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ATTENTION TO WOMEN DRUG USERS IN EUROPE

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Guidelines
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Introduction

Women represent almost a quarter of the population consuming some form of illicit drugs in Europe, according to EMCDDA estimates. The organisation recognises that “whilst most drug services are designed with male drug users in mind — as they are the predominant client group — it is widely accepted that drug policy and programme effectiveness are enhanced when sex differences are acknowledged and the different needs of women and men are addressed”.

Starting from this recognition, IREFREA Italy joined the Democracy, Cities and Drugs II (DC&D II) project in 2008 in order to work on gender and women’s specific issues as per the objectives of the overall project. The DCDII project aims at supporting EU cities in developing local partnership-based drug policies. It aims at involving the relevant stakeholders so that a coordinated, participative, targeted, and thus resource effective approach can be developed in the treatment of drug-related problems. The relevant stakeholders include local authorities, health services, criminal justice services, communities (including visible minority ones), and drug service users.

IREFREA Italy lead the “Women and Drugs” thematic platform within the DC&DII project and worked specifically with the cities of Crotone, Venice and the Veneto region in Italy, Nottingham/Nottinghamshire in the UK and Stuttgart in Germany.

The activities developed during the three years of project work consisted of a series of initially informative meetings, eventually developing into work sessions with the cities joining the platform. Data was collected through a questionnaire on local policies and services related to the specific needs of women who abuse substances. Exchange visits organised in the framework of the project allowed representatives from the cities, such as policy makers and service providers, to visit other countries and witness how services are organised there.

A Scientific Group worked throughout the duration of the project on the drafting of the major project output: a set of guidelines addressing professionals and policy makers on integrated assistance for women who abuse substances. The guidelines draw from existing literature and case studies, guidelines and recommendations from international bodies and national/local expert groups and case studies drawn from the exchange visits. The guidelines and outcomes from the thematic platform work have been presented at the final DCDII conference in Vienna in February 2011 and disseminated throughout the DCDII network of cities and stakeholders.

What do we mean by "Women drug users in Europe"?

Throughout the duration of the project and particularly throughout the drafting of the guidelines, the Scientific Group decided to adopt a broad definition of substance/drug misuse. This decision was made in accordance with city representatives. We initially looked at the EMCDDA definition of "problem drug use" as "injecting drugs, the long-term or regular use of opioids, cocaine and/or amphetamines". This definition specifically includes regular or long-term use of prescribed opioids such as methadone, though it doesn't include their infrequent or irregular uses, nor does it include the use of ecstasy or cannabis.

We also recognised that the EMCDDA is currently examining a re-definition of problem drug use in view of the growing problem of stimulants-abuse, in addition to a growing number of cannabis-related treatment demands. Moreover, we could not ignore the high impact caused by the misuse of licit substances in women's lives (such as pharmaceutical drugs and other types of drugs, in addition to alcohol). This consideration was made in light of the practices and the patterns of women substance misusers accessing harm reduction or treatment services in Europe.

In short, the present guidelines tend to focus more on problematic substance use (including licit substances, such as pharmaceutical drugs and alcohol) and on the harm that the abuse of these substances cause on women. Limited attention was given to the recreational use of substances. Hence, whenever encountering the terms substance/drug misuse and their related services in these guidelines, the above definition must be taken into account.

The DCDII project unfolds on an EU-wide level. The guidelines tend to draw from literature collected from European and US sources. Case studies are drawn from exchange visits carried out during the project in Germany, UK and Italy.

Objectives of the Guidelines

The "Women and Drugs" thematic platform of DC&D II project aims at providing tools to support policy makers and practitioners in EU cities. Policy makers are assisted in the design and implementation of drug services which are attractive, respectful and appropriate to the specific needs of women with substance misuse problems.

The final product of the thematic platform consists in a set of guidelines (included in this publication) based on integrated assistance available for women substance abusers. The guidelines draw from the analysis of relevant literature in the field, such as guides procured by relevant international entities conducting research on a local and national level. The guidelines were further developed through cooperation with policy makers and practitioners from the various cities participating in the "Women and Drugs" thematic platform. These individuals drew concrete examples from their local services coupled by their expressed needs for further development on a local level.

The guidelines provide useful tools and case studies aimed at increasing the knowledge of relevant drug and alcohol service providers, while specifically focusing on how to address the needs of women. The platform's work concentrated on creating a venue for representatives to share their experiences and to learn from the available research and best practices available on a European level. Last but not least, the platform worked towards the development of local policies appropriately addressing the specific needs of women drug users.

City representatives participating in the platform performed an assessment on the appropriateness of their current policies and services for women drugs users. They subsequently joined platform workshops to share their views on existing best practices experimented on local level. Furthermore, representatives attended exchange visits between Italy, Germany and England in order to witness how policies and service are administered in other countries. Finally, these individuals performed a study of the existing research in the field.

The results of these activities were all taken into account during the preparation of the guidelines. We present these results to policy makers and local practitioners in an easily accessible format. The guidelines will be administered by cities taking part in the DCDII project and introduced within the wider network of project stakeholders. They will also be presented to the European Commission and the European Agency on Health and Consumer protection as a model for best practices.

Methodology

The methodology for the development of the guidelines includes:

- the development of a questionnaire aimed at mapping out the services available for women substance misusers within the cities involved in the project; what are the available policies/initiatives aimed at addressing women's needs?
- an analysis of the information collected through the questionnaire by the city representatives joining the platform
- an analysis of the existing literature of official sources in addition to other literature available in Europe and abroad.
- the collation of existing operative protocols and guidelines regarding available services for women substance misusers (assessments, drug prevention, treatment, harm reduction, integrated services and networking with other women's services)
- the drafting of a set of guidelines regarding the various aspects of working with women substance misusers.

During the course of the project, exchange visits were organised between representatives of the service providers and policy makers at the city level: two representatives from Venice, Italy visited services in Nottingham/Nottinghamshire, England. Two representatives from Nottinghamshire visited services in Italy, in Venice and Milan and in Stuttgart, Germany. Two representatives from Stuttgart went to Nottinghamshire. The data collected during the research visits regard the appropriateness of services. The lessons learned from these exchange visits have been included as case studies in the text comprising the current guidelines (see the case studies boxes).

1.Women and addiction in Europe

This chapter aims at identifying patterns of substance use among women and identifying the major problems arising from substance misuse. Our attention was focused on the more problematic types of drug use1 associated with the most dangerous substances. These include the most common illicit substances as well as alcohol and pharmaceutical substances. Indeed, alcohol and pharmaceutical drugs represent one of the most problematic areas of substance abuse among women.

The chapter includes a panorama of the patterns of substance abuse among women in Europe, categorized by illicit drugs, alcohol and pharmaceutical drugs. The chapter subsequently mentions the most common problems associated with substance misuse in women: mental health and dual diagnosis, and risk behaviours for infections, both linked to intravenous drug use and to unprotected sex. The latter is typically associated with problematic drug use in women and sometimes sex work.

A specific paragraph is dedicated to pregnancy and maternity, and the dynamics between drug abuse and treatment, including substitution treatment.

The social and environmental aspects related to substance abuse (education, social settings, access to housing and the job market) are also placed into consideration. Gender violence often plays a major role on the onset of substance use and in the development of patterns of problematic drug use. Finally, women in prison and in the criminal justice system tend to have or to develop specific problems with drug abuse, which need to be taken into consideration within the criminal justice context.

1.1.Substance abuse

1.1.1Illicit drugs

Data from the European Union confirm a global outlook whereby male drug users out-number women drug users by far. The phenomenon is also more common among men than women European countries as well. Nevertheless, some national research studies suggest that the gender gap may be narrowing in a few countries, at least in the case of some types of drug use (EMCDDA 2006a).

1- "Problem drug use" is defined by the EMCDDA as "injecting drug use, the long-term or regular use of opioids, cocaine and/or amphetamines". This definition specifically includes regular or long-term use of prescribed opioids such as methadone, though it doesn't include their infrequent or irregular use, nor does it include the use of ecstasy or cannabis. As a reaction to the growing stimulants-use problem in addition to the growing number of cannabis-related treatment demands, EMCDDA is currently re-examining possible breakdowns according to the specific drug. The most effective way of estimating the population of regular cannabis users is also being considered.

It is difficult to study trends in drug use within a gender perspective. An attempt done by the EMCDDA in 2006 (EMCDDA, 2006a) showed that, for example, for cannabis use and binge drinking, differences in drug use between men and women are substantially narrowed in many European regions, at times showing an almost equal consumption between the genders. Another trend identified by the EMCDDA (based on school surveys in Europe) demonstrated a higher proportion of female students using tranquillisers or sedatives without a doctor’s prescription compared to male students.

Patterns of drug use based on gender differences are demonstrated by the percentage of patients entering treatment services in Europe. Most of the care provided by drug treatment services is for opiate, cocaine and cannabis problems for male clients, outnumbering by far their female counterparts. The percentage of women patients is around 20% (EMCDDA 2005). Research suggests that the overall percentage women drug users accessing treatment is lower than that of men: Perhaps the data highlights the fact that women still face more barriers than men in accessing treatment, a concern that should to be taken into consideration[2]. Overall available data from European treatment centres in 2004 suggest that males outnumber females by a ratio of 4 to 1 among the drug patients requesting treatment for the first time. The gender ratio in 2004 was of 1 women for every 3.6 men for new drug patients, and 1 female for every 4.3 men for all clients in terms of outpatient treatment (EMCDDA 2006a).

