

IMPLEMENTING A GENDER APPROACH IN DRUG POLICIES: PREVENTION, TREATMENT AND CRIMINAL JUSTICE



Carine Mutatayi, Sarah Morton,
Nadia Robles Soto, Kristín I. Pálsdóttir
and Cristiana Vale Pires

**A handbook for practitioners
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About the authors

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Preface

The Pompidou Group provides a multidisciplinary forum at the wider European level where it is possible for policy makers, professionals and researchers to exchange experiences and information on drug use and drug trafficking. Formed at the suggestion of French President Georges Pompidou in 1971, it became a Council of Europe enlarged partial agreement in 1980 open to countries outside the Council of Europe.

On 16 June 2021, the Committee of Ministers of the Council of Europe adopted the revised Pompidou Group statute that extends its mandate to include addictive behaviours related to licit substances (such as alcohol or tobacco) and new forms of addictions (such as internet gambling and gaming). The new mandate focuses on human rights, while reaffirming the need for a multidisciplinary approach to addressing the drug challenge that can only be tackled effectively if policy, practice and science are linked.

To better reflect both its identity as a Council of Europe entity and its broadened mandate, the Pompidou Group changed its official name from the “Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs” to the “Council of Europe International Co-operation Group on Drugs and Addiction”. As of 2022, it encompasses 41 out of 46 member states of the Council of Europe, Mexico, Morocco and Israel, and the European Commission.

Within the framework of the Pompidou Group work programme, 2019-22, a new activity “Implementing a gender approach in different drug policy areas: from prevention, care and treatment services to law enforcement and the criminal justice system” has been introduced. This activity is a continuation of the work already undertaken by the Pompidou Group towards integrating a gender dimension into drug policy.

In fact, it goes one step further since its objective is the elaboration of a handbook that should contain: a set of principles and practical examples to provide concrete guidance for implementing a gender approach in planning and service delivery on prevention, care and treatment services for the persons who use drugs or are vulnerable regarding drug use; as well as guidance for law enforcement agencies and the criminal justice system on practical integration of gender approaches in their work domain.

It was understood that the handbook should provide a range of perspectives and views with clear indications of the way forward for integrating gender into all aspects of drug policy, and therefore differs from a position paper or policy briefing.

As an international governmental organisation, the nomination of experts in the working group was undertaken by the permanent correspondents of the Pompidou Group, who are senior officials in drug policy and who represent their countries in

the group's activities. Eleven countries (France, Greece, Iceland, Ireland, Italy, Malta, Mexico, North Macedonia, Serbia, Slovenia, Switzerland) were nominated – two more experts joined after further consultation by the Pompidou Group secretariat: one researcher from Portugal and one from the Scottish Trans Alliance/Equality Network, who was invited to review the draft handbook from a trans, including non-binary, perspective. One should note that this was a first attempt by the Pompidou Group secretariat and above all for the authors contributing to the different chapters to be trans-inclusive in their drafting and these efforts were massively appreciated by the Scottish Trans Alliance/Equality Network.

The work was undertaken during the Covid-19 pandemic via 12 video-conferences between March 2020 and October 2021. Before the first video-conference, each nominated expert provided a country report on the integration and implementation of gender in their national drug policy. The working group agreed on a methodology, distribution of tasks and table of contents during the video-conferences on 12 May and 23 June 2020.

Five chapter leaders – Carine Mutatayi (France), Kristín I. Pálsdóttir (Iceland), Sarah Morton (Ireland), Nadia Robles Soto (Mexico), Cristiana Vale Pires (Portugal) – along with two co-drafters per chapter and two reviewers (Marilyn Clark, Malta, and Bidisha Chatterjee, Switzerland) were nominated. One final reviewer contributed to the process (Marie-Claire Van Hout, United Kingdom).

Embracing evidence-based work, this handbook builds on an important corpus of bibliographical references at the intersection of drugs and gender issues, compiled by the authors with a significant contribution from the Observatoire français des drogues et des tendances addictives (OFDT), the French Monitoring Centre on Drugs and Addictions.

In view of the ongoing close collaboration between the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Pompidou Group, it was also decided to invite Linda Montanari, co-ordinator of the European Group on Gender and Drugs recently set up with support from the Pompidou Group, to also review the handbook. This reviewer considered that the handbook represented a big step forward.

The chosen methodology involved discussion, debate and development of the work, led by the chapter leaders, and assisted by the co-drafters, with guidance and feedback from the other participants. Decisions were always taken in a spirit of openness, respect, trust, compromise and common agreement and all drafts were then agreed on with the full group. The lack of opportunity to meet in person was sincerely regretted.

Testimony

Lilly Sofie Ottesen,
former Pompidou Group Chair

Over the years, men have dominated the seats of the permanent correspondents of the Pompidou Group,¹ including the seat of the chair and the seat of the president of the group. However, in recent years, we have seen more women correspondents, two female chairs and even two female presidents.

What is the reason behind these numbers? Does it indicate that men are more interested in drug policy than women? Not necessarily. In my view, the history of low numbers of women correspondents and presidents is mainly linked to a more general issue – the fact that in the past and still today, fewer women than men hold leading positions in most fields.

What has brought about the change we have seen? Well, the obvious answer is that it reflects a more general trend that we have seen in more and more countries, and in more and more fields, as regards female participation and leadership.

Could there be other factors? Could the change be partly connected to changes in the drug policy field itself? Over the years, we have seen the policy field shift from a strong focus on law enforcement measures to a broader focus where human rights and public health play more central roles. Are women more interested in these angles and perspectives than in the law enforcement perspective? I think the answer could be yes, to some extent. I do not know the statistics in Europe at large, but at least in Norway the ratio of men working in the Ministry of Justice is higher than the ratio of men working in the Ministry of Health, an indication of this divergence in interest.

Now, if that is the case, more questions – which I am not able to answer in full – emerge; why is this so? Why are women more interested in human rights and health? And furthermore – does it matter? Does it matter if there is a gender imbalance at the Ministry of Justice or at the Ministry of Health? Or if the chair of the permanent correspondents is always a man?

To me, the answer is yes. It matters, because diversity in gender, as well as diversity in age, profession, where you are from and so on, brings about different experiences, and different perspectives, which again leads to a better debate, and to better solutions. Having said that, it is not my intention to advocate strong measures to ensure

1. Permanent correspondents are senior officials in drug policy nominated by the 42 member states of the Pompidou Group. Their committee is the Pompidou Group's decision-making body between ministerial conferences. The ministerial conference brings together the relevant political authorities of its members every four years: it defines the strategic direction and priorities of the Pompidou Group for the following four years, adopts a corresponding pluri-annual work programme and elects the president and vice-president.

perfect gender balance and a completely even distribution of age in every group, work place or institution. However, we must acknowledge the fact that if we surround ourselves with people with the same experiences as ourselves only, then we run the risk of not seeing all the relevant perspectives.

When raising my voice in different forums to state that we need to consider a gender perspective when developing measures in different policy fields, I have sometimes met with resistance. More often than not, the resistance is founded on the misunderstanding that what I want is to focus on the differences between the genders, or that I claim that all women have the same needs and that all men share the same characteristics. This is of course not what I believe. Sometimes all women need something that men do not and vice versa, and sometimes a majority of women and a minority of men share the same characteristic, but very often such use of gender grouping would be discriminatory. Not only because all women do not have the same needs, and all men are not the same, but also because considering just the two genders, men and women, could have a discriminatory effect, as we also need to take into account broader gender diversity.

Against this backdrop, I have learned that I need to not only say that a gender perspective is important, I also need to show why and how I think it should be included.

So, why is it that we need to consider a gender perspective when we develop measures for people who use drugs? Or for any other target group, for that matter? In my view, considering gender for different groups can be a tool that, used wisely, helps us broaden our horizons and develop better policies and measures.

If we do not take gender, age, profession and other elements in a person's background into account, we might not be able to develop measures in a way that will meet that person's needs. All persons of the same gender or age should of course not be offered the same measures; my point is merely that by breaking the target group into subgroups, and maybe into sub-subgroups, we are reminded that there may be differing needs within the target group. Gender, socio-economic status, age and so on can all shed light on not only why a person has a drug problem, but also what it would take for that person to get rid of their problems. What do they need, in addition to quitting drugs?

In conclusion: looking at groups should not be a straitjacket, but done wisely it can guide us, as it reminds us that if we set up measures targeted at the average person who uses drugs, we risk missing them all.

Lilly Sofie Ottesen (NO)

Former Chair of the Permanent Correspondents (2015-18)

Introduction – Improving gender sensitivity within drug policy

Authors: Carine Mutatayi, Sarah Morton, Kristín I. Pálsdóttir

Purpose of the handbook

This handbook provides policy makers and practitioners in the drug field with evidence-based and operational recommendations to develop and implement policies and interventions that better integrate specific gender needs (gender-sensitive approach) and support more gender equity (gender-transformative approach) for people concerned with the provision of drug-related prevention and care (risk and harm reduction, treatment, reintegration), including in the criminal justice system.

Faithful to the principle of the Pompidou Group in ensuring a link between research, policy and practice and a focus on human rights, this handbook first explores theoretical views about gender and drug policy, draws on available scientific knowledge and presents recommendations and examples for practice. It is based on extensive debate and a consensus of experts from 13 countries and various professional backgrounds, for cross-cultural relevance.

The handbook explores the complex areas of drug policies and gender that challenge our modern societies, animating lively debates, especially with the rise of feminist and lesbian, gay, bisexual, transgender, queer/questioning, intersex + (LGBTQI+) movements in recent years. It was therefore essential for its authors to offer, in the glossary, definitions related to these two domains and, in this introduction, to explain the gender-related notions addressed.

Authors agreed on language conventions for a better integration of the multiple aspects of drug and gender issues and the most comprehensive argumentation possible within the multifaceted dimensions of their field.

- ▶ Here the term “drugs” refers to illicit drugs and may encompass licit psychoactive substances, including alcohol, tobacco and misused psychotropic medicines. In this handbook, all these licit and illicit substances are addressed.
- ▶ Person-centred formulations, such as “women who use drugs” or “women who are in prison” will be preferred to generic designations (drug users, inmates, etc.), according to best practice language promoted by the International Network of People Who Use Drugs.

- ▶ As specified in the glossary, “gender” refers to “socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men”, according to Article 3c of the Istanbul Convention (Council of Europe 2011).
- ▶ “Transgender” (or “trans”) is an umbrella term for a diverse range of people whose gender identity does not correspond to their at-birth sex designation. This includes trans women, who identify as women but were designated as male at birth; trans men, who identify as men but were designated as female at birth; and non-binary people. A non-binary person is someone who identifies “as either having a gender which is in-between or beyond the two categories of ‘man’ and ‘woman’, as fluctuating between ‘man’ and ‘woman’, or as having no gender, either permanently or some of the time” (Valentine 2016). They may have been designated male, or designated female, at birth.
- ▶ The terms “men”, “women” and “trans people” (including trans women or trans men) are used in this handbook independently of any consideration of age, so women may include girls and men may include boys.

Most of the evidence relating to gender and drugs that forms the basis of the analysis and recommendations of this report relates exclusively to women, or the differences between men and women. As such, the focus of this report and its recommendations are largely on gender-sensitive and gender-transformative approaches that centre women. However, we recognise that for a truly gender-transformative approach, policy and practice needs to be able to account for greater gender diversity, addressing the needs of all people of marginalised genders (see the Women’s Funding Network website).² As such, where possible we will also include and integrate evidence relating to trans people of all genders. The handbook focuses on gender, and not on sexual orientation. While we know that people of all genders who have non-heterosexual or fluid sexual orientations have increased risk factors for drug use, adverse outcomes and (being victims of) violence, these issues are not specifically addressed by the recommendations proposed here.

This introduction highlights multidimensional components of the gender-related concepts that are used in this handbook, further developed in the glossary. Then it outlines the rationale for supporting gender-sensitive approaches in drug policies and interventions and the principles that should sustain their development and have sustained the creation of this handbook.

Three core chapters are proposed, the first one being transversal, providing additional insight to foster the following two, respectively dedicated to policy makers and practitioners.

Chapter 1 begins with an overview of existing epidemiological evidence on gender-based differences in drug use and related consequences. To draw this picture, we refer to data available at the international level, privileging United Nations, World Health Organization (WHO) and EMCDDA sources, taking into account the lack of gender-disaggregated data with regard to some drug and health indicators, especially concerning trans people. Secondly, with a special

2. Available at www.womensfundingnetwork.org, accessed 22 January 2022.

focus on the European situation, Chapter 1 synthesises how gender specificities are taken into account in drug policies and interventions.

Chapter 2 outlines why it is important that a gender-sensitive approach gains traction within drug policies and accordingly sets forth recommendations, key components and processes for decision makers.

Chapter 3 addresses practitioners working in the fields of drug prevention, harm reduction, treatment and the criminal justice system. It aims to reinforce their knowledge on evidence-based practice and to highlight leveraging opportunities to develop gender-sensitive missions and work approaches. Illustrative evaluated examples of gender-sensitive or gender-transformative experiences are provided in an annex.

Attributes of a gender-based approach

Gender is addressed as a bio-psycho-socio-cultural construct that interacts with, but is distinct from, the biological categories of males and females. Traditionally, these aspects have been considered through the lens of a binary categorisation of man or woman that reflects the mainstreamed social norms assigned to each group regarding their social relationships (Hurtig and Pichevin 1986; Manandhar et al. 2018; Mead 1950; Oakley 1972; Schmidt et al. 2018). These biological and social roles and representations vary across time, social class and culture but are historically based on different levels of power and a hierarchy favourable to men.

Gender has emerged as “both a personal, assumed identity and a socially ascribed identity, and these may line up, or be in conflict” (Macaulay 2020). A person may identify as a gender that does not correspond to their at-birth sex designation. There is considerable diversity in how individuals and groups understand, experience and express gender through the roles they take on, the expectations placed on them, relations with others and the complex ways that gender is institutionalised in society (Abrams 2019; Schmidt et al. 2018). For some people, their gender identity does not fit into the two categories, nor is it static; it exists along a continuum and can change over time.

A gender-based approach in the drug field considers the biological attributes and socially constructed roles, behaviours, expressions and identities of girls, women, boys and men in a given culture at a given time and the ways they influence drug issues in people of all genders. When considering these various expressions of genders and the global conditions of women and trans people of all genders, the need for more adapted and equitable responses in the drug field is obvious. Gender sensitivity and gender transformativity, both further explained in the glossary, support this initiative.

According to WHO’s classification framework, gender-sensitive policies and programmes “consider and acknowledge gender norms, roles and inequalities but take no action to address them” (see glossary). Gender-sensitive (or gender-aware) responses then recognise that, in their sociocultural environment, men and women have differing, and sometimes conflicting, needs, interests and priorities with regard to drug use and related triggers, risks and harms. Such responses target men’s and women’s specific needs, but leave the existing distribution of resources and responsibilities intact.

On the other hand, according to WHO (see glossary), gender-transformative policies and programmes “recognize differences in gender roles, norms and access to resources; and/or actively try to change these, to promote gender equality.” Therefore, gender-transformative (or redistributive) responses formally intend to critically reflect on, question or transform the existing distribution of resources and responsibilities or even institutional practices and broader social norms to create more equitable gender relations and leverages. Gender-transformative “approaches aim to move beyond individual self-improvement among women and toward transforming the power dynamics and structures that serve to reinforce gendered inequalities” (Hillenbrand et al. 2015).

Gender mainstreaming matters

Gender equality is a fundamental human right, but gender inequality persists everywhere and has always been present. Uneven relations between men and women, gender stereotypes and discrimination affect all societies (United Nations 2020a). For many women and girls, inequality starts at birth and unequal gender status affects their lives as it “shapes the contexts in which they evolve” (Covington 2008). Violence and drug-related harms affect women who use drugs in a very specific way (Liquori O’Neil and Lucas 2015; UNODC 2017a).

Throughout the world, from the early 20th century, the responses and societal measures that were defined to address drug and addiction issues have been influenced by a vision of behaviours, patterns of drug use and related criminality that represents men as the major protagonists. This dominant male lens that has coloured drug policies, services and programmes has its roots in inherited social representations fostering the idea that substance use and transgression in general are a “man’s thing” (Belknap 2015; Cardi 2007; Thompson and Gibbs 2016; Vuattoux 2016).

Historically, in all societies, prevailing gender norms have affected drug use patterns among men and women. Because of gender norms, men have been more likely to adopt the social or recreational uses of alcohol and other drugs as a reinforcement of their virility and to enhance their participation and conviviality in public life (Lisansky Gomberg 1982; Lisansky Gomberg, Raskin White and Carpenter 1982; Thomasset 2018). On the other hand, because of the social construction of femininity, women have been assigned to domestic and care domains. Consequently, they have tended to privately use legal, and more socially acceptable, drugs for therapeutic or self-medication purposes (Lisansky Gomberg 1982; Lisansky Gomberg, Raskin White and Carpenter 1982; Romo-Avilés 2018). Women have substantially suffered from addiction to opiates, cocaine and other stimulants, sedatives and antidepressants, when these drugs were legal and medically prescribed (Kandall 2010). The entrance of women into the public domains of life and their growing economic and social autonomy have changed the way women use alcohol and other drugs. It has led them, over the last 100 years, to increasingly use substances in public spaces and for social purposes, while old gender norms continue to prevail in our societies.

In recent decades, men-centred drug responses and policies have also been influenced by official national statistics on drug use and related criminality that have

shown an overrepresentation of men (Alexander 2011; Belknap 2015; EMCDDA 2019a; UNODC 2020b; Vuattoux 2016). Regrettably, the intersection of gender specificities with drug issues has been insufficiently addressed by research in European countries, especially with regard to the specific needs, expectations and motivations of women. Notwithstanding these limitations, research also evidences acute vulnerabilities among women, and indeed trans people of all genders, who use drugs. Chapter 1 describes how data show a close connection between problematic substance use and intimate partner violence, sex for compensation and trauma histories, as well as pregnancy and mothering (Cockroft et al. 2019; Tirado-Muñoz et al. 2018; UNODC 2017a). Transgender people also report high rates of victimisation (bullying and harassment) and violence associated with heavier alcohol and drug use patterns as well as higher suicide risk (Johns et al. 2019; Reisner et al. 2015a).

In international and national policies, gender is generally understood to cover women and girls, although everybody has a gender. Guidance that recognises greater gender diversity, with trans, including non-binary, inclusion is hard to come by (Goldsmith and Hillyard 2019; Schmidt et al. 2018). There is a need for a better inclusion of all genders. Women's drug use is increasing and the percentage of women also rose within the prison population worldwide across the 2010s – except in Europe where their number has decreased by 29% – substantially in relation to drug offences. In spite of such findings, the overall disregard of women's experiences with drug addiction and trafficking calls the rationality of drug policies into question. Few countries:

provide adequate drug-related harm reduction and treatment to women, and virtually all countries need to expand gender-sensitive measures in order to improve the access of imprisoned women to adequate drug treatment and to achieve the highest attainable standard of health for women (INCB 2017; Penal Reform International and Thailand Institute of Justice 2021).

Engaging now in gender sensitivity and transformativity

Within recent research, structural inequality weighing on women provided an ongoing societal backdrop to women's substance use (Morton et al. 2020). This structural inequality is manifested in poverty, lack of access to education, and limited expectations of self-accomplishment and of self-assertion. These structural factors show that developing gender sensitivity in social, economic and health policies, as in drug policies, is inextricably linked to the defence of human rights.

For the last 10 years, the scientific and political spheres have provided growing impetus to better integration of “gender-sensitive” approaches in the conception and implementation of counterdrug responses. New voices are calling for a more modern approach to substance use disorders, putting the emphasis on human rights and dignity, and hence on gender-sensitive and evidence-based approaches (UNODC 2021c; WHO and UNODC 2020). The priority given to the curbing of the impact of drug use on fetuses and children is an early, yet widely recognised and implemented, gendered policy response. It is crucial to take a step forward to strive to reduce health and social inequalities while respecting the right to diversity, dignity and human

rights. More efficient pathways of sustainable recovery, empowerment and social integration of all citizens demand the development of drug responses adapted to the specific needs of segments of the population other than men.

The awareness of the importance of incorporating gender perspectives into national and international drug policies and practices can be traced through policy documents, recognising the lack of gender-sensitive services in the past and the need for better integrating them in the future (Commission on Narcotic Drugs 2012a, 2016; INCB 2017; Liquori O’Neil and Lucas 2015; UN Women 2017). In 1988, a symposium on women and drugs was the first initiative by the Pompidou Group to attempt to integrate a gender dimension into drug policies in Europe. In the last 10 years, the Pompidou Group has intensified its endeavours to promote a gender dimension in drug policies among its member states, with the following publications covering:

- ▶ the gender dimension of the non-medical use of prescription drugs in Europe (Clark 2015);
- ▶ the scientific literature on women, drugs and violence (Benoit, Dambele and Jauffret-Roustide 2015);
- ▶ a consultation of professionals on women, drugs and violence (Benoit and Jauffret-Roustide 2015);
- ▶ a synthesis on violence, women and rape drugs (Pompidou Group 2017).

It is within the framework of the Pompidou Group work programme 2019-22 that a new activity on “Implementing a gender approach in different drug policy areas: from prevention, care and treatment services to law enforcement and the criminal justice system” has been set up, and this handbook is part of this impressive initiative.

The intersection between drug use and gender arises as a relevant lens in the design, implementation and evaluation of gender-sensitive research, interventions and policies in all drug response areas. Globally, significant changes are needed to favour investment in health, even if tangible progress has been made to address all aspects of drug demand reduction, especially in the framework of the United Nations Drug Control Programme (UNDCP)-WHO joint commitment that was reinforced in 2018 (WHO 2018b). For instance, in 2018, only 26% of United Nations Office on Drugs and Crime (UNODC) expenditures were oriented to prevention, treatment, reintegration and alternative development, while 31% of expenditures were focused on countering illicit drug trafficking and transnational organised crime (UNODC 2018c). A gender-sensitive approach in drug prevention would provide good leverage to boost healthy psychosocial life skills and a sense of equity among youth. In the fields of harm and risk reduction and treatment, it would contribute to need-responsive, empowering care. In the criminal justice systems, a gender-sensitive approach would foster sustainable rehabilitation.

In these different areas, gender-sensitive responses are likely to find new ways of taking into account aspirations that may differ from those offered by the traditional roles of mothers, caregivers and guarantors of family respectability, and determined by the satisfaction of men. A relevant gender-sensitive approach

should be able to address not only the harms directly related to drugs and drug use but also the social and cultural determinants of drug use and health and law enforcement policies.

Important underlying considerations for a gender-sensitive approach

To embrace and integrate gender-sensitive and gender-transformative approaches in the drug field, a set of overarching principles need to be accepted. This handbook has drawn on these principles, which require the consideration of decision makers, officials and practitioners who implement drug policies and services. The following are proposed as a shared foundation for a sound, refined, ethical and sustainable approach to promoting gender sensitivity in drug responses.

- ▶ Gender sensitivity should be recognised as a universal principle, relevant for public health and public order objectives, for all citizens. Herein, gender mainstreaming must be acknowledged as a priority approach to designing drug policies and response.
- ▶ People who use drugs encompass heterogeneous groups with varied needs and expectations in relation to their gender, age and social class, and equity requires the enhancement of adapted responses for women and non-binary people.
- ▶ Therefore, the vulnerabilities, opportunities, diversities and inequalities of all genders, together with their respective needs, concerns and experiences, should be assessed and recognised in order to be better addressed.
- ▶ In accordance with human rights and values in healthcare, a gender-sensitive approach must preserve the inviolability of physical and psychological integrity and of human dignity, and must respect the moral, cultural, religious and philosophical convictions of citizens.
- ▶ Gender-sensitive responses are likely to be innovative in line with the modern, non-domestic expectations of women and with the aspirations of self-realisation of women and non-binary people.
- ▶ Target populations and professionals who address them should be given a voice in the implementation of appropriate responses tailored to individual needs.
- ▶ A gender-sensitive approach must be evidence-based and assessed for its potential positive and unintended negative impacts across genders, in order to ensure the highest possible quality of responses. Its impact must be evaluated through the prism of the underpinning gendered and social norms as well as the structural factors of inequity.
- ▶ Integrating gender mainstreaming should be designed and implemented thoroughly to avoid any perverse effect of discrimination and to respect the norm of men and women living together in the world shared by modern societies.

Drawing on and implementing gender-sensitive approaches in drug responses has to do with the political and institutional management of minority identities (Vuattoux 2016). All stakeholders are called on to engage in this process, but they should be aware of potential pitfalls. It is crucial to consider the multifactorial context where drug uses emerge, since structural, social, economic and cultural inequalities and dominant gender norms deeply impact individual and group drug use patterns (Morton et al. 2020).

Current drug policies are driven by strong objectives of rationalisation that favour action addressing the majority population groups with the ambition of universalising laws, policies and action. From this perspective, gender sensitivity of drug policies can be misunderstood in the face of the principle of non-discrimination. Indeed, women and non-binary people must not be profiled nor discriminated as an “inherently vulnerable” population (Wincup 2019). It is therefore essential to raise awareness that the development of gender sensitivity and gender mainstreaming within the drug policy area is based on substantial evidence and has scientific and ethical grounds. This echoes the European Union’s policy on gender equality and women’s empowerment.

