

Brief Report

Understanding the “Revolving Door” in a Community Substance Use Service: Gender Differences in Readmission

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Abstract

Background: Access to substance use disorder (SUD) treatment remains a concern in Brazil, particularly among socioeconomically disadvantaged populations affected by cocaine and crack-cocaine use. Community-based services such as the HUB de Cuidados em Crack e Outras Drogas (HUB) in São Paulo aim to engage vulnerable individuals but often face a “revolving door” pattern of repeated admissions. Evidence on predictors of readmission in community-based support services, particularly gender differences, remains limited. This study examines gender-specific predictors of readmission to the HUB within 12 months and changes in clinical characteristics over time. **Methods:** This is a retrospective observational design study. Records from all individuals who sought treatment for their alcohol and/or drug use in HUB between June 2024–2025 were analysed (number of records = 13,645; number of service users = 6528). This timeframe refers to the study period during which data were collected. **Results:** Among 6528 service users, most were men (92.6%), with higher readmission rates than women (53.4% vs. 38.6%). Homelessness and synthetic cannabinoid use predicted readmission for both genders. Among men, younger age, substance use patterns, and greater clinical severity were associated with readmission. Among women, recent crack-cocaine use was linked to lower readmission. Over time, men showed worsening substance use and clinical indicators, while women showed reduced stimulant use but increased psychotic symptoms and help-seeking. **Conclusions:** The “revolving door” pattern of repeatedly entering and leaving services without continuity of care is common in community-based support services like HUB. Risk profiles differ between men and women. The limited predictors identified for women suggest that routine clinical assessments may overlook important social and structural vulnerabilities. These findings highlight the need for gender-sensitive approaches that account for distinct emotional and cognitive pathways and the service needs of men and women.



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Keywords: readmission; substance use services; Brazil; women

1. Introduction

Access to substance use disorder (SUD) treatment remains a major public health challenge both globally and in Brazil [1,2]. Despite the availability of a variety of interventions, many individuals with SUD do not access or remain engaged in treatment due to structural barriers (e.g., service availability and cost), social factors (e.g., stigma), and individual

factors (e.g., low perceived need for treatment) [3,4]. Women, in particular, often face additional barriers to accessing and remaining engaged with services compared with men, including caregiving responsibilities, discrimination in family and wider society and limited availability of trauma responsive care [5]. Although substance use is more prevalent among men, women experience a faster progression from substance use to SUD [6]. This acceleration of progression to SUD is often associated with greater addiction severity and harms associated with drug use (e.g., physical and sexual abuse, worse mental and physical health) [7,8]. The double stigma associated with being a woman and a person who uses drugs may also contribute to underreporting in epidemiological data across Latin American countries by discouraging disclosure and open discussion of substance use practices [9,10]. Nevertheless, available evidence indicates that women remain substantially underrepresented in treatment services. In Brazil, women account for only 17–22% of individuals accessing substance use treatment [11,12], which is similar to rates found in Argentina (18.4%) and Mexico (25%) [10].

Drug use in Brazil is dominated by stimulant drugs, particularly cocaine and crack-cocaine [13]. The possession and use of these drugs remain illegal under Brazilian law. While use occurs across different sectors of Brazilian society, harm is disproportionately concentrated among socioeconomically disadvantaged populations. Individuals living in poverty and social marginalisation often experience unstable housing, violence, and limited access to education and employment [14]. These structural vulnerabilities increase the risk of problematic substance use and reduce recovery capital, limiting access to healthcare and the ability to engage with support services [4]. In addition, evidence suggests that drug law enforcement in Brazil disproportionately affects marginalised ethnic and racial groups, particularly Black and mixed-race populations living in deprived urban areas, contributing to inequalities in criminal justice involvement, incarceration, and access to health and social care [15,16].