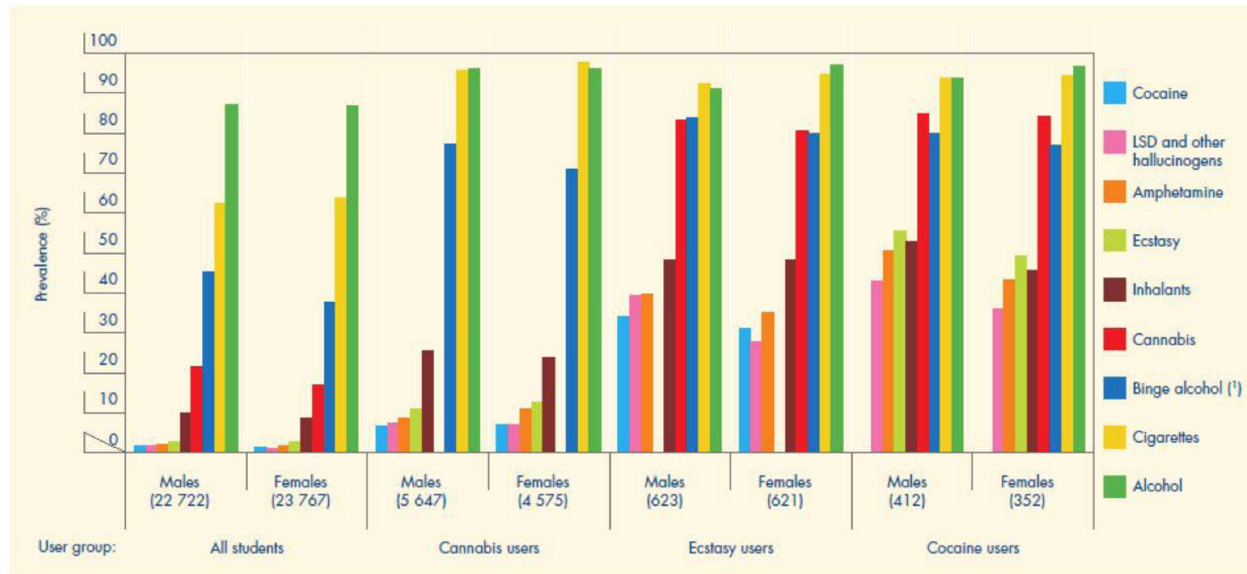
Among those receiving drug treatment in Europe, the percentages are highest among the youth (those under 20 years old), with problems relating to amphetamine-type stimulant drugs (ATS). Female percentages are also highest among older patients (over 39 years old) with problems relating to the use of sedatives or pharmaceutical drugs (EMCDDA 2005).

With reference to intravenous drug use (IDU), the WHO reported a rapid increase in recent years of the portion of female IDUs, especially in Eastern Europe and Asia (IHRD 2007). According to available epidemiological data, women are more likely than men to abuse and become dependant on substances such as tranquillizers and sedatives when used without prescriptions (Simoni-Wastila et. al, 2004).

Research has also shown that women typically become dependent on substances more quickly than men, such as cannabis, cocaine and other stimulants, as well as opioids, inhalants and hallucinogens (UNODC 2004).

2- Studies indicate that women encounter multiple barriers to treatment access, have more severe problems at treatment entry, and are more likely to seek treatment for their substance use problems in mental health facilities than in substance abuse treatment settings (Lynch et al., 2002).

A glance at substance use among 15- to 16-year-old students in 15 European countries, categorized by the type of drug user and by gender.



(¹) Binge drinking is defined as consuming five or more drinks in a row.
NB: User groups are defined as those who have lifetime experience of the substance. Total numbers for the 15 ESPAD countries are given in brackets.
Lifetime prevalence rates are the average for 15 countries (Germany, Greece, France, Italy, Lithuania, Hungary, Malta, the Netherlands, Slovenia, Slovakia, Finland, Sweden and the United Kingdom together with Norway and Croatia, where ESPAD experts provided individual drug use data).

1.1.2 Alcohol

Europe is the continent where alcohol consumption is the highest in the world: 75% of EU citizens declared to have drunk alcoholic beverages during the past year (Eurobarometer, 2007). A slight increase of alcohol consumption in the European Union was registered between 2003 and 2006. While examining 15 countries in the European Union, six percent more people surveyed in 2006 admitted to having consumed alcoholic beverages within the previous month as opposed to those surveyed in 2003 (Eurobarometer, 2007).

National data regarding alcohol consumption vary between the European countries. At the top of the list is Ireland, where 36% of the people surveyed declared drinking 3-4 drinks in one occasion and a further 34% declared drinking 5 drinks or more. At the other end of this list, 25% of Bulgarians and around a fifth of Germans (19%), Latvians (18%), Lithuanians (18%), Cypriots (18%), Italians (17%) and Luxembourgers (17%) reported to have consumed less than one alcoholic beverage per day (Eurobarometer, 2007).

Generally speaking, men drink more alcohol than women do. A higher number of women than men report drinking less than one or two drinks on one occasion; however higher number of men than women declare drinking 3-4 or more than 4 drinks on a given occasion.

National socio-demographic results in terms of gender follow the overall country trends. In countries where the general amount of alcohol consumption is lower, such as in Italy (17% drank less than one drink; 71% 1-2 drinks) or in Portugal (14% drank less than one drink; 69% 1-2 drinks), a higher share of both male and female respondents claimed to drink a maximum 2 drinks. On the other hand, in Ireland where the amount of alcohol usually consumed on one occasion is high (36% claimed to drink 3-4 drinks and further 34% more than 4 drinks), figures for both gender are high as well (Eurobarometer, 2007).

With respect to **"binge drinking"**[3], men drink more on one occasion and do so more often than women do; 41% of women claimed to never have drunk as much, whereas this is only the case for 22% of men. National gender related figures follow again the overall country results. Taking the two extreme examples, in Portugal 55% (46% of men and 68% of women) reported to never have drunk 5 or more drinks, while in Ireland only 11% did so (7% of men and 16% of women, Eurobarometer, 2007).

An EMCDDA gender perspective report underlines that male predominance in general is lower in those countries where the prevalence of binge drinking is highest. The gender differential of intensive alcohol use ranges from a 1 to 1 ratio in Ireland, the United Kingdom and Norway, to a 2.3 to 1 ratio in Poland, largely similar to the ratios for cannabis use. The gender correlation with respect to cannabis use and binge drinking increases proportionally according to the increased use of those substances (EMCDDA, 2006a).

Other studies show that in recent years risky alcohol consumption has increased among young girls and adolescents. Most countries show a rise in binge-drinking for boys from 1995 to 2003, and nearly all countries demonstrate this trend for girls as well. Generally speaking a rise in binge-drinking and drunkenness across most of the European Union is correlated to these trends. (Anderson and Baumberg, 2006).

The trend indicates that a large number of female consumers are exposed to alcohol-related damages. Indeed, the female population present a greater physiological sensitivity and vulnerability to alcohol with respect to males, especially when taking into account female physiological conditions such as menstruation, pregnancy and breast-feeding (O.N.Da, 2008).

3- Binge drinking is defined as a dangerous practice of consuming large quantities of alcoholic beverages in a single session. In particular, experts agree that binge drinking is when one consumes 5 or more alcoholic drinks within a couple of hours.

The recommended drinking levels for women are lower than those for men. The reason for this is that women are at greater risk than men to develop alcohol-related problems. Alcohol passes through the digestive tract and is diffused into the bodily fluids. The more available water in the body, the more the alcohol is diffused. Men weigh more than women do, while women have less bodily fluids than men. A woman's brain and other organs are thereby exposed to more alcohol and to its toxic by-products. Drinking more than one drink per day can increase the women's risk for motor vehicle accidents and related injuries, high blood pressure, stroke, violence, sexual assaults, suicide and certain types of cancer (NIAAA, 2008).

1.1.3 Pharmaceutical drugs

Prescription substances bring improvements in health and quality of life when used under a doctor's direction. Patients who have taken some of these medications on a long-term basis, abuse their prescriptions or buy these medications for non-medical reasons can experience changes in brain activity, leading to addiction.

Common prescription substances which lead to addiction include opioids (often prescribed to treat pain, including oxycodone, propoxyphene, hydrocodone, hydromorphone, meperidine, and diphenoxylate), central nervous system depressants, often prescribed to treat anxiety and sleep disorders (such as the barbiturates pentobarbital sodium, and the benzodiazepines diazepam and alprazolam), stimulants prescribed to treat narcolepsy, attention-deficit hyperactivity disorder, and pharmaceuticals used to treat obesity, such as dextroamphetamine and methylphenidate.

As in American literature, several European studies suggest that women are more likely than men to be prescribed a drug that can be abused (in some cases up to twice the number of men). This is especially the case with opioids and depressants for the central nervous system. Sleeping and anti-anxiety drug abuse are less visible than other, more common forms of addiction among women (PNS, 2008; Stocco, 2000). It is important to note that a lifetime prevalence of the use of benzodiazepines without a medical prescription (for sleeping or anxiety problems) among school students between the ages of 15 and 16 is markedly higher in females than in males in most of the EU data (EMCDDA, 2006a).

Children, adolescents and some adults with attention-deficit hyperactivity disorder (ADHD) are being treated with methylphenidate (MPH; Ritalin, Concerta, Metadate, or Methylin). The use of these drugs has been controversial because of their potential for abuse and addiction, as they bear pharmacological similarities to cocaine and amphetamines. The increased coercive use of medications by some school systems has also been controversial (Lakhan, Hagger-Johnson 2007; Oullette 1991). Abuse of these prescribed drugs is common amongst students wishing to enhance their mental abilities, improve their concentration and help them to study. Those who use it to stay awake longer in a recreational context do so by taking it orally, while intranasal

and intravenous uses are the preferred means for inducing euphoria.

Increased alcohol consumption is also frequent when misusing stimulants, causing additional negative health effects.

Research has shown increased prescription drug abuse and addiction in women, a high co-occurrence with disorders relating to substance abuse, and underutilisation of substance abuse treatment services (McCabe SE, Cranford JA, West BT, 2008). Instead of asking for specific drug treatment, women tend to trust health professionals who aren't necessarily aware of their problem (NIDA, 2005).

Other sources of easy access drugs for women are non-prescription drugs, such as cough and cold medicines containing dextromethorphan (OTC - Over The Counter medications), which can also be abused (in high dosages the drug acts as a dissociative hallucinogen). A new marketplace has emerged in internet that offers -among other products - several herbal smoking blends sold as "room incense" that are actually "spice" alternatives similar to cannabis when smoked (EMCDDA, 2009; NIDA, 2005).

1.2 Other issues

1.2.1 Mental health and dual diagnosis

There is a high percentage of women substance users who suffer from mental disorders. This specific type of diagnostic co-morbidity is called dual diagnosis. This specific type of diagnostic comorbidity, called Dual Diagnosis was defined as the co-existence, in one and the same subject, of a disorder related to psychoactive substance abuse and another psychiatric disorder (World Health Organization, WHO, 1995). As far as addiction is concerned, co-morbidity refers to the co-presence of a serious mental disorder and a disorder caused by substance abuse/dependence (De Leon, 1989; Buckley, Brady, Hermann, 2010; Bobes, Casas, Szerman, 2009). Personality disorders and other types of mental illness that may have "severe disabling evolution" are also being included in recent reports dealing with "severe mental illness" and dual diagnosis.