Chapter 1

Current evidence on the gender dimension of substance use, related harms and responses

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In our modern societies, drug and alcohol issues and responses have been generally addressed through and for men's considerations. This approach has been enhanced by information systems that, for decades, have shown higher prevalence rates of drug consumption and related adverse outcomes among men and boys, compared to other citizens of the same age. When addressing gender and drugs, research has focused on the differences between men and women in drug use, the reproductive and traditional domestic roles of women (including pregnancy and motherhood), and informal income activities (begging or sex for compensation). However, more recent research and increased awareness on the part of practitioners and civil society organisations (CSOs) have led to a better consideration of the reality of drug issues among women and, to a smaller extent, trans people of all genders who use drugs.

When supporting the development of gender-sensitive and gender-transformative drug policies, it is important to highlight the current situation for different gender groups. This is the aim of this first chapter, which draws a picture of the state of drug use (including alcohol consumption) and its consequences among these groups, according to the available sources. Further, the chapter proposes to summarise how gender specificities are taken into account in drug policies and implemented actions, in the field of prevention, harm reduction and treatment. The legal consequences of drug use, illustrating the responses of criminal justice systems, are discussed in a single specific section.

It is worth noting that this chapter does not aim to be exhaustive concerning the broad areas of drug demand and drug supply reduction as it is primarily intended to present indicators and aspects that support and justify the guidance provided for policy makers and practitioners, in the following chapters, at the heart of this handbook.

Disproportionate drug-related issues among women and trans people

More use and heightened risks are observed in men

Epidemiological surveys consistently show that at all ages, boys and men are more likely to engage in licit or illicit drug use, especially in problematic patterns. Worldwide, nearly 7 in 10 people who use drugs are men (UNODC 2020b).

In 2019, in the vast majority of European countries, boys were more likely than girls to have smoked cigarettes, used e-cigarettes and drunk alcohol early in life, at age 13 or younger (ESPAD Group 2020). In 2020, 16.6% of Europeans aged 15-34 reported using drugs in the last year, with almost twice as many men (21%) as women (12%) (EMCDDA 2020).

Boys and men report higher rates of licit and illicit drug use, in particular for more intensive use. Boys take up habits earlier than girls.

Worldwide, seven out of 10 persons who use drugs and eight out of 10 undergoing drug addiction treatment are men.

Men are 1.5 times more likely to drink alcohol than women and 4.2 times more likely to smoke.

In Europe, three quarters of lethal overdoses involve men.

Across the world, in 2018, men were 1.5 times more likely to drink alcohol than women and 4.2 times more likely to be current tobacco smokers (32.4% versus 5.5% among women) (WHO 2018a, 2019b). In addition, among current users, women consume less of both products than men, with 7.0 litres of pure alcohol per capita consumption (APC) versus 19.4 litres for men in all WHO regions. In the European Union (EU), illicit drug use is mostly reported by men, at any time of life, with 57.8 million men having consumed illegal drugs v. 38.4 million women (EMCDDA 2020). For instance, men are 1.5 times more likely than women to have tried cannabis in their lifetime (47 million versus 31 million), 2.25 times more likely to have tried cocaine (9 million versus 4 million) and 2 times more likely to have tried MDMA (6 million versus 3 million) (EMCDDA 2021c). In general, the same overrepresentation of men is observed for alcohol and tobacco use.

These differences are often accentuated for more intensive or regular patterns of use and are reported over age categories for most psychoactive substances. For instance, almost three quarters of high-risk cannabis users, who declare a daily or almost daily consumption, are boys or men in the EU (EMCDDA 2020). Amphetamines are reported as the substance with the smallest gender gap among patients in specialised health centres, though 26% of clients consulting due to them are women.

The higher rates of drug-related risks and adverse outcomes in the male population are another common statistic. According to 26 sentinel hospitals in 18 European countries, in 2017, 76% of drug-related acute toxicity presentations to emergency departments were men. Late presentation for HIV testing involves 58% of men who inject drugs, and 51% of women who inject drugs on average, between 2000 and 2011 (Mocroft et al. 2013).

In the EU, in 2019, 77% of lethal overdoses involved men (EMCDDA 2021a). The mortality rate due to overdoses is almost four times higher in men than in women in the population aged 15-64 (35.1 cases per million men versus 9.5 cases per million women) (ibid.). In 2016, an estimated 2.3 million deaths and 106.5 million disability-adjusted life-years (DALYs) were attributable to the consumption of alcohol in the male population worldwide versus 0.7 million deaths and 26.1 million DALYs among women (WHO 2018a).

According to the available statistics, nearly 7 in 10 drug users are men and this is even higher among those undertaking drug treatment, that is 8 men out of 10 clients (UNODC 2020b). People entering treatment for problems related to cannabis are predominantly male, with an average ratio of five males to one female (EMCDDA 2020).

The gap in drug use between women and men is narrowing

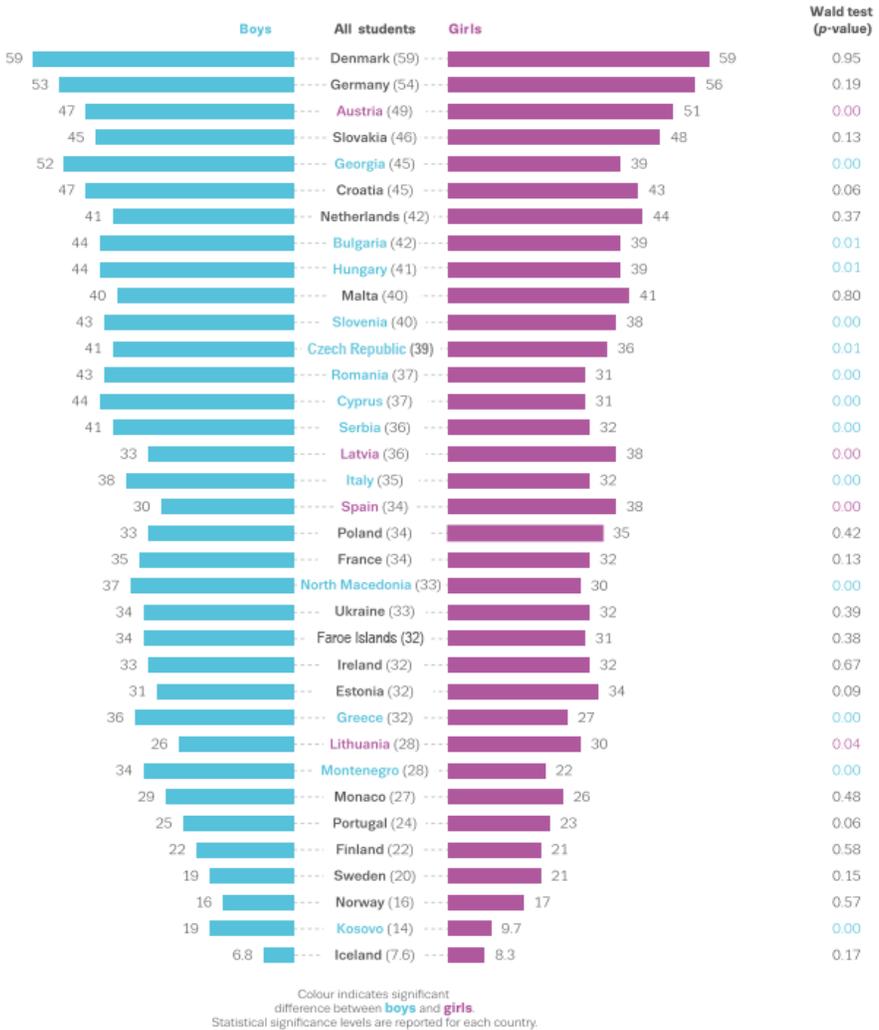
The gender gap in drug use is narrowing, especially in the youth population, and especially for recent and current drug use, in many Western countries where opportunities for drug use arise (UNODC 2018d). In 30 European countries, the average prevalence of drug use among girls rose from 68% (in 1995) to 78% (in 2019) of the corresponding prevalence rate among boys (ESPAD Group 2020). In some European countries, prevalence rates have converged between genders, especially for licit drugs and for some patterns of use, over the last 25 years. In Europe, in 2019, boys and girls aged 16 claimed similar rates of daily cigarette use (10%), past month smoking (20%), past month drunkenness (14% versus 13%, respectively), use of an illicit drug once or twice in lifetime (6.4% versus 5.2%) and lifetime inhalant use (7.3% versus 7.1%) (ibid.). The odds of heavy episodic drinking are quite similar between girls and boys or even higher among girls in a few countries (Figure 1). Since 2011, the average lifetime prevalence of inhalants has been the same for European boys and girls. In Mexico, the lifetime prevalence of inhalant use in teenagers aged 12-17 was higher in girls (1.5%) than in boys (1.2%) (Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz et al. 2017).

In 2019, among European girls and boys, similar rates of daily cigarette use (10%), past month smoking (20%), past month drunkenness (13-14%) and lifetime inhalant use (7.1-7.3%) were seen.

Girls (8.5%) are 1.7 times more likely than boys (5%) to say they have used unprescribed tranquillisers or sedatives.

The prevalence of the non-medical use of opioids and tranquillisers is comparable between men and women, if not actually higher among women.

Figure 1. Prevalence of heavy episodic drinking (≥5 drinks on one occasion; 1 drink = ~2 cl of ethanol) at least once in the last month by gender (%)



Source: ESPAD Group 2020.

There are a few exceptions where the gender gap is reversed, with women being more highly represented than men. This is the case for the lifetime experience of some psychotropic drugs, regardless of age. In adults, the non-medical use of opioids and tranquillisers is similarly spread among men and women, if not actually higher among women (UNODC 2018d, 2021c). On average, over the two past decades, European girls were more likely to report using tranquillisers or sedatives without prescriptions than boys (8.5% versus 5.5% in 2019; 9% versus 6% in 1995) (ESPAD Group 2020). In Uruguay, in 2018, the majority of cocaine base paste users were men (86%), most of them being aged 26-35 (38%); however, a higher proportion of younger users, aged 18-25, were women (Observatorio

Uruguayo de Drogas and Junta Nacional de Drogas 2019). In Bolivia, the regular use of cocaine was more often reported by women (57%) than by men in 2018, although the past-year prevalence of cocaine use is reportedly higher among men (UNODC 2020b). In many countries of South and Central America, the non-medical use of stimulants like weight loss pills (e.g. sibutramine hydrochloride monohydrate, phentermine) is reportedly more prevalent among women than among men (ibid.).

The gap in drug use patterns between women and men is related to unequal opportunities in access to drugs, especially illicit drugs, and it is based on social, cultural, economic and environmental factors (UNODC 2018d). If some drug use rates have grown among women and girls over the 2000s and the 2010s, this may be associated with changes in these factors, such as the growing participation of women in public life and social domains. If access to drugs by men and women were equal, the likelihood of substance use would not differ between men and women (ibid.). It can be assumed that men-centred assumptions have shaped how the drug phenomenon is questioned, leading to certain ways of producing results that demonstrate the disproportionate involvement of men. To some extent, the structuring of monitoring systems has concealed drug issues among other genders.

Women who use drugs are disproportionately affected by drug-related health issues

Among people who use drugs, women tend to progress more rapidly than men to drug use disorders and the negative health impacts of drug use (UNODC 2021c). The increase of DALYs attributed to drug use disorders in 2015 was greater among women than men, particularly in relation to opioid use (increase of 25% versus 17%) and cocaine use (40% versus 26%) (UNODC 2017b). Between 2010 and 2017, the number of deaths attributed to drug use disorders has increased disproportionately among women, with a 92% surge related to opioids compared to a 63% increase among men (Institute for Health Metrics and Evaluation 2017). At the global level, in 2019, even though women had a lower burden of disease associated with drug use disorders compared to men, this burden drastically increased over the decade with a 35% increase of deaths

related to opioid use and a 45% increase of deaths attributed to drug use disorders in general (Institute for Health Metrics and Evaluation 2019).

Deaths attributed to drug use disorders have almost doubled among women (+92%): they have increased significantly more rapidly than in men (+63%).

Women are at particular risk of acquiring HIV and other blood-borne diseases and women who inject drugs are 17 times more likely than other women to be living with HIV.

Women who report drug-related issues are more likely to be coping with an experience of violence than men, as are transgender people with drug issues.

Some 68% of drug-injecting women have experienced interpersonal violence in a recent intimate relationship.

Women with a drug use disorder are more likely than men to be diagnosed with a psychiatric co-morbidity such as depression, panic disorder and psycho-trauma (EMCDDA 2015; Evans-Lacko et al. 2018; Harrop and Marlatt 2010; Tirado-Muñoz et al. 2018). A study targeting 226 women who injected drugs in five European countries (Austria, Italy, Poland, Spain and the United Kingdom) showed that 87% had a psychiatric disorder, mainly depression, panic disorder and post-traumatic stress disorder (Tirado-Muñoz et al. 2018).

Compared to men, women experience more unpleasant symptoms when attempting to quit drug use (Becker and Koob 2016; Becker, McClellan and Glover Reed 2017; Hogle and Curtin 2006). They report sporadic factors of relapse (occurring without apparent trigger or intent) such as negative affects related to previous physical and sexual abuse (Becker, McClellan and Glover Reed 2017; Greenfield et al. 2007; Hyman et al. 2008; Walitzer and Dearing 2006).

In the general population, girls and young women are particularly vulnerable to HIV and sexually transmissible infections (STIs) compared to boys and men, and this is related to more frequent experiences of gender-based violence (GBV) and harmful gender norms (WHO 2015a, 2021b). From 2015 to 2019, 280 000 girls and young women (15-24 years old) acquired HIV, even though this is, globally, 19% less than figures at the beginning of the 2010s. Women who use drugs use condoms less often with both their intimate partners and their clients if they are sex workers (El-Bassel et al. 2014). Women who inject drugs (WWID) are 17 times more likely than other women to be living with HIV (UNODC et al. 2014). They face a higher risk of acquiring HIV, viral hepatitis and other STIs than their male peers (UNODC 2016a). According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) Global AIDS Monitoring 2019 updates, from 2013 to 2017, WWID had higher rates of HIV infection than men who inject drugs in Eastern Europe (33.0% versus 27.9%), Western Europe (42.8% versus 40.3%), Latin America (38.5% versus 34.6%) and North America (34.5% versus 31.3%) (Degenhardt et al. 2017). In 2019, female sex workers were 30 times more likely to be living with HIV than women in the general population, while (in countries with data) transgender sex workers are up to 20 times more likely to acquire HIV than cisgendered sex workers (UNAIDS 2021). Women in prison are five times more likely than other women to be living with HIV (UNODC et al. 2014).

Worldwide, almost half of all people who inject drugs (PWID), that is 5.5 million people, are estimated to be living with hepatitis C and 8.3% (an estimated 940 000 people) have an active hepatitis B infection (UNODC 2020b). Data gathered from the European information network on drugs and drug addiction (REITOX) showed high variability in hepatitis C prevalence among PWID in 2015 as rates ranged from 16% to 80% among WWID and from 13% to 85% among men who inject drugs (EMCDDA 2021c). There are no recent global estimates of hepatitis C and/or hepatitis B infection rates among WWID although they are known to be at high risk of infection (Dugan et al. 2021).

Among women aged 15-49 worldwide, 35% “have experienced physical and/or sexual intimate partner violence or non-partner sexual violence” (United Nations 2020a, 2020b). WWUD, especially women who are dependent on drugs, report

additional conditions of vulnerability related to the experience of violence. Women who go to parties and nightlife settings that are characterised by high alcohol and drug consumption among participants report more experiences of sexual violence (Balasch et al. 2018; Palamar and Griffin 2020). WWID often report having faced interpersonal violence, in the past or recently. For instance, a cross-sectional study that targeted 226 WWID in five European regions (Austria, Catalonia, Italy, Poland and Scotland) showed that 68% of women who inject drugs had experienced interpersonal violence in their current or most recent intimate relationship (Tirado-Muñoz et al. 2018). Internalised trauma is a frequent risk factor among women who experience drug use disorders.

A woman with drug use disorders faces a double stigma for using drugs and for being a woman who breaks the social norms of temperance and exemplary behaviour that are traditionally assigned to her gender. In this regard, WWUD may feel self-stigma as well. For instance, fear of child protection and welfare implications may drastically restrain their willingness to access services (EMCDDA 2015; Evans-Lacko et al. 2018; Harrop and Marlatt 2010; Tirado-Muñoz et al. 2018). Women engaged in treatment also register lower perceived well-being but higher feelings of guilt and shame, and obligations to family and care responsibilities (Babineau and Harris 2015). Such perceptions and bad feelings may affect a wide range of women who have problematic drug use.

Trans people are more vulnerable too

A body of evidence outlines higher rates of licit and illicit drug use and endured violence or discriminatory experiences among trans people of all genders compared to the general population (Coulter et al. 2018; Hunt 2012; Hyde et al. 2014; James et al. 2016; Johns et al. 2019; Kann et al. 2018; Livingston et al. 2017; Lyons et al. 2015; Reisner et al. 2016; Rimes et al. 2017; Scheim, Bauer and Shokoohi 2017; Valentine and Maund 2016; Yi et al. 2017). The surveys address drug use patterns, related harms and risk behaviours in trans people and show that they also face a high burden of drug-related health issues. The scarce data on genders other than men and women often aggregates gender, sex, gender identity, sexual orientation and intersex considerations (Pyle 2019; SAMHSA 2012).

US transgender adolescents have 3 to 10 times higher odds of lifetime drug use, including abuse of opioids (36%), cocaine (27%), heroin (26%) and meth-amphetamines (25%), compared to boys (respectively, 11.5%, 4.3%, 2.2% and 2.3%).

Transgender teenagers are more often victims of violence or discrimination than other teenagers. They are also three times more likely than girls and six times more likely than boys to attempt suicide.

For example, trans people report a heightened risk of drug use disorders compared to the general population (Reisner et al. 2016; Yi et al. 2017). A systematic review of alcohol research targeting trans people (mostly carried out in the USA) shows high prevalence of hazardous drinking in trans populations (Gilbert et al. 2018). According

to two recent large-scale studies in the US,³ trans teenagers declare increased alcohol use, marijuana use or other illegal drug use (cocaine, heroin, methamphetamines and misused prescription opioids) compared to other teenagers (Johns et al. 2019; Reisner et al. 2015a). A systematic review of studies targeting US trans people (aged 34 on average) found that an estimated 12% of trans women reported injecting illicit drugs and 39% of trans men reported having sex while drunk or high (Herbst et al. 2008). Trans people of all genders are more likely to have substance use problems than cisgender men and women, and they are more likely to turn to certain substances; these patterns are also acknowledged to contribute to minority stressors, such as discrimination (Lee et al. 2016). Negative emotions, and social and relational anxiety related to gender identity, may influence the use of alcohol and other drugs. It is relevant to identify how gender influences drug use patterns and to understand the role of alcohol and drug use in the replication of the dominant conventions of gender (Hunt et al. 2019).

Trans people are more likely to be victims of physical or psychological violence than cisgender people, and this is particularly true for young people (Kann et al. 2018; Livingston et al. 2017; Reisner et al. 2016; Scheim et al. 2017; Yi et al. 2017). In addition to higher rates of alcohol and drug use, trans teenagers also declare higher rates of bullying at school (35% versus 15% in cisgender boys) or cyberbullying (30% versus 10% in cisgender boys) and of harassment in comparison with other teenagers (Johns et al. 2019). Rates of experienced violence including in sexual encounters are from three to six times higher for trans teenagers than for cisgender boys and from two to six times higher than for cisgender girls (ibid.). In this survey, suicide risk is also more important since 35% of transgender adolescents have attempted suicide in the last 12 months, six times and three times more than cisgender boys and girls, respectively (ibid.).

Young transgender people are more vulnerable to acquiring HIV than their age peers in the general population or older transgender people (WHO 2015b). The population groups that are especially vulnerable to STIs include sex workers and their clients, men who have sex with men, transgender people, young adults and adolescents, mobile populations and people affected by conflict and civil unrest (WHO 2021b). An Italian study among 243 transgender people (218 trans women and 25 trans men) who had confirmed serological data, showed that the prevalence of HIV, hepatitis B and hepatitis C infections was respectively 0%, 4.0% and 8.0% in trans men, and 12.1%, 4.6% and 3.7% in trans women (Luzzati et al. 2016).

As a result, although fewer in number within the population who use drugs, trans people disproportionately use drugs and disproportionately face significant adverse health outcomes, including heightened morbidity and mortality (Chibanda et al. 2014; Leventhal, Huh and Dunton 2014; Reisner et al. 2015b; Whiteford et al. 2013).

3. The Teen Health and Technology Study that sampled 5 542 adolescents aged 13 to 18 and the 2017 edition of the Youth Risk Behaviour Survey that sampled 131 901 US high school students in grades 9-12 in 10 states.

Women are insufficiently served by drug treatment services

Women who have problematic substance use are disproportionately affected by substance-related health issues, as they are highly vulnerable and marginalised and face significant barriers in accessing treatment services (UNODC 2016a, 2017a, 2020b).

Worldwide, women are under-represented in drug treatment centres, accounting for only 2 in 10 clients despite making up 3 in 10 drug-dependent people.

Worldwide, although women make up 3 in 10 people who use drugs, they account for only 2 in 10 clients in treatment for drug addiction (UNODC 2020b). Access to drug treatment centres tends to be more limited for people with low or intermediate economic status and those with low levels of formal education (Evans-Lacko et al. 2018; UNODC 2020d). In the EU, the situation seems slightly less unfavourable since women account for a quarter of people who have developed (illegal) drug-related health problems and a quarter of people entering drug treatment.⁴ Women, worldwide, are disproportionately affected due to gender inequality in access to education, employment and fair wages: for example in the EU, they earn on average 16% less per hour than men. This highlights how gender intersects with a number of other structural variables.

Trans people are insufficiently served too

Recent European studies have highlighted the difficulties of trans people in accessing general and specialised healthcare services (including mental health services). According to a study carried out in Georgia, Poland, Serbia, Spain, and Sweden, 55.8% of transgender people, whether they used drugs or not, have already delayed (sometimes, regularly or all the time) going to general healthcare services because of their gender identity (Smiley et al. 2017). The reported obstacles are related both to the fear of stigmatisation and to the observed lack of knowledge among practitioners about their specific needs (Kcomt et al. 2020; Smiley et al. 2017). Thus, substance use is associated with lack of appropriate treatment and delays in needed medical and preventive care (Reisner et al. 2015b). Despite trans people coping with heightened risks related to drug use, mainstream drug and healthcare services are globally unaware of their specific experiences, health and social needs in relation to their drug use or addiction, and trans people are underserved or ignored in drug treatment programmes. Trans people's needs would be better met with specific training and better advertising of services implementing a trans-inclusive approach or trans-specific support (Valentine and Maund 2016).

Six out of 10 trans people have already delayed a medical consultation due to their gender identity.

Drug and care services globally do not address trans people's specific experiences and needs with regard to their drug use and the drug services they may need.

4. Available at www.emcdda.europa.eu/html.cfm/index247559EN.html, accessed 26 January 2022.

Heightened burden for women and trans people facing criminal justice

Gender differences are also observed in engagement in drug trafficking and in legal consequences to drug offences across the range of criminal justice responses (from arrests to sentencing and incarceration). In general, there are fewer women than men at any stage of the law enforcement chain when it concerns drug offences (from arrests to convictions and incarcerations) (UNODC 2018d). In the population in contact with criminal justice systems, women and trans people are acknowledged as particularly vulnerable groups (UNODC 2009, 2016b). But there is a lack of data about the difficulties faced while being addressed by the criminal justice system and adverse consequences upon exiting the system, especially for trans people (UNODC 2020a).

Exploitation by criminal networks and participation in drug trafficking

Participation in drug trafficking depends on many factors, but socio-economic vulnerability has been shown to be a major driver, especially in circumstances of limited income options

Women are particularly vulnerable to being involved in drug trafficking and are disproportionately affected.

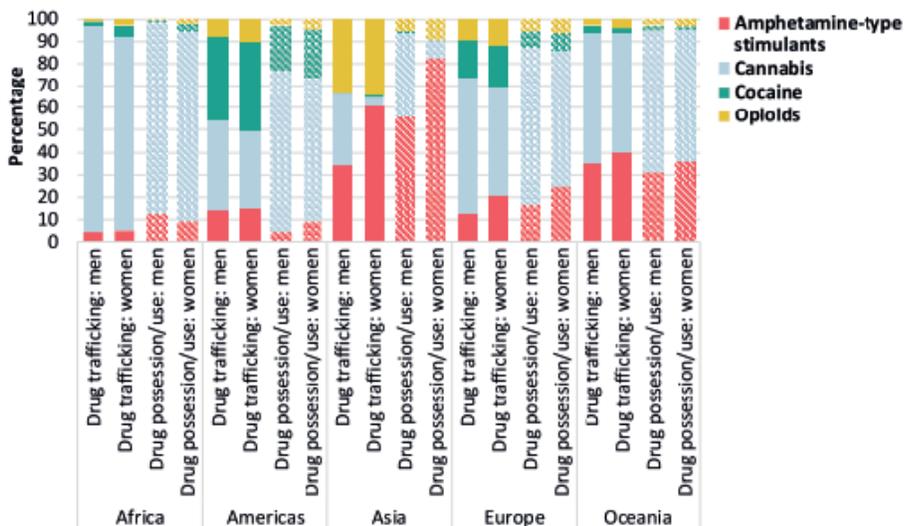
and employment. In this respect, women are especially vulnerable to becoming involved in drug selling as they are more likely to be precariously employed, in low-income situations and in social isolation, and they are often more likely to be caring for family, including as single parents. Women's part in the drug trade may be also shaped by other gender-based drivers, such as a greater vulnerability to intimidation, coercion or intimate ascendancy and violence triggered in general by the illegal drug market (UNODC 2018d). Drug-related intimidation (DRI) and coercion are ongoing issues, with forced recruitment of younger people into the drug economy and threats targeting mothers to persuade them to cover their child's drug-related debt or to dissuade them from withdrawing a child from trafficking. Such intimidation and coercion patterns are additional gendered aspects to illicit drug markets within the European context (Connolly and Buckley 2016; Murphy et al. 2017).