Brazil's public healthcare system, the Unified Health System (Sistema Único de Saúde—SUS), provides universal and free SUD treatment focused on rehabilitation, harm reduction, and social reintegration. As part of efforts to expand access for vulnerable populations, community-based services such as the HUB de Cuidados em Crack e Outras Drogas (HUB) were established in São Paulo. The service is strategically located near geographic areas characterised by high concentrations of individuals who use and/or trade drugs (known as open drug scenes, ODS), enabling engagement with individuals who often face substantial barriers to healthcare access. It provides immediate clinical and psychosocial assessments, crisis care and short-stay detoxification beds. Beyond acute intervention, the HUB seeks to support longer-term recovery and social reintegration by promoting continuity of care, engagement with specialised treatment, and access to broader health and social support services.

Crack-cocaine use is highly prevalent among HUB service users [11]. The clinical profile of dependence characterised by intense cravings and frequent relapse combined with high psychiatric comorbidity and poor living conditions makes sustained engagement with the service challenging [4,11]. This often results in a “revolving door” pattern, where individuals repeatedly enter and disengage from services, returning in crisis without achieving continuity of care [17]. Understanding these patterns may require consideration of behavioural reinforcement and coping processes underpinning substance use. For many individuals, crack-cocaine use may function not only as a source of immediate reward and reinforcement [18], but also as a maladaptive coping strategy for managing trauma, emotional distress, violence exposure, social exclusion, and other chronic stressors [19]. These emotional, cognitive, and social functions of substance use may differ across genders, potentially influencing patterns of service engagement, relapse, and return to care. Despite

the clinical and public health relevance of this issue, evidence on predictors of this revolving door pattern within community-based services remains limited, particularly regarding gender differences. This study therefore aimed to examine 12-month readmission to the HUB according to biological gender, specifically to (1) identify factors associated with readmission cases and (2) assess changes in clinical characteristics between first and last admission assessment.

2. Methods

This study employed a retrospective observational design based on electronic health records of service users who sought support for their alcohol and/or drug use at the HUB between June 2024–2025. This period overlapped with ongoing police dispersal (“wash-up”) operations within the local ODS (popularly known as “Cracolândia”), starting in late May 2025 that dispersed individuals across different areas of the city, impacting service utilisation. The records comprised anonymised data collected during triage assessments, which follow a standardised and mandatory procedure conducted for all patients at each admission to the service. Ethical approval was granted by the Research Ethics Committee of the Federal University of São Paulo (CAAE: 39437220.4.0000.5505).

2.1. Sampling

The study included all service users admitted to HUB during the study period, totalling 13,645 admissions from 6528 unique individuals. The initial admission was defined as everyone’s first triage assessment within the study period. A readmission case referred to a subsequent admission within the study timeframe.

Overall, 3412 (52.27%) service users were readmitted during the study period. The latest admission was defined as the latest one within the study timeframe. Among readmission cases, 2567 (75.23%) had completed clinical assessment data in both initial and last admissions.

2.2. Measures

Service users’ gender, age and housing status (homelessness = living on the streets/public shelters) were extracted. Involvement with ODS included: attendance at an ODS on the day of service access, being a frequent attendee in the past 12 months, and being newer to the scene (less than 12 months).

A history of treatment in the past 12 months was defined as admission to a structured SUD treatment in community or in inpatient services, regardless of completion. The Alcohol Use Disorders Identification Test (AUDIT) [20] was used to assess alcohol consumption in the past 12 months; possible alcohol dependence was defined as scores > 20. Self-reported use of cocaine, crack-cocaine, cannabis, synthetic cannabinoids (*k* drugs as known in Brazil), solvents, and methamphetamine in the past 12 months was recorded. Polydrug use was defined as concurrent use of cocaine, crack-cocaine, and cannabis. Participants reporting cocaine and/or crack-cocaine use were asked about their use in the past 3 months (no = 0/yes = 1). Those reporting recent use completed the Brazilian-adapted Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) [21] to assess severity (8 items; total scores ranging from 8 to 34).

Symptoms of substance intoxication, psychosis, and disorientation were assessed using the Mental Health Risk Scale developed by the HUB clinical team. Items were rated on a four-point Likert scale (none to severe) and dichotomised as high or severe. Lifetime suicide attempts were assessed.