There is a higher rate of dual diagnosis present in women than in men, particularly in affective and anxiety disorders. The same is true for personality disorders (mostly Cluster B), posttraumatic stress disorder, suicide attempts and eating behaviour disorders. Schizophrenia and other psychotic symptoms are also frequent in women (Stocco et al., 2000, Instituto de la Mujer, 2007).

Affective disorders (especially depression, moodiness and low self-esteem, loss of interest or pleasure in enjoyable activities) and anxiety disorders (excessive anxiety with physical and emotional effects such as apprehension, nervousness or fear) are common and significant pathologies to be treated in addicted women. Both disorders develop disabling conditions which adversely affect the individual's family, work or school life,

sleeping and eating habits, and general health, as well as increasing the risk of suicide.

Personality disorders are defined as "an enduring pattern of inner experiences and behaviours that deviate markedly from the expectations of the culture of the individual who exhibits it". This pattern can result in the person adopting maladaptive coping skills, which may lead to personal problems and social disruption. Addicted women have frequent co-morbidity with personality disorders, which also increases the risk of suicide (DSM-IV; Instituto de la Mujer, 2007).

Posttraumatic stress disorder is characterised by intrusive thoughts, nightmares and flashbacks of past traumatic events, avoidance of reminders of trauma, hyper-vigilance and sleep disturbances, all of which lead to considerable social, occupational, and interpersonal dysfunction. The diagnosis is found in the subset of people who have experienced trauma who are unable to cope with the consequences of trauma and whose well-being over time is greatly impacted by these consequences. Trauma exposure has been associated with physical illness (body mass index, etc) but also psychiatric co-morbidity (substance abuse is two to four times more prevalent in these patients). Sexual assault is the most frequent type of trauma experienced by women, but all different kinds of abuse are suffered by women before or during drug addiction. Overall, women are four times more likely to develop this disorder than men, after exposure to traumatic events (Ciechanowski, 2010; Instituto de la Mujer, 2007)

A lifetime prevalence of eating disorders (such as anorexia and bulimia) is estimated to be higher in women than in men. Among the women misusing substances, the prevalence of these disorders seems to be greater. In addicted women, many eating disorders are thought to be behavioural patterns stemming from emotional conflicts that need to be resolved in order to develop a healthy relationship between patient and food. These are serious mental illnesses with a high incidence of co-morbidity and also with a high mortality rate among all psychiatric disorders (Charles & Pull, 2004).

Causes for the high co-morbidity between substance misuse and mental health issues are not known and prevalence varies between country populations. Etiological theories in dual diagnosis include factors that are common to both disorders: a substance use disorder secondary to mental illness; a mental illness secondary to substance use, and bidirectional models.

Women have more difficulties than men with treatments for dual pathologies, arising from difficulties related to drug addiction and mental illness. Drug addiction damage in a woman's body occurs earlier and more intensely than in men. Women seek treatment later than men, and addiction treatments are often not ready to deal with dual diagnosis cases. In addition to this, women with mental illness usually suffer some degree of impaired cognition. This makes them feel embarrassed, and contributes to a lack of compliance, and to difficulties with changing their lifestyle. Moreover, these women don't seek specific services; they usually prefer

to see general practitioners. Women typically don’t ask for mental or addiction treatments, or for social help. As a result, doctors that are unprepared in these cases may delay assistance (Instituto de la Mujer, 2007).

1.2.2 Risk behaviour for infections (IDU and sexual health)

Drug use, particularly intravenous drug use (IDU) remains one of the major risk factors for acquiring blood-borne infections for both men and women. In the case of women intravenous drug users, the IDU stigma is coupled by gender discrimination. These factors combined can push women into behaviours that increase their risk of HIV and other infections. This chapter provides explanations and some examples of the increased vulnerability of women to infections, both through intravenous drug use and through sexual intercourse.

With reference to the risk of infections related to sharing needles and other drug paraphernalia, research indicates that a significant number of women begin using/injecting drugs in the context of a sexual relationship. Women are also more likely than men to borrow or share injection equipment, particularly with their sexual partners. They also often rely on men to acquire and inject them with drugs (Doherty et al. 2000; Vidal-Trecan at al, 1998, Pinkham et al. 2007). Women share needles with more people in their social network than men do (Sherman et al. 2001). This brings to an increased risk for acquiring blood-borne infections, particularly hepatitis C, which is generally very high among intravenous drug users.

Biological and social factors contribute in increasing women drug users’ risks for HIV (see the box below). Overall data available for 25 European countries in 2005 showed that 35% of newly diagnosed cases of HIV were among women, reaching 41% in Eastern Europe, where the epidemic is mainly concentrated among IV drug users (Euro-HIV, 2007). Studies in nine EU countries showed that the average HIV prevalence was more than 50 percent higher among women IV drug users than among their male counterparts (EMCDDA 2006).

Female drug users are not only vulnerable to infections as a result of unsafe IV drug practices; they are often times involved in unsafe sexual activities as well. Women engaged in problematic substance use are more likely to provide sex in exchange for housing, sustenance, and protection, to get involved in sex work, suffer violence from sexual partners and have difficulty insisting that their sexual partners use condoms. All these put them at increased risk for HIV infection.

The correlation of IV drug use, sex work and unsafe sexual practices has significantly increased the risk of HIV infection among women, particularly in parts of the world such as Eastern Europe (UNODC, 2004). Women multiply their special needs as drug users/substance abusers when they become pregnant. Special care for womens’ health and for that of their babies is necessary. The prevention of HIV transmission from the mother to the child is of great concern, in addition to providing support for their motherhood.

Female vulnerability to HIV/AIDS

Females are more than twice as vulnerable as males to HIV infection via sexual transmission. Sexually transmitted infections (STDs) such as syphilis, gonorrhoea, chlamydia, trichomoniasis and herpes can greatly increase the risk of getting infected with HIV. Genital ulcers and the decreased immunity associated with STDs make it easier for HIV to enter into a female body (UNODC 2006).

Females often face problems negotiating safer sex (i.e. the use of condoms) and female drug/substance users are even more disadvantaged as they are often marginalised by society. Women in these cases often experience strong feelings of powerlessness, low levels of self-esteem and self-confidence (UNODC, 2006).

In some parts of the world, there is also a substantial overlap between commercial sex work and drug use. It is estimated that between 20 and 50 percent of women IV drug users in Eastern Europe are involved in sex work (IHRD, 2007).

Sex workers who use drugs, particularly those identified as IV drug users, have reduced earning power and normally attract less clients. They are perceived as being at greater risk for infections. This might lead them to avoid harm reduction and drug treatment sites and services, in order to reduce the stigma associated to being identified as IV drug users. Drug-using sex workers often engage in higher risk forms of sex work. They feel the greater financial pressure imposed by the need to acquire drugs and they often work in the most marginal conditions. These women are seen as undesirable and at risk of infections within brothels and similar establishments (IHRD, 2007).

With reference to specific sexual orientations, the unfavourable and often illegal status of transgender women and women who have sex with women (WSW) reduces access to health care from non-discriminatory providers. Health care providers can give these women care and information appropriate to their needs, thus reducing their risk factors when bargaining for safer sex and clean injecting equipment. There is very limited research on WSW and transgender women who use drugs. However existing evidence suggests that discrimination towards these women puts them at heightened risk of HIV infection (IHRD, 2007).

Risk behaviour for infections needs to be considered not only with reference to HIV, but also so other blood-borne diseases such as Hepatitis C and B. Women are also vulnerable to sexually transmitted diseases, which can also have an impact on their risks of being infected with HIV.

Hepatitis C is the most common infectious disease among IV drug users, since it is transmitted through the sharing of needles, syringes and, unlike HIV, other injection-related equipment (Eurasian Harm Reduction Network, 2007b). There isn't much research available in Europe on the levels of Hepatitis among women drug

users. The EMCDDA reported in 2006 that median sero-prevalence for the hepatitis C virus (HCV) is quite similar in male and female IV drug users: 58.1 % in males and 56.4 % in females. It is generally understood that is more difficult to acquire HCV through sexual transmission than it is to acquire HIV. Infection among IV drug users will therefore be almost exclusively the result of sharing syringes and other injecting paraphernalia (EMCDDA 2006).

While the HIV epidemic is stabilizing overall across the EU, hepatitis C is increasingly prevalent and disproportionately affects drug users (EMCDDA 2009). High rates of sexually transmitted diseases among women drug users have been reported in many European countries, combined with a lack of high quality, affordable STD services. This is likely to increase STD prevalence and to allow STDs to go untreated (IHRD 2007).

1.2.3 Pregnancy and maternity

Family members who live in the same environment as substance abusers are generally impacted upon in a negative way. The negative effects are increased when the substance abusing family member is the mother (EMCDDA, 2009).

Data regarding women and mothers who use drugs in Europe

Each year there may be up to 30,000 pregnant opioid-using women in Europe. The number of pregnant women with other drug problems may be similarly high. In the United Kingdom alone, it is estimated that there are between 250,000 and 350,000 children of problem drug users — about one for every problem drug user. Many of these women are reluctant to seek care, fearing negative judgement or unfriendly responses from service staff. Research reports point to the need for specialised, supportive and services respecting the anonymity of drug-using mothers. However it is important to recognise that pregnancy and motherhood can be strong motivating forces to help women face up to and overcome their drug problems (EMCDDA, 2009).

Data from British studies in 2000 found that over 90% of women drug users presenting themselves to the respective institutions were of childbearing age (Clarke & Formby, 2000).

In Europe, women are relatively overrepresented among drug users living with children: the male-female gender ratio among the drug treatment population as a whole is 3.6 to 1, compared with a male-female gender ratio among drug clients living with children, which is of 1.1 to 1. As in the general population, women are the main providers of childcare among drug users.

Women drug users who become **pregnant** form an additional sub-group requiring specific attention and

care, both for them and for their babies (EMCDDA 2006a). Drug use is associated with direct and indirect complications throughout pregnancy, postnatal morbidity and developmental delays (Hunter and Powis 1996).

