only services. The first four recommendations are not necessarily gendered, although the stigma attached to women who use substances was a thread running through all recommendations.

5.1 More services are needed

Some participants spoke of the need for more services, an observation found in other research (Leonard and Windle, 2020) and consistently reiterated at the Citizens Assembly (2024):

> **I'm very grateful that I got in here and I do think there needs to be more treatment centers, more facilities. (Ms. D)**

> **I think there should be one on the Southside for Southside people. I don't drive. I made friends with a girl up there but then I have to account on her if she's going or not and then it's just very kind of long and awkward. (Ms. K)**

> **The services are there. As sure as shit there's not enough of them, absolutely not enough of them and I would imagine if the stigma switched there would be a requirement for a lot more. (Ms. J)**

The last quote provided an interesting insight - many women avoid treatment because of the associated stigma and, if that stigma were reduced, demand for services would increase, and the system would not cope.

The paucity of addiction services often drifted into the paucity of linked services. Several participants spoke of how difficult it was to access mental health services for their children. One participant emphasised the need for more, and better resourced, IPV services.

5.2 Recovery should be less expensive

The only change Ms. L suggested was to make residential services free of charge. Ms. S also suggested more financial supports as 'it can be so difficult for people to get funding or to pay'. Women can incur associated costs, including childcare and transportation costs, and may have to take more time off work, due to caring responsibilities and the lack of available options suiting their needs (also Morton et al., 2023). That is, more options would reduce associated costs.

5.3 Greater integration of addiction and mental health services

Ms. K spoke of the need for greater integration between addiction and mental health services. She identified how many people in addiction services have co-occurring mental health issues, so should be linked-in immediately with mental health teams (also Ivers et al., 2021). The importance of this recommendation is found in around 80% (N=11) of participants in this study reporting one or more co-occurring mental health conditions, and one-half reporting at least one attempted suicide (also Cambridge et al., 2022).

Ms. A, Ms. S and Ms. W highlighted the need for more detoxification beds (also Leonard and Windle, 2020). This is because the residential treatment services they attended did not admit people with substances in their system. They felt the lack of space to detoxify made it too difficult for some. Indeed, some participants recalled detoxifying at home from benzodiazepines, alcohol and/or heroin. Some did this with the support of family, others were alone. Ms. A felt that this was urgent as 'there's people dying in the process of' detoxification. Detoxification without medical support is potentially harmful, dependent on the substance and, individual circumstance and context. Some can safely detoxify in the community; others need in-patient medical support (Kleiman et al., 2011). This can represent a barrier to the most vulnerable attending services, including those who are homeless:

> **There are some people who are very motivated for treatment [however …] they need to smoke a bit of weed [cannabis] because they're sleeping on the court house steps and they can't come here because they need to be abstinent […] detox units would help (Ms. W).**

5.5 More women-only services

Some participants identified the need for women-only services, both residential and community-based, or an option for women-only spaces within predominantly male spaces. Several participants expressed the need for more women-only 12-step meetings and for them to be more convenient:

> **To have a female group in the city would make a difference […] I know that there was a good [women-only] group […] I think that has stopped. But that was during the day but like people work say Monday to Friday. (Ms. I)**

Ms. N recommended more women-only groups within residential treatment and aftercare:

> **A programme with women in mind […] I'd love just to have that for women because there's not much available. You know self-esteem, boundaries, […]. Self-care, self-worth, very important, anxiety, worry. Those kind of workshops, healing shame, those kind of workshops. (Ms. N)**

Ms. V said she often preferred mixed-gender services, but wanted female spaces sometimes and acknowledged that many women need female spaces. She identified the complexity of people needing different spaces on different days, and that different people have different needs. Ms. V also highlighted the need for residential services to have separate recreation rooms – 'every other woman I have spoken to' wanted 'the option' of separate rooms. Ms. Y was also overall positive about her experience of mixed-gender services but felt that residential services could facilitate the development of pro-recovery relationships between women.