2.3. Analysis

Descriptive statistics summarised the sociodemographic, treatment, and clinical characteristics of males and females who returned to services; categorical variables are presented as counts and percentages of non-missing observations. Logistic regression was used to identify factors associated with readmission (yes/no), excluding variables with <10% prevalence (see Supplementary Material for detailed information on missing values). Separate models were fitted for each predictor adjusted for age, homelessness, and cocaine/crack-cocaine use in the past 12 months. A subsample with clinical data at initial and last admission was analysed to assess change over time using chi-square tests (categorical variables) and *t*-tests (continuous variables). Stata SE v18.0. was used.

3. Results

Of the total sample, 6044 (92.58%) participants were male and 484 (7.42%) were female. A greater proportion of males returned to service ($N = 3224$; 53.36%) than females ($N = 187$; 38.64%). Table 1 summarises characteristics by gender. Participants were in their mid-thirties (male: $M = 37.05$, $SD = 9.47$; female: $M = 35.77$, $SD = 10.40$). Homelessness was more common among males than females (62.71% vs. 45.74%), as was attending ODS in the past 12 months (62.71% vs. 49.89%). More than half of males (71.21%) and females (61.36%) reported crack-cocaine use in the past year, with most reporting crack-cocaine/cocaine use in the past three months (88.29% and 83.18%, respectively).

Table 1. Characteristics and factors associated with readmission cases according to HUB service user biological gender.

	Male Service Users (N = 6044)			Female Service Users (N = 484)		
	N (%)	Adjusted OR (95% CI)	<i>p</i> Value	N (%)	Adjusted OR (95% CI)	<i>p</i> Value
Male (female = 0)						
Age	37.05 (9.47)	0.86 (0.82, 0.91)	0.000	35.77 (10.40)	0.95 (0.79, 1.16)	0.640
Homelessness (no = 0)	3746 (62.71%)	1.40 (1.25, 1.56)	0.000	220 (45.74%)	1.26 (1.79, 1.99)	0.001
Frequented ODS the day entering service (no = 0)	2826 (47.20%)	0.88 (0.79, 0.99)	0.031	176 (36.44%)	0.81 (0.53, 1.25)	0.324
Frequented ODS in the past 12 months (no = 0)	3632 (61.80%)	1.34 (1.19, 1.51)	0.000	236 (49.89%)	1.35 (0.49, 3.68)	0.360
New to ODS – less than 12 months (no = 0)	1813 (44.37%)	0.78 (0.62, 0.97)	0.033	135 (48.91%)	1.26 (0.79, 1.99)	0.554
Attended substance use treatment in the past 12 months (no = 0)	1768 (52.70%)	2.17 (1.77, 2.65)	0.000	186 (55.86%)	1.39 (0.66, 2.93)	0.383
Spontaneous entry (HUB) (no = 0)	2098 (85.49%)	0.87 (0.65, 1.16)	0.365	236 (88.72%)	1.51 (0.32, 6.98)	0.249
Substance used in the past 12 months (no = 0)						
Cocaine	4525 (74.87%)	1.78 (1.40, 2.63)	0.000	282 (58.26%)	0.61 (0.30, 1.25)	0.180
Crack-cocaine	4304 (71.21%)	2.15 (1.70, 2.73)	0.000	297 (61.36%)	0.38 (0.17, 0.88)	0.023
Cannabis	3530 (58.41%)	1.45 (2.31, 1.62)	0.000	212 (43.80%)	0.97 (0.67, 1.42)	0.899
Synthetic cannabinoids (k-drugs)	1752 (28.99%)	1.99 (1.77, 2.25)	0.000	153 (31.61%)	1.88 (1.23, 2.88)	0.002
Solvent	822 (13.60%)	1.68 (1.44, 1.97)	0.000	65 (13.43%)	0.69 (0.39, 1.23)	0.213
Methamphetamine	197 (3.26%)	1.55 (1.15, 2.09)	0.004	14 (2.89%)	0.97 (0.31, 2.99)	0.957
Poly drug use	2694 (44.57%)	1.63 (1.47, 1.81)	0.000	139 (28.72%)	1.33 (0.89, 2.00)	0.164
Alcohol—AUDIT scores	27.67 (9.27)	1.83 (1.12, 2.99)	0.015	23.76 (10.45)	0.44 (0.14, 1.34)	0.149
Probably alcohol dependence—AUDIT > 19 (no = 0)	420 (79.25%)	1.10 (0.70, 1.71)	0.670	26 (68.42%)	0.37 (0.09, 1.75)	0.212