Girls and women who are involved in drug trafficking often undertake peripheral roles that are low reward but carry a high risk of arrest. They most often take on the tasks of lookouts, "banks" (storing or conveying money), "drug minders" (storing or conveying products), and any roles they can fulfil with more discretion than men, as women more often escape police and judicial control compared to men. A growing number of women are engaged in intermediary roles (for example financial controllers, supervisors of small-scale drug dealing and selling, money laundering) or even lead roles, especially in Latin American cartels (Anderson 2005; UNODC 2018d). However, male domination is still the norm in drug trafficking.

Arrests and convictions

In all continents, almost 90% of people who come into contact with the criminal justice system for cannabis-related offences are men while women are more likely to be prosecuted for minor trafficking charges or possession of drugs: in Europe, this is especially the case in relation to cannabis, amphetamine-type stimulants and cocaine (UNODC 2020c). This unbalanced distribution of gender in arrests is not solely because of a division in delinquency between men and women. In some instances, it also issues from informal patterns of police control and justice proceedings.

Figure 2. Distribution of men and women brought into contact with the criminal justice system for drug law offences, by drug type and region, 2014-18



Source: Responses to the annual report questionnaire (UNODC 2020c).

Various social studies hypothesise that justice systems in Western countries are globally more readily “protectionist” towards girls and women, educative responses being more often directed to them, while boys and men are more often defined by their acts of transgression alone and subjected to coercive measures (Russell 2013; Vuattoux 2016). This is especially true for minors (Vuattoux 2016). For instance, in France, girls benefit more than boys from measures of educational assistance that keep them in the civil sphere as “minors in danger” whereas boys are more likely to be designated and treated as “delinquents” by the justice system. This tends to diminish the presence of girls within criminal statistics (Barbier 2016; Cardi 2004).

In western countries, educative non-custodial measures are favoured for girls and women in contact with the justice system.

Drug-related offences dominate the chargesheets of women who are sentenced, given the increase in prison sentences for crimes of poverty and petty crimes.

The Irish Prison Service and Irish Probation Service Strategic Plan 2018-20 stresses the importance of using community sanctions for women whenever possible so as to increase access to education and recovery, support resettlement and respond to domestic violence (Irish Prison Service and the Probation Service 2018). In Mexico, the authorities that design drug-related judicial policies acknowledge the need to improve the integration of a gender perspective in criminal justice programmes. Therefore, they take into account whether women may commit crimes as a result of coercion from male relatives (for example partners, siblings, parents), in a situation of violence, coercion or domination.

In contexts where the focus is on low-level drug offences, women may be disproportionately convicted and incarcerated for drug offences (UNODC 2018d). Drug-related offences remain the predominant charge for which women are brought into contact with the criminal justice system (UNODC 2020c). Worldwide, 35% of women in prison have been sentenced for drug-related offences versus 19% of men, while in Europe this rate varies substantially: from 5% in Bulgaria to approximately 25% in Denmark, Finland and Sweden, up to 40% in Spain (EMCDDA 2021b; UNODC 2018d). This overrepresentation is related to the criminalisation of poverty and the increase in prison sentences for petty offences such as low-level drug-related offences (for example possession of small amounts of illegal drugs) (Penal Reform International and Thailand Institute of Justice 2021). Women are mainly convicted for petty crimes closely linked to social precarity; a minority of them are convicted of violent offences, many of them having been victims of violence themselves. Given the less dominant roles generally assigned to them in drug trafficking, women tend to be sentenced for minor drug-related offences (UNODC 2011, 2018d). Nevertheless, they are often punished disproportionately to the minor roles they play in drug trafficking, for instance when mitigating circumstances (that would recognise women's vulnerabilities and lesser roles) are not considered, as was the case, for instance, in the UK until 2012 (Fleetwood, Radcliffe and Stevens 2015). However, there are recent indications that women's involvement is gradually expanding into higher levels of drug supply chains (UNODC 2018d).

Sentencing trends for drug offences depend very much on jurisdictions but, in Western countries, a body of institutional reports and research indicates that, although custodial sentences for women are in general shorter than for men, the gender difference in length of sentencing is narrower for drug offences (Butcher, Park and Morrison Piehl 2017; Cho and Tasca 2019; Ministry of Justice 2020; United States Sentencing Commission 2018). Over the last 25 years, more benevolent sentencing for girls and women has tended to be disproportionately accorded to white females,⁵ and this analysis stresses the intersectionality of gender and race in sentencing. Furthermore, the treatment of women in criminal proceedings tends to be more lenient when charges are consistent with stereotypes of female offenders (for example perpetrating a crime after having been victimised, or stealing to provide for loved ones).

5. This propensity was theorised by Farnworth and Teske in 1995, under the (now-criticised) term of selective "chivalry" (Farnworth and Teske 1995).

Incarceration of women

In Europe, the number of women in prison has increased over the last few years, given the stable proportion of women in the overall prison population, which is growing (Aebi and Tiago 2020; EMCDDA 2021b). Worldwide, women in prisons are mainly sentenced for non-violent crimes, including when they are charged for drug offences (Fazel, Yoon and Hayes 2017). The proportion of prisoners sentenced for drug-related offences is also higher in women than in men (UNODC 2018d). Women in prison are reported to be particularly vulnerable and at risk of problematic drug use, with complex social and health profiles (EMCDDA 2021b). Within the world prison population, 51% of women suffer from drug use disorders versus 30% of men (Fazel et al. 2017). In Europe, imprisoned women have a higher prevalence of infectious diseases compared with the general population (Tarján, Horváth and Stöver 2018).

While women are subject to the same correctional procedures as men according to a principle of neutrality, in prisons they have even less access than their male counterparts to healthcare services, including those addressing drug use and sexual and reproductive health needs (Covington and Bloom 2003; UNODC 2018d). The separation of genders in detention is a widespread, if not universal, principle in prisons, in order to protect vulnerable persons, including in prisons that incarcerate both men and women when collective activities (workshops, trainings, etc.) are organised. However, this principle of separating men and women may have adverse effects when it hinders women's access to collective premises and activities and therefore to work, training, sociocultural and sports activities, and care services (Bès 2020; UNODC 2018d). This "isolation" can be exacerbated for women incarcerated with very young children.

Women are often affected in the long term by the serious social and health consequences of incarceration and this is especially true for those who use drugs (Covington and Bloom 2003; UNODC 2018d). Indeed, when released from prison, women who use drugs face the double stigma of their status as ex-offenders and as drug users, which reinforces the unequal challenges they face because of their gender, including discrimination, low incomes, social isolation, and acute vulnerability to coercion and violence. All these conditions constitute barriers in accessing healthcare and social services (Anderson 2005; UNODC 2018d). In Western prisons, maintaining or initiating drug treatment is a widespread objective targeting prisoners who use drugs (EMCDDA 2021b). Pregnant women in prisons may be subject to targeted policies, with a focus on childcare skill learning (EMCDDA 2021b; Messina, Bloom and Covington 2020). However, the particular health and social vulnerabilities and needs of women and transgender people who use drugs – as acknowledged in previous sections – may be exacerbated by the living conditions in prison (EMCDDA 2021b).

Within the global prison population, the proportion of those sentenced for drug offences is higher among women (35%) than among men (19%).

Some 51% of women in prison have a drug use disorder versus 30% of men in prison.

In European and African prisons, women have a higher prevalence of infectious diseases compared with the general population.

Incarceration of trans people

These living conditions may also heighten health and social vulnerability among trans people who use drugs. The specific situation of trans people who are in prison are not taken into account. In Europe, only a few countries are able to meet the needs of trans people in prison, that is to fully uphold their gender identity rights and the specific security issues they face (for example transphobia, maltreatment, violence) (Van Hout and Crowley 2021). In some cases, non-binary people who have medically transitioned may be housed in the male/female estate that is “closest” to their current physical sex characteristics or identity (or what might be understood as being the closest). Such an assignment is not universally applied to all trans people who are in prison, especially in the context of overcrowded prisons, which might mean that other considerations are given priority.

Gender-specific needs are marginally covered by drug policies

In Western countries, national drug strategies (NDS) highlight globally higher rates of avoidable premature death among men and their lower life expectancy in relation to their higher prevalence of drug use and risk factors. They

recognise behavioural and biological variations between men and women. However, despite international organisations calling for gender-transformative policies (see Box 1), NDS are still limited in their integration of gender considerations. In only addressing pregnancy and motherhood, the emphasis is primarily on the (unborn) child’s interests, given that the harmful behaviours of their mother can affect them in the long term. This is particularly the case in societies where parental caregiving is assigned to women.

Addressing pregnancy and motherhood are the most common ways of incorporating gender in national drug strategies.

Globally, other gender-specific needs, expectations and stakes (for women or non-binary people) and the way they intersect with drug issues are overlooked. Little concern is attached to the socially and culturally shaped aspects of gender, documented by sociological literature and, for a long time now, by feminist studies (Hurtig and Pichevin 1986; Manandhar et al. 2018; Mead 1950; Oakley 1972). Herein, drug policies are still predominantly driven by men’s issues and needs, and they confine the gender-sensitive approach to the traditional assignment of women to maternal and caregiving duties. This current focus also fails to address the specific needs of non-binary people and to develop gender-inclusive responses accordingly.

The marginal treatment of gender specificities in NDS and policies may stem from assumed ideologies. The current men-centred approach of drug policies is influenced by the dominant representations that identify drug use and delinquency (drug-related transgression) as a male propensity. This situation may also arise from a belief in the neutral and universalist value of policies and, paradoxically, the willingness of neutrality and non-discrimination against a gender. Several hypotheses may explain the lack of inclusion of trans, including non-binary people’s stakes, in drug policies. Many strategies and policies will continue to view gender specificity as only

relating to men and women. Even when these may aim to acknowledge and include greater gender diversity, there is a lack of knowledge on the size of this part of the population; epidemiological studies on substance use rarely ask about sex, gender or gender identity, meaning that trans people of all genders are invisibilised in such studies; and there is a lack of consistent methodologies to process these data and compare them to existing data from the general population.

Box 1. International organisations call for gender-transformative policy

The EU Drugs Action Plan 2021-25 sets forth the need to better identify and address the barriers that women face in engaging with and sustaining involvement with treatment and rehabilitation services (European Commission 2020). Beyond Europe, the same impetus may be seen in the recent endeavours and appeals endorsed by WHO and UN agencies aiming at gender equality (Inter-American Drug Abuse Control Commission, Executive Secretariat 2020; Liquori O’Neil and Lucas 2015; Manandhar et al. 2018; United Nations 2015; UNODC 2017a; WHO 2019a). Statements calling for more gender-sensitive and effective responses proliferated during the 2010s, as illustrated by the following, non-exhaustive, list of decisions and agreements: the Outcome Document of the 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem, the 2019 Ministerial Declaration, the UN System Common Position on Drugs, various UN Commission on Narcotic Drugs resolutions (55/5, 59/5, 61/4, 62/6), as well as the Bangkok and Tokyo Rules and the international guidelines on human rights and drug policy (Commission on Narcotic Drugs 2019; The Yogyakarta Principles plus 10 2017; UN General Assembly 1991b; United Nations 2020b; UNODC 2011, 2016c; WHO et al. 2019).

Few gender-sensitive drug responses are available

Across all drug policy areas (that is prevention, harm reduction, treatment, criminal justice), investment in gender-sensitive policies has expanded through the advocacy of international organisations, including European bodies (see Box 1). However, further efforts are needed as gender-sensitive services and interventions continue to be a minor part of existing drug responses in the drug field within the EU. Many such responses have been developed ad hoc by civil society, on the basis of the principles of agency and empowerment, implying that women develop and implement services by and for themselves. But many gender-sensitive measures are limited to how drug use or addiction intersects with pregnancy and maternity issues, without taking into account, or only doing so in a limited way, other types of expectations of women, as they are still influenced by established social representations on the role of men and women.

Gender-oriented programmes or services are insufficiently researched and poorly monitored. To date most scientific research has been carried out in high-income countries and is quite often based on the experience of civil society, community organisations and practitioners.

Gender-sensitive drug prevention is still limited

Alcohol labelling warning against drinking during pregnancy, recommendations of “safe” amounts of alcohol for men and women (using standard drink measures) and gender-targeted media campaigns are certainly the most widespread gender-oriented prevention measures.

Drug prevention programmes, however, are in general insufficiently monitored and evaluated (Burkhart and Helmer 2019; UNODC 2018b). This precludes a clear view of whether a gender-sensitive approach does exist in prevention (EMCDDA 2019a). Incomplete information obtained through anecdotal channels suggests limited integration of gender-sensitive components or methods in drug prevention in Western societies. This situation may be critically linked to practical and economic reasons related to time constraints and involving content adjustments. It may also lie in ideological motives, such as a desire not to “discriminate” (see Chapter 3 for practitioners), or other barriers.

Gender-sensitive approaches are poorly developed in drug prevention programmes.

Over the last few decades, experts’ anecdotal feedback (e.g. from conferences, workshops) on drug prevention approaches has emphasised how fear-based warnings are particularly directed at girls and women, linking drug use with the risk of sexual abuse or violence. This is an area of concern, considering first the risk of stigmatisation and second, the demonstrated ineffectiveness of fear-based approaches for drug prevention purposed (ibid.). Indeed, these messages directed to girls and women may disproportionately put the blame on them by fostering the idea that women are assaulted because they consume drugs and put themselves at risk of being assaulted.

Harm and risk reduction and treatment – from gender blindness to gender partiality

Despite their focus on public health and human rights, drug treatment and harm reduction programmes and services tend to be “gender blind” or “male focused” since they are mostly designed, implemented and evaluated on the basis of the experiences and needs of men who use drugs (Canadian HIV/AIDS Legal Network 2020; Romo-Avilés 2018). They tend to reproduce the structural and institutional gender inequities and systems of oppression of wider society (Canadian HIV/AIDS Legal Network 2020; Romo-Avilés 2018; Smye et al. 2011). This mostly explains why, historically, women have been underrepresented among clients in specialised drug treatment services and the issues of trans people are poorly addressed.

Drug treatment and harm reduction services tend to be “gender blind” or “male focused”.

Some specialised services deal specifically with pregnancy and motherhood issues in WWUD.

New forms of bio-psycho-social addiction support have emerged and integrated wider women’s needs.

However, in the last few decades, professionals and CSOs engaged in drug responses have pioneered the integration of gender-oriented approaches in their regular practice. In line with mainstream representations of male versus female roles, they first focused on pregnancy among women who use licit or illicit drugs in order to better prevent drug use during gestation and to improve childcare skills. Over time, the issue has encompassed the cases of very young children with the aim of consolidating the mother–child bond and fostering maternity to support rehabilitation. Despite their relevance, these interventions are partial and tend to reinforce gender stereotypes since they are merely focused on reproductive and traditional childcare roles without considering other dimensions of women’s existence (Romo-Avilés 2018; Yaremenko, Shulga and Varban 2015).

Some specialised practitioners have recognised the underrepresentation of women among their clients to be a result of major barriers in accessing services. New forms of drug treatment and harm reduction interventions, including psychosocial or educative and medical support (for example socio-aesthetic workshops, sophrology), have emerged, integrating women’s needs and expectations beyond their maternal role, and promoting women’s empowerment (see Chapter 3). These services, however, remain marginal in the scope of an addiction treatment system predominantly oriented to male clients (EMCDDA 2019a; Mutatayi 2019). For instance, in Europe, in recent years, there has been growing momentum to develop trauma-informed interventions that address both drug addiction and mental illness, stigma reduction, empowerment and life skill development for women who use drugs. Various harm reduction services meaningfully involve, or are led by, women who use/used drugs (for example Metzineres in Barcelona, Spain). In Mexico, a non-governmental organisation (NGO) has opened a safe injection room for women with the dual aim of preventing intravenous viral infections and assaults. These services aim at improving women’s access to, and maintenance of, harm reduction and treatment, by supporting them in various aspects of their lives and empowering them to be part of key decisions that affect them. Indeed, the availability of tailored gender-sensitive harm reduction and treatment programmes does increase women’s access to and involvement in treatment (Ayon et al. 2017; Open Society Foundations 2011; Shirley-Beavan et al. 2020), as well as that of gender-diverse people (Senreich 2010).

On the basis of the scarce information available, it appears that drug care services that are able to take up trans people’s issues are marginal (Reisner et al. 2016; Smiley et al. 2017; Valentine and Maund 2016). Many trans people still avoid visiting a harm reduction or treatment service for drugs because they fear gender-based institutional violence (Valentine and Maund 2016). Even if trans people are welcome in drug treatment centres, staff may feel unable to understand their specific needs and provide them with the appropriate assistance.

Conclusion

For women, and trans people of all genders, the heavy burden of drug use and addiction in terms of health and social harms is alarming. Because of major barriers in accessing drug treatment, many women who use drugs only resort to, or are brought to, help services at a late and serious stage, when facing crisis situations or

acute health and social outcomes. In the near future, considering trends observed in the general population, the proportion of women with problematic substance use is likely to grow. Important barriers to help services are also faced by trans people.

This calls for the urgent development of gender-sensitive drug responses, including but not limited to the pregnancy and maternity domains. In the field of drug prevention, there is a specific need to develop gender-transformative programmes, especially for young people, for whom gender gaps in drug use are narrowing faster than for adults. For effective gender-transformative responses, it is important that innovations come from both policy makers and practitioners, both of whom are targeted by this handbook.

Gender is a central dimension in the analysis of drug use pathways (types of drugs, motivations, patterns and contexts of use) and related risks, harms, and health, social and legal consequences. It is important, in this context, to understand how gender, associated social norms, and alcohol and drug use influence each other. More generally, gender is a relevant lens to assess how national and local government responses (including in the area of health and criminal justice) contribute to reducing health inequalities in society. However, the integration of gender perspectives in drug responses and its impact are still poorly assessed and this is particularly the case with respect to prevention and criminal justice responses that do not relate to pregnancy and maternity.

There is a need to collect systematic and reliable gender-disaggregated data (including on trans people), and conduct further quantitative and qualitative research on the gender dimension of engagement in drug-related activities. Research and evaluation of the appropriate responses that truly respond to women and trans people's situations of vulnerability and are aligned with human rights principles will be essential to build and promote new good practices and their transferability.

Chapter 2

Guidance for policy makers

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Background

Due to its link with substance use, gender should be considered an indispensable criterion in the effective construction of drug policies. As part of the initiative of the Pompidou Group to integrate a gender perspective in drug policies, in 2015 a project was carried out to explore the gender dimension of the non-medical use of prescription drugs (NMUPD) in Europe and the Mediterranean region. Recommendations for policy development were as follows (Clark 2015):

- ▶ to develop coherent policies that address the use and misuse of substance use, with specific reference to gender differences;
- ▶ to develop studies of substance use that address specific issues, such as the initiation, escalation, and physical and psychosocial consequences for women as an “at risk” category;
- ▶ to explore the relationship between experiences of physical, sexual and psychological violence and substance use;
- ▶ to study the relationship between violence against women and substance use.

Another Pompidou Group project that evaluated the degree to which gender and violence experienced by women is taken into account in harm reduction and treatment programmes made recommendations for the effective overall management of violence experienced by women who use psychoactive substances (Benoit and Jauffret-Roustide 2015: 58-63):

- ▶ incorporating the gender dimension in harm reduction and addiction treatment facilities;
- ▶ creating at institutional level the conditions for the effective overall management of women who use drugs and experience violence;
- ▶ supporting actions through training programmes;
- ▶ incorporating the gender dimension into the health surveillance system.

Aligning with these recommendations, the purpose of this chapter is to provide essential elements that can be considered by decision makers to effectively incorporate a gender perspective in drug policies and in the planning and implementation of plans and programmes, in order to understand it as a process rather than an objective in itself.

Historical overview of drug policies and gender perspectives

The 21st century heralded a focus on gender in drug policy. The UN drug conventions from 1961 and 1971 make no mention of “gender” or “women”, for example. Women drug users in the 1970s “were hidden from view” in the field: marginalised, stigmatised, silenced and “targets of social injustice” (Ettorre 2007: 5). Therefore, treatment of substance use “developed as a single-focused intervention based on the needs of addicted men” (Covington 2008). The first publication on the subject of women and drug problems came out in 1980, in the aftermath of International Women’s Year in 1975, claiming that the study of women and drug use “was in fact a non-field in many respects and that most texts in the field did not include words such as male/female, men/women, or sex differences in their subject indexes” (Kalant 1980: 1-2).

The first reference to women in high-level UN documents on drugs dates back to 1998, in the Political Declaration adopted at the second UNGASS on drugs, which called on member states “to ensure that women and men benefit equally, and without any discrimination, from strategies directed against the world drug problem, through their involvement in all stages of programmes and policy-making”, and affirmed the international community’s determination to provide the necessary resources for treatment and rehabilitation and to enable social reintegration to restore dignity and hope to children, youth, women and men who have become drug abusers (UN General Assembly 1998).

In 2008, the Council of Europe’s Committee of Ministers recommended that the member states, “in the context of protection of human rights, make gender one of the priority areas of action in health through policies and strategies that address the specific health needs of men and women and that incorporate gender mainstreaming” (Council of Europe 2008). In the 55th Session of the Commission on Narcotic Drugs, the resolution promoting strategies and measures addressing the specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies, promoted by Italy at the European level, addressed the need for more evidence-based information on all aspects of substance abuse, in particular regarding women-specific aspects and developing and implementing programmes and strategies (Commission on Narcotic Drugs 2012b).

Through the resolution, the UN Interregional Crime and Justice Research Institute (UNICRI) was also invited to share with the UNODC its experience on relevant programmes and measures addressing the specific needs of women. Subsequently, the UNICRI initiated the Drugs, Alcohol and Woman Network: Promoting Gender-Based Drug Use Prevention and Recovery project to address gender differences in drug use and addiction, and to promote gender-responsive drug policies in drug prevention and recovery (ibid.). The outcome of the project was a toolkit mainly focused on the needs of women, designed to improve policy and practice with a gender mainstreaming approach in the field of substance use (Liquori O’Neil and Lucas 2015).

Another resolution in 2016 requested:

the United Nations Office on Drugs and Crime to continue to support Member States, upon request, in mainstreaming a gender perspective in their policies and programmes

related to the world drug problem, and invites other relevant United Nations entities, within their mandates, to cooperate in this regard (Commission on Narcotic Drugs 2016).

In addition, the annual report of the International Narcotics Control Board for 2016 points out that women are provided with suitable drug dependency treatment in only a few countries and that there is a need to expand gender-sensitive treatment in “virtually all countries” (INCB 2016) to attain the highest standard of health for women. The report also encourages the collection of gender-disaggregated data, better funding for women’s treatment, and the importance of gender-sensitive, trauma-informed, women-only substance abuse treatment programmes in community treatment, citing the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules) (ibid.).

In 2019, the Ministerial Declaration of the Commission on Narcotic Drugs reaffirmed its commitment to adopt a balanced and evidence-based approach to the world drug problem, based on the principle of common responsibility, and recognising the importance of properly incorporating gender perspectives and age in drug-related policies and programmes, as well as paying attention to individuals, families, communities and society as a whole, focusing in particular on women, children and youth (Commission on Narcotic Drugs 2019).

Over the decades, high-level documents have confirmed an increasing trend towards gender mainstreaming. However, this dimension is still interpreted as a binary one. It is now a priority to consider gender more broadly and ensure that decision makers and policy makers have a more inclusive understanding of this category. Hereafter, gender is referred to as a non-binary category, so it should be understood that way in all the elements mentioned below.

Key elements for drug policies

Monitor and describe the situation of drug use with a gender perspective

Without a doubt, the most important factor for successful gender mainstreaming is reliable information and analysis (UNODC 2021b: 23). Even though at a global level and in developed regions gender differences regarding drug use, their consequences and access to services have been described in outline, there is still much to learn about the subject. The lack of resources for collecting reliable data and limited awareness of the problem, as well as negative attitudes towards women’s substance use, may result in women and non-binary people being underrepresented in epidemiological samples or not answering surveys and interviews accurately (Currie 2001).