Ms. S's back and forth on the issue illustrates the complexity and need for choice:

> **Women's groups do work well. People can feel safer especially if they have a history of not feeling safe around men. But then […] I would have felt safer around men than I would have around women. […] But like having the men on their own and the women on their own it just creates a stronger foundation. (Ms. S)**

> **Interviewer: Would you have women and men integrated at certain times?**
>
> **Are you talking about like the 28-day programme, well the 28 day programme I wouldn't separate them because it's such a short period of time together like. The 12-week programme [...] like yeah I think having a mixed group on the longer ones would be fine. (Ms. S)**

5.6 Treatment services need trauma-informed architecture

Trauma-informed care is founded upon providing safe environments. Elliott and colleagues (2005:476) identified how physical settings can:

> **Create a place perceived as safe and welcoming for survivors. A welcoming environment includes sufficient space for comfort and privacy, absence of exposure to violent or sexual material [...], and sufficient staffing to monitor the behaviour of others that may be perceived as intrusive or harassing.**

Four participants reported feeling unsafe while living in a mixed-gender residential service (section 4.4.9). Two suggested simple preventive measures, including improved door security systems on bedrooms and functioning CCTV:

> **On a very practical level locks on the doors [...] they can be a two way lock you know or a little snib. Like someone if they put their shoulder on it they can open it, but at least give that sense of it has to be a bang for someone to come into the room [be]cause that was, that was really really hard for me. (Ms. B)**

Ms. W felt unsafe during weekends, because some male residents were aggressive, and recommended the need for staff who are capable and willing to prevent aggressive behaviour. Ms. B also spoke of her abusive partner coming to visit her unannounced, and recommended services prevent abusive partners accessing residential sites.

Some participants spoke of women fearing their children will be into care, but all had found social workers to be supportive. While some felt this barrier was founded in perception more than reality, women cannot fully engage in recovery if they feel unsafe and the threat of losing children creates an unsafe environment (see Harris et al., 2024). Ms. N recommended the need for clear communication from social services regarding children:

> **[Women need to know] it's not going to be reported to Tusla, because that is going to stop nine times out of ten. I'm not going [be]cause my children will be taken off me [...] it's a huge block, huge block for women. (Ms. N)**

Ms. S felt that building design prevents services from being trauma-informed and, while most residential services are moving towards trauma-informed care they are, at present, trauma-sensitive. We asked Ms. S to elaborate on this:

> **The size of the place is too small [...] It's not soundproof [...] I can still hear a conversation that's going on [in adjoining counselling room] [...] it's like the sound carries. I could be doing meditation before group therapy, and I can hear everybody laughing and joking in the kitchen [...] The carpets are filthy [...] like all the bedrooms, there's an echo in the hallway if someone closes the door, you'll hear it the whole way. (Ms. S)**

This section has shown that for any service to be trauma-informed they must invest in making women feel comfortable and safe (for examples see Grabowska et al., 2021).

5.7 Parents need childcare and services need to work around school times

The provision of childcare for parents has been one of the key recommendations of other Irish studies (Ivers et al., 2021; Morton et al., 2023) and, official reports and alcohol/drug strategies (Windle and Cronin, 2025).

> **Maybe more supports for women who have kids and trying to navigate that [be]cause the kids might be in care, the kids might be with the grandmother, or with the father whichever and they're trying to sort themselves. (Ms. S)**

Ms. N and Ms. K spoke about how aftercare can be difficult while juggling childcare. Ms. N suggested all services provide childcare and are built around the school day so parents can drop children to school and collect them. She stressed that this needed to apply to all services, rather than just services for women, so men can care for their children. Ms. K felt that being a mother in recovery could be lonely and mothers needed support to build pro-recovery networks:

> **I think there should be some sort of service for mothers [...] I've no support. [...] I'm struggling with the, I feel I'm isolated away from everyone else. It's very different once you're a mam. They're together and they can do things. I think there's no services [for people] like myself now at the minute. (Ms. K)**

While only three women explicitly recommended childcare, it was common for participants to recall the difficulties of scheduling residential treatment, and aftercare, around caring responsibilities (section 4.4.5). This required the support of networks of friends and family that not all have.