Table 1. Cont.

	Male Service Users (N = 6044)			Female Service Users (N = 484)		
	N (%)	Adjusted OR (95% CI)	p Value	N (%)	Adjusted OR (95% CI)	p Value
Cocaine and/or crack-cocaine used in the past 3 months (no = 0)	2962 (88.29%)	1.19 (0.86, 1.63)	0.288	277 (83.18%)	0.12 (0.05, 0.30)	0.001
Cocaine and/or crack cocaine addiction severity level	29.01 (2.92)	1.36 (1.19, 1.55)	0.000	28.78 (2.86)	1.01(0.46, 2.17)	0.980
Health risk level—High/Severe (no = 0)	436 (7.21%)	0.86 (0.64, 1.15)	0.698	43 (8.88%)	1.16 (0.47, 2.83)	0.456
Intoxication level—High/Severe (no = 0)	87 (96.67%)	1.10 (0.32, 3.83)	0.877	<10	-	-
Psychotic symptoms—High/Severe (no = 0)	3070 (75.04%)	1.48 (1.28, 1.71)	0.000	259 (81.45%)	1.22 (0.33, 4.48)	0.459
Disorientation level—High/Severe (no = 0)	1017 (17.03%)	0.90 (0.78, 1.04)	0.162	105 (21.88%)	1.14 (0.45, 2.89)	0.709
Suicide attempts ever in life (no = 0)	1322 (21.87%)	0.93 (0.82, 1.06)	0.333	138 (28.51%)	0.82 (0.54, 1.25)	0.368

Note: in bold $p < 0.05$.*Factors associated with returning to services (Table 1)*

Male service users were more likely to be readmitted, were younger, were not attending ODS on the day of access to HUB but had attended in the past 12 months, had used structured addiction treatment in the past year, had used any of the reported substances including polydrug use, and had higher AUDIT scores, greater cocaine/crack dependence severity, and reported high/severe psychotic symptoms. For both genders, homelessness and synthetic cannabinoid use were associated with readmission cases. Female service users who had used crack-cocaine in the past year and used crack-cocaine and/or cocaine in the past 3 months were less likely to be readmitted.

Changes in clinical characteristic from first to latest service access according to gender (Table 2)

Table 2. Clinical characteristics at initial and latest admission according to gender.

	First Admission	Latest Admission	Chi2/t-Test	
Frequented ODS the day entering service				
Male	1091 (96.29%)	1558 (95.82%)	71.36	<0.001
Female	42 (3.71%)	68 (4.18%)	15.11	<0.001
Spontaneous entry (HUB)				
Male	1752 (93.99%)	983 (92.82%)	37.42	<0.001
Female	112 (6.01%)	76 (7.18%)	5.53	0.019
Alcohol—AUDIT scores				
Male	29.05 (8.26)	28.28 (10.41)	0.57	0.289
Female	24.5 (16.26)	25.12 (11.90)	0.89	0.785
Cocaine and/or crack-cocaine used in the past 3 months				
Male	1815 (95.33%)	1.031 (96.18%)	154.79	<0.001
Female	89 (4.67%)	41 (3.82%)	24.61	<0.001

Table 2. Cont.