Ideally, the construction of drug policies should be based on the national situation and must consider at least a diagnosis with indicators disaggregated by sex. However, currently only 47 countries out of 201 reporting to the UNODC have data disaggregated by sex for the last five years (UNODC 2018a). In this sense, national drugs observatories are a key instrument for formulating policies with a gender perspective.

Based on the Lisbon Consensus, the EMCDDA identifies 13 areas of policy interest for all supranational and international organisations, which are especially useful

in the construction of diagnoses to understand the drug problem (EMCDDA and CICAD-OAS 2010). Taking into account those related to drug demand reduction, disaggregation by sex could be carried out for the following indicators:

- ▶ drug consumption among the general population (prevalence and incidence);
- ▶ drug consumption by young people (prevalence and incidence);
- ▶ high-risk drug consumption (for example injecting, dependence);
- ▶ services utilisation;
- ▶ drug-related morbidity;
- ▶ drug-related mortality;
- ▶ social exclusion and disadvantage.

These core areas and indicators of interest, broken down by sex, can provide essential information to describe the national situation of drug use and its characteristics, which will contribute to the development of national drug plans adjusted to the reality of the country and the needs of the population. Nonetheless, this description should also include gender-sensitive data, which in addition to being broken down by sex reflect the social realities of different gender identities, according to the following guidelines (UNODC 2021b: 26):

- ▶ data are collected and presented disaggregated by sex as a primary and overall classification;
- ▶ data reflect the social realities of different genders;
- ▶ data are based on concepts and definitions that adequately reflect the diversity and experiences of different genders;
- ▶ data collection methods take into account stereotypes and social and cultural factors that may induce gender biases.

Development of strategies and action plans with a gender perspective

A policy is a course of action selected from among alternatives to guide and determine present and future decisions. In this sense, the overall national drug policy-making process may be seen as an “umbrella” under which the following common structural elements fall: an NDS and a supporting action plan that in turn encompass programmes, projects and activities that logically implement them (CICAD 2009).

As gender is one of the social determinants of drug use, it should be considered a crucial element in the planning of strategies, action plans and their components. In the incorporation of a gender perspective, strategic planning is a fundamental process, since it allows clarification of the mission, vision and defining objectives to establish strategies and action plans that allow their achievement. Across the entire strategic planning process, perhaps the stage where the gender perspective can be reflected most easily is in the design of the action plan. An action plan represents a detailed description of the strategies and steps or lines of action used to meet specific objectives; even when the action plans of each country are unique, there

are common fields of intervention in their conceptualisation such as prevention, treatment, social reintegration, harm reduction, legislation, research, and subnational and supranational co-operation, among others. In this context, a gender perspective can be introduced as a priority in those fields in which the provision of services to the population already exists, such as prevention, treatment, social reintegration and harm reduction.

In addition, it is very useful to have a roadmap that helps translate policies into actions and give them direction. Four steps can be implemented to integrate a gender perspective into action plans and their components:

- ▶ consider the goals to be achieved, for example: more people who use drugs have access to treatment that consider their gender differences;
- ▶ describe the intervention in general terms, for example: treatment services tailored to people’s needs based on their gender;
- ▶ outline the path of change (or assumptions) that connect the intervention with the objective, for example: more treatment devices that effectively implement gender-tailored programmes;
- ▶ identify connections between the “how” and “why” stages to move through the change assumptions, for example: (how?) through training, more professionals will know how to implement a gender perspective in treatment; (why?) in order to have a greater number of treatment options, tools or methods.

To simplify this perspective, a conceptual framework for the design of action plans is presented in Figure 3.

Figure 3. Conceptual framework for the design of an action plan



Examples of gender mainstreaming in national action plans

The incorporation of a gender perspective into the structure of national action plans is carried out differently from country to country (as a general, specific or transversal element).

- ▶ As a general element, in Switzerland, the National Strategy on Addiction and Action Plan conceives gender at a more conceptual level. It considers as an objective the creation of favourable conditions that take into account the interaction between social realities such as work, the environment, living conditions and individual behaviours with factors such as gender.

In addition, it considers as a strategic objective “networking addiction policy partners and strengthening co-operation”, which includes promoting exchanges with national agencies specialised in gender, such as the Federal Office for Gender Equality (The Federal Council 2017: 15).

- ▶ In the action plan on addictions in Spain, gender is addressed as a specific element incorporated in lines of action such as “Incorporate in a practical way the gender perspective in preventive programmes” and “Include the gender perspective in all levels of the care process”, besides having gender-specific considerations regarding barriers to access to treatment (Ministerio de Sanidad, Servicios Sociales e Igualdad 2018: 11-14).
- ▶ The Programa de Acción Específico de Salud Mental y Adicciones (Specific Action Programme for Mental Health and Addictions) in Mexico incorporates gender as a transversal element, determining that all its strategies and lines of action must consider a gender perspective that accounts for gender diversity. Consequently, all lines of action, as far as possible, should be implemented with a gender perspective (Secretaría de Salud 2021).

Evaluation of action plans with a gender perspective

Evaluation is an essential element in the implementation of national action plans, and deserves to be addressed separately from other components, especially when considering the incorporation of a gender perspective. Although the evaluation should be seen as a continuum that begins from the planning stage and goes beyond the end of the action plan, it can also be seen as a mechanism that helps to provide feedback on the achievement of the planned objectives and determine the level of progress of the action plan.

An action plan with a gender perspective requires, from the planning stage, that specific mechanisms be conceived to evaluate concrete achievements regarding the incorporation of a gender perspective; to be measured, these concrete achievements must be translated into measurable goals. These goals usually establish the final result against which the current state or baseline will be compared and helps to track the plan’s progress and to identify improvements. Some of the essential characteristics of these goals is that they are meaningful, measurable, simple, comprehensive and reliable.

For example, if we return to the action plan mentioned above, our objective with a gender perspective to be integrated could be to improve availability and access to treatment programmes with a gender perspective. Then the goal to be achieved could be to increase the number of centres that offer treatment with a gender perspective. To evaluate the usefulness of this goal we can ask the following questions.

- ▶ Is it meaningful? Yes, because if more devices incorporate a gender perspective into treatment, there will be greater availability of services.
- ▶ Is it measurable? Yes, because it considers the number of devices with a gender perspective.
- ▶ Is it simple? Yes, because generally monitoring and data are easily accessible.

- ▶ Is it comprehensive? Yes, because it can be directly related to a range of services.
- ▶ Is it reliable? Yes, because there are usually formal records of the number of treatment devices.

Additionally, to simplify and help in the design of goals with a gender perspective some practical questions can be considered.

- ▶ Does the goal reflect specific desired achievements in gender mainstreaming?
- ▶ Can progress towards gender mainstreaming be measured through the action plan?
- ▶ Is the goal challenging, but realistic and achievable with available resources?
- ▶ Does the objective specify a gender outcome rather than an activity?
- ▶ Is the organisation or actor responsible for achieving the objective identifiable?
- ▶ Is there at least one goal for each established objective (prevention, treatment, etc.)?

The value of having clear, specific and measurable goals related to gender mainstreaming is that through their evaluation they will provide certainty as to whether the objectives are being met, or if it is necessary to make adjustments during the implementation of the action plan. In addition, in the future it will be possible to carry out evaluations of the results of the action plans.

Gender budgeting

Budget is an essential issue to consider in drug policies. In 2005, the Steering Committee for Equality between Women and Men (CDEG) of the Council of Europe looked more closely at the different methods available for implementing the strategy of gender mainstreaming and agreed that gender budgeting should be a priority, since budgets are important as a policy and planning instrument for governments (Council of Europe 2005). A budget includes all the economic resources to implement the national drug action strategy or plan; this may include direct sources of financing, such as government institutions with responsibility for implementing the action plan, or indirect sources, such as resources for the transversal implementation of a gender perspective allocated to institutions with responsibilities for gender matters, and resources from CSOs or private organisations. To identify and promote the existence of a budget for gender mainstreaming in drug policies, three national situations and courses of action can be considered.

- ▶ If there are resources available in the country, sources of financing and the budget available to implement gender mainstreaming strategic objectives should be mapped during the design of the action plan, and priority actions to which resources will be assigned should be decided on.
- ▶ In some countries there may be resources allocated to the national drug plan, but no defined resources for gender mainstreaming. In this case, it will be necessary to advocate for the available budget to also be directed to priority gender mainstreaming actions. A progressive approach could be

to include relevant gender issues within general actions for which budget has been assigned, for example in media campaigns, without the campaign being necessarily focused on gender mainstreaming.

- ▶ In other countries there may not be resources available for gender mainstreaming in drug policies. In this case, considering the diagnoses, needs and concerns regarding drugs and gender, a map of stakeholders and decision makers on budget issues can be drawn up to promote the allocation of resources through advocacy strategies.

In preparing and promoting gender budgets, it is very important to disseminate the lived realities of women, men and non-binary people and make visible existing inequalities to highlight the impacts of spending decisions and to review public finance decisions to ensure that they promote gender equality rather than reinforce existing inequalities (EIGE 2020).

Spain and Mexico provide two examples of affirmative and progressive actions allocating resources for gender mainstreaming in national drug plans.

- ▶ The action plan on addictions in Spain proposes as a line of action “Promote comprehensive care and co-ordination of resources for women who suffer gender violence, and their daughters and sons, to avoid institutional victimisation”, and establishes as an activity “Design and implementation of a pilot project of specific residential support resources for women with addiction problems who are victims of gender violence”. In addition to addressing a specific problem such as violence against women who use substances and are victims of violence, they also promote the co-ordination and efficient use of resources for treatment in this regard.
- ▶ In Mexico, the Federation’s Expenditure Budget allocates public resources to promote gender equality in all government programmes; in the health sector, these resources are split across different actions, including the prevention and treatment of addictions. Although the resources allocated are limited, this initiative has increased the recognition of gender mainstreaming in planning the budget for the national drug action plan.

As gender mainstreaming is not present in a significant number of national drug plans and strategies, it is expected that there are no planned budgets for this purpose. Therefore, decision makers should consider that developing drug policies with a gender perspective inherently implies advocacy for progressive budgets.

Guide to evaluate the inclusion of a gender perspective in drug policies

In addition to the key elements mentioned previously, it may be useful for decision makers to have a guide (checklist) to identify whether the policies in their country, region or state have a gender perspective, taking into account the different stages of developing and implementing the plan. These criteria have been established by the UNODC to assess the implementation of essential elements for gender mainstreaming in programming.

Table 1. Criteria for assessing plans and programmes (adapted from UNODC 2021b: 52)

Plan component	Criteria	Yes	No*	Partially*
Situation analysis				
Addressing the problem	Does the background/context analysis of the plan examine: (a) the different situations of women and men, boys and girls? (b) the expected impacts the plan will have on the different groups?			
Counterpart capacity	Are women/gender-focused groups, associations or gender units in partner organisations consulted in the policy/plan development?			
Strategic context	Is the different impact of plans, regional and national strategies on women and men, boys and girls considered?			
Synergies with other projects/programmes	Are lessons learned and best practices on gender equality and women's empowerment incorporated? Have key findings and recommendations emanating from relevant research, other United Nations entities and policy/plan evaluations been incorporated?			
Target groups	Does the plan include strategies to reach out/identify the underrepresented sex that would benefit from the plan?			
Gender equality and women's empowerment	Does the policy/plan include targeted actions for gender equality and women's empowerment? Are gender aspects included in non-targeted actions?			
Human rights	Have national and/or international policies on women's rights been consulted?			
Plan description				
Location and duration	Does the plan ensure that both women and men can access and participate in project/programme activities (target at least 30% of whichever gender is underrepresented)?			
Engendering the results chain	Are outcomes, outputs and activities designed to meet the different needs and priorities of women and men, boys and girls?			

Plan component	Criteria	Yes	No*	Partially*
Guidance for the development of gender-sensitive indicators	Does the results framework include gender-responsive indicators, targets and a baseline to monitor gender equality and women's empowerment results?			
Plan management				
Staffing	Is there gender-balanced recruitment of plan personnel and gender-balanced representation in plan review committees?			
Budget	Have adequate financial resources been allocated for the proposed gender activities?			
Monitoring and evaluation	Will the plan collect and use sex-disaggregated data and qualitative information to analyse, monitor and evaluate its implementation in a gender-sensitive manner?			

* In case of answering no or partially, it is recommended to analyse what actions can be implemented to achieve the criterion.

Capacity building in gender mainstreaming

Decision makers can promote the incorporation of a gender perspective in drug policies through the building of gender mainstreaming capacities in organisations and working groups responsible for implementing national plans. WHO has outlined the following aspects that can be implemented so staff are more sensitive to the relevance of gender mainstreaming (WHO 2011a, 2011b):

- ▶ promote a needs assessment to better understand the gaps in knowledge and skills related to gender and drug use;
- ▶ help staff improve understanding of drug use and gender implications;
- ▶ analyse the degree of application of gender analysis skills by those who design and implement programmes;
- ▶ evaluate the level of institutional support for integrating a gender perspective into the work of staff;
- ▶ identify factors that facilitate or inhibit integration of a gender perspective into the work of staff;
- ▶ bring gender into mainstream objectives, operational planning and the whole programme cycle;
- ▶ encourage leaders to include references to gender and women's empowerment systematically in all public speeches and explicitly encourage their staff to do the same in their technical work;
- ▶ build partnerships with women's organisations and ministries of women's affairs (or equivalent);

- ▶ promote sex parity in staffing;
- ▶ establish gender competences for staff performance in job descriptions, performance management and development;
- ▶ enhance the leadership skills of female staff;
- ▶ promote financial and human resources allocated to gender perspective implementation;
- ▶ establish mechanisms and guidelines to improve resource allocations for work on gender;
- ▶ establish accountability for incorporating a gender perspective in current and future plans and programmes;
- ▶ support the development of evidence and tools on gender and drug use.

Examples of policies with a gender perspective at national and local level

Some countries, such as Ireland, Mexico and Spain, have incorporated gender perspectives into their drug policies at different levels of planning and implementation. The case of Reykjavik, Iceland, is presented as a local example.

Ireland

Drug policy within Ireland has been mediated through successive national drug or substance misuse strategies, which since 2012 also include alcohol. The current strategy, *Reducing harm, supporting recovery: A health-led response to drug and alcohol use in Ireland 2017-25*, (Department of Health 2017) was launched in July 2017. Regarding the inclusion of women, the strategy recognises that women can experience barriers to engaging and sustaining involvement with treatment and rehabilitation services. In that sense, the strategic action “Expand addiction services for pregnant and postnatal women” aims at:

- a. strengthening links between maternity services and addiction services;
- b. quantifying the need for additional residential placements for pregnant and postnatal women who need in-patient treatment for addiction to drugs and/or alcohol across the country;
- c. developing services to meet that need ensuring that such facilities support the development of the mother–baby relationship;
- d. providing dedicated support for pregnant women with alcohol dependency, including examining the need to expand the role of the drug liaison midwife (DLM)⁶ in this regard – any such expansion will likely generate a need to further increase the number of such midwives;
- e. resourcing the National Women and Infants Health Programme (NWIHP) to provide DLMs and specialist medical-social workers in all maternity networks;

6. The drug liaison midwives see pregnant opioid-dependent women in their clinics, and support them throughout their pregnancy and for six weeks post-birth.

- f. supporting maternity hospitals/units to strengthen their methods of detecting alcohol abuse and supporting women to reduce their intake; and
- g. engaging the NWIHP to develop a consistent approach to informing women about the risks of alcohol consumption during pregnancy.

Further, one activity includes “disadvantaged women” in relation to responses to address exclusion and poverty, and two others relate to wraparound services for women generally and for women exiting treatment, especially with regard to housing provision.

On the other hand, there are no gender-specific actions within the current drug strategy addressing prevention, which in the Irish context tends to focus on education and awareness raising of the harms of drug use. Prevention actions are traditionally focused on young people and initiatives that will sustain young people successfully within secondary education. In addition, there are no specific actions addressing women and the criminal justice system within the current drug strategy. However, the Irish Prison Service and Irish Probation Service Strategic Plan 2018-20 (Department of Justice and Equality 2017) makes four specific references to women, noting the importance of using community sanctions where possible and naming actions to increase access to education and recovery, support resettlement and respond to domestic violence. The National Strategy for Women and Girls 2017-20 (ibid.) also links to the actions within the NDS (Morton et al. 2020).

The 2017 Irish NDS has undergone a mid-term review (Department of Health 2021), and this has included consideration of how gender aspects of the strategy could be strengthened, in line with the forthcoming women’s health strategy. In consultations, there has been general acceptance that the current strategy has tended to focus on pregnancy and motherhood, or to have designated women or non-binary persons as a “special population” (Wincup 2019). There is increasing awareness of the need for gender-sensitive, if not gender-transformative, drug policy and intervention. Achieving better outcomes for women who use drugs across the life course will be a priority. However, as in most jurisdictions, policy makers face a myriad of resource and technical challenges in translating this requirement into strategic actions. Six Strategic Implementation Groups have been set up, with independent chairpersons also joining the National Oversight Committee responsible for implementation of the strategy (Department of Health 2021). A key development is the highlighting and prioritising of actions to address gender-specific needs of women across a range of services, responses and interventions.

Mexico

According to the General Law for Equality between Women and Men, decreed in Mexico in 2006, equal opportunities and treatment must be guaranteed for men and women, in order to promote the empowerment of women and avoid discrimination based on sex. In this context, a gender perspective applied to national policies consists in the implementation of mechanisms that allow the identification and assessment of discrimination, inequality and exclusion of women, as well as the

actions that must be taken to address gender issues and create the conditions of change that allow progress in the construction of equality.

Accordingly, it is established that public policies must be transversal, that is in their preparation and execution, the incorporation of a gender perspective is guaranteed in order to assess the implications of any action that has been programmed for women and men, such as legislation, public policies, and administrative, economic and cultural activities in public and private institutions. Implementing these measures is the responsibility of the federal, state and municipal governments.

Although drug use in Mexico has long been a predominantly male concern, use has increased exponentially among women in recent years, mainly among adolescents. In this context, the health system has begun to incorporate a gender perspective in policies and programmes through various instruments and agencies. For example, the Sectorial Health Programme 2019-24 (Secretaría de Salud 2019) establishes among its strategies, in the field of mental health and addictions, guaranteeing access to mental health services, psychological support and comprehensive care for mental disorders and problems related to the use of substances. This targets those affected by natural disasters, humanitarian emergencies, violence or migration. As a line of action, the programme seeks to facilitate access to mental health services, psychological support and preventive measures at the first level of care, under the principle of equity and non-discrimination and with sensitivity to the life cycle and gender concerns.

The Specific Action Programme on Mental Health and Addictions 2020-24 (ibid.) considers that attention to mental health and the consumption of psychoactive substances should be mainstreamed by a gender perspective, including differentiated actions for the benefit of women: pregnant women, indigenous people, migrants and non-binary people. In addition, the Programme against Drug Dependence 2021-24 (CONADIC 2021) considers comprehensive care with a gender approach that accounts for gender diversity, which addresses the particular needs of women and people of sexual diversity in a manner that is free from stigma and the imposition of assigned roles. For prevention, it considers the objective of ensuring a comprehensive approach to the consumption of psychoactive substances that includes mental healthcare and prevention of use and assesses associated risks, incorporating a non-binary gender perspective, multiculturalism, respect for human rights and sensitivity to the life cycle. Regarding treatment, another objective is to guarantee effective and timely access to comprehensive care services in mental health and addictions for people who consume psychoactive substances or who present with addictive behaviours, incorporating the non-binary gender perspective and a respectful approach to human rights, non-discrimination and quality in care.

Additionally, the Mexican Government includes in the Federation's Expenditure Programme a gender budget that is applicable to the prevention and care of addictions, and includes follow-up indicators covering training for health personnel with a gender perspective, actions of prevention with a gender perspective, care for women who use drugs, and psychological support for women survivors of violence.

Spain

The National Strategy on Addictions 2017-24 (Ministerio de Sanidad, Servicios Sociales e Igualdad 2017) recognises that a gender perspective is essential, and can work as an analytical tool for all programmes of research, intervention and prevention. The strategy seeks to develop greater awareness of a gender perspective; to raise awareness in society as a whole in order to promote aspects that work to improve protection for women and so encourage men to adopt them too; to promote the prevention and early detection of gender violence towards women who are addicted to psychoactive substances and in environments where these substances are used; to drive forward programmes that focus on the needs of women (e.g. their dependence on psychoactive drugs such as hypnotosedatives and opiate-derived pain relievers) by analysing all the aspects linked to their use and developing non-pharmacological treatment alternatives; and to address the differences and specificities of men and women regarding challenges such as social change, new forms of addiction and new usage patterns and trends. The strategy also incorporates a gender perspective among its guiding principles through the Organic Law 3/2007 for the effective equality of women and men, which mandates the incorporation of a gender perspective as a framework for analysis and the development of tools that allow women's addictions across a range of presentations and their impacts to be made visible, analysed and addressed.

From this perspective, in the area of prevention, the strategy identifies women as its target population (especially those of reproductive age and those who are pregnant); in comprehensive and multidisciplinary care, it asserts that a gender perspective must be incorporated at all levels of the care process, considering the conditioning factors of drug use in women, promoting treatments focused on women, and addressing conditions such as motherhood or gender violence. In the field of harm reduction, too, the strategy identifies women as a target population. Regarding social incorporation, it places special emphasis on labour market integration, beyond including women as the target population, and it also establishes that the expansion and adaptation of services and programmes must take into account the differentiated impact of addictions on women.

Reykjavik

Drug use in Iceland is insignificant compared to other European countries and it is mainly young people that use illicit drugs on a regular basis (Gunnaugsson 2013). Since 2014, the Parliament of Iceland has debated adopting policies that focus on harm reduction. In this context, the term "gender" is not mentioned in the Alcohol and Drug Policy Document but "women" are mentioned in the context of pregnancy and the potential negative effects of drug use (Thomas and Bull 2018). Nonetheless, Iceland is moving towards a more gender-sensitive and harm-reductive system. Perhaps the biggest changes in alcohol and drug policy in recent years have been at the local level, such as in the capital, Reykjavik.

In 2014, the City of Reykjavik adopted a new policy regarding "outsiders", responding to a rapid increase in the homeless population in the city after the financial crash

in 2009: 62% of these people considered themselves to be homeless as a result of problematic substance use. In this sense, the policy presented by the City of Reykjavik in 2019 had a clear focus on the human rights of homeless people, incorporating a gender perspective through the adoption of ETHOS⁷ – European Typology on Homelessness and Housing Exclusion – which has proven to be a very important instrument to eliminate the invisibility of homeless women, who are often victims of violence and marginalised in the health and welfare system (City of Reykjavik 2019: 7). Consequently, the number of services for women has increased, as well as understanding and sensitivity to the needs of women who use substances.

Conclusion

Making recommendations to decision makers to effectively incorporate a gender perspective in drug policies is complicated because there are different elements to take into account, such as the structure of organisations in charge of drug policies, the political context, the economic and social situation and the gender agenda in the country. Undoubtedly, a greater number of governments are now open to gender equality and consequently to gender mainstreaming in public policies, including drug policies. Nonetheless, gender mainstreaming is a long-term exercise that must be conceived as a process (because it is transformative in itself) and not as an end (because there are perhaps decades to go before the desired minimums are met).

Since drug policies are a general approach and at the same time the basis of the approach to the drug problem in the countries, it is quite useful if, from language to action, decision makers adopt an integrating vision of gender mainstreaming, so that drug policies have key principles that can be translated into effective practices that contribute to creating new ways of making policies and closing gaps and inequities based on gender in drug-related issues.

Finally, it must be considered that drug policies are located at two poles in their applicability to countries. On the one hand, drug policies have similarities because they share common elements. But at the same time they are as unique as the country in which they are implemented. In this sense, there is no standard to qualify the best drug policy. Nonetheless, a policy that incorporates a gender perspective is undoubtedly close to being better and a policy that comprehensively adopts a gender-transformative approach is even better.

7. ETHOS classifies people who are homeless according to their living or “home” situation. These conceptual categories are divided into 13 operational categories that can be used for different policy purposes such as mapping of the problem of homelessness, and developing, monitoring and evaluating policies.

Chapter 3

Guidance for practitioners

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While there is overarching agreement on the needs, requirements and mechanisms for developing and including gender-sensitive and gender-transformative approaches to existing and new interventions and responses, enacting such positive change can remain challenging for practitioners and service providers. In this chapter we explore the domains of (1) prevention; (2) law enforcement and the judicial system; and (3) intervention, support and treatment, with a view to highlighting innovations in theory and practice. We include examples of how the structural and complex aspects of gender inequality are being addressed and responded to, as well as the challenges that remain, with a focus on women's experiences and needs.

Prevention

Aimed at reducing the incidence of drug use and progression to addiction, prevention targets the majority of the population that has not developed a problem or those who are only showing the first signs of it, primarily youth. Three broad categories of drug prevention can be distinguished according to targeted groups. Universal prevention is directed at all members of a target group in the general population, regardless of their underlying risks and drug use (EMCDDA 2019b). Selective prevention targets vulnerable people who are at risk of addictive behaviours. Indicated prevention consists in individualised preventive approaches targeting people showing the first signs of problematic use or those on the verge of requiring treatment, and also includes educative approaches for safer use. Indicated interventions help (young) drug users to deal with their risk factors for escalation in substance use, including their own personality traits.