Effects of licit substances consumption during pregnancy

Alcohol consumption during pregnancy is highly toxic. Prenatal exposure to alcohol is often correlated with cognitive deficits that appear in childhood, such as reduction in general cognitive functioning and deficits in learning abilities, such as verbal learning, spatial memory, logic, reaction time, balance, and other cognitive and motor skills (Anderson and Baumberg, 2006). Even though these deficits are strictly found in children with Foetal Alcohol Syndrome (FAS), children with pre-natal exposure to lower levels of alcohol can show analogous problems. Indeed there is some evidence that alcohol, even when consumed at low quantities (particularly during the first trimester of pregnancy) can increase the risk of spontaneous abortion, low birth weight, pre-mature birth and intra-uterine growth retardation. There is also some evidence indicating that alcohol may reduce milk production in breastfeeding mothers (Anderson and Baumberg, 2006).

Taking **benzodiazepines** near the time of delivery can cause withdrawal symptoms such as not being able to control body temperature, difficulty breathing, muscle weakness, irritability, crying, sleep disturbances, tremors, and jitteriness (OTIS, 2010).

Effect of illicit drugs consumption during pregnancy

Studies performed on the use of **marijuana** during pregnancy indicate unclear results since many women who smoke marijuana also use tobacco and alcohol. Smoking marijuana increases the levels of carbon monoxide and carbon dioxide in the blood, reducing the oxygen supply available to the foetus. Smoking marijuana during pregnancy can increase the chance of miscarriage, low birth-weight, premature births, developmental delays, and behavioural and learning problems.

Cocaine exposure during pregnancy may increase the risk of a spontaneous abortion and cause placental abruption, which can lead to severe bleeding, premature birth and foetal death. Women who use cocaine during their pregnancy have a 25 % increased chance of premature labour. Babies born to mothers who use cocaine throughout their pregnancy may also have smaller heads and retarded growth. Babies who are exposed to cocaine later in pregnancy may be born into addiction and suffer from withdrawal symptoms such as tremors, sleeplessness, muscle spasms, and feeding difficulties.

Heroin use during pregnancy increases the chance of premature birth, low birth weight, breathing difficulties, low blood sugar (hypoglycaemia), bleeding within the brain (intracranial haemorrhage), and infant death. Babies

can also be born addicted to heroin and can suffer from withdrawal symptoms, which include irritability, convulsions, diarrhoea, fever, sleep abnormalities, and joint stiffness. Mothers who inject narcotics are more susceptible to HIV, which can be passed on to their unborn children.

Taking **methamphetamines** during pregnancy can lead to problems similar to those associated with cocaine use. The use of speed can cause the foetus to have less oxygen when breathing, leading to reduced birth weight. Methamphetamines can also increase the likelihood of premature labour, miscarriage, and placental abruption. Babies can be born addicted to methamphetamine and suffer withdrawal symptoms that include tremors, sleeplessness, muscle spasms, and feeding difficulties. Some experts believe that learning difficulties may result as the child gets older. (OTIS, 2010)

Because of stigma and discrimination, substance users might find it difficult to access medical and psychological services. This problem is exacerbated when women become pregnant. On the other hand, pregnant women are typically highly motivated to change their behaviour in order to help their unborn child. If they are attracted to non-stigmatising services, identification and treatment of women who use drugs can decrease maternal drug use during pregnancy. Such interventions can significantly improve the health and social situation of the woman and that of her unborn child's.

The absence of supportive and anonymous antenatal, maternity and drug services can lead to missed opportunities for women seeking to deal with their drug problems. Even when services are caring and supportive, they might risk being underprovided in the specialist knowledge necessary for female drug users.

In conclusion, a drug addiction treatment model that offers extra hospital care and attention for drug-using women and mothers could be very effective. This model would ideally respond to woman who need residential care or home visits enabling them to stay with their children during drug detoxification and rehabilitation (EMCDDA, 2009).

1.2.4 Gender violence: a glance to the situation in Europe

European data estimates that one in five women experiences some form of violence (European Women's Lobby, 2001). In England and Wales alone there were over 1 million female victims of domestic violence between 2009-2010. Every year, over 300,000 women are sexually assaulted and 60,000 women are raped. Overall in the UK, more than one in four women experiences domestic abuse during their lifetime [4].

The link between substance use and gender violence/domestic abuse is complex. There is no reliable evidence of a cause-effect link between the two. However, where problems with substance use exist, domestic abuse is

often present as well. The physical or sexual abuse of women is often perpetrated by a male partner or other male family members. Studies show that women with substance use problems are more likely than men to have experienced physical and/or sexual abuse (UNODC, 2004).

A history of violence can have an impact on a woman’s experience with substance abuse and mental health problems. Women who use substances are also more likely to live in environments where violence or sexual abuse is a common pattern.

According to available research, experience with child abuse also seems to be a factor influencing women’s involvement with substance abuse. An international study (Vogt 1998) found that a significant background variable for female drug addiction is past experience of violence, especially sexual exploitation. A study from Germany shows for example that 50-60 per cent of women addicted to illicit substances other than cannabis were reported to have a history of physical and sexual abuse (Zenker at al. 2003). Some research studies from Italy have shown that about 50 % of young female drug users with anti-social behaviour and one-third of female psychiatric patients are victims of untreated sexual abuse during childhood (Gelinas, 1983; Malacrea, 2006). This figure is relevant if compared with the percentage mentioned above, concerning the fact that one woman in five, that is 20% of the female population in general, experiences some form of violence.

Neglect and abuse in childhood are common trends in the personal backgrounds of many female substance users. These women tend to define their substance use as the best coping mechanism available to them. Parental negligence and lack of attention in addition to the trauma of physical or sexual abuse make women more vulnerable to developing problems with substance abuse. In the absence of adequate support, such conditions can become a descending spiral (EMCDDA, 2009).

Social, physical and psychological deprivations expose women to the influence and exploitation of male partners. Substance use can also drive women into sex work as a source of income (EMCDDA, 2009).

1.2.5 Social and environmental aspects related to substances misuse

Generally speaking, discrimination based on gender within the socio-economical context is still very common in many European countries. Even in equal work conditions, women earn only 76.9% of the gross wage paid to men (on average in the European Union). Women also continue to be responsible for 80% of the housework, even when they work outside the home (European Women’s Lobby, 2001).

A Eurostat report surveying people outside of the labour market reveals that the share of inactive women in the working age population (15–64 years) has declined from 40.5% to 36.7% between 1999 and 2006.

4- Una volta nella vita

Nevertheless, these rates are still much higher than the percentage of inactive men, almost stable at 22% in 2006 (Hardarson, 2007).

There is a greater gender disparity in the socio-economic conditions of problematic substance users than there is in the general population. Studies show that, compared with their male counterparts, women substance users may suffer greatly from a range of problems such as significant difficulties finding employment, a lack of income, little social support, etc. (EMCDDA, 2006a).

Considering an already tough job market for women in general, woman with drug misuse problems find even more difficulties entering the labour market, even after having successfully completed a drug rehabilitation programme. Literature and case studies indicate that women with drug misuse problems have less resources and support than men and need assistance to develop an economic independence, safe housing and a social support networks (UNODC, 2004).

Compared with male drug users in treatment, a higher share of female patients are economically stagnant and unproductive (a group that includes housewives, pensioners and invalids). Unemployment rates are more than 10% higher among female drug users in treatment than among male drug clients (EMCDDA, 2006a). Moreover, living conditions differ between female and male drug consumers: a high proportion of male drug treatment clients live in institutions, whereas a relatively high proportion of female clients live with their children, either with or without a partner (EMCDDA, 2006a).

According to Verster and Solberg, social exclusion and problem drug use are two, very closely interrelated phenomena. Social reintegration can be a possible solution to both (Verster and Solberg, 2003). Moreover, the two authors claim that the social reintegration services in the majority of European countries are provided for a large groups of patients. The patients are not necessarily only drug users, but individuals who need support in entering the labour market.

Quantitative data on social reintegration are available for a small number of countries. The data suggest that social reintegration services have a more limited coverage with respect to treatment programmes. For instance, in Germany, 7,380 slots are available for social reintegration (of which about 4.000 are not only for drug users but for a wide range of socially and economically disadvantaged people), compared to approximately 55,000 slots specifically available for drug treatments.

In conclusion, even if the national and the European drug strategies recognise that social reintegration is an important part of the response to drug use, the actual availability of social reintegration services is still limited throughout Europe (Verster and Solberg, 2003).

1.2.6 Women and criminal justice, women in prison

Drug offences are one of the most common crimes women commit in Europe, with drug-use playing a key role in the offences they committed (UNODC, WHO 2009). Results from European studies in England and Ireland are consistent with findings in international literature. These findings point to a high prevalence of health problems, psychological and psychiatric disorders amongst women in prison, higher than that of male prisoners (Zurhold et al., 2005). Many imprisoned women have a drug problem; research has also shown that rates in problematic drug use are higher among women than among men in prison (Quaker Council for European Affairs, 2007). It is estimated that at least 75% of women arriving in prison have some sort of drug- or alcohol related problem at the time of their arrest (Fowler, 2002; WHO Regional Office for Europe, 2007a).

Recent prison studies in Europe and worldwide confirm that there is widespread drug use inside of prisons and that IV drug use takes place in prison as well, even if at much lower levels than outside of prison (EMCCDA, 2009). According to data collected by EMCDDA, female prisoners in the European Union are more likely to inject drugs than male prisoners (EMCDDA, 2004).

Women drug users in prison: a research conducted in 5 European countries

Between 2003 and 2004 a group of women prisoners in five cities in Europe (Hamburg, Barcelona, Glasgow, Warsaw and Vienna) were interviewed as part of a study aimed at identifying prison drug policies and practices (Zurhold, 2005). The study focused on evaluating which female drug users in prison make use of the available drug services, how they assess these services and the impact that the services had on relapse prevention. The study showed that many of the female prisoners were not serving their first incarceration. Up to 72% of the interviewed women were previously incarcerated, many of them up to four or more times.