	First Admission	Latest Admission	Chi2/t-Test	
Cocaine and/or crack cocaine addiction severity level				
Male	29.14 (2.74)	29.04 (2.97)	0.57	0.284
Female	28.29 (2.89)	28.94 (2.19)	0.78	0.778
Health risk level—High/Severe				
Male	32(96.97%)	320 (94.12%)	3.98	0.046
Female	<10	20 (5.88%)	0.17	0.678
Intoxication level—High/Severe				
Male	87 (96.67%)	90 (97.83%)	0.10	0.751
Female	<10	<10		
Psychotic symptoms—High/Severe				
Male	1257 (95.08%)	1,186 (94.88%)	55.25	<0.001
Female	65 (4.92%)	64 (5.12%)	11.87	0.001
Disorientation level—High/Severe				
Male	372 (93.47%)	560 (95.40%)	5.40	0.020
Female	26 (6.53%)	27 (4.60%)	0.372	0.542
Suicide attempts ever in life				
Male	490 (92.63%)	653 (94.23%)	21.39	<0.001
Female	39 (7.37%)	40 (5.77%)	2.25	0.133

Note: in bold $p < 0.05$.

At their latest admission, male service users showed statistically significant reductions in reports of same-day ODS attendance, spontaneous help-seeking, and severe risk and psychotic symptoms, and a statistically significant increase in reports of cocaine/crack-cocaine use, disorientation symptoms, and suicide attempts. Female patients showed statistically significant increases in same-day ODS attendance, spontaneous help-seeking, and severe psychotic symptoms, alongside a reduction in cocaine/crack-cocaine use.

4. Discussion

In this descriptive study using records from a substance use support service located in an area with a high concentration of individuals who use drugs in open public spaces, more than half of the service users were readmitted to the service within 12 months of their first admission. This rate is similar to those reported in structured SUD treatment services, where approximately 40–60% of individuals re-enter treatment within one year [22,23]. Consistent with many SUD treatment settings, most HUB service users were men [11,24] and readmission rates were also higher among men (53.36%) than women (38.64%). This contrasts with findings from studies of inpatient/detoxification SUD treatment, where gender is often not a significant predictor of readmission [22,25].

Notably, a wide range of factors predicted readmission among men, whereas only a few were identified for women. Synthetic cannabinoid use and homelessness were the only predictors by both genders. In contrast to men, where use of all reported substances, higher AUDIT scores, and polydrug use were associated with readmission, among women, crack-cocaine use was associated with a lower likelihood of readmission. The limited number of predictors identified for women highlight that predictors of service readmission among women may extend beyond substance use patterns and clinical severity alone. Women who use drugs often experience distinct social and structural vulnerabilities [26,27]. In open drug scenes in Brazil, women face compounded challenges including caregiving responsibilities, gender-based violence, stigma, and barriers to accessing services [28]. They

also tend to have stronger and longer-standing ties to these environments, suggesting a more entrenched cycle of addiction and social marginalisation than men [29]. For many individuals, accessing the HUB may reflect a perceived need for help and may represent the first, and sometimes only, point of contact with care. This moment therefore constitutes a critical window for engagement. Although both men and women from ODS experience extreme vulnerability, including poverty, homelessness, violence, gang-related violence, and other adverse social and health outcomes [19,28], our findings suggest that pathways into services and patterns of engagement may differ by gender.

These findings can be interpreted within frameworks of behavioural reinforcement and coping, whereby substance use may serve distinct emotional and cognitive functions across genders [30,31]. Among men, readmission may be associated with increased substance use and clinical deterioration, reflecting more acute, externally driven crises, consistent with evidence linking substance use to impulsivity and risk-taking behaviours [32]. In contrast, among women, patterns of engagement may be shaped by more complex coping processes related to trauma, social adversity, and emotional regulation, in line with research highlighting substance use as a means of managing negative affect and trauma-related symptoms [33]. Within this context, lower attention to emotions among women may reflect a tendency towards emotional avoidance, a key mechanism underpinning substance use and relapse among women [30].