To date, drug prevention programmes have rarely been designed to be gender sensitive or specific to girls or women. This gender-blind approach suggests that programme designers do not consider that gender norms start influencing drug-related risks, drug intake and its outcomes from the early developmental stages of childhood and adolescence. However, gender norms do play a central role in defining acceptable and unacceptable behaviours for men and women (Hunt and Antin 2019).

Through the lens of gender norms, the social use of alcohol, tobacco or drugs is tolerated or even encouraged among boys and men, but is condemned when it concerns girls and women, who have been traditionally relegated to private (hidden) contexts for substance use. Using these substances can be a way of complying

with traditional gender roles or, inversely, a way of turning away from norms and experimenting with new possibilities for self-affirmation and identity construction (Measham 2002; Van Havere et al. 2009).

The gender gap in the social use of drugs is narrowing, especially among young people, for certain products and patterns of use in many countries (see Chapter 1). This context and the continued structural inequalities between genders call for more adapted and fine-tuned prevention responses, especially for youth. Gender-sensitive forms need to be developed within the scope of universal, selective and indicated prevention, on the basis of evidence-based knowledge in respect to efficacious interventions, protective factors and risk factors. However, while scientific literature and experts advocate for the development of evidence-based approaches for prevention programmes (UNODC 2018b), there is scarce guidance on how to integrate gender-sensitive considerations in project design (for example mediators, mechanisms) and implementation. Further research on what works for which gender will be needed (UNODC 2017a).

Drug prevention and gender: what does the literature say?

Evidence-based prevention

Prevention programmes must build on the evidence on efficacious ways of preventing addictions in girls, boys and non-binary young people, given their specific needs and without (re)producing discriminatory patterns. The scientific literature indicates that psychosocial mechanisms and cognitive abilities are more effective in preventing, reducing or helping to control alcohol drinking, smoking or other drug use among young people (see Box 2). The enhancement of these psychosocial mechanisms and cognitive skills enables young people to resist social pressure and incentives to consume drugs. They are most often tested in the context of school-based programmes, schools being the main social environment where young people of all genders experience interactions between peers.

Box 2. Good practices of substance use prevention

In the field of universal or selective drug prevention, particular psychosocial approaches have been evidenced as effective in curbing substance use. In general, these preventive approaches rely on mechanisms of social influence, by critiquing some social pressure mechanisms or inversely by building on other psychological drivers and on cognitive skills such as self-assertiveness, communication skills and problem-solving abilities (EMCDDA 2019b; UNODC 2013b, 2017a, 2018b). Prevention programmes based on social influence first target the beliefs, misconceptions and dynamics that can lead individuals to consume drugs. They enable participants to develop resilience and resistance skills and exercise them through interactive methods. Targeting multiple-risk behaviours in universal school-based interventions may be effective in preventing tobacco use, alcohol use, illicit drug use and antisocial behaviours. Little evidence is available about the benefits of such an approach at a family or individual level (MacArthur et al. 2018).

Prevention programmes targeting high-risk, vulnerable and disadvantaged young people have been shown to be more effective in preventing, delaying or reducing substance use when implemented both in the community and at school (Jones et al. 2006). In settings where drinking takes place, prevention is more likely to reduce alcohol consumption, assaults, traffic accidents and underage drinking when it combines training, including Responsible Beverage Service training and enforcement of licensing and age limits for purchasing alcohol (Jones et al. 2011).

For those in the early stages of drug use, motivational interviewing (MI) is recognised as a promising method to prevent substance use, as there is now consistent evidence about its role in reinforcing resilience (Foxcroft et al. 2014; Lindson et al. 2019; Smedslund et al. 2011). In the same vein, mentoring (see glossary) has been shown to be more fruitful than no intervention at all (Thomas, Lorenzetti and Spragins 2011).

For more information, see the EMCCDA's best practice portal (available at www.emccda.europa.eu/best-practice, accessed 31 January 2022).

Evaluations of prevention programmes commonly highlight differences in outcomes between boys and girls. However, the intervention process is generally too poorly detailed to show which implemented components or dimensions have generated healthy outcomes in which gender groups (that is, what works for whom?). Given this state of affairs, it is recommended that a gender perspective be mainstreamed into school-based prevention programmes at the inception stage so that these “gender-sensitive measures” can be evaluated for outcomes at a later stage.

Protective factors and risk factors

Findings on the protective and risk factors and gender-specific motivations of using drugs provide pathways to conceptualise gender-sensitive programmes in universal drug prevention (UNODC 2017a, 2018b). They help to discern why some approaches are likely to be more effective for a particular gender and how to make programmes more gender sensitive.

It is worth noting that girls and boys share many risk factors and protective factors in relation to drug use. Factors related to family bonding, child-rearing and relationships with pro-social peers are protective for both girls and boys. Poor self-esteem, difficult or permissive family or school environments as well as having antisocial or norm-breaking peers (friends) are risk factors for alcohol and cannabis use among teenagers (Bränström, Sjöström and Andréasson 2008). However, gender-based differences are also evidenced in the drivers or barriers to drug use. Box 3 summarises findings about the main protective factors against drug use that have been evidenced for girls. Family-based factors are particularly relevant.

Adverse childhood experiences are consistent risk factors that predict poor health in later life and increase the risks of smoking and substance use in students, and they may concern significantly more boys than girls (Raleva and Ignjatova 2016). On the other hand, weak management of stress and eating disorders are also correlated with problematic drug use among young girls. Trauma, especially when it is

correlated with sexual abuse or domestic violence, is highly predictive for addictions in women and girls, as argued in Chapter 1 (EMCDDA 2015; Evans-Lacko et al. 2018; Harrop and Marlatt 2010; Tirado-Muñoz et al. 2018).

In a gender equity approach, drug prevention must not build on factors that foster an oppressive situation or discrimination of any genders, especially girls, women and non-binary people.

Box 3. Main protective factors against drug use identified for girls at the individual, family and social levels

Individual level:

- ▶ positive self-image and body image (Elliot et al. 2008);
- ▶ assertiveness, problem-solving skills and resiliency (Norman 1997; Turner, Norman and Zunz 1995);
- ▶ commitment to school and a strong academic record (Griffin et al. 2000; Hawkins, Catalano and Miller 1992);
- ▶ positive attitude towards rules and substance use restrictions (Bränström, Sjöström and Andréasson 2008).

Family level:

- ▶ strong attachment or relationship with parents (Bonevski, Ignjatova and Naumovska 2016; Griffin et al. 2000; Hawkins, Catalano and Miller 1992) and attachment to at least one trusted adult to whom they can refer;
- ▶ mothers' knowledge of their daughters' whereabouts, activities and companions (Schinke, Fang and Cole 2008);
- ▶ mothers' listening ability and availability with regard to being contacted (ibid.);
- ▶ mothers' employment, fathers' high level of education, having responsibilities within the family (Norman 1997; Turner, Norman and Zunz 1995);
- ▶ parental control of the child's schedule and relationships (e.g. curfews) (Bränström, Sjöström and Andréasson 2008);
- ▶ family rules against the use of alcohol and other drugs.

Social level:

- ▶ developing among peers who do not use psychoactive substances (ibid.);
- ▶ having pro-social peers supportive of a respect for rules and health recommendations (ibid.);
- ▶ having relationships with caring adults outside the family (Norman 1997; Turner, Norman and Zunz 1995);
- ▶ popularity with peers, positive high school experiences and participation in sports (Norman 1997; Turner, Norman and Zunz 1995).

Some studies have presented traditional forms of education based on restrictive views of the roles and attitudes assigned to females (Rohrbach and Milam 2006) and involvement in religious activities (Griffin et al. 2000; Hawkins, Catalano and Miller 1992) as protective. To some extent, such factors may be rather oppressive and prevention workers may consider promoting other familial or social factors of regulation.

Source: Liquori O’Neil and Lucas 2015; UNODC 2017a.

Normative patterns of use

There are many commonalities between girls and boys with regard to the motivations to use or to start using drugs. For all, social pressure is crucial. Sociability and relational aspects are stakes that dominate the narratives of the “first times”: they trigger the initiation into drugs then operate as catalysts (Obradovic 2017, 2019). However, different genders may express specific motivations towards licit or illicit substances. For instance, a study among French teenagers showed that girls are more likely to privilege intimate dynamics of mutual acceptance and validation with their “best friend(s)”, to consolidate an alliance, especially for their first cigarette; boys seem more inclined to experience group sensations, often with elders and mentors, aspiring to social recognition (ibid.).

In recreational and social spaces, women are invited to use alcohol and drugs as expected in these contexts, while they are required to take responsibility for their personal safety, for example by showing more self-vigilance, self-regulation and more protective behaviours (Balasch et al. 2018; Pires et al. 2018). They also face social pressure to preserve a traditional image of temperance (to maintain their “reputation”) in all things, including sexuality (Sell et al. 2018). Men experience more episodes of severe intoxication, overdoses, accidents and interpersonal violence, whereas women report more experiences of sexual violence (Balasch et al. 2018; Palamar and Griffin 2020), as well as domestic, physical and emotional violence. Recent studies show that non-binary people are at high risk of experiencing drug use and adverse outcomes, and have increased risks of being confronted with violence (see Chapter 1).

Recommendations for gender-sensitive good practices for drug prevention

A reasonable set of recommendations can be proposed, building on efficient or promising ingredients mostly evidenced in gender-blind programmes and combining components that are consistent with protective or risk factors identified in girls and non-binary young people.

Gender sensitivity is not simply a matter of targeting one particular gender, biological state or role (such as pregnancy or motherhood), for instance by addressing boys/men and girls/women separately or by meeting gender quotas in the delivery of programmes. Gender-sensitive programmes in prevention should consider gender diversity, specific vulnerabilities and the impact of gender socialisation in increasing these vulnerabilities from childhood and early adolescence. They should therefore examine: (1) the social norms towards gender and drug use in a given cultural context;

(2) the social interactions between genders. They should explore how these psychosocial dimensions can influence drug use, in order to build resilience. More needs to be done to understand the particular vulnerability and needs of trans people of all genders in relation to drug issues.

The gender-blind nature of current drug prevention programmes may reflect practical barriers as well as theoretical standpoints and it is important to assess the former. For instance, including gender-adapted content or separated sessions by genders in prevention programmes may result in trivial additional time and costs compared to gender-blind programmes. However, these organisational, budgetary or time conditions can prove to be acute constraints for delivery settings, such as schools. The rationale for distinct content or sessions in order to adapt prevention to gender considerations may appear contradictory with evidence-based recommendations that require realistic social situations that often bring members of different genders together. Developing personal and psychosocial skills, building on social representations, dispelling received ideas (normative education), empowering individuals with coping skills (against drug offers, peer pressure) depends on inter-gender influence. In addition, gender issues foster a controversial debate that is likely to create an unfavourable climate to the development of a gender approach in drug prevention programmes (UNODC 2018b).

Universal prevention: preventing use, fostering gender values

Universal prevention is mostly directed at young people who are citizens in the making. Nowadays, the recognition of gender diversity is part of the struggle of young people to defend their rights in education, labour, social and health contexts. It is important to raise awareness about gender norms that ground social inequity and, as regards psychoactive substances, that might have been internalised during their education. It is important to adopt a fine-tuned approach so as not to stigmatise any gender, nor to provoke rejection because of norms and inequalities chiefly generated by preceding adult generations.

Drug prevention programmes benefit from incorporating one or more of the following psychosocial or cognitive approaches, especially for girls (Liquori O’Neil and Lucas 2015):

- ▶ to dispel misconceptions about what is “normal” drug use, for example to dispel the widespread belief, especially among youth, that “everyone takes drugs” or “substance use is a matter of boys”, by providing an accurate estimate of the prevalence of drug use among all genders. This work on “normative beliefs” aims to reduce the acceptability of drugs (Blake et al. 2001; Kumpfer, Smith and Summerhays 2008). It enables discussing and understanding the role of alcohol, tobacco and drugs in building sociability and relationships;
- ▶ to help to resist peer pressure and to circumvent the influence of “antisocial” peers with attitudes that are incompatible with healthy choices (ibid.; ibid.). Gender-sensitive programmes should address situations that involve gender-based power dynamics and relationships and their influence on the onset or scaling up of substance use;
- ▶ to reinforce assertiveness (ability to express oneself and defend one’s choices and rights without harming others) and communication skills;

- ▶ to encourage self-esteem. Some girls experience lower self-esteem and the partial loss of their “voice at the table” through social conditioning that tends to restrict their free expression as a means of preserving social relationships (McLean Taylor, Gilligan and Sullivan 1997; Spira, Grossman and Wolff-Bensdorf 2002);
- ▶ to enable young people to identify risky situations and to develop coping skills, in other words to help to reduce interpersonal tension, to manage conflict and to cope with stress;
- ▶ to include family and community components. Programmes with family and community components are particularly promising if they stress the importance of listening, family ties and protective rituals, and clarify the influence exercised by peers and social groups. They also help to clarify the relevance of clear rules on “what’s prohibited” and exemplary parental behaviour and attitudes towards psychoactive substances (Liquori O’Neil and Lucas 2015). They inform parents about the risk factors for drug use and seek to strengthen children’s communication, conflict management and self-efficacy skills, among others.

The programme Tutor on Orientation and Prevention (TOP, Italy) helps boys and girls to discuss gender dynamics and how they intersect with drug use, in a space conducive to their free expression, with the help of facilitators.

The safe and non-judgmental spaces created by facilitators promote assertiveness, especially among those who experience more social conditioning in self-expression, namely girls.

Several gender-sensitive components are worth developing across the aforementioned psychosocial and skill-enhancing methods:

- ▶ to discuss gender norms of masculinity and femininity, and their fluidity and permeability (what is it to be a man, a woman, neither or both in Western societies?) in order to address the way these gender norms may drive or maintain patterns of drug use, related risk taking and the perpetration of violence, including domestic and sexual violence (Martínez-Redondo and Luján-Acevedo 2020);
- ▶ to discuss how gender norms may divert someone from searching for needed help in relation to drug issues and consider ways to prevent such barriers and pitfalls;
- ▶ to promote solidarity between genders and make young people aware of their co-responsibility and key role in preserving safety among their peers in a gender-equitable way: the concerns of pregnancy and violence are not confined to girls;
- ▶ to allow participants to discuss drug and gender issues in small groups that facilitate informal expression and exchange;

The TOP discusses whether help services can work with young people without making any gender judgments. The difficulties that girls or boys may experience in talking about drug problems are discussed.

A three-step session can be envisaged. First, girls and boys separately discuss the role of substance use in gender interactions; second, they come together and discuss the conclusions of each group; third, all aim to reach a consensus on inclusive collective protective rules with regard to substance use.

- ▶ to allow participants to address sensitive issues – for example drugs and body image, puberty, sexuality, pregnancy and sexual abuse risk – without participants of the opposite sex being present. Girls prefer the facilitator (prevention worker) to be a woman and to share her personal experiences (Sumnall et al. 2006). If gender-specific sessions are organised, it is relevant to combine them with mixed sessions that reflect more real-life conditions.

Selective prevention: addressing people at risk, tackling gender specificities

Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance use (tobacco, alcohol, illicit drugs and NMUPD). With regard to children (including adolescents), selective prevention may be directed towards children who are marginalised and living in poverty, children whose parents are drug dependent, children who lack education or are not attending school, children who are victims of abuse or neglect, children in conflict and post-conflict areas, children who have experienced trauma, children with mental or physical health challenges, children in the childhood protection system in public or private orphanages, children who are living and working on the street, children involved with the juvenile justice services, and any children who lack the support networks required to abstain from substance use.

Despite a lack of strong evidence, it can be assumed that psychosocial approaches that have been shown to be effective for universal prevention also have potential for groups with a higher risk for substance use. Therefore, in selective prevention (directed towards groups at risk), it is worth relying on these validated psychosocial approaches and addressing aspects aligned with the representations and risk taking of the targeted groups, especially gender-based issues. It is therefore relevant that interventions of selective prevention address more directly social and health risks and harms related to substance use and, in particular, how they are influenced by gender norms and gender considerations.

On this basis, the following components could be taken into consideration for a gender-sensitive prevention of substance use:

- ▶ to address norms of masculinity and their role in alcohol and drug use behaviours, risk taking and antisocial behaviours, such as committing violence, including GBV because conformity to masculine norms is evidenced as a predictor of heavy drinking patterns among men (Iwamoto et al. 2011) and perpetration of GBV (Martínez-Redondo and Luján-Acevedo 2020);
- ▶ to address the ways drinking culture and drug use may stimulate or amplify hegemonic domination behaviours in certain men, in order to denormalise rape-supportive attitudes, to refute rape myths – *id est* beliefs that shift blame from the

The programme Ponto Lilás (Portugal) conducts outreach at large-scale festivals to prevent and respond to gender-based and sexual violence, in particular in relation to drugs and drinking.

It raises awareness on GBV, safer alcohol and drug use patterns, and harm reduction. The programme engages bystanders to respond to crisis situations of GBV, and addresses drug and drinking risks and increased social vulnerability.

rape perpetrator to the victim – and victim blaming regarding drug-facilitated sexual assault (see also glossary) as the adherence to rape myths and beliefs that rape is pervasive, due to societal attitudes about gender and sexuality (rape culture, see glossary) may predict sexual violence in nightlife environments (Hayes, Abbott and Cook 2016; LeMaire, Oswald and Russell 2016; Tinkler, Becker and Clayton 2018; Wegner et al. 2015);

- ▶ to organise outreach work (mobile teams) to “move towards” people in their usual social environments or in leisure settings;
- ▶ to involve bystanders in the development of peer-based selective prevention programmes, especially for programmes implemented in recreational settings. Bystanders can have an active role in detecting, preventing and interrupting violence, in particular sexual violence in drinking and drug use environments (Ham et al. 2019; Jouriles et al. 2018; Leone et al. 2018). Bystanders may be part of civil society or members of the community targeted by the prevention interventions. Their participation in drug programmes requires sound training.

Indicated prevention: early work on personal strengths and weaknesses

Indicated interventions target individuals who show the first signs of drug use, and aims to prevent them from escalating drug use by coping with personal risk factors and building up their personal resources. Research highlights that, among people who suffer from drug use disorders, women are particularly affected by adverse outcomes. In their life stories, determining circumstances and intimate risk factors are often identifiable from adolescence, such as having experienced violence from family members or from dating or sexual partners. Individual responses are more appropriate to account for these risk factors for problematic drug use.

In indicated prevention, these responses are developed for people, especially young people, who show the first worrying signs of drug use but who may have already faced adverse experiences or trauma. They are basically psychological responses, counselling, mentoring and motivational interviewing (MI), and sometimes border psychotherapy (see glossary). In some respects, adapting indicated prevention interventions for better inclusion of gender-based considerations draws on some approaches recommended to drug treatment teams, when it concerns:

- ▶ adopting a trauma-informed approach;
- ▶ enhancing resilience;
- ▶ resorting to outreach work (mobile teams) and/or a low-threshold approach to “move towards” people who have poor mobility or who are constrained in accessing help services by fear of stigmatisation.

In general, interventions resort to MI, a person-centred approach that enables the client to identify and galvanise personal resources to make positive healthy changes (see glossary). The trauma-informed approach and resilience-based approach are compatible with MI, but a

The programme “I want to know” (North Macedonia) consists of counselling prevention services for young people who are at risk of using or are currently using drugs. It is gender sensitive and non-binary friendly.

referral to psychological services may be considered for people who have had to cope with traumatic experiences.

There is a need to develop more adapted services and interventions for trans people of all genders who use drugs, especially young people, which may address their special needs in respect to their substance use and gender identity. Such services must make it possible to overcome both the psychological obstacles encountered by trans people (fear of stigmatisation) and the possible practical obstacles (geographical distance from help services). With regard to these considerations, recommendations for indicated prevention practitioners are:

- ▶ to promote specific preventive programmes for trans people who use psycho-active substances;
- ▶ to include staff with specific training on specific issues experienced by trans people;
- ▶ to create a supportive and respectful environment where trans people can talk openly about their drug use and its relation with the specific issues regarding their gender identity (for example social anxiety, difficulty in having intimate romantic and sexual relations, mental health, gender dysphoria) (Valentine and Maund 2016);
- ▶ to offer the possibility of teleconsultation for people who are geographically remote, have limited means of travel or who would be more reassured by this kind of support, at least until a relationship of trust can be established.

The programme works on motivation for change, assertiveness, stress management and decision making. Girls who start using drugs after an assault are followed up individually. In case of auto-aggression, referral to public health institutions is organised. Psychiatrists who offer offline and online drug prevention services to non-binary persons are specifically trained and continuously consult with a civil association of non-binary persons.

Further drug prevention research is needed

Gender-sensitive programmes of universal drug prevention are yet to be developed. Gender-sensitive dimensions should be incorporated into the design and delivery so that gender-sensitive, effective components and gender-based outcomes can be appropriately evidenced. Evaluation is required for all the experimental programmes that will emerge in this respect, in order to ensure that they are effective and respectful of people's rights. Further research and evaluation are all the more necessary given that a lack of awareness about the relevance and potential of gender-sensitive drug prevention is a basic obstacle (EMCDDA 2019b).

Most primary studies on the specific vulnerability of girls were conducted in the 2000s, and after this period, few researchers looked at the subject or the need to adapt prevention to the needs and responsiveness of girls. Even if the findings in this area are now somewhat dated, they offer valuable food for thought given the lack of evaluated gender-sensitive experiences in drug prevention. According to the current state of knowledge, the integration of modules specific to girls in prevention programmes and their evaluation are common sense. Overall, there is only a small amount of evidence about trans people, and even less that looks at the need to adapt prevention work to their specific needs.

Further research is needed to update and confirm the reasoned recommendations provided here. Better bridging action and research is needed to assess the specific needs and motivations of girls and trans young people of all genders, and to evidence the most effective drug prevention approaches for them. There is also a need to take into account the new stakes of sociability that emerged with the cultural revolution of the internet and social networks (Facebook was set up in 2004, WhatsApp in 2009, Instagram in 2010 and Snapchat in 2011).

Citizen involvement in research is one such collaboration in which a beneficial and reciprocal partnership may be developed. This collaboration could inspire citizens to gain enhanced understanding of scientific matters and to help researchers in the advancement of science. In return, it could also motivate researchers to listen to and value the views of citizens, but also involve them in future research (Gjoneska et al. 2021).

Incorporating gender sensitivity into drug research and drug policy evaluation is essential to reinforce relevant and evidence-based responses, and to promote the well-being of all citizens and defend their inalienable rights of equity. If the analysis of drug use and treatment manages to integrate gender considerations and their social dimension, it will help improve responses for all those in need, especially women and trans people of all genders, who face more difficulties in accessing appropriate and inclusive assistance.

Criminal justice system

Globally, almost 11 million people are detained in prisons or other closed settings (Penal Reform International and Thailand Institute of Justice 2020b). The global female population was estimated to be 741 000 in 2020 and is increasing (ibid.). In Europe, in January 2019, 41 114 women were incarcerated in 27 EU member states, Norway, Turkey and the United Kingdom, constituting around 5% of the total European prison population (EMCDDA 2021b).

Women who use drugs and the criminal justice system: what does the literature say?

Women in custodial settings are a minority prison population, with unique vulnerabilities and distinct pathways into crime and contact with the criminal justice system (Van Hout et al. 2021). Many are disproportionately affected by lower socio-economic status, trauma, interpersonal violence and mental illness, and are from racial or ethnic minority backgrounds (Ervin et al. 2020; Jones 2020; Karlsson and Zielinski 2020; Lenihan 2020; Lynch, Fritch and Heath 2012; Penal Reform International 2021; Penal Reform International and Human Rights Education Associates 2017; Penal Reform International and Thailand Institute of Justice 2020b; Tripodi and Pettus-Davis 2013; UNODC 2008; Wolff, Blitz and Shi 2007). Women are generally detained for less severe, non-violent crimes, often heavily underpinned by poverty (“crimes of survival”) and drug-related offences (not all of them may be using drugs) (Penal Reform International 2021; Penal Reform International and Thailand Institute of Justice 2020b; van den Bergh, Plugge and Aguirre 2014; Wattanaporn and Holtfreter 2014).

While constituting a minority of prisoners globally, the proportion of women incarcerated for drug offences far exceeds that of men. Key factors underpinning this

include the targeting by criminal laws of behaviours related to sexuality, and punitive responses to women with substance use disorders or women involved in minor drug offences. The intersectionality of gender, poverty, drug use and sex work is well evidenced in the global literature, with several especially vulnerable groups of women arrested or detained for drug offences. These include: single mothers or pregnant women living in poverty and/or homeless; victims of coercion and GBV; commercial sex workers; trafficked or migrant/undocumented/non-national women; sexual minorities and transgender women; and women with complex co-morbid psychiatric or learning disabilities (Bronson et al. 2017; Meyer et al. 2017; Penal Reform International and Thailand Institute of Justice 2020b; Tripodi and Pettus-Davis 2013; UNODC 2008; Van Hout et al. 2021).