With reference to drug use while in prison, 50% of the women interviewed admitted to an ongoing use of illicit drugs during their first weeks in prison. The percentage dropped to 38% within the course of imprisonment. Many women had already participated in various community drug services before their conviction. However, 91% of the respondents had never utilised the available drug and treatment services during their imprisonment. These services include prison medical care and counselling offers, maintenance treatment and in some cases, psychiatric treatment and health education training.

Services related to addressing women's needs, prison release and subsequent professional support can be summarised as follows: only a small percentage of the respondents received a treatment plan, assessing their need for support, initiating the required referrals to drug and treatment services while in prison or after their release. The women generally expressed dissatisfaction with preparation services for their release.

A considerable number of female drug users expected to face multiple problems after their prison release. These women affirmed their need for professional support in order to deal with these problems. At all five

of the study sites, the women stated that they needed support with problems related to drugs and finding employment, in addition to financial and legal problems.

Drug related services in prison are still underdeveloped in many European countries. These services include treatment, particularly harm reduction and preparation for release/aftercare. They are not always available to women prisoners, and when available, they are rarely designed with a gender-sensitive approach.

The European study cited above is consistent with international literature stressing that women drug users in prison possess specific needs. Imprisoned women who are often burdened by drug dependence are also dealing with psychological distress, poor health and a lack of supportive relationships. Hence there is a great need for psycho—educational and skills training for specific interventions, in order to prepare them for community life (Ramsay 2003). Specific treatment should include counselling, vocational preparation, mental health care, self—esteem promotion and drug abuse treatment (Taylor 1996).

The key is to successfully transition from prison to the community. This means not only linking up with community drug services for initiating – or continuing – a care plan related to drug abuse; it means building an overall reintegration plan. Such a reintegration plan should aim at dealing with issues such as housing, financial and emotional stability, the development of vocational and life skills, and providing professional support by social and health services after imprisonment (Parsons and Warner, 2002).

2. Working with women misusing substances: gender sensitive services

We have analysed female trends of substance misuse in Europe with their related problems. This chapter will look into specific and appropriate interventions necessary to deal with the problems. The interventions have been identified by literature and international good practices, with examples and case studies drawn from the exchange visits organised during the course of the project.

We begin by underlining several barriers that women typically face in accessing services related to problematic substance use in Europe. Some examples of these services are harm reduction, care, treatment (residential as well as outpatient and substitution treatment) and social/economic reintegration. We will then consider interventions related to harm and risk reduction, from specific care and treatment for pregnant women to services for women suffering from dual diagnosis, including women within the criminal justice system.

The interventions examined are those which focus on the effects of a variety of problematic substances. We don't wish to dwell on the different types of drug abuse; instead, we'll elaborate on the different types of interventions available for women who use drugs and alcohol and the interventions available for dealing with their effects. We have also prepared a set of recommendations for practitioners and policy makers working with these women. The recommendations are made in this chapter and summarised in chapter 3.

2.1 Barriers to accessing services and gender-responsive services

Men constitute the greatest percentage of those using substances. It comes as no surprise therefore that in many parts of the world, men have far greater representation amongst substance misuse treatment and harm reduction services. Consequently, most of these programmes are not focused on women's needs. Many of these services don't offer spaces or times for women, nor do they take measures to ensure that women are specifically looked after within the program.

Contrary to these circumstances, women patients do indeed experience the need to feel accepted and welcomed by these services providers. The structure and organisation of substance misuse services often create unwanted barriers, inhibiting access to females. Women may find services to be intimidating, alienating, or simply unsupportive (IHRD, 2007). Women may find services to be unattractive when in a male dominated environment. Since women substance users are more likely than other women or male users to have experienced psychological, physical or sexual violence, they have a greater need for safe, non-threatening environments where their problems can be addressed.

Trends regarding drug use must also be taken into consideration when designing gender sensitive services. The EMCDDA cites that if young European females are increasingly likely to experiment with drugs in the same manner as males, then the likely impact on future drug use trends must be determined. The implications for preventative treatment policies and services must also be taken into consideration (EMCDDA, 2006).

A 2002 research from the Home Office in the UK (Becker et al. 2002) identified some of the barriers and gaps in substance misuse services which women were facing, such as the following:

- Lack of childcare facilities
- Stigmatisation and child protection issues
- Lack of women-only services
- Lack of provisions for ethnic minority women
- Poor social support networks
- Weak maternity services
- Negative attitudes from health care professionals

In the **harm reduction** field, many programs have few (if any at all) women outreach workers, perhaps limiting the ability of these programmes to attract women (IRHD, 2007). Recommendations to improve the gender sensitivity of harm reduction services include the need to provide low-threshold syringe access, mobile services, and secondary exchange (see chapter 2.2.). These considerations can results in less stigmatising care for women. Moreover, sexual and reproductive health information and services should be incorporated into harm reduction services. Integrated harm reduction programmes should be provided for sex workers who use drugs (IHRD, 2007). When talking about **treatment**, outpatient services should provide specific spaces or attention to women, particularly to women with children. Services directed towards women should acknowledge that women will often be ashamed of their addiction problems.

With respect to **residential treatment**, several meta-analyses on the effectiveness of women’s substance abuse treatment programmes found better outcomes for women attending women-only treatment (Ashley et al., 2003; Orwin et al., 2001). In particular, women-only services may be more attractive for women with small children, lesbian women, women with a maternal history of drug or alcohol problems and women who have suffered sexual abuse in childhood (Copeland, 1992). These results suggest that gender-sensitive treatment services may attract women who may not have otherwise sought treatment for their substance abuse problems (UNODC, 2004).

Social reintegration is defined as social intervention designed to integrate former or current substance misusers into the social community. Social integration includes measures to deal with housing, **education**

and **employment issues** (including vocational training). Other measures, such as counselling and leisure activities, may also be considered. The EMCDDA 2005 and 2006 annual reports, literature, facts and figures from member states all concur with the following conclusion: the living circumstances of drug users are far more problematic and precarious than those of the general population. The question of social reintegration has therefore been highlighted in the last series of European Action Plans. It was identified as one of the decisive aims meant to improve the health and social status of drug users (EMCDDA, 2005; EMCDDA, 2006).

In general terms, gender sensitive services should be shaped first of all to protect women's health. They should involve women in services and management decisions. They should create women friendly environments, reach out to the most marginalised women, and respect the complex needs of women (including those related to motherhood), plan services and create networks with related service providers (IHRD, 2007; UNODC, 2004; UNAIDS, 2006). There should be a clear recognition of the diversity between men and women, and what the implications are for services addressing these diversities. More attention should be paid on gender mainstreaming within all services.

It is now accepted that understanding gender differences in drug-related behaviours is a critical requirement for developing effective responses. Ensuring fair access to services and sensitivity to gender-specific issues within services are two of the key themes for developing high-quality care in this area (EMCDDA, 2006a).

2.2 Risk behaviour for infections (IDU and sexual health)

Paragraph 1.2.2 illustrated the specific vulnerabilities that women have to infections resulting from risk behaviours while injecting drugs and having sexual intercourse. Risk behaviours linked to both **intravenous drug use** (IDU) and sexuality should be addressed with gender specific approaches.

Women support groups, specialised counselling and women outreach workers can help women drug users to negotiate safer injection practices. Gender-sensitive syringe exchange and outreach can provide women with injection supplies and reduce their reliance on men (IHRD, 2007). Secondary syringe exchange[5] - when a woman obtains and returns syringes through another person who visits a syringe exchange site - can increase access for women who are typically unable to use syringe exchanges directly (Miller, 2001). Tampons, sanitary pads, and other useful women's products (including standard safe injecting kits) can all be provided by harm reduction services. By doing so, services can succeed in attracting and retaining women, making them aware of the programmes that are sensitive to their needs as women drug users (IHRD, 2007). Collaborative

5 - Secondary syringe exchange (SSE) is an organic process by which IDUs distribute syringes to other IDUs (close friends and partners, IDUs living in proximity, people to whom IDUS might sell drugs) and is an important complement to needle and syringe exchange programmes.

relationships between harm reduction programmes and other gender oriented services, such as women's shelters, services related to domestic violence, and rape and domestic violence prevention programmes, can reduce women's vulnerability to their partners (IHRD, 2007).

Peer education and outreach programmes have long been a mainstay of HIV prevention efforts. Peer educators are considered key role players in encouraging behaviour change (AIDS Action Council, 2001). This can be particularly true for special categories of drug users, such as women, young people and prisoners. Outreach through peer intervention can be one of the most effective ways to access hidden populations, such as women using drugs or involved in sex work. Outreach can be an effective way to educate these groups about health risks, provide them with infection prevention materials, and facilitate their access to services. Women peers can also provide emotional and practical support to women accessing services or living with diseases such as HIV/AIDS. Peer workers tend to have life experiences similar to those they are serving, and they are trained to provide peer counselling to women. They serve as role models to women who are learning how to navigate the medical and social services system.

The treatment of women who use drugs reflects society's expectations and beliefs about all women and all drug users. The problems faced by women drug users are often larger-than-life representations of the problems faced by other women or by male drug users. Power imbalances related to gender, a particularly critical point for women drug users involved in sexual activities and sex work, increase women's vulnerability to abuse, especially towards male partners. This vulnerability is coupled by a stigma against women drug users, leaving women with reduced access to harm reduction services, drug treatment, and sexual and reproductive health care.

It is sometimes difficult to identify drug users as **sex workers**, since these women may not want to reveal the fact that they sell sex. However, it is crucial to consider women drug users involvement in sexual activities and sex work in order to address specific sexual and reproductive care interventions. Women who sell sex but do not openly identify themselves as sex workers may avoid settings specifically designed for sex workers. Instead, they may prefer to access local primary health care services or maternal and child health services. Providers should be sensitised and accountable for providing respectful and high-quality services without discriminating those who may be involved in prostitution. Sex workers who are also drug users require additional support , such as access to drug-treatment and harm-reduction programmes (UNAIDS, 2009).

Women involved in prostitution may have partners who are addicted to drugs themselves. They may rely on their partner's earnings to support their addiction. The opportunity for these women to distance themselves from these individuals therefore becomes an important issue. If women don't wish to distance themselves from their partners, it becomes vital to consider the partner's drug treatment needs and factor these needs into any potential care plan. The treatment offered to the partners should be entirely separate from what is offered to women (Home Office, 2007).