5.8 Front-line medical practitioners need to be better informed about available services

Several participants expressed their frustration at the lack of knowledge that frontline medical practitioners, especially GPs, had about existing addiction services (section 4.4.2). Some participants suggested that all frontline medical professionals should have an up-to-date list of all available addiction services and receive training on different options. This could involve a simple decision tree, whereby GPs can find which service fits the needs of individual patients.

Ms. G offered another simple, cost-effective, solution - GPs and other medical practitioners' hand, or email, patients a two page sheet listing all available services: 'it doesn't need to be a big rigmarole. You don't need to know the ins and outs of stuff, just the basics'. Ms. G suggested that the sheet should include, for each service, the following:

- whether they are mixed-gender or women/men-only,
- whether they are religious and, if so, what religious denomination,
- which models of care or therapy they offer,
- length of programme,
- whether they offer HSE beds,
- cost and whether covered by insurance.

These suggestions are not only important for navigating options but may help maintain recovery, as research has shown that encouragement from medical professional can increase attendance in addiction services (Manning et al., 2012).

5.9 Addiction services need to be advertised more widely

Ms. N suggested the need for more advertising of services in places frequented by women who use substances, notably GPs, off-licenses, supermarkets and on the radio.

> **They're going to be listening to the radio at home on their own drinking at the kitchen table [...] Just very very basic stuff because you have to think of where they're actually going to be. They're not going to be in the psychotherapist's office [...] they might not have a laptop to go online [so advertise] in Cash Convertors for money [...]. I'd put it up on the notice board and hope for the best. (Ms. N)**

Ms. Y recommended more direct online advertising of services which could also challenge harmful stereotypes.

5.10 Stereotypes must be challenged

Several participants identified the need for a broader cultural shift aimed at dismissing some of the stereotypes of 'the addict', and lessening the associated stigma, because the stereotyped, stigmatized, image of an addict can be a barrier to recovery (see Anti-stigma Network, nd; Radcliffe and Stevens, 2008). Participants spoke about the need to acknowledge that addiction was not limited to older men from economically disadvantaged areas:

> **Awareness is massive [...] people are still hiding behind the closed door [...] it's "what will Mary think, what will Paddy think", "oh Jesus wait until so and so finds out that she's going into treatment" [...] but the men will get help quicker because the women will push them. Whereas the mammies and the women will still stay because there's a huge stigma attached to it. (Ms. D)**

> **The image of having an addiction is all wrong [...] It's a 45-year-old woman sitting in IT with a business analyst, next to a couple of developers and a project manager. You know that's what an alcoholic is today [...] we need to change the face of what an addict is. (Ms. J)**

For Ms. J this needed a public conversation:

> **I think there needs to be more talk about it and people need to be told its ok, because what happens afterward is amazing [...] I suppose campaigns and things like that, but nobody wants to talk about it, much like suicide. (Ms. J)**

5.11 Improved integration between IPV and addiction services

Bank and colleagues (2022:31-33) drew from a systematic literature review to recommend the integration of IPV and addiction services. They suggested that all services be trauma-informed, 'all healthcare and social work practitioners' are trained to identify the 'signs and symptoms of domestic violence', and to provide 'empathetic, non-stigmatising care', and increased housing for women with children 'who use substances and whose homes are unsafe' (also Morton et al., 2023). This was echoed by Ms. B who recommended that addiction services screen all women for IPV, and that residential services work closely with IPV services:

> **There needs to be a screening. The questions need to be asked eyeball to eyeball, "is there any difficulties at home", and allow room for a woman to be saying my husband is wrong or my partner is wrong [...] you can be an alcoholic and be a victim of violence as well [....] it's not either or, I think there needs to be more compassion and room around that and definitely a screening process with a female. (Ms. B)**

The final part of that quote indicates how the focus on taking individual responsibility for actions inherent in some treatments can inadvertently make victims of IPV more vulnerable to further abuse (see section 4.4.8):