In Europe, the prevalence of drug use prior to incarceration and drug use disorders is significant among incarcerated women (Fazel, Yoon and Hayes 2017; van de Baan et al. 2021). Patterns of drug use among women in European prisons are similar to that reported by men, with the majority reporting lifetime cannabis use, as well as use of heroin (19% in Spain to 49% in Latvia), cocaine (21% in Lithuania and the Czech Republic to 41% in Latvia) and amphetamines (17% in Portugal to 64% in Slovenia) (data from the 2019 European Questionnaire on Drug Use among People living in Prison (EMCDDA 2021b)). When compared to incarcerated men, higher rates of communicable disease such as HIV/Aids, hepatitis B, hepatitis C and syphilis are evident among women, and are directly linked to drug- and sex-related risk behaviours (for example injecting drug use, sex work) (ibid.). Women are also significantly more likely to overdose in the week following prison release (Crowley and Van Hout 2016).

Gender-neutral legal frameworks

The Bangkok Rules (UN Secretariat 2010) are soft law principles that lay the foundation for intensified efforts to support women in detention (Barbaret, Jackson and Jay 2017; Huber 2016; Penal

“[Bangkok] Rule 61 requires courts to consider mitigating factors when sentencing women in contact with the law, noting specifically lack of criminal history, relative non-severity and nature of the offence, caretaking responsibilities and typical backgrounds.

Rule 62 requires the ‘provision of gender-sensitive, trauma-informed, women-only substance abuse treatment programmes in the community’ for diversion and alternative sentencing purposes for offences entailing drug use.

Rule 64 specifically encourages non-custodial sentences for pregnant women and women with dependent children to be preferred.

The United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules) commits governments to reduce the unnecessary use of imprisonment through non-custodial measures and provide that pre-trial detention should be a measure of last resort.

Article 3 of the UN Convention on the Rights of the Child requires children’s best interests to be assessed and taken into account as a primary consideration in all actions or decisions concerning them, which includes decisions around mother’s imprisonment.”

Source: Penal Reform International et al. 2020.

Reform International and Thailand Institute of Justice 2020b). They were developed to support and complement, as appropriate, the 1955 Standard Minimum Rules for the Treatment of Prisoners (United Nations 1955), the 1991 Basic Principles for the Treatment of Prisoners (UN General Assembly 1991a), the 1991 United Nations Standard Minimum Rules for Non-custodial Measures (Tokyo Rules) (UN General Assembly 1991b) and the updated 2016 UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) (UN General Assembly 2016). Recent reviews have emphasised that despite global increases of women in prison, the criminal justice system and its institutions remain largely designed for the dominant male population, and the Bangkok Rules are implemented in a piecemeal manner (Lenihan 2020; Penal Reform International and Thailand Institute of Justice 2020b; Van Hout et al. 2021). While essentially underpinned by inherent tensions in human rights for women, “protection versus protectionism” (Barzano 2013), the Bangkok Rules are insufficiently broad regarding gender diversity in their adoption of a cis-normative stance (OHCHR 2016; Van Hout and Crowley 2021).

Global dialogues on gender-sensitive responses to the distinctive needs of women in detention settings continue to emphasise the urgent need to prioritise non-custodial measures for women in contact with the law (UNODC and WHO 2020). Many countries, however, retain a comprehensive, punitive and gender-neutral legal framework to arrest, prosecute and sentence offenders for a range of drug-related offences (Penal Reform International, Linklaters LLP and International Drug Policy Consortium 2020). The Bangkok Rules state that:

[W]omen offenders shall not be separated from their families and communities without due consideration being given to their backgrounds and family ties. Alternative ways of managing women who commit offences, such as diversionary measures and pretrial and sentencing alternatives, shall be implemented wherever appropriate and possible.

The international drug control conventions expressly allow the provision of non-custodial measures such as drug treatment and education as alternatives to conviction or punishment for personal drug consumption offences and for all other relevant offences in “appropriate cases of a minor nature” (UNODC 2013a:135). International standards urge governments to enable courts to account, during prosecution and sentencing, for claims of self-defence by women who are survivors of violence and their typically low-level role as well as exploitation in the drug trade.

Penal Reform International 10-point plan: gender-sensitive drug policies for women

1. Decriminalise drug use and drug possession for personal use.
2. Use pre-trial detention only as a measure of very last resort.
3. Remove mandatory minimum sentences for drug offences.
4. Abolish the death penalty for drug offences.
5. Establish and implement gender-specific mitigating factors in legislation governing the prosecution and sentencing of women for drug-related offences.

6. Increase the use of alternatives to imprisonment for women convicted of drug-related offences.
7. Adopt a health-based gender-sensitive approach to drug use and dependence.
8. Ensure drug laws and policies address the special needs of pregnant women and mothers.
9. Address the disproportionate impact of drug laws on foreign national women.
10. Develop gender-responsive training and dialogues on women and drug policies.

Source: Penal Reform International 2016.

Recent commentaries emphasise that the complexities and intersectionality of poverty, GBV and the caregiving responsibilities of women in contact with the criminal justice system for drug-related offences are inadequately reflected in legislation or extant sentencing guidance, and ill-considered sentencing practices by magistrates (Nougier and Cots Fernández 2021; (Penal Reform International, Linklaters LLP and International Drug Policy Consortium 2020). Considerations that may mitigate culpability or incur a reduced sentence for these women can include pregnancy, GBV and coercion to commit crime, and being a single parent or victim of trafficking. Globally and in Europe, women continue to be disproportionately impacted by pre-trial detention and mandatory minimum sentencing, and for those who use drugs or are drug dependent there is a lack of evidence-based and gender-sensitive harm reduction and treatment provision in closed settings.

Under the equivalency of care principle, prisoners have the same right to health as those living in the community, including access to evidence-based drug treatment, gender-sensitive healthcare and harm reduction measures (Mandela Rules 24-35) (Penal Reform International 2016; UNODC et al. 2012). The UN Committee on the Elimination of Discrimination against Women (CEDAW) has established that discrimination against women in detention encompasses ill-treatment that affects women disproportionately, including detention conditions that do not respond to the specific needs of women. Within the male-dominated criminal justice system, women's gendered and unique health needs are often neglected and ill-resourced; particularly regarding their sexual and reproductive health, mental health and the treatment of drug dependence (Gadama et al. 2020; Nakitanda et al. 2020; Penal Reform International and Thailand Institute of Justice 2020b; UNODC 2008). Drug treatment and related care services (e.g. for HIV, hepatitis C) in prisons warrant a scaling up in many European countries (EMCDDA 2021b). The Bangkok Rules specify several key standards in the care of women in prison and are particularly relevant to those detained on drug-related offences.

- ▶ Imprisonment of women should always be a last resort. Suitable non-custodial alternatives shall be made available whenever possible.
- ▶ Medical screening on entry should include comprehensive screening to determine primary healthcare needs. It should also determine: sexually transmitted or blood-borne diseases including HIV; mental healthcare needs; reproductive

health history and related health issues; the existence of drug dependency and sexual abuse and other forms of violence suffered prior to admission:

- gender-specific healthcare services at least equivalent to those available in the community shall be provided to women prisoners;
- comprehensive mental healthcare and rehabilitation programmes shall be made available for women prisoners;
- programmes to prevent and treat HIV/Aids shall be responsive to the specific needs of women, including prevention of mother-to-child transmission;
- specialised gender-sensitive treatment programmes for women who use drugs shall be provided;
- strategies and support to prevent suicide and self-harm among women prisoners shall be part of a comprehensive policy of mental healthcare for women prisoners;
- women prisoners shall receive information and education about all relevant preventive healthcare measures.

The 2015 UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) has described a range of concerns regarding the situation of women in detention. Many are especially relevant to women who use drugs, including the detention of women in compulsory drug treatment centres, the punitive denial of opiate substitution treatment (OST) causing withdrawal while detained (including in pre-trial detention), excessive prescription of psychotropic drugs as a control measure by the authorities and the lack of other gender-sensitive health and mental health support for women (Giacomello 2020; Hopkins 2017; SANPUD, Metzineres and Harm Reduction International 2019; Šimonović 2019; Van Hout, Fleißner and Stöver 2021).

Practical recommendations for criminal justice system practitioners

Proportionate and alternative sentencing for drug-related offences

Many countries continue to adopt a gender-neutral custodial and non-custodial regime across the various stages of the criminal justice delivery system, with legal, policy and administrative frameworks lacking a focus that deliberately takes into account the particular, often victim-centric pathways of women arrested and detained for drug offences. Such gender-neutral approaches can be gender sensitised by criminal justice policy makers and practitioners to give greater attention to dimensions experienced specifically by women as gender-based violence, the role of caregiving and the intersectionality of caregiving and drug use for women. In many countries, there is a need to reform legislation and/or sentencing guidelines to ensure that histories of abuse are considered in relevant cases (UNDAW and UNODC 2008).

Reforms in Latin America to address the over-incarceration of women for drug offences have included preferring non-custodial sentences, offering sentence reductions for low-level drug offences, and gender-responsive amnesties and pardons for low-level drug offences.

Reforms of sentencing guidelines in the United Kingdom have resulted in more proportionate sentencing for drug offences, particularly women in situations of vulnerability engaged as drug couriers. Judges evaluate whether the person charged with the drug-related offence played a “leading”, “significant” or “lesser” role in the drug trade, and take into consideration the circumstances of vulnerability and the quantities of drugs involved (UNODC 2020a).

HOW TO IMPLEMENT?



From the justice perspective, treatment can be implemented as an alternative to conviction or punishment throughout the criminal justice system from pretrial to trial to the post-sentencing stage.

ADMINISTRATIVE RESPONSE	CRIMINAL JUSTICE RESPONSE		
Pre-arrest	Pretrial	Trial/sentencing	Post-sentencing
Police	Police, prosecutor, defence, examining magistrate	Judge, probation officers	Prison director, parole board, minister of justice
Administrative response with information/referral to treatment	Caution with a diversion to education/treatment	Postponement of the sentence with a treatment element	Early release/parole/pardon with a treatment element
	Conditional dismissal/conditional suspension of the prosecution	Deferring the execution of the sentence with a treatment element	
	Conditional bail [alternative to pretrial detention]	Probation/judicial supervision	
		Special courts/docks (e.g., the Drug Treatment Court)	

Source: Busse et al. 2018.

The UNODC Toolkit on Gender-Responsive Non-Custodial Measures (UNODC 2020a) provides an overview of international and regional standards and recommends that policy makers incorporate provisions of the Bangkok Rules and Tokyo Rules into domestic law and practice. The toolkit provides a basis for guidance on applying non-custodial measures for women in conflict with the law as well as gender-sensitive application of criminal laws, policies and procedures. It is aimed at judges and prosecutors as well as other criminal justice professionals working with women in contact with the criminal justice system, such as defence lawyers, probation officers and CSOs (UNODC 2020a).

LBH Masyarakat in Indonesia provides free legal services for people who use drugs (PWUD), empowering them to become trained paralegals and provide community legal assistance, including as trained paralegals in supporting families and communities, and preparing legal defence and support documents such as psychiatric or medical assessments. Action for Justice Indonesia also provides free legal advice to women in contact with the law for drug offences and supports them in securing treatment options as an alternative to criminal prosecution (UNODC 2020a).

Community and prison-based support

With regard to the special needs and unique vulnerabilities of women who use drugs both in contact with the criminal justice system and who are incarcerated, enhanced provision and accessibility of gender-specific, drug-related interventions for women (psychological support, self-esteem training, opiate substitution, needle exchange, overdose prevention) along the justice pathway is warranted (Bui and Morash 2010; Sacks, McKendrick and Hamilton 2012; Valencia et al. 2020; van den Bergh, Plugge and Aguirre 2014; Van Hout, Fleißner and Stöver 2021; Zurhold et al. 2011).

A recent Cochrane Review has however stressed that a range of interventions (collaborative case management, acceptance and commitment therapy, buprenorphine treatment, cognitive skill development combined with a therapeutic community intervention, and cognitive skill development combined with standard therapy, single sessions of a computerised intervention, dialectic behavioural therapy, and case management therapeutic community programmes and intensive discharge planning upon release) make little or no difference to reducing drug use, re-incarceration or rearrest in comparison to treatment as usual (low-certainty evidence) (Perry et al. 2019). That said, efforts to provide such tailored services should be underpinned by gender-sensitive and human rights training for CSOs and criminal justice practitioners in order to build sufficient continuity of care spanning prisons and communities (Van Hout, Fleißner and Stöver 2021).

Gender-specific, trauma-informed, women-only treatment programmes should be prioritised in cases where the woman suffers from drug dependency. Access to evidence-based drug disorder treatment in the community is important as part of non-custodial sentencing. Drug dependence treatment and harm reduction programmes need to be

The Healthy Options Programme Skopje (HOPS), North Macedonia, within the projects “Access to justice for the most marginalised” and “Advancing human rights of sex workers and people who use drugs”, which target female or transgender women sex workers, drug users and their families, offers free legal assistance in the areas of human rights, criminal law, civil and economic law, family support, misdemeanours, administrative law, discrimination and more, including protection of victims of GBV and domestic violence. The services are provided in the form of advice, referrals, and preparation of documents and access to institutions through procedures and representation before the competent courts for strategic cases where there is discrimination and a serious violation of human rights. Within these projects the HOPS also offers paralegal support to hard-to-reach people from these groups, documenting cases of human rights violations and creating advocacy arguments to improve their situation.

Ireland has created a “one-stop shop” multidisciplinary approach where women can access a range of services or one key worker with specialist knowledge. Other one-stop shops exist in the United Kingdom (218 Service in Glasgow, Anawim women’s centre in Birmingham, Platform 51 in Cardiff, the Willow Service in Edinburgh, and the Inspire Women’s Project in Belfast).

offered on an equal basis to men and women and not be available only in male prisons. Drug treatment or rehabilitation in detention should never be mandatory (UNODC and WHO 2020).

The Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England provide a series of key standards for substance misuse for women in prison (3.1-3.4) (Public Health England 2018). Essentially:

- ▶ substance misuse programmes for women prisoners should be gender responsive by considering their unique needs in all aspects of design and delivery, including accessibility and availability, staffing, programme development, programme content and programme materials, and in addressing trauma and concurrent disorders;
- ▶ substance misuse services should be trauma-informed and trauma responsive;
- ▶ substance misuse treatment programmes in prisons should include a peer support and mutual aid element;
- ▶ women prisoners undergoing substance misuse treatment should have access to purposeful activity (for example time spent at work, education, training, physical activity, family visits and offending behaviour programmes), planned as part of recovery within the treatment and care package.

In the Russian Federation, a Social Rehabilitation Centre for Women and Girls was established in 2007 to support post-incarceration women as well as women who have received non-custodial measures (for example legal advice, counselling, vocational training, employment support) (UNODC 2020a).

In England, a women's centre provides a range of services addressing mental and physical health, education, finances, relationships, employment and training support to develop resilience, and seeks to reduce re-offending by addressing root causes and the harmful impact of short-term prison sentences (Irish Penal Reform Trust 2013; UNODC 2020a).

Group counselling in prisons in Sweden, Turkey and the United Kingdom includes group cognitive-behavioural therapy, the tobacco, alcohol and drug dependence treatment programme (SAMBA) and discussion of new psychoactive substances in prison groups. Peer-to-peer prison-based interventions are implemented in Belgium, the United Kingdom (User Voice) and Ireland (Ana Liffey Drug Project, Irish Red Cross), and used to support knowledge exchange and self-help (EMCDDA 2021b).

For further information, the EU-funded project Throughcare has designed a toolkit to support countries in designing and implementing interventions for effective engagement and concerted action between prison authorities, community services and civil society to ensure continuity of care during the transition from prison to the community (EMCDDA 2021b).

Surveillance and research

A research-based approach supporting practice and that informs evidence-based interventions to understand the impact of GBV, exploitation, trauma, drug use, drug use disorders and drug-related criminal offences on the health and human rights of these vulnerable women is warranted (UN Women 2014).

In Europe, this includes the EMCDDA methodological framework to monitor drugs in this setting, including tools such as the European Questionnaire on Drug Use among People living in Prison (EMCDDA 2021b).

The ROSE network in Italy collects information on the healthcare needs of women and trans women in detention, in order to support the authorities in providing suitable healthcare (EMCDDA 2021b).

Intervention, support and treatment

“Intervention, support and treatment” refer to both more traditional forms of intervention for problematic substance use that aim to achieve and sustain abstinence, and stabilisation and harm reduction initiatives that seek to reduce the impacts and/or harms of use (Bates et al. 2017). In addition to these specific responses to substance use, we also include wider family or health interventions and responses that pay attention to the impacts of problematic use, such as domestic violence interventions, homeless services or sexual health clinics. This becomes particularly pertinent when we consider how women may present to or access available services and the range of responses available to them. Within the majority of jurisdictions, women will have some access to detoxification and drug treatment services, as well as, potentially, harm reduction or wider health responses that also include a focus on problematic substance use. While there is substantial debate with regard to the ideological underpinning and efficacy of the range of intervention, support and treatment responses to substance use, including the impacts of different approaches and models, these issues are acknowledged but are not the focus of this section, which instead aims to consider the gender-specific issues, barriers and recommendations for intervention, support and treatment, while also highlighting relevant examples of good practice.

There have been some critiques of how substance use intervention, support and treatment are constructed and prioritised in relation to gender. For instance, it has been argued that responses to women’s substance use have been contextualised within a neoliberal discourse, resulting in increased social surveillance of particular aspects and a lack of consideration of the factors that empower women to access health and social services (Benoit et al. 2014). It has also been argued that health interventions operate from a moral construction of the pregnant body and motherhood that can serve to reinforce stigma and shame for women, while also prioritising interventions in relation to those specific roles or circumstances for women. Such moralistic health intervention programmes that prioritise fetal and infant rights lose sight of the treatment needs of women (Salmon 2011). Further to this, Martin and Aston (2014) argue that particular consideration must be given to how women and their needs are defined. They argue that within the literature there is a dominant

view of women as a “special population” with “unique treatment needs” (p. 335). Defining women who use substances and their intervention needs in this way has the potential to limit the range of gender-sensitive intervention options available to women, including transgender women. Given the potential negative impacts of these theoretical constructs on treatment and intervention practice and service delivery, the complexity of presenting issues for women, which has been explored in detail by MacDonald, Christophers and Morton (2020), is summarised below.

Complex needs and general health

It has been argued that women often present to services at a crisis point, with complex needs coinciding with deteriorating physical and mental health (MacAfee et al. 2020; National Women’s Council of Ireland 2018). Issues may include substance misuse, domestic violence and mental health challenges (Holly and Horvath 2012). Another challenge to staff and services is meeting the needs of service users with physical and intellectual disabilities. In Ireland, for example, data indicate that people with disabilities form 27.1% of the homeless population – double that of the population in general (Central Statistics Office 2016). These needs may be further compounded by compromised or poor emotional, coping, and life skills (Babineau and Harris 2015). Poor self-reported health is a common complaint among women with complex needs and the health impact of chronic illnesses can be compounded by a lack of women-specific services, difficulty finding childcare and past negative experiences interacting with service providers (MacDonald, Christophers and Morton 2020; Mayock, Parker and Sheridan 2015).

Income, poverty and sex work

Women presenting to services may be experiencing difficulties due to low income, or other more complex challenges such as financial abuse (Mayock, Parker and Sheridan 2013); they may also be having trouble with rent payments, childcare costs and fluctuating incomes. Women who are using substances may also be engaging in sex work, either through financial need or as a result of coercion, trafficking or exploitation. Gerassi (2018) highlights that over 50% of women accessing substance use treatment in the US report having engaged in transactional sex, and that accessing treatment and support is fraught with difficulties. This is reflected in other jurisdictions, such as Ireland, where Ruhama (2018) found that among sex workers contacted during their outreach activities 34% were either homeless or at risk of homelessness and 50% reported themselves to be experiencing problems with drugs or alcohol.

Groups less well-represented

Migrant women may present to services with additional challenges, including language issues or worries about their legal status that may make it difficult for them to speak openly about their challenges or to navigate health, homeless and addiction services (Fitzpatrick and Stephens 2014; Mayock and Sheridan 2012). Social stigma and ostracisation of women who transgress social norms in certain migrant communities

can also compound the challenges experienced (ANEW Support Services 2019; Roze et al. 2020). The LGBTQI+ community is underrepresented in the literature although they can experience homelessness due to specific gender/sexuality issues (Focus Ireland 2019) that service providers may not necessarily be sensitised to. Regular services and accommodation may not be appropriate or safe for LGBTQI+ individuals. Older women were also not well-represented and may experience added risks due to chronic health conditions or frailty (Stöckl, Watts and Penhale 2012).

Cyclical service use

Lack of support after initial substance use treatment can lead to relapse and re-entry into the system (Babineau and Harris 2015). Women who leave residential treatment, the care system, psychiatric hospitals or prisons, and those who have entered private stable accommodation, but are then unable to pay rent or maintain childcare costs, are all at risk of cycling through multiple services. Domestic violence may also be a factor, where women may leave refuges without adequate support and end up returning to the homes of abusive partners, only to have to seek refuge again (Morton and O'Reilly 2016; Yamawaki et al. 2012).

Substance use patterns and trajectories

Substance use patterns may also have gender-related differences, and the term “trajectory” is often used to identify critical events and factors that contribute to the persistence of substance use or changes within substance use patterns during the life span (Hser et al. 1997). For instance, Greenfield et al. (2010) have highlighted the risk of women undergoing an accelerated progression from initiation of substance use through dependence to the first treatment episode (Anglin, Hser and Booth 1987) compared to men (Grella and Joshi 1999). Known as telescoping, accelerated progression has been connected to opioids, cannabis and alcohol and may result in women presenting with more complex medical, psychological and social issues (Greenfield et al. 2010). Women’s substance use may intersect with wider social factors, including intimate relationships with men, and women who use substances are also more likely than men to have experienced physical or sexual abuse. Along with the factors outlined previously, including intimate partner violence, physical abuse and sexual abuse, other childhood issues have been found to be key features of women’s substance use trajectories (DeHart and Moran 2015).

Given the complexity of how women present for treatment, let us turn to the evidence with regard to intervention, support and treatment.

Intervention, support, treatment and gender: what does the literature say?

Treatment

At a European level, the EMCDDA reported in 2017 that one fifth of all entrants to drug treatment in Europe are women. However, there is considerable evidence that women who use substances are less likely than their male counterparts to enter treatment

(Greenfield et al. 2007). This has led to recommendations for gender-responsive approaches to drug treatment to meet the needs of women (EMCDDA 2017). Given the high levels of stigma (Ignjatova et al. 2018) and trauma experienced by women who use substances (Cockroft et al. 2019), a trauma-informed approach has been proposed, although Martin and Aston (2014) guard against simply assuming that the impacts of women's substance use are best addressed in this way.

Some preconditions to women entering treatment have been identified within the literature. Green et al. (2016) found that women are more likely to access treatment through primary healthcare or mental healthcare facilities. This suggests that having a connection to a healthcare service facilitates both the decision to access treatment and successful access to treatment. Caring roles, pregnancy and motherhood can be strong motivating factors for entering treatment. Therefore, women's childcare needs are an important consideration where treatment is concerned (EMCDDA 2017; Otiashvili et al. 2013). Greenfield et al. (2007) found that the rates of entry into treatment, retention and completion of treatment are significantly lower for women as compared to men. In a study by Zankowski (1987), the most commonly cited reason by women for leaving treatment early was related to the care of children, a factor that has already been highlighted as a barrier to accessing treatment. The poorer rates of treatment entry, retention and completion reflect the fact that treatment approaches have traditionally been designed for men. Existing treatment approaches may still adopt a punitive and confrontational style rather than one of exploration, where substance use issues are considered within the environmental context. Further barriers to sustaining treatment include the involvement of extended family or a partner without consent (particularly where there are children), as well as a lack of strategies to support women effectively where relapse has occurred (Ignjatova et al. 2016).

The importance of gender-specific treatment models that acknowledge and respond to the physical, psychological and emotional abuse experienced by women in treatment has also been underlined (Hanes 2017; Zand et al. 2017) and the role of alcohol or drug use as a way to cope with experiences of abuse, oppression and harm has been highlighted (George, Boulay and Galvani 2011). It has been further argued that addressing complex psychosocial issues that impact on women's substance use trajectories are best done within gender-specific groups and interventions (Evans et al. 2013; Ignjatova et al. 2016), and that a lack of gender expertise, gender-specific responses and support for mothering are barriers to sustaining treatment. It is crucial to acknowledge the experiences and dynamics of oppression and abuse, and how these may relate to substance use patterns, and utilise life experiences as learning tools rather than using them to shame the women (Bailey, Trevillion and Gilchrist 2019; Evans et al. 2013). For some women, access to gynaecological care and addressing sexual and reproductive health issues is key (Ignjatova et al. 2016).

Several barriers to treatment have been identified.

- ▶ Men and women differ with respect to perceived barriers and facilitators for alcohol treatment. Women have been hindered in seeking treatment for substance use by an array of issues that can be broadly categorised into

issues relating to social stigma; fear of losing children; and healthcare providers' perspectives on healthcare and substance use treatment (Small, Curran and Booth 2010).