From DCDII exchange visits – POW and Health Shop in Nottingham, Women's Point in Venice

The **Prostitution Outreach Work** (**POW**) was created to address the sexual health needs of sex workers in a disadvantaged area of Nottingham city. POW aims to empower disadvantaged people to independently decide and to determine the direction of their lives. POW is organised to provide a drop in service and outreach work for sex workers, addressing in the following specific issues: sexual health (STI, safe sex, condoms), personal safety, dealing with physical and sexual assaults, substance misuse & treatment.

With reference to sexual health, POW provides a complete package of services including STI screening, contraception, smear testing, free condoms, in-house and outreach counselling and support. The service aims at helping sex workers to prevent sexual transmitted infections and diseases, to avoid sexual violence and sexual abuses, to exit from the sex market, if they want to.

The **Health Shop** provides harm reduction services to male and female drug users while promoting patient health. The service is confidential and completely free. It provides information and free materials to individuals while aiming to prevent sexually transmitted diseases, providing STI screening, contraception, smear testing, free condoms, and in-house psychological support. The service also offers advice and support for men based on issues regarding their sexual orientation.

The "**Women's Point (Punto Donna)**", offered by the Venice Drug Service in close alliance with other local services, provides counselling, information and orientation to women with alcohol and drug problems. It gives women easier access to local services such as: psychological counselling service, medical and gynaecological clinic, infective diseases outpatient centre, anti-violence centre, obstetrics-gynaecology hospital department, paediatric clinic, etc. The Women's Point provides free pregnancy testing, condoms and information material.

2.3 Pregnancy and Motherhood

Substance has several effects on women during pregnancy and on the child before and after birth, as underlined in paragraph 1.2.3. Women who misuse substances often face multiple socio-legal-economic problems, which promote stigma and fear about revealing their drug habit to service providers, since they fear that the child may be taken away from them after birth.

The fact that a parent misuses substances does not automatically mean that children are at risk of abuse or neglect. However, assessments must evaluate the impact of the substance misuse on the unborn child and on its welfare and safety. During pregnancy, assessments should be administered through multilateral collaboration, which includes the parents, so that an individualised care plan with counselling and treatment can help to change the problematic behaviour (NHS, 2005).

Early screening for substance abuse in a pregnant woman should be the initial step in a programme which considers the health, social and psychological factors of the pregnant woman and that of her child. Screening methods through tests could be administered by general practitioners or gynaecologists who suspect substance abuse in a pregnant woman. However, when there are no evident symptoms, the most practical screening method is to ask specific questions. This can be done as a routine practice, eventually leading to inquiries concerning the amount of substances consumed. A health care professional can pose questions about lawful substances first, followed by questions concerning illicit drugs (Morse et al., 1997).

The risk factors related to an increased likelihood of chemical addiction include late initiation of prenatal care, multiple missed prenatal visits, a poor obstetrical history, children with neuro-developmental or behavioural problems, children who don't live with the mother, a pattern of drug or alcohol mediated medical problems, substance abuse in a partner or family member, and frequent engagements with law enforcement (Morse at al., 1997).

All health care professionals have the basic skills to identify and refer at-risk women for treatment. Those providing obstetric care however are in a key position to provide screening, early diagnosis, counselling, and the initiation of treatment for women using drugs during pregnancy. Pregnant women and their families benefit from non-judgmental information regarding the maternal and foetal risks of substance use. They also benefit from counselling on the benefits of treatment and what strategies are available for quitting drug use (Chang, 2010).

From DCDII exchange visits – pregnancy diagnosis and referrals

It is essential for community drug services and harm reduction services working with women to get involved in the early diagnosis of pregnant women drug users. Most of the harm reduction services and services for sex workers observed during the exchange visits in Germany, Italy and the UK, such as "High Noon" and "La Strada" (for female and male prostitutes) in Stuttgart, and general drug services such as "SerT" in Milan, provide pregnancy tests and easy referral to medical and social services.

In the low threshold service called **Health Shop** in Nottingham City, pregnancy tests are periodically administered to women accessing the service (this helps in the early screening of eventual pregnancies). In case of pregnancy, women can choose to interrupt or to continue the pregnancy. Whichever the case may be, she can ask for emotional support to help her make a decision.

Kirkby in Ashfield (Nottingham County) has a Women's Alcohol & Drug Service called **WANDS,** which covers the whole area of Nottinghamshire and provides information about sexually transmitted infections, free pregnancy testing, contraception and free access to genital/urinary medications. WANDS makes arrangements

to accompany clients during their visits to other health care services.

Specific and comprehensive antenatal care should be provided to pregnant women with substance misuse problems. Such care may address some of the maternal and neonatal complications of maternal substance use. Examples of this type of care include the identification of co-morbid conditions, such as psychiatric disorders and physical/sexual/emotional abuse, counselling regarding the risks of the substances being used, and testing for sexually transmitted diseases.

Frequent prenatal visits should be scheduled in order to monitor maternal and foetal health and to provide education and support (Chang, 2010). In particular, the gestational period should be confirmed with the establishment of an accurate baseline for following foetal growth, especially if there's evidence of pregnancy complications (eg, growth restriction, third trimester bleeding, maternal withdrawal). The paediatrician should be informed of the possibility of neonatal withdrawal.

The aim pregnancy treatment is to protect women and the pre-born from substance misuse. Often, the issue of treating a pregnant woman who misuses substances raises the issue of whether such treatment should be mandatory. Unfortunately there is little research shedding light on this difficult ethical topic. For those patients who abuse substances but don't suffer from a physiological dependence syndrome, psychosocial approaches are the mainstream forms of treatment: education and motivational talks, CBTs, brief interventions and family therapy, especially with a consuming partner. On the other hand, when women have a physiological addiction syndrome, pharmacological interventions are needed to manage withdrawal symptoms, to support abstinence, to reduce the harms associated and to prevent complications from substance misuse (Lingford-Hughes et al., 2004).

Pharmacological interventions may be used for detoxification or substitution treatment, through the use of prescribed medications administered under supervision. Monitoring for the consumption other substances apart from medical treatment is extremely important, as it is the only way to protect the foetus and to avoid counterproductive health effects. Since high dosage consumers pose a serious risk for the foetus, hospitalization may be necessary.

Treatment for the abuse of licit substances during pregnancy

Women are advised not to drink **alcohol** during pregnancy due to the high risk that it poses on foetal damage (see Chapter 1.2.3). Women withdrawing from alcohol should be detoxified with medications, though prescribed benzodiazepines are recommended for no longer that 10 days (to avoid potential addiction to the medication). Other detoxification methods include nutritional and vitamin supplementation and easy access to appropriate maternal and foetal monitoring (ideally done as an inpatient). The use of pharmacotherapy to maintain abstinence, through the administration of disulfiram, acamprosato, etc., isn't recommended during pregnancy (Lingford-Hughes et al., 2004).

A pregnant woman addicted to **benzodiazepine** should quit using these substances. If withdrawal syndrome occurs, a gradual dose reduction for detoxification should be planned which aims at being drug-free at least 2 weeks before delivery. In the event that high anxiety requires benzodiazepine-treatment, lorazepam may be the safer choice, particularly during the second trimester (Medrano Albéniz et al., 2009).

Treatment for the consumption of illicit drugs during pregnancy

Methadone substitution and maintenance treatment is the appropriate first line intervention for a woman with an **opioid** addiction who is either pregnant or planning on being pregnant. Methadone offers overwhelming advantages compared to non-treatment, such as oral administration, measured dosage, quality control, safety and steady availability. It also provides a unique opportunity to bring women into medical and obstetrical care systems, thereby improving maternal and foetal health. Methadone has not been linked to the development of birth defects; splitting dosages can minimize foetal effects such as neonatal abstinence syndrome. Methadone treatment should be maintained throughout pregnancy and during the intra-partum and postpartum periods (NSW Department of Health, 2006).

Buprenorphine substitution and maintenance treatment is a good alternative to methadone, although there isn't much information available. Buprenorphine could be continuing in patient doing well with it before being pregnant. Methadone or buprenorphine dosages may be adjusted during hormonal changes in pregnancy. If detoxification from these treatments is necessary, the second trimester is the preferred period, due to potential miscarriage risks in first trimester and the risk of premature labour in the third trimester. Potential problems with opioid analgesia during labour should be anticipated (Lingford-Hughes et al 2004).

Prescribed treatment measures for other drugs, such **cannabis, tobacco, cocaine** or for other stimulants aren't elaborated upon in literature for pregnant women. The first line of treatment would be to quit using these substances and to seek psychosocial treatment. Many pharmaceutical substances are contraindicated during pregnancy. However, other pharmaceuticals that aren't recommended during pregnancy should be considered if psychosocial interventions fail and if the overall risk/benefit ratio of using them is worthwhile. For example, nicotine replacement therapy in the form of gum or the trans-dermal patch can be considered for woman who are heavy smokers within their first trimester of pregnancy (Medrano Albéniz et al. 2009).

Mothers should be encouraged to breastfeed safely; mothers misusing substances should either stop taking those substances or stop breastfeeding. Women under methadone treatment during pregnancy can continue breastfeeding since there is a minimal transmission of methadone in breast milk (Chang, 2010). Women should continue breastfeeding after terminating methadone treatment in order to avoid withdrawal syndrome for the baby. Limited information is available on other types of pharmaceutical treatments available during

detoxification and how to help substances misusers maintain abstinence. Finally, breastfeeding should be stopped if contraindicated medications need to be prescribed (Medrano Albéniz et al., 2009).

The prevention of infections: It is particularly important to prevent vertical transmission of blood-borne viruses during labour. Antiretroviral therapy reduces the risk of vertical (mother-to-child) transmission in HIV positive mothers. An elective caesarean section can reduce the risk of perinatal transmission to the infant (NSW Department of Health, 2006).

Only HIV-positive mothers should avoid breastfeeding completely and use formula milk instead. On the other hand, there is no evidence that breastfeeding increases the risk of hepatitis C or B transmission from mother to infant. HCV women should be informed of probable risks and abandon breastfeeding if there is suspicion of blood contamination through cracked, abraded or bleeding nipples. It is extremely important that all infants of HBsAg (hepatitis B surface antigen) positive mothers receive active and passive immunisation within 12 hours after birth in order to prevent transmission (NSW, 2006).