> **When you come into treatment in general it is a kind of "lets strip you back here" and you have to be accountable, take responsibility, get the denial out of the way. You are the problem, and in ways that's great if you're a single woman who's an alcoholic and not in an abusive situation. But if you're a mother coming from an abusive situation that stripping back actually is detrimental because whatever tiny smidgeon of self-worth or hope you had of, of saying that the behavior of the [abusive partner] was wrong, you have none when you're after treatment [...] you are the problem. She's been hearing this for years like from somebody and it's part of why she's drinking and now these professionals are also reaffirming you are the problem. So, it puts the woman in a really really vulnerable position in the home [...] you go home very humble and very like everything is my fault and it's my behavior, so you can kind of do what you fucking want. So, the males can be quite delighted with that initially, but then they realize [...] that the woman is getting a little bit stronger [...] It's actually dangerous to get sober if your living in an abusive situation. (Ms. B)**

As such, Ms. B recommended all women be made aware of these dynamics and are prepared for re-entry into potentially unsafe environments. This requires greater cooperation between addiction and IPV services, including IPV support workers coming into addiction services to speak to women.

5.12 Recovery needs to be fun

Ms. N was critical of 12-step meetings, so we asked her what she would do to improve these services. Her responses centred on the need for more fun:

> **I'd have a coffee [...] I'd have a woman there meeting the women and I'd have a man there meeting the men [...] the Americans do it really well. It's just a little bit more "hi how are you welcome". It's not running to the chair and sitting down and running out the door and I know why people are running they have kids, they have a job, they have a car [...] and the pro-socials are very important [...] [be]cause if you don't enjoy recovery it's not sustainable. (Ms. N)**

Several participants spoke of the need for a diverse range of pro-social activities within residential and community-based treatments. Ms. V felt that the recreation room in a residential service was too much of a male space, with men constantly watching sport, and many of the women wanted a separate space where they could watch television, read and socialise:

> **I would strongly recommend you know the women's room or something. The women can pick their own space and just chill out in pyjamas or something. It's like if you're here six weeks it's a long time and you want to be comfortable in your environment you know. Rather than being in a room full of men [...] they're all watching sport, and [you] just go to bed. (Ms. V)**

5.13 More options to suit diverse needs

The women in this study had diverse backgrounds, experiences and needs. All services need to reflect this diversity. Some participants said they needed women-only services, others needed mixed-gender environments. Some found religious-based services comforting or useful, others were repelled at the thought. Some preferred female counsellor, others favoured male counsellors.

> **[Some people] didn't want to go to the religious services [...] maybe he doesn't want to talk to a male counsellor, maybe he'd feel more comfortable with a female counsellor. (Ms. G)**

> **I think in treatment people should be given the choice because I know some of the men got a woman and they would have loved a man. I think they just should if possible. (Ms. B)**

> **If some people want to do it with [residential service] and they want to do it by doing the Rosary every day at 6 o'clock and it works for them, then that's their guide. (Ms. J)**

One of the principles of trauma-informed services is that women have choice in their recovery (Elliott et al., 2005). If women need to navigate a predominantly male-spaces amongst services designed for men, then their choices are limited.

6. Conclusion

The key finding of this report is that women with SUD are not a homogenous group.

The women interviewed for this study had diverse backgrounds, experiences and needs, and provided diverse recommendations for improving addiction services. However, all identified recovery as a predominantly male space. Some wanted to attend women-only services, others were more comfortable in mixed-gender environments. Most wanted the *option* of women-only services or spaces.

As mixed-gender services tend to be male-spaces within which women must navigate a place, all integrated services must be (re)designed for both men and women. In some services this may mean women-only areas (i.e. recreation rooms or therapy groups). For a service to be trauma-informed, all must feel safe, secure, empowered and with choice over their recovery.

The participants in this study were not necessarily calling for a radical overhaul of addiction services. They wanted the same range of options as men in addiction. Ireland remains a country where women still undertake the majority of housekeeping and childcare, are less likely to work than men and receive lower wages. This means that men have more time and resources for recovery. Men suffer less stigma, are less likely to be victims of IPV and tend to have more social supports. Women have less time and less resources, and suffer greater stigma and IPV, and have fewer options. The cards are stacked against women, but the recommendations made by participants in this study are achievable for all services. Some require minimal resources, but all require a commitment to gender-sensitive and trauma-informed care.

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