- ▶ Social stigma has been found to be negatively associated with substance use treatment and is a major impediment to treatment seeking, treatment access and treatment completion. Stigma is particularly prevalent where women are pregnant and mothering (Wolfson et al. 2021).
- ▶ Lack of childcare and family responsibilities have been identified as barriers to women accessing treatment. Jackson and Shannon (2012) argue that an absence of child supervision may be more of a concern than treatment and on the basis of this concern women may not seek and/or access treatment. Otiashvili et al. (2013) found that women denied themselves access to treatment due to responsibilities at home as a mother, wife or partner. Women described feeling that they could not commit to the demands of treatment.
- ▶ Fear that a child or children will be removed into care is also a major barrier to women disclosing their drug use within health settings; they fear that seeking help and accessing treatment makes their substance use visible, risking subsequent involvement of social services (Niccols et al. 2021).
- ▶ Availability of treatment places and options are also an issue, including waiting lists and entry criteria, physical and mental health issues, and transportation (Jackson and Shannon 2012).
- ▶ Finance and funding of gender-specific treatment is a challenge, as comprehensive programmes may be deemed too expensive to fund.
- ▶ Substance use tends to be addressed by moralistic rather than empowering models of care (Benoit et al. 2014).

Despite the fact that detoxification and abstinence-based treatment remain the dominant lens through which we consider policy responses and interventions, there has been substantial development within recent decades of substance use harm reduction, stabilisation, and family and health responses that may also have a gender aspect (Wincup 2016). The importance of a wide range of possible responses, support and interventions has been highlighted given how issues intersect in women's lives (Bailey, Trevillion and Gilchrist 2019; Neale et al. 2018; Newcomb et al. 2020). There has been limited development of gender-specific interventions within these wider approaches but innovation does exist, including gender-transformative day services that aim to support women to consider or address their substance use. These include gender-focused drug stabilisation day services that provide childcare and education options (see "Walk Tall, Dream Big" Addiction Service for Women, the SAOL project, County Dublin, available at saolproject.ie, accessed 4 February 2022); domestic violence services that support and/or accommodate women who are actively using substances (Morton and O'Reilly 2016); gender-specific, harm reduction in-reach into homeless services or hostels (Merchants Quay Ireland 2019); and gender-specific, low-threshold services that provide needle exchange, healthcare services (such as

within sexual health services) or brief interventions (ibid.). This is not an exhaustive list, but serves to highlight sites of innovation and positive change.

In addition to these practice-setting innovations, there has also been attention to gender-specific needs and responses in relation to how issues are known to intersect with the lives of women. This includes consideration of trauma histories and the need for trauma-informed responses (Roze et al. 2020). A trauma-informed response approach to care is based on what has been described as the simple shift from “What is wrong with you?” to “What has happened to you?” (Gilliver 2018; Menschner and Maul 2016). Seeking to validate an individual’s experience is key, with a view to both identifying the most appropriate intervention and support, and mitigating the negative impacts of traumatic experiences (McGee 2015). The link between trauma histories and problematic substance use has received significant attention (Torchalla et al. 2012), but it is only more recently that gendered aspects such as childhood sexual abuse, sexual violence and domestic violence have been considered in relation to women’s substance use trajectories, harms and impacts (Newcomb et al. 2020).

Practice barriers that limit access to services where gender is a consideration

Morton et al. 2020 investigate barriers to accessing support and how these may be enacted within practice settings, particularly where women are attempting to deal with further issues beyond their substance use, such as housing difficulties, poverty or domestic violence. These are summarised below, together with contributions from the panel of experts contributing to this project.

Knowledge of services

Some women can have difficulty getting to know what services are available to them, and often desire more information before commencing treatment. They may also have misconceptions about services, such as fear of commencing methadone treatment (Merchants Quay Ireland 2019). Certain agencies may be presented in the media as a “drug service” with negative connotations, and their other services might not be reported or advertised as prominently, meaning they are subsequently overlooked by potential service users (ibid.).

Safety

Coercion, abuse, and domestic, sexual and GBV are safety concerns for women attempting to access services. Fear of physical harm from abusive partners can act as a barrier to women accessing homeless or substance misuse services or leaving a relationship (Mayock, Sheridan and Parker 2012; Morton et al. 2020). In the same vein, a perceived negative reputation of hostels or refuges can deter women from seeking them out due to safety

The Family Associate programme runs in four cities in Serbia: Belgrade, Kragujevac, Novi Sad and Nis. Although the programme seeks to work with families, this is done with a clear understanding of the impact of gender, with interventions and support often focused on mothers who are experiencing domestic violence, poverty and problematic substance use. Beyond recognition of gender impacts on mothers, the project assists them in securing welfare and practical support, and supports them in accessing treatment for their substance use.

concerns for themselves and/or their children (Mayock, Sheridan and Parker 2012; O'Carroll and Wainwright 2019). A lack of gender-specific consideration in the broader social responses may also lead to safety and protection issues, as many services are very male dominated/focused, or gender blind (Morton et al. 2020).

Service configuration and provision

Service restrictions may impact on service users' access, particularly those with complex needs. Such restrictions might include a barring of women with histories of antisocial behaviour, active drug users and migrant women who do not satisfy the habitual residency condition (Roze et al. 2020). A need to fulfil criteria to access services – such as falling within catchment areas, being drug free and being willing to undertake mandatory counselling as a condition of entry – can be a major barrier to engagement with services (Neale et al. 2018; Taylor 2010). Overburdened services and long waiting lists across services often lead to service users regularly being turned away (Canavan et al. 2012). Overburdened services can also increase insensitivity to individual needs – for example, women in recovery may be placed alongside active drug users. Female problem drug users require access to drug treatment programmes, as well as the creation of women-focused programmes (Mayock, Parker and Sheridan 2015). During service navigation, there are burdens on the service user due to the application process, literacy issues, and attitudinal aspects such as negative past experiences with service providers, and feelings of hopelessness or fear of authority figures that could also limit women's engagement with services (O'Carroll and Wainwright 2019).

There are also a number of child-specific issues that affect service engagement. There is a definite need for support for pregnant women/women with children in service engagement (ANEW Support Services 2019; Mayock, Parker and Sheridan 2015). Fear of becoming "visible" and children being taken into care can also be a barrier to seeking help (Merchants Quay Ireland 2019; O'Carroll and Wainwright 2019). The need to accommodate women with children also extends to a need for child-friendly spaces in services so children can be occupied while their mothers are accessing support or counselling (Babineau and Harris 2015), and spaces for visitation for women whose children have been placed in care (Greenwood 2016).

18ANO (Athens, Greece) is a women-only interdisciplinary treatment programme founded in 1987. This gender-sensitive programme seeks to provide a safe environment for women so that trust can be developed with staff and other residents. Therapeutic intervention encompasses understanding and responses to trauma, and the impact of gender on women's lives is the focus of a weekly psychoeducational group.

Ashleigh House, Coolmine Therapeutic Community (Dublin, Ireland) is a women-only residential treatment centre that provides a full daycare service to children up to pre-school age so women can attend the seven-month programme while ensuring the full needs of their young children are met. The programme includes treatment and integration stages, and the Parents under Pressure (PuP) programme is also delivered to mothers.

Stigma

Stigma may be amplified by gender-specific factors, for example the stigmatisation of substance-using women as “bad mothers” (Savage 2016) and stigma around substance use and mental health can also be a barrier to engaging with healthcare services (Agterberg et al. 2020). Women engaging in sex work and experiencing addiction may feel the need to hide both their drug use and their connection to transactional sex, thus adding to health and well-being risks by not seeking out health services (Whitaker, Ryan and Cox 2011). Even disruption of basic needs, such as poor self-hygiene, can be a source of embarrassment for women engaging in healthcare services (O’Carroll and Wainwright 2019).

CAARUD L’Echange and CAARUD RLR are two French NGOs providing low-threshold services such as specific initiatives to create trust with women and relationships with women as a basis for supporting them to access further support and interventions. By providing women with only drop-in sessions, they seek to assist women in addressing immediate health issues and self-care requirements, while also providing a relational basis for further intervention without judgment or stigmatising responses.

Challenges for foreign non-national women

Migrant women who use substances may face specific challenges – these may be social, cultural, legal and language-related. Social isolation and cultural expectations can act as further barriers to accessing information about services and entitlements (National Women’s Council of Ireland 2018; Roze et al. 2020). Women may also face difficulties accessing social welfare or employment, depending on their immigration status.

Practical recommendations for treatment practitioners and programme developers

Based on the evidence within the literature and examples of good practice and expertise provided by the advisory group, the following recommendations are made with regard to intervention, support and treatment.

Acknowledge and address structural inequalities

Structural inequalities undermine the work done by services that support women, creating difficulties at all stages of accessing, maintaining and moving on from treatment and care intervention. Inequalities may arise within treatment services themselves. There may be a degree of gender blindness with mixed gender accommodation, lack of female-focused care, or simply a male-dominated gender disparity among service users (Mayock, Parker and Sheridan 2013). To address this problem, approaches could include the introduction of specific days where women-only services are provided, in addition to expansion of designated women-only areas or creation of more women-focused facilities. In some instances, a gender-inclusive approach has been taken with the view that while this allows the possibility of interaction between genders, safe areas and spaces are provided for women only, while also allowing the possibility of the development of respectful relationships between gender groups.

Nonetheless, reconfiguration of services to accommodate the needs of women, guided by gender-sensitive policies and training for staff, will help to address existing challenges of gender blindness. Tools such as the Nobody Left Outside Service Design Checklist might also help in the planning stages for creating or adapting services to be more inclusive and accessible (Lazarus et al. 2020).

Structural inequalities may also increase the risk of drug use relapse. Conditions such as poverty and unemployment, for instance, can be addressed through targeted support, particularly financial or life skills training, that in addition to improvements to coping and employability, may have the additional benefit of improving women's self-esteem and efficacy (Nelson et al. 2012). Co-location of services that cover physical health, mental health and social support in an integrated care model may offer the potential to address this issue (Jego et al. 2018).

Build trust

"Trust" has been identified as a key component within low-threshold substance use⁸ provision more generally and usually implies trust between the service user and the practitioner and between the service user and the agency (Edland-Gryt and Skatvedt 2013). How trust is built is a key question. Positive client and practitioner interactions can be the key to engendering trust (McNeil, Guirguis-Younger and Dilley 2012; Morton and O'Reilly 2019). The values of practitioners may also underpin trust building, so where these values centre on addressing inequality, unconditional positive regard and relational caring (Wright 2004) conditions for trust can be created. Attending to language in regard to women with complex needs (for example common use of the word "chaotic" in relation to women's behaviour) may also be key.

8. The concept of "low threshold" refers to drug services that do not require abstinence and that seek to reduce barriers to access as much as possible. Interventions typically focus on ensuring that basic needs are being met (i.e. housing, food, medical) and a collaborative style is used to implement harm reduction strategies (Fernandez et al. 2006).

Comunità San Patrignano Società Cooperativa Sociale (Rimini, Italy) is a mixed gender treatment and recovery centre. The centre has created dedicated accommodation for women, and for women and children, along with after-school and childcare facilities. Job-skilling opportunities are provided and psychotherapeutic support includes a trauma focus. Providing support for exploring gender identity and trauma histories involves a constantly evolving therapeutic practice. Key for women leaving the community is ensuring economic stability, safe and appropriate housing, and a supportive network, including for children where they are present.

Metzineres (Barcelona, Spain) was created to respond to the specific barriers women who use drugs may face, including stigma, structural violence, GBV, criminalisation and lack of access to services. An all-female interdisciplinary team provides harm reduction and person-centred support services. Clients are involved in programme design, implementation and evaluation. In addition, the service has a community focus to address stigma: both seeking to create and maintain a safe community setting for service users and to develop engaged support from the geographical community. Providing access to physical and emotional safety within the service is a key goal.

Safety considerations

Safety tends to be understood with regard to practitioners and the organisation and is connected to intoxication, violence and drug dealing within low-threshold services or those dealing with complex needs (Morton and O'Reilly 2019). It also considers the personal safety of clients in relation to domestic or sexual violence, sex working or the risks of drug acquisition. Attending to safety can require the practitioner to stay both vigilant yet relationship-focused, with clarity with regard to staff responsibilities within organisations important in ensuring a safe context and safe engagement when service users have complex needs (ibid.).

Cuan Saor Women's Refuge (Tipperary, Ireland) is a domestic violence service that supports and provides accommodation for women who are experiencing domestic violence, including if they are actively using substances. In addition, a range of trauma-informed interventions are provided, including routine enquiries for Adverse Childhood Experiences (ACEs), art therapy, play therapy and counselling. Strong links and in-reach from the local substance misuse and social work services, as well as support to access substance misuse stabilisation and treatment services, are key to supporting services users effectively.

Consider immediacy and pathways

Immediacy is key for a successful pathway through drug treatment into stable, resourced life conditions. Service providers must also be cognisant of the vulnerability of women with complex needs leaving care to becoming entrapped in unhealthy relationships, substance use, crime and violence (Morton et al. 2020). The following actions would help streamline pathways and attend to immediacy:

- ▶ speedy access to affordable housing and appropriate services to ensure safe pathways out of treatment and care settings;
- ▶ addressing waiting lists for detoxification services and treatment for gender-specific services;
- ▶ seamless referrals are challenging to achieve – but dedicated case-workers are identified as key in improving mechanisms to bridge services and navigate the complex landscape of service provision;
- ▶ women often assume they are ineligible for certain support services because they do not fit certain criteria, for example, within “domestic violence” or “addiction”. Practitioners note that women often do not engage with drug services. Keeping service terminology and criteria general may promote inclusion.

The HOPS offers services in a gender-specific programme for sex workers (women and trans people of all genders), women drug users and their families, as part of group or individual counselling. This includes prevention of GBV/domestic violence and prevention of human trafficking. In the same environment, they offer services for prevention of HIV/Aids, hepatitis B and C and other bloodborne infections and STIs; sexual and reproductive health information; exchange of injection equipment; distribution of condoms and information material; as well as motivating clients for treatment through the existing models of treatment of drug addictions in North Macedonia.

Conclusions and recommendations: towards gender mainstreaming in drug responses

This handbook seeks to promote gender sensitivity in drug responses as an essential leverage point to reduce health inequities and to respect human rights, especially the rights to diversity and dignity for women, men and non-binary people. Enacting positive change with regard to complex social issues can be both a challenging and protracted process, often requiring support, expertise, commitment and resources from a range of individuals, organisations and state structures. In this handbook, we have outlined the international policy contexts to gender and substance use, as well as innovation and advancements within the fields of prevention, criminal justice, and treatment and intervention. How we define and understand gender and gendered impacts within society is ever evolving, as is our understanding of substance use initiation, trajectories and responses for individuals and within communities. In the international context where drug policies and responses are predominantly tailored to men's perspectives, gender mainstreaming primarily seeks to better address the needs, rights and expectations of women and non-binary persons. Within this context, it is important to highlight the key tenets of policy and practice in order to support policy makers and practitioners in their efforts to effect positive change in the field. Drawing on the evidence base, this conclusion will highlight the key points and recommendations for policy and for practitioner intervention.

Policy

Given state sovereignty and national specificities, there is no supreme standard to qualify the best drug policies. But gender mainstreaming is fundamentally aligned with the humanistic values supported by Western and European societies. Gender mainstreaming can be a long-term process rather than a result in itself and incorporating a gender perspective into drug policy requires consideration of organisational structures, political will, and the economic and social context. The wider response to gender mainstreaming within policy in any given jurisdiction will also inform actions and motivations towards positive change. Within this handbook, we have presented a number of examples of the mechanisms and challenges to incorporating a gender perspective within drug policy and the following key points are important to highlight.

- ▶ The UNODC checklist for assessing the implementation of gender mainstreaming within programming is a useful construct to assess and plan progress and to review existing strategy or policy documents (UNODC 2021b).

- ▶ Capacity building within organisations and working groups is crucial to support gender mainstreaming within drug policy and there are practical steps that can be enacted as per the WHO guidelines (WHO 2011a). These actions include elements such as resourcing, through to the development of evidence and reporting on gender aspects.
- ▶ Women and non-binary persons are often considered a “special population” (Wincup 2019) within drug policy and this can be limiting in terms of enacting gender-sensitive and gender-transformative responses; it can limit actions to narrow or very specific elements rather than addressing the wider dimensions of the impacts of gender on drug use.
- ▶ Inclusive, gender-sensitive drug policy should address the particular needs of women and non-binary persons while also challenging stigma and addressing the breadth of areas that may be impacted in a person’s life and across the life cycle. Such approaches may need to be aligned with a more general gender mainstreaming approach across the healthcare and criminal justice system.
- ▶ Where a comprehensive and multidisciplinary gender-transformative policy approach is sought, labour market integration, access to education and poverty risks should also be addressed directly.
- ▶ Policy change may be incremental and change may be enacted to address pressing or specific problems such as women who are homeless and using substances problematically, but targeted initiatives may then support broader policy change and development.

Practitioners

Organisations and practitioners are often at the forefront of recognising and responding to the gendered aspects of drug use, and therefore can have a role in not only developing interventions to meet the needs of women and non-binary persons but in initiating positive, gender-transformative change. Accepting that the range of preventive responses can intersect with the criminal justice system and treatment and intervention, the following points are useful to consider.

- ▶ Gender-sensitive approaches need to be considered across the spectrum of universal, selective and indicated prevention strategies and programmes, and should include consideration of the gendered nature of both social norms and social interactions.
- ▶ There is strong evidence to support gender-sensitive components within universal prevention such as discussion of gender norms across patterns of use and help seeking, promotion of solidarity across genders, and discussion of sensitive and gender-specific aspects of drug use in conditions facilitating the expression of persons of any gender.
- ▶ Within selective prevention programmes, evidence indicates that inclusion of key aspects is important, including addressing gender norms related to substance use and how these may contribute to harm and risk, engaging with people within their social environments or leisure settings, and encouraging bystander intervention to address gendered risk in substance-using settings.

- ▶ Within indicated prevention interventions, person-centred approaches that build on and develop resilience and personal resources provide crucial leverage to promote healthy changes. A trauma-informed approach is also relevant, since young or novice drug users may have already been affected by adverse experiences such as GBV.
- ▶ Specific prevention programmes are required for trans people of all genders and non-binary persons, and the creation of supportive and respectful environments and staff training are key for encouraging discussion and disclosure, particularly in regard to elements around gender identity.
- ▶ The gender-neutral nature of legal frameworks and the criminal justice system combines with institutions designed for the dominant male population, posing very particular risks and vulnerabilities for women and non-binary persons.
- ▶ The complexity and intersectionality around poverty, GBV and caregiving responsibilities need to be adequately reflected in legislation or extant sentencing guidance, although robust guidelines do exist for gender-sensitive reform of penal systems relating to drug policy (Penal Reform International 2016).
- ▶ The rates of women accessing and completing substance use treatment are comparatively lower than those for men; there is a need to consider more widely the factors that promote treatment and access. Despite the existence of cases of practice and policy innovation, research on the effectiveness of interventions designed specifically for women is lacking (Tuchmann 2010).
- ▶ Beyond the need for gender-sensitive, if not gender-transformative treatment and care, there is also a requirement to evaluate and research the impacts of such responses. This is also true for prevention programmes and interventions.
- ▶ Given the intersection of gender and structural inequalities, outcome evaluations of treatment and intervention programmes may need to focus on subtle positive changes (Timpson et al. 2016) such as improved psychosocial functioning and increased well-being and stability for those presenting to services with complex needs (Tompkins and Neale 2018). Attending to well-being, stability and psychosocial functioning may be key success indicators (ibid.), as well as ongoing engagement with services, and trust in practitioners and improvements in safety (Morton and O'Reilly 2019).

The initiatives and projects highlighted within this handbook demonstrate the increasing interest and commitment to gender-sensitive and gender-transformative drug policy, as well as the ability of governments, policy makers and practitioners to enact innovative and effective responses. Those initiating, co-ordinating, leading and evaluating innovation and positive change are key to developing comprehensive gender-sensitive drug policy, and it is hoped that this handbook will support further transformation by providing useful frameworks, evidence and examples.

Glossary

Author: Cristiana Vale Pires

EIGE – European Institute for Gender Equality

PWUD – People who use drugs

UNDCP – United Nations International Drug Control Programme

WHO – World Health Organization

WWID – Women who inject drugs

WWUD – Women who use drugs

About the glossary

Through the different stages of drafting of the handbook, it quickly became clear that a glossary would be a necessity for the researchers involved in the process. Cristiana Vale Pires therefore volunteered to engage in this work. The glossary below is the result of her research and covers the terminology used in the publication and the latest definitions found in the current literature.

We recognise that language is not neutral and can be used as a tool for the normalisation of gender diversity and the creation of respectful, inclusive and egalitarian social and cultural norms. In this handbook, we intentionally use gender-inclusive language and concepts to acknowledge and make visible the specific experiences of women and gender-diverse people. This glossary is non-exhaustive and is based on the terminology already used by other international organisations. The definition of some concepts refers to structural gender imbalances between men and women. In this publication, we recognise gender diversity beyond the binary male–female, and in this sense we will use the same concepts across the chapters to refer to the experiences of women, transgender and non-binary people.

Bisexuality – “When a person is emotionally and/or sexually attracted to persons of more than one gender” (ILGA-Europe 2019).

Childcare – “Provision of public, private, individual or collective services to meet the needs of parents and children” (EIGE 2021).

Cisgender/Cis – “A person who identifies with the sex they were assigned at birth. Cisgender is the word for anyone who is not transgender” (Equality Network 2017).

Criminal justice system – “addresses the consequences of criminal behaviour in society and has the objective of protecting people’s right to safety and the enjoyment of human rights. It refers, specifically, [to] the work of the police, prosecution and judiciary with regard to criminal matters, as well as the access to legal aid, prisons and alternatives to imprisonment, restorative justice and victim protection and reparation. It also includes cross-cutting issues, such as gender, human rights

and the considerations for victims and children within the criminal justice system” (UNODC 2021a).

Disability-adjusted life years or DALYs – the DALYs metric estimates the number of healthy years of life lost to disability and premature death.

Discrimination – “Unequal or unfair treatment which can be based on a range of grounds, such as age, ethnic background, disability, sexual orientation, gender identity, gender expression and/or sex characteristics. Can be divided into four different types of discrimination, which all can lead to victimisation and harassment: direct discrimination, indirect discrimination, multiple discrimination and experienced discrimination” (ILGA-Europe 2019).

Diversity – “Differences in the values, attitudes, cultural perspective, beliefs, ethnic background, sexual orientation, gender identity, skills, knowledge and life experiences of each individual in any group of people” (EIGE 2021).

Domestic violence/Domestic abuse/Intimate partner violence (IPV) – “can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person...

...Anyone can be a victim of domestic violence, regardless of age, race, gender, sexual orientation, faith or class...

...Victims of domestic abuse may also include a child or other relative, or any other household member. Domestic abuse is typically manifested as a pattern of abusive behavior toward an intimate partner in a dating or family relationship, where the abuser exerts power and control over the victim. Domestic abuse can be mental, physical, economic or sexual in nature. Incidents are rarely isolated, and usually escalate in frequency and severity. Domestic abuse may culminate in serious physical injury or death” (United Nations 2021).

Double standards – “Defining the content of formal and informal behavioural cultures, which means that the criteria or standards used to evaluate and regulate women often differ from those for men, benefiting the latter” (EIGE 2021).

Drug – “Any psychoactive substance, i.e. a substance that, if taken in sufficient dose, can alter mental and physiological processes” (EMCDDA, Brotherhood and Sumnall 2011).

Drug-facilitated sexual assaults – “all forms of non-consensual penetrative sexual activity whether it involves the forcible or covert administration of an incapacitating or disinhibiting substance by an assailant, for the purposes of serious sexual assault; as well as sexual activity by an assailant with a victim who is profoundly intoxicated by his or her own actions to the point of near or actual unconsciousness” (ACDM 2007 in Pompidou Group 2017).

Drug law offences – “offences such as drug production, trafficking and dealing as well as drug use and possession for use” (EMCDDA 2021c).

Drug prevention – “Any activity that is (at least partially) aimed at preventing or reducing drug use, and/or its negative consequences in the general population

or subpopulations, including preventing or delaying the initiation of drug use, promoting cessation of use, reducing the frequency and/or quantity of use, preventing the progression to hazardous or harmful use patterns, and/or preventing or reducing negative consequences of use" (EMCDDA, Brotherhood and Sumnall 2011, p. 252).

Drug-related death or overdose – death that is "directly due to use of illegal substances" (EMCDDA 2021c).

Drug treatment – "an activity that directly targets people who have problems with their drug use and aims at achieving defined aims with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice. This activity often takes place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems" (EMCDDA 2017).

Drug use or drug/substance misuse – "The consumption of a drug for purposes other than prescribed medical treatment or scientific investigation. Drug use can be abstinent, infrequent (experimentation), occasional (e.g. less than weekly) or regular (e.g. at least once per week)" (EMCDDA, Brotherhood and Sumnall 2011, p. 252).

Empowerment – "Helping people gain power to take action to control and enhance their own lives, and the processes of enabling them to do so" (EMCDDA 1999, p. 174).

Female – "Biologically based references to the sex of a woman" (EIGE 2021).

Femininities – "Different notions of what it means to be a woman, including patterns of conduct linked to a women's assumed place in a given set of gender roles and relations" (EIGE 2021).