From DCDII exchange visits – WANDS in Nottingham and Lagaya in Stuttgart

A exemplary model of comprehensive prenatal care guidance was found at the "Safer Nottinghamshire Drug and Alcohol Action Team" ("DAAT"), which produces several interesting materials about drug use, women and maternity – see Pregnancy Protocols produced by the Nottinghamshire County in 2005 for examples.

WANDS provides assistance to pregnant women through a Specialist Drug & Alcohol Liaison Midwife. The midwife is able to offer support, advice and information to pregnant women who are using drugs and/or alcohol. The midwife is also able to work with women engaged in drug or alcohol treatment programmes. The programme underlines the importance of providing antenatal and postnatal care of up to six months, therefore ensuring that every woman who is referred is given a tailored care package to meeting the needs of both the mother and the pre-born child. WANDS uses trained workers who are prepared for gender specific issues and makes it a priority to have woman workers on their professional team.

Similar work is done in **LAGAYA** (Women's Addiction Advice Centre) in Stuttgart. A woman who becomes pregnant is referred to a midwife specializing in the complex needs of women. LAGAYA also recognises the need of mothers to be well supported within the community after their discharge, since the increased stress of motherhood can trigger a relapse or an increased consumption of substances.

Multidisciplinary teams of health care providers (including gynaecologists, drug specialists, general practitioners, mental health personnel, etc) and social service providers should work together to participate in and to comprehensively assess the care of mothers and children.

Despite their desire to give birth to healthy babies, be good mothers, and retain custody of children, lack of child care presents the greatest obstacle for women wishing to enter treatment,. Many women do not want to leave their children while they undergo inpatient substance misuse treatment. In fact, studies show that women are more likely to remain and succeed in treatment when they retain custody of their children (UNODC, 2004).

From DCDII exchange visits – JELLA and MARA in Stuttgart and Casa Aurora in Venice

Specific attention is paid to women with substance misuse problems within the services belonging to **LAGAYA** in Stuttgart called **JELLA** and **MARA.** JELLA is an inpatient educational and therapeutic housing service for young ladies between the ages of 14 and 21. MARA offers an outpatient assisted accommodation for homeless women with illicit drug problems or for those in a substitution program. If a woman gets pregnant she can stay until the baby is due and then be resettled to a mother-baby facility. The staff members assist women by accompanying them to doctors' appointments and prenatal health care visits.

In Venice, Italy, the socio-therapeutic community **Casa Aurora** provides a specialised residential therapeutic programme tailored on the needs of pregnant women and mothers with children. Casa Aurora's interventions are directed towards the physical and mental health of the women patients, individual and group psychotherapy, emotional support and vocational training and guidance. Services are also provided for children's needs: special children activities are implemented; special attention is paid to children's health and their psychological development. The service provides networking with educational and recreational facilities in the territory. The focus is on the mother-child relationship, providing specific evaluation on mother-child relationship, and parenting skills thematic workshops for mothers, drug workers and practical external supervision for the equip.

2.4 Dual Diagnosis

High levels of physical and psychological co-morbidity are an issue for women who are addicted to substances (see chapter 1.2.1). In order to properly diagnose these conditions, individuals should be evaluated for the presence of a co-morbid disorder, whether they be in mental health or drug-abuse intervention settings. This can be done through routine screening using a valid, age and gender appropriate tool.

Diagnoses need to distinguish between primary mental disorders and substance-induced conditions. Assessment of the patient's condition and history should identify the temporal relationships between episodes of mental illness and substance abuse, although it isn't easily done. Individuals with dual diagnosis are at higher risk of suicide than those with only a mental health or substance related disorder. They should therefore be purposely evaluated and monitored for this.

Individuals with a dual diagnosis are more likely to be non-compliant towards treatment and have poorer outcomes than those with only a mental health or substance use problem. High rates of under-treatment of one or both conditions have been observed for dual diagnosis patients in several countries. Treatment of the two conditions is often split between settings specializing in either mental health and substance use disorder. This phenomenon contributes to low rates of detection and poor coordination of care (Buckley, 2010).

Women also tend to have a different experiences with substance addiction and treatment with respect to men. All these issues need to be taken into account in the diagnoses and provision of treatment for dual diagnosis women patients. Moreover, gender differences in dual diagnosis are being studied only as of recently and very little specific literature is available as a result.

Most authors and professionals believe that the dual diagnosis treatment should entail simultaneous, integrated treatment aimed at both conditions while under the same care plan. Others maintain that there isn't sufficient evidence to support this theory. While super-specialised units are being developed in the USA, in Europe they are still being considered. The treatment of dual diagnosis entails many difficulties, arising from patient's characteristics, lack of training in staff services and lack of specific, integrated approaches (Asociación Dual,

2010; Ley, 2000; Tiet, 2007).

The primary long term treatment goals for dual diagnoses include reducing psychiatric symptoms, improving involvement at work, in relationships, and in other activities, reducing substance use, and improving quality of life. Since treatment for dual diagnosis can be challenging, a reasonable intermediate goal would be the establishment of stable, appropriate care.

Treatment for dual diagnosis must target motivation, cognition, and social skills issues. These issues can be dealt with through biopsychosocial interventions, including motivational interviewing, cognitive behavioural therapy, and social skills training. Two additional treatment models, assertive community treatment and intensive case management, both provide external support for patients with these deficits. Psychosocial treatments are being investigated as adjunct treatments in managing patients with a dual diagnosis (Buckley, Brady, Hermann, 2010).

From DCDII exchange visits – Women services in Stuttgart

Women services in Stuttgart pay special attention in evaluating alcohol and drug misusers for mental health disorders, including eating disorders. For example, **LAGAYA** is a special women service provider that addresses drug abuse and eating disorders, while proactively working with woman with dual diagnoses. LAGAYA works holistically with woman by providing therapy for psychological, emotional and medical issues, group work and referral to other relevant medical services. A 24 hour therapeutic facility named JELLA is also available for young women in Stuttgart. Young ladies can live there for up two years. At the facility young women learn to live without drugs, return to school and find new goals for their lives. Young women who have been harmed as a result of alcohol or drug use or who have experienced suicide attempts are referred to residential rehabilitation hospitals.

Communication and coordination between services is essential when care is carried out by two or more service providers. Agreement on a common treatment plan and information sharing on clinical status, treatment compliance, substance use, and risk levels can contribute to better results. The clinician who is treating only one of the conditions should closely monitor clinical status and treatment responses for both disorders (Buckley, Brady, Hermann, 2010).

From DCDII exchange visits – Direct Access in Nottingham

The Nottinghamshire DAAT provides a service called **Direct Access** (DA) within the premises of Newark Hospital in Nottinghamshire. Direct Access is provides a good example of coordinated and integrated care, delivering a range of services to support individuals and families with substance misuse issues. The DA is not a gender specific provision; it is defined as a rapid access, community drug treatment and prescription programme. It provides an assessment interview, substitution medication, and direct referral to the Pharmacy and Mental

Health Department at Newark Hospital. DA promptly addresses diagnosed cases of mental health disorders, such as compulsory eating and depression. DA is also in direct contact with the Sexual Health Clinic.

Flexible, minimum and intermediate goals during treatment need to be developed by clinicians and therapeutic results should be assessed on a regular basis. Relapses should be anticipated and treatment should be maintained in spite of them. Patients should be referred to self-help groups for peer support. When available, services that address dual diagnosis may be particularly valuable. It is also imporant to ask women about the problems that they experience with the treatments administered so as to offer more appropriate services and therapeutic methods (Buckley, Brady, Hermann, 2010; Instituto de la Mujer, 2007).

Occasionally, patients with a dual diagnosis may encounter medication-free treatment philosophies in certain substance abuse programs. Patients should nevertheless be educated about the importance of taking medication. Patients and families should be educated about both disorders, the interaction between them, and the options available for treatment. They should be aware of early signs of a crisis or relapse and have a prepared plan of action. Family support and involvement in care can play an important role in achieving better outcomes (Buckley, Brady, Hermann, 2010).

Ideally, there a continuum of care should be provided that allows for the patient's stability with the least intensive and restrictive level of clinical services. During episodes of greater clinical instability or relapse, more intensive levels of care may include intensive outpatient programs, residential, crisis stabilization, and inpatient care (Buckley, Brady, Hermann, 2010).

From DCDII exchange visits – Schwerpunktpraxis in Stuttgart and WANDS in Nottingham

In Germany, the **Schwerpunktpraxis** is a medical and psychosocial treatment centre for drug users where 35% of the clients are women. They have a psychiatrist who can assess organic mental health issues, place people in psychiatric care when required, and also refer them to counselling services such as LAGAYA.

In Nottingham County, **WANDS** is a gender oriented service commissioned and governed by the DAAT for drug and alcohol misuse (particularly on behalf of the NTA in the NHS framework). It's a counselling service implemented by women and for women. The Mental Health Service is one of the services that women use the most, for diverse reasons such as self harm, anxiety, and depression.

2.5 Violence against women and drugs

As seen in chapter 1.2.4, experiences of violence are very common among women substance abusers. In general terms, a series of strategies need to be adopted in order to address gender violence. Such strategies should be integrated with interventions aimed at working on the drug abuse problem. Violence should be prevented by challenging those attitudes and behaviours encouraging it and by intervening early on to prevent the violent episodes from happening. Appropriate levels of support should be provided when violence occurs. Partnership between services should be established to obtain the best possible outcomes for victims and their families.

Some general results on best practices and their effectiveness in addressing violence against women can be drawn from a review of available evaluations, provided by contemporary research available on projects websites (Haider, 2008). A multi-agency, multi-sector approach has been particularly effective in confronting violence against women. It is especially important to establish the following elements: collaboration between police, prosecution and probation officers in the justice sector; partnerships with health and social services sectors, in order to prevent gaps in victim protection and perpetrator responsibility; and to provide comprehensive support for victims of violence.

Legislation and national action plans to prevent and confront violence against women can provide the political attention and the resources to address these issues. Criminalising violence is also effective in changing public perceptions. Awareness and support programmes empowering women and providing them with emotional, legal, and/or financial support are effective in improving women's ability to break up or to renegotiate violent relationships. Training guidelines and seminars are all instrumental in promoting awareness, disseminating information, and improving the practices of agencies who deal with victims of violence.