Gender differences were also observed in clinical trajectories when comparing characteristics between the first and last assessment among individuals who returned to the service within the study period. Among men, re-engagement with the service tended to occur during periods of increased substance use and acute mental health symptoms including disorientation and suicide attempts. In contrast, women appeared more likely to access services self-directly over time. Although cocaine/crack use decreased among women, severe psychotic symptoms increased as did the involvement with open drug scenes. Women in these settings face poverty, limited formal support, and cumulative adversity, which contribute to trauma [28]. As drug use decreases, trauma-related and psychiatric symptoms may resurface [34], complicating recovery and sustaining involvement in open drug scenes.

These patterns have important implications for intervention. They suggest the need for gender-sensitive approaches that account for distinct emotional and cognitive pathways, including tailored interventions such as cognitive behavioural therapy (CBT) and mindfulness-based approaches to support coping, trauma processing and relapse prevention. Relapse should be understood not only as a behavioural outcome but also as part of a broader emotional and cognitive process, requiring integrated responses that address both substance use and underlying psychosocial needs. Despite growing recognition of these issues, there remains limited systematic information on the availability and implementation of gender-centred treatment responses to drug-related problems across Latin American countries, including Brazil [9,35]. Although policy guidelines and recommendations targeting women who use drugs are beginning to emerge, evidence regarding their implementation remains scarce [9]. Our findings add to growing calls for further investigation into gender-specific pathways to treatment engagement, relapse, and recovery, alongside the development and evaluation of interventions capable of addressing the complex psychosocial needs of women who use drugs.

Our findings must be interpreted while considering limitations. All measures relied on self-reported data, which might have underestimated/overestimated the clinical reports. Data from EHR are not collected for research purposes and thus clinical measurements are subject to the exigencies and habits of prevailing clinical practice. This might have influenced the missing data. The Mental Health Risk Scale assessing symptoms of substance

intoxication, psychosis, and disorientation was not psychometrically evaluated. In addition, first admission may not have been the first time service users attended the service as some might have attended it before June 2024. Also, changes observed in clinical characteristics between the first and last assessments may have been influenced by the relatively limited observation period, which may not have been sufficient to capture longer-term patterns of recovery or changes in psychosocial functioning. Lastly, the current paper was designed as a descriptive, exploratory-focused study. Therefore, the variables examined were restricted to those routinely available within clinical records, limiting the ability to assess other potentially relevant factors. Future research should explore a broader range of psychosocial, behavioural, and structural factors that may influence engagement with services among people who use crack-cocaine. These include trauma history, experiences of physical and sexual violence, psychiatric comorbidity, coping strategies, emotional regulation, social support, family relationships, and perceived stigma. Greater attention should also be given to gang-related violence, criminal justice involvement, and access to social protection resources, given their potential influence on continuity of care and recovery trajectories.

5. Conclusions

Vulnerability to problematic drug use is multifactorial but is often exacerbated by social deprivation, trauma, and inadequate healthcare support. Without supportive environments, individuals seeking help in substance use services may continue to fall through gaps in care. People experiencing homelessness and those using drugs in open public spaces are at particularly high risk of repeatedly cycling in and out of services, often returning in crisis without continuity of care. Within this context, the specific needs of women remain under-addressed. Although our findings indicate that men were more likely than women to repeatedly return to the service, and that clinical characteristics associated with drug use were linked to men's returns, these associations were not observed among women. This suggests that the factors influencing women's re-engagement with services may differ from those affecting men and remain poorly understood and assessed in clinical settings. These findings highlight the importance of gender-sensitive approaches that account for distinct emotional and cognitive pathways and service needs of men and women.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/psychiatryint7040167/s1>, Table S1: Completeness of variables from total sample of 6528 service users.

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Informed Consent Statement: Patient consent was waived as the study was based on anonymised electronic health records with no direct participant involvement, in accordance with relevant ethical and data governance approvals.

Data Availability Statement: Researchers can access the linked data by contacting the HUB de Cuidados em Crack e Outras Drogas at suporte@faculadadehub.com.br. Access to the codes used in this study can be obtained by contacting the corresponding author.

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