Sharing information and exchanging best practices across agencies and different countries is key in improving the capacity of organisations to address violence.

From DCDII exchange visits - working with victims of violence in Nottingham and Venice

Women's Aid in Notts County provides housing and protection for female victims of domestic violence. It is based on a holistic approach and offers a set of integrated provisions that meets all needs of women, working in partnership with specialist services and with other relevant agencies in the territory. The range of services offered includes: protective housing, the support of specialists (such as psychiatrics) in facing the complex problems of woman (such as mental health issues etc.), drug treatment if the case, childcare, self-esteem workshops, vocational guidance, education and professional training. The partnership with the Newark Hospital (Mental Health Department and Direct Access service) allows facing health and mental health problems in a proper and integrated way.

Anti-Violence Net (Rete Antiviolenza), Venice

Since 2004 the Venice municipality has promoted and supported the **anti-violence network,** made up by 35 different governmental and non-governmental agencies and organisations, establishing a permanent round table of experts in Venice to discuss how to face and to prevent violence against women and children. The network and round table have produced many workshops and tools for the health and social field operators. Overall however, they are contributing to enrich the local Service's culture by addressing violence against women and children and by sharing information and exchanging best practices across different agencies.

2.6 Social and economical reintegration

There are many challenges in developing effective social reintegration for women in Europe with substance misuse problems or with complex recurring problems involving drug misuse, violence, etc. In general, some of wider gender inequalities in the labour market, such as the under-representation of women in labour policy measures, can be addressed by political intervention. Other matters such as the improvement of flexible working time arrangements allowing for a better work-life balance for women willing to work require the support of policy makers. Several measures are required in order to successfully confront the gender-specific difficulties in the labour market (European Foundation for the Improvement of Living and Working Conditions, 2008).

With reference to rehabilitation programs for drug/substance addiction, social reintegration activities can be options for part of the post-treatment phase. Social reintegration activities focus on training, education and skill development, employment and housing. Issues particularly relevant are education, the development of employment skills, the promotion of income-generating projects, and providing transitional housing. Securing stable housing is often a key focus for women wishing to keep or recuperate custody of their children. Unfortunately, linking drug services with housing services for women is an area where little attention seems to be given.

Assistance may also be necessary in helping women to develop transversal social skills, such as friendship and relationship building, as well as getting access to recreational activities that provide alternatives to substance use. In most European countries, integrated services are provided by the regional and local authorities and NGOs. The primary drawback of these intervention programmes is insufficient funding, particularly within southern and eastern European countries. This trend likely to continue in the future as a result of the economic crisis (EGSSI, 2010).

From DCDII exchange visits – social and economic reintegration in Nottingham

Double Impact (based in Notts County) aims at providing quality social and economic re-integration for drug users and former drug users, helping them to improve their personal, social and work skills. The service provides tier 2 and tier 3 support[6] for those who have drug or alcohol abuse problems and related issues. Double Impact seeks to empower individuals towards transforming themselves and creating choices through quality aftercare service. This includes giving access to education, self-improvement programmes, self-esteem projects, housing, training and employment for people stabilised or recovering from drug use. Help is given to people who are actively seeking employment, have had drug and/or alcohol problems, and want to gain new skills, qualifications and experience to work in the health and social service fields. In order to facilitate women's participation in courses and training, Double Impact organizes and/or pays for childcare services for their children.

2.7 Women and criminal justice, women and prison

Special needs related to women with drug misuse problems in prison have already been identified in chapter 1.8. International organisations, women's organisations and specialised care providers express concern that specific services for women drug users in prison are still under-developed. The same could be said for drug services in general, particularly for harm reduction services which, when present, rarely target specific needs for women.

Tailored treatment programmes may help women to feel safe and supported, owing to their focus on gender-specific issues (Quaker Council for European Affairs, 2007). A gender sensitive approach to women's health care integrates specialised addiction treatment programmes for women in prison (UNODC, 2008). Research has shown that treatment models (particularly prison-based therapeutic communities) are effective for imprisoned women as long as they address sex and violence issues, improve women's self-esteem and develop a positive client-staff relationship. Relapse can and should be prevented through psychological treatment, extensive individual counselling (aimed at building up personal skills) and ongoing care (Zurhold et al. 2005).

Drug treatment for prisoners with substance use problems is widely supported. Substitution treatment should be available for all women in prison with opioid-addiction problems. The progress of substitution treatment programmes in prison should be monitored. This includes developing required staff support measures, with

6 - In the British schema of services, tier 2 services refer to open access services such as Advice & Information, Drop-in Service, Harm Reduction Services. Tier 3 services refer to community services including Community Drug Teams, Drug Addiction Units, and Day Treatment (www.drugscope.irg.uk)

clear guidelines from the start of the programme as per the application and management of substitution treatment, preventing the misuse of the prescribed substitution substances (WHO, 2007a).

Continuity of treatment should be guaranteed to women when entering prison, being released from prison or when being moved into another prison. Individual prisons have difficulty in monitoring success rates since female prisoners are frequently transferred, hence interrupting treatment. Prisons should have a set of clinical protocols as a minimum requirement for the care of women, such as their increased vulnerability to HIV/AIDS infection, their engagements in risk behaviour, and the fact that they often serve short prison sentences.

Services in prison should address the multiple needs of women, such as reproductive health, mental illness, substance use problems and physical and sexual abuse. Clear protocols should be in place to prevent, report and combat sexual violence in prison.

From DCDII exchange visits - supported employment services offered by the DONA LUNA project together with ZORA in Stuttgart

Some of the women supported by **Dona Luna** are released directly from prison to perform community service. The programme’s overall aim is to move women out of drug use and into employment, since the majority of criminal offences are likely to be drug-related issues. Dona Luna works aims at addressing issues relating to employment, drug use and social reintegration, thus helping women to move away from the criminal justice system.

From DCDII exchange visits - women in Bollate Prison in Milan

The female incarceration unit in **Bollate Prison** is based on therapeutic interventions rather than on punitive incarceration. Women can work in prison while receiving full working wages which are deposited directly into their own bank accounts. They are able to work in various workshops run by external cooperative businesses. The women learn new skills; they use their time in prison productively and creatively while nurturing a positive self-esteem. There is also a very warm, welcoming environment for family visits, for male and female prisoners and for the children of the incarcerated women. In fact, women can keep their children in prison up to the age of three.

From DCDII Exchange visits – Women's Group, Probation Service in Mansfield

Employment, training and education are key factors in breaking the cycle of re-offending. Nottinghamshire Probation Area works with offenders to identify and overcome barriers relating to employment, training and education by helping women with the job search, thereby building confidence and self-esteem. Common problems that women face are poor qualifications and training, and lack of life and social skills. In particular, the Probation Service carries out a women's support group called "Women Group", offered to former female offenders who are serving their probation.

"Women Group" allows women to have a social experience among peers, exchange information, compare their own experiences, learn new coping skills and better understand what local resources are available. The group is free and most of the women joining the group have had experiences with drug and alcohol use or have drug/alcohol users in their families. Women discuss common issues, get support from each other and talk about best practices. Two women run the group, one of whom is a probation officer. The group is informal and confidential. The women can continue to participate in the group once their sentence is completed.

3. Recommendations

General recommendations

- Specific training should be provided to promote sensibility towards gender specific issues for all staff members dealing with woman substance misusers.
- Gender mainstreaming should be integrated into all services available for substance misusers. Women specific services should be established when necessary.
- An awareness of the what barriers exist which may prevent women from accessing services is essential in reaching out to those women who remain hidden from services. Outreach should be used in all settings as an instrumental tool of reaching the most hidden populations of women drug/substance users.
- Confidentiality of services is fundamental.
- Women should be involved in the organisation of policies and services destined for drug users and patients.

Combating risk behaviours for infections

- Devise harm reduction services by using a gender-based approach.
- Empower women to adopt safer injecting behaviours by encouraging them to become less dependant on partners who provide injecting devices.
- Combine harm reduction with sex work services.
- Acknowledge the need for HCV prevention and treatment; express a greater level of commitment towards developing programs and strategies addressing HCV and liver diseases.

Pregnancy and maternity

- Provide early screening, antenatal care, and substance misuse treatment during pregnancy (including substitution medication, such as methadone for opioid abusers), harm reduction counselling, specific treatment during labour, postnatal care and breastfeeding information. These are the most important steps to cover in order to provide a good coordinated-integrated healthcare assistance.
- Make treatment available for mothers, in light of the improved treatment outcomes demonstrated by mothers who can keep custody of their children. Child protection measures must also be taken when necessary.
- Provide mother-child specific programmes including psychological and social support for mothers and children, mother-child relationship activities, childcare and network services support, as well a children-friendly environment.

Dual diagnosis

- Train professionals in both the mental health and drug treatment field on the complexity of dual diagnosis and related treatments.
- Monitor the use of prescription drugs in women (particularly anti-anxiety medications), as a result of the high risk of drug addiction and the consequences that are often times undetected by health professionals.
- Health professionals should recognise the various mental illnesses associated with drug misuse (anxiety, depression, eating and posttraumatic disorders, amongst others) due to the high prevalence of dual diagnosis in women.
- Integrated and gender-sensitive treatments can lead to improved outcomes in the dual diagnosis prognosis and treatment.

Social and economic reintegration

- Vocational guidance, education, professional development and skill qualification should be provided when needed, along with gender specific treatment services, aimed at helping women in the social and occupational reintegration phase.
- Ensure that collaborations are in place with services capable of addressing housing, education and skill development issues, according to the needs that be.

Women and the criminal justice system

- Treatment models are effective for imprisoned women as long as they address issues relating to sex and violence, improve women's self-esteem and foster a positive patient-staff relationship. Particularly effective treatment models are those which conduct research on prison-based therapeutic communities.
- Drug substitution treatment for prisoners with substance use problems is widely supported.
- Continuity of treatment should be ensured for women when entering prison, being released from prison or moving into another prison.
- As a minimum requirement, prisons should have a set of clinical protocols addressing the care of women. Prison services should address multiple needs, such as reproductive health, mental illness, substance use problems and physical and sexual abuse. They should also address women's greater vulnerability to HIV/AIDS infection, engagement in risk behaviour, and the fact that women often serve short prison sentences.
- Clear protocols should be implemented to prevent, easily report and combat sexual violence in prison.

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