Feminism(s) – "Political stance and commitment to change the political position of women and promote gender equality, based on the thesis that women are subjugated because of their gendered body, i.e. sex" (EIGE 2021).

Gender – "socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men" (Article 3c of the Istanbul Convention) (Council of Europe 2011).

Gender-based violence (GBV) – "Violence directed against a person because of that person's gender, gender identity or gender expression, or which affects persons of a particular gender disproportionately" (EIGE 2021).

Gender binary – "The dominant idea in Western society that there are only two genders, that all people are one of these two genders, and that the two are opposite" (Equality Network 2017).

Gender-blind policies and programmes – "Ignore gender norms; are blind to differences in allocation of roles and resources; are not intentionally discriminatory but reinforce gender-based discrimination; and/or often ignore the lack of opportunities/discrimination that underpins what appears to be fair practice" (WHO 2021a).

Gender budgeting – "Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring

revenues and expenditures in order to promote gender equality” (EIGE 2021). See also **Gender mainstreaming**.

Gender equality – equal rights, responsibilities and opportunities of men, women and non-binary people.

Gender expression – “Refers to people’s manifestation of their gender identity to others, by for instance, dress, speech and mannerisms. People’s gender expression may or may not match their gender identity/identities, or the gender they were assigned at birth” (ILGA-Europe 2019).

Gender gap – “Gap in any area between women and men in terms of their levels of participation, access, rights, remuneration or benefits” (EIGE 2021).

Gender identity – “refers to each person’s deeply felt internal and individual experience of gender, which may or may not correspond to the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms” (Committee on Legal Affairs and Human Rights 2009, p. 7).

Gender-informed approaches – “consider how social factors such as gender relations, roles, norms, gender identity and gendered policies affect individual experiences of substance use, the effectiveness of treatment, and a person’s ability to access care and treatment” (Schmidt et al. 2018).

Gender mainstreaming – “Systematic consideration of the differences between the conditions, situations and needs of women and men in all policies and actions” (EIGE 2021). In this handbook, we consider that gender mainstreaming also addresses the specific conditions, situations and needs of non-binary people.

Gender neutral – “Policy, programme or situation that has no differential positive or negative impact in terms of gender relations or equality between women and men” (EIGE 2021).

Gender norms – “Standards and expectations to which women and men generally conform, within a range that defines a particular society, culture and community at that point in time” (EIGE 2021).

Gender perspective – “Perspective taking into account gender-based differences when looking at any social phenomenon, policy or process” (EIGE 2021).

Gender roles – “Social and behavioural norms which, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex” (EIGE 2021).

Gender-sensitive policies and programmes – “consider and acknowledge gender norms, roles and inequalities but take no action to address them; and/or are similar to gender aware (awareness of the issue), which does not necessarily mean that something is then done about it” (WHO 2021b).

Gender socialisation – “Process by which individuals learn the cultural behaviours associated with the concepts of femininity or masculinity” (EIGE 2021).

Gender-specific policies and programmes – “recognize differences in gender roles, responsibilities and access to resources, and take account of these when designing interventions; and/or do not try to change the underlying causes of these differences” (WHO 2021a).

Gender system – “System of economic, social, cultural and political structures that sustain and reproduce distinctive gender roles and the attributes of women and men” (EIGE 2021).

Gender transformative – “recognize differences in gender roles, norms and access to resources; and/or actively try to change these, to promote gender equality” (WHO 2021a).

Gender-unequal policies and programmes – “privilege men over women or vice versa; have clear and undisguised inequalities; and/or deny women’s rights or give men rights and opportunities that women do not have (or vice versa)” (WHO 2021a). In this handbook, we consider gender-unequal policies and programmes those that also do not address gender diversity.

Harassment – “Unwanted conduct related to the sex of a person occurring with the purpose or effect of violating the dignity of that person, and of creating an intimidating, hostile, degrading, humiliating or offensive environment” (EIGE 2021).

Harm reduction – “Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws” (Harm Reduction International 2021).

Hegemonic masculinity – “Cultural norm that continuously connects men to power and economic achievements” (EIGE 2021).

Heteronormativity – “Refers to the set of beliefs and practices that consider gender to be an absolute, unquestionable binary, and therefore describe and reinforce heterosexuality as a norm. It implies that people’s gender, sex and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being ‘normal’” (ILGA-Europe 2019).

Heterosexual person/straight person – “A person who is emotionally and/or sexually attracted to people of a different gender only” (Equality Network 2017).

Homophobia – “Fear, unreasonable anger, intolerance or/and hatred directed towards homosexuality” (ILGA-Europe 2019).

Homosexual – “People are classified as homosexual on the basis of their gender and the gender of their sexual partner(s). When the partner’s gender is the same as the individual’s, then the person is categorised as homosexual. The term focuses on sexuality rather than on identity and may, in some contexts, have a negative and pathologising connotation” (ILGA-Europe 2019).

Indicated prevention – “In the context of drug prevention, activities that are targeted at individuals with an increased individual risk of (harmful) drug use” (EMCDDA, Brotherhood and Sumnall 2011: 259).

Intersectionality – “Analytical tool for studying, understanding and responding to the ways in which sex and gender intersect with other personal characteristics/

identities, and how these intersections contribute to unique experiences of discrimination” (EIGE 2021).

Intersex – “A term that relates to a range of physical traits or variations that lie between stereotypical ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category. That is why intersex activists frequently prefer to use the term sex characteristics (for example, when talking about grounds that can be protected against discrimination). There is not one static state called ‘intersex status’, so using the term sex characteristics reflects the fact that being intersex is a bodily experience and only one part of a person’s identity” (ILGA-Europe 2019).

Intoxication – “refers to using legal or illegal drugs to alter one’s state of consciousness, whether visible to others or not, in order to change the way that the person interacts with the world. The notion of intoxication, thus, has some kind of purpose, whether to ease pain and trauma, to have fun, to socialise, to rebel, to express anger, to fit in, to chill out, to work long hours, relax or simply to provide a break in a mundane routine, as with the micro-intoxications related to smoking tobacco or drinking tea or coffee” (Hutton 2020).

Lesbian – “A woman who is sexually and/or emotionally attracted to women” (ILGA-Europe 2019).

LGBTQI+ – Abbreviation for lesbian, gay, bisexual, transgender, queer/questioning, intersex and other gender and sexually diverse people.

Low threshold – “Easily accessible facilities for drug users with user-friendly services with a greater emphasis on harm reduction than on abstinence. Visitors can have something to eat and drink, hygienic facilities are often provided, needles can usually be exchanged and methadone is sometimes dispensed” (EMCDDA 1999, p. 176).

Masculinity – “A gender perspective, or way of analysing the impact of gender on people’s opportunities, social roles and interactions, allows us to see that there is pressure on men and boys to perform and conform to specific roles. Thus, the term masculinity refers to the social meaning of manhood, which is constructed and defined socially, historically and politically, rather than being biologically driven. There are many socially constructed definitions for being a man and these can change over time and from place to place. The term relates to perceived notions and ideals about how men should or are expected to behave in a given setting. Masculinities are not just about men; women perform and produce the meaning and practices of the masculine as well” (UN Women 2021).

Minority stress, minority stressors – The minority stress model specifically refers to the discrepancy and conflict that arises between the values of the minority group and the dominant culture or society, and has been largely conceptualised and utilised within the sexual minority health arena (Meyer 2003).

Motivational interviewing – “directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence” (Rollnick and Miller 1995).

Multiple discrimination – “Certain groups of women, due to the combination of their sex with other factors, such as their race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status, are in an especially vulnerable position. In addition to discrimination on the grounds of sex, these women are often subjected simultaneously to one or several other types of discrimination” (Gender Equality Commission 2015).

Non-binary person – “A person identifying as either having a gender which is in-between or beyond the two categories ‘man’ and ‘woman’, as fluctuating between ‘man’ and ‘woman’, or as having no gender, either permanently or some of the time” (Gender Equality Commission 2015).

Outreach work – “outreach work in the drug field is a proactive method used by professionals and trained volunteers or peers to contact drug users. Its aims are to inform them about the risks associated with drugtaking, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individuals or collective means” (EMCDDA 1999: 164).

Patriarchy – “Social system of masculine domination over women” (EIGE 2021) (see **Gender system**).

Peer education – “Peers educating drug users by communicating preventive messages, in particular on safe drug use and safe sex, to their peers in their own language within a common subculture” (EMCDDA 1999, p. 177).

Problem drug use – “injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines” (EMCDDA 2021c).

Protective factors – “In the context of drug prevention, a factor that reduces the likelihood of initial drug use or the progression to more harmful forms of use. Protective factors can be found on different levels, such as individual (e.g. social competence, impulse control, high educational attainment), family (e.g. cohesive family unit, care and support, parental supervision), peers/community (e.g. norms against drug use), contextual (e.g. high socio-economic status)” (EMCDDA, Brotherhood and Sumnall 2011, p. 268).

Queer – “Previously used as a derogatory term to refer to LGBTI individuals in the English language, queer has been reclaimed by people who identify beyond traditional gender categories and heteronormative social norms. However, depending on the context, some people may still find it offensive. Also refers to queer theory, an academic field that challenges heteronormative social norms concerning gender and sexuality” (ILGA-Europe 2019).

Rape culture – “Complex of beliefs that encourages male sexual aggression and supports violence against women” (EIGE 2021).

Rape myths – “attitudes and beliefs that are generally false yet widely and persistently held and that serve to deny and justify sexual aggression” (Lonsway and Fitzgerald 1994).

Risk factors – “In the context of drug prevention, a factor that increases the likelihood of initial drug use or the progression to more harmful forms of use. Risk factors can be found on different levels, such as individual (e.g. antisocial behaviour, lack of self-esteem, poor school performance), family (e.g. parental drug use, lack of support,

lack of parental supervision), peers/community (e.g. drug-using peers), contextual (e.g. low socio-economic status, high drug availability)" (EMCDDA, Brotherhood and Sumnall 2011, p. 271).

Selective prevention – "In the context of drug prevention, activities that are targeted at individuals with an above-average risk of drug use by virtue of their membership in a particular population group (adapted from Springer and Phillips 2007, e.g. school drop outs, young offenders, children of drug users and clubbers, see **Risk factors**). These groups are also known as vulnerable populations" (EMCDDA, Brotherhood and Sumnall 2011, p. 271).

Sex – "Biological and physiological characteristics that define humans as female or male" (EIGE 2021).

Sex characteristics – A term that refers to a person's chromosomes, anatomy, hormonal structure and reproductive organs: "This is seen as being a more inclusive term than 'intersex status' by many intersex activists, as it refers to a spectrum of possible characteristics instead of a single homogenous status or experience of being intersex" (ILGA-Europe 2019).

Sexism – "Actions or attitudes that discriminate against people based solely on their gender" (EIGE 2021).

Sexual harassment – "Any form of unwanted verbal, nonverbal or physical conduct of a sexual nature with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment" (Article 40 of the Istanbul Convention) (Council of Europe 2011).

Sexual orientation – "refers to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or of the same gender or of more than one gender. Sexual orientation is a profound part of the identity of each and every human being and covers heterosexuality, bisexuality and homosexuality" (Committee on Legal Affairs and Human Rights 2009, p. 7).

Sexual violence – "any sexual act performed on the victim without consent" (EIGE 2021).

Sexual violence including rape – "a) engaging in non-consensual vaginal, anal or oral penetration of a sexual nature of the body of another person with any bodily part or object; b) engaging in other non-consensual acts of a sexual nature with a person; c) causing another person to engage in non-consensual acts of a sexual nature with a third person. Consent must be given voluntarily as the result of the person's free will assessed in the context of the surrounding circumstances" (Council of Europe 2011; Gender Equality Commission 2015).

Substance use disorder – "is a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA 2013, p. 483).

Transgender/Trans – "an inclusive umbrella term referring to people whose gender identity and/or gender expression differ from the sex/gender they were assigned at

birth. It may include, but is not limited to: people who identify as transsexual, transgender, transvestite/cross-dressing, androgyne, polygender, genderqueer, agender, gender variant, gender non-conforming, or with any other gender identity and/or expression which does not meet the societal and cultural expectations placed on gender identity" (ILGA-Europe 2019).

Trans man – "A person who was assigned female at birth but has a male gender identity and therefore transitions to live fully as a man" (Equality Network 2017).

Transphobia – "Refers to negative cultural and personal beliefs, opinions, attitudes and behaviours based on prejudice, disgust, fear and/or hatred of trans people or against variations of gender identity and gender expression" (ILGA-Europe 2019).

Trans woman – "A person who was assigned male at birth but has a female gender identity and therefore transitions to live fully as a woman" (Equality Network 2017).

Trauma – "describes the effects of experiences that overwhelm a person's capacity to cope. These experiences may be early life events of abuse, neglect, and witnessing violence, or later life events such as sexual assault, partner violence, natural disaster, war, accidents, sudden unexpected loss, forced disconnection from home or culture, etc." (Schmidt et al. 2018, p. 36).

Trauma-informed practice – "Trauma-informed practice means integrating an understanding of past and current experiences of violence and trauma into all aspects of service delivery. The goal of trauma-informed services and systems is to avoid re-traumatizing individuals and support safety, choice, and control in order to promote healing" (Schmidt et al. 2018, p. 37).

Universal prevention – "Universal prevention typically aims to prevent or delay the onset of drug use. Individuals or groups with an above-average risk of drug use are not singled out" (EMCDDA, Brotherhood and Sumnall 2011, p. 276).

Victim blaming – "'Victim blaming' exists to a certain degree with all forms of violence. In order not to question the safety of the world around us when we hear of a violent incident, we may examine the behaviour of the victim and assure ourselves that if we avoid such risks and behaviour (e.g. being out late alone, venturing into certain areas, leaving our door unlocked, dressing in a 'provocative' way) we will avoid violence. This natural act of psychological self-defence, however, focuses our attention on the perceived responsibility of the victim, and may neglect to fully question the conduct of the perpetrator. By shifting the blame to the victim in gender-based violence, the focus is on the victim, often a woman, and her behaviour, rather than on the structural causes and inequalities underlying the violence perpetrated against her" (UN Women 2021).

Victimisation – "a person's experience of suffering a rights violation by a criminal offence; offences against the person are understood as violating individuals' rights protected by criminal law" (EIGE 2021).

Violence against women – "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (UN Women 2021).

References

- Abrams M. (2019), *64 terms that describe gender identity and expression. Why does it matter?*, Healthline, available at www.healthline.com/health/different-genders#1, accessed 4 February 2022.
- Aebi M. F. and Tiago M. M. (2020), "Council of Europe annual penal statistics – SPACE I: prison populations survey 2019", Council of Europe, Strasbourg.
- Agterberg S. et al. (2020), "Treatment barriers among individuals with co-occurring substance use and mental health problems: examining gender differences", *Journal of Substance Abuse Treatment* Vol. 112, pp. 29-35.
- Alexander M. (2011), *The new Jim Crow: mass incarceration in the age of colorblindness*, The New Press, New York.
- Anderson T. L. (2005), "Dimensions of women's power in the illicit drug economy", *Theoretical Criminology* Vol. 9, No. 4, pp. 371-400.
- ANew Support Services (2019), "Annual report 2018", Dublin.
- Anglin M. D., Hser Y. I. and Booth M. W. (1987), "Sex differences in addict careers. 4. Treatment", *American Journal of Drug and Alcohol Abuse* Vol. 13, No. 3, pp. 253-80.
- APA (2013), *Diagnostic and statistical manual of mental disorders. DSM-5* (5th edn), American Psychiatric Association, Washington, DC.
- Ayon S. et al. (2017), "Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: role of community-based outreach and drop-in centers", *AIDS Care* Vol. 30, No. 4, pp. 480-7.
- Babineau K. and Harris A. (2015), "Pathways through treatment: a mixed-methods longitudinal outcomes study of Coolmine Therapeutic Community", Coolmine Therapeutic Community, Dublin.
- Bailey K., Trevillion K. and Gilchrist G. (2019), "What works for whom and why: a narrative systematic review of interventions for reducing post-traumatic stress disorder and problematic substance use among women with experiences of interpersonal violence", *Journal of Substance Abuse Treatment* Vol. 99, pp. 88-103.
- Balasz M. et al. (2018), "Sex-related differences in heavy episodic drinking among young adults living in Porto, Bologna and Tarragona: patterns, protective behaviors and negative consequences", *Journal of Alcohol and Drug Education* Vol. 62, No. 3, pp. 72-93.
- Barbarete R., Jackson C. and Jay J. (2017), "UN rules for the treatment of women prisoners and non-custodial sanctions for women offenders (the Bangkok Rules): a gendered critique", *Papers: Revista de sociologia* Vol. 102, No. 2, pp. 215-30.
- Barbier K. (2016), "Accessoires. L'invisibilisation des femmes dans les procédures pénales en matière de stupéfiants", Thèse de sociologie, Centre de recherches sociologiques sur le droit et les institutions pénales (CESDIP), Université Paris-Saclay.

Barzano P. (2013), "The Bangkok Rules: an international response to the needs of women offenders", in *Visiting Experts' Papers, Work Product of the 153rd International Senior Seminar, UNAFEI, Tokyo*, available at www.unafei.or.jp/english/publications/Resource_Material_90.html, accessed 4 February 2022.

Bates G. et al. (2017), "The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A 'review of reviews'", *HRB Drug and Alcohol Evidence Review* 5, Dublin.

Becker J. B. and Koob G. F. (2016), "Sex differences in animal models: focus on addiction", *Pharmacological Reviews* Vol. 68, No. 2, pp. 242-63.

Becker J. B., McClellan M. L. and Glover Reed B. (2017), "Sex differences, gender and addiction", *Journal of Neuroscience Research* Vol. 95, Nos. 1-2, pp. 136-47.

Belknap J. (2015), *The invisible woman: gender, crime, and justice* (4th edn), Cengage Learning, Stamford, CT.

Benoit C. et al. (2014), "Providers' constructions of pregnant and early parenting women who use substances", *Sociology of Health & Illness* Vol. 36, No. 2, pp. 252-63.

Benoit T., Dambele S. and Jauffret-Roustide M. (2015), "Violences, subies ou produites, et usage de substances psychoactives chez les femmes en Europe et dans la région méditerranéenne. Revue de littérature et élaboration de pistes de recherches" [Violence experienced or perpetrated, and psychoactive substance use among women in Europe and in the Mediterranean region. Literature review and identification of lines of research], Pempidou Group, Council of Europe, Strasbourg.

Benoit T. and Jauffret-Roustide M. (2015), "Improving the management of violence experienced by women who use psychoactive substances. Consultation of professionals in September and October 2015 in four European cities: Paris, Rome, Madrid and Lisbon", Pempidou Group, Council of Europe, Strasbourg.

Bès F. (2020), *Prisons pour femmes : la double peine*, Observatoire international des prisons (OPI), available at <https://oip.org/analyse/prisons-pour-femmes-la-double-peine>, accessed 4 February 2022.

Blake S. M. et al. (2001), "A review of substance abuse prevention interventions for young adolescent girls", *Journal of Early Adolescence* Vol. 21, No. 3, pp. 294-324.

Bonevski D., Ignjatova L. and Naumovska A. (2016), "Attachment style, self-esteem and manifest anxiety in patients undergoing treatment for opiate addiction", *Heroin Addiction and Related Clinical Problems* Vol. 18, No. 1, pp. 31-6.

Bränström R., Sjöström E. and Andréasson S. (2008), "Individual, group and community risk and protective factors for alcohol and drug use among Swedish adolescents", *European Journal of Public Health* Vol. 18, No. 1, pp. 12-18.

Broderick G. et al. (2019), "Putting relationships first in social work", *Open Access Practice & Research Journal* (Winter).

Bronson J. et al. (2017), "Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009", Special Report, US Department of Justice, Washington, DC.

- Bui H. N. and Morash M. (2010), "The impact of network relationships, prison experiences, and internal transformation on women's success after prison release", *Journal of Offender Rehabilitation* Vol. 49, No. 1, pp. 1-22.
- Burkhardt G. and Helmer S. M. (2019), "Drug prevention: exploring a systems perspective", EMCDDA, Lisbon.
- Busse A. et al. (2018), "Treatment and care for people with drug use disorders in contact with the criminal justice system: alternatives to conviction or punishment" [Scientific poster], UNODC, WHO.
- Butcher K. F., Park K. H. and Morrison Piehl A. (2017), "Comparing apples to oranges: differences in women's and men's incarceration and sentencing outcomes", NBER Working Paper Series No. 23079, National Bureau of Economic Research.
- Canadian HIV/AIDS Legal Network (2020), "Gendering the scene: women, gender-diverse people, and harm reduction in Canada".
- Canavan R. et al. (2012), "Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities", *BMC Health Service Research* Vol. 12, article 222.
- Cardi C. (2004), "La production du genre au sein de la justice des mineurs : la figure de la délinquante chez les juges des enfants", in Denèfle S. (ed.) *Femmes et villes*, Presses universitaires François-Rabelais, Tours.
- Cardi C. (2007), "Le contrôle social réservé aux femmes : entre prison, justice et travail social", *Déviance et Société* Vol. 31, No. 1, pp. 3-23.
- CDC (2020), *Infographic: 6 Guiding principles to a trauma-informed approach*, Centers for Disease Control and Prevention, available at www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm, accessed 4 February 2022.
- Cekovski I. and Dimitrievski V. (2018), "Legal needs and access to justice for people who inject drugs and sex workers in Macedonia", Healthy Options Project Skopje (HOPS), Skopje.
- Central Statistics Office (2016), *Census of population 2016 – Profile 9 health, disability and carers*, Central Statistics Office, available at www.cso.ie/en/releasesandpublications/ep/p-cp9hdc/p8hdc/p9d, accessed 4 February 2022.
- Chibanda D. et al. (2014), "Mental, neurological, and substance use disorders in people living with HIV/AIDS in low- and middle-income countries", *Journal of Acquired Immune Deficiency Syndromes* Vol. 67, Supplement 1, pp. S54-S67.
- Cho A. and Tasca M. (2019), "Disparities in women's prison sentences: exploring the nexus between motherhood, drug offense, and sentence length", *Feminist Criminology* Vol. 14, No. 4, pp. 420-40.
- CICAD (2009), "How to develop a national drug policy: a guide for policymakers, practitioners, and stakeholders", Inter-American Drug Abuse Control Commission (CICAD/OAS), Washington, DC.

City of Reykjavík (2019), “Stefna í málefnum heimilislausra með miklar og flóknar þjónustuparfir 2019-2025” [Policy on the matters of homeless people with complex needs 2019-25].

Clark M. (2015), “The gender dimension of non-medical use of prescription drugs in Europe and the Mediterranean region”, Pompidou Group, Council of Europe, Strasbourg.

Cockroft J. D. et al. (2019), “‘A scarlet letter’: stigma and other factors affecting trust in the health care system for women seeking substance abuse treatment in a community setting”, *Substance Abuse* Vol. 40, No. 2, pp. 170-7.

Comiskey C. et al. (2021), *An evaluation of the co-design of a citywide pilot anti-stigma training programme*, Trinity College Dublin, Dublin.

Commission on Narcotic Drugs (2012a), “Resolution 55/5. Promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies”, United Nations, Vienna.

Commission on Narcotic Drugs (2012b), “Promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies”, No. E/CN.7/2012/L.8/Rev.1, United Nations Economic and Social Council, Vienna.

Commission on Narcotic Drugs (2016), “Resolution 59/5: mainstreaming a gender perspective in drug-related policies and programmes”, United Nations, Vienna.

Commission on Narcotic Drugs (2019), “Ministerial declaration on strengthening our actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem”, United Nations, Vienna.

Committee on Legal Affairs and Human Rights (2009), “Discrimination on the basis of sexual orientation and gender identity”, Council of Europe, Strasbourg.

CONADIC (2021), *Programa contra la Farmacodependencia 2021-2024*. Comisión Nacional contra las Adicciones.

Connolly J. and Buckley L. (2016), *Demanding money with menace: drug-related intimidation and community violence in Ireland*, Citywide Drugs Crisis Campaign, Dublin.

Correlation and Pompidou Group (2021), “Covid-19 and people who use drugs. Essential interventions to save lives and protect people”, Pompidou Group, Council of Europe and Correlation – European Harm Reduction Network, Strasbourg/Amsterdam.

Coulter R. W. S. et al. (2018), “The effects of gender- and sexuality-based harassment on lesbian, gay, bisexual, and transgender substance use disparities”, *Journal of Adolescent Health* Vol. 62, No. 6, pp. 688-700.

Council of Europe (2005), “Gender budgeting. Final report of the Group of specialists on gender budgeting”, EG-S-GB (2004) RAP FIN, Directorate General of Human Rights, Council of Europe, Strasbourg.

Council of Europe (2008), "Recommendation CM/Rec (2008)1 of the Committee of Ministers to member states on the inclusion of gender differences in health policy", available at https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d4212, accessed 4 February 2022.

Council of Europe (2011), "Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention)", Council of Europe Treaty Series No. 210.

Covington S. S. (2008), "Women and addiction: a trauma-informed approach", *Journal of Psychoactive Drugs* Vol. 48, Supplement 5, pp. 377-85.

Covington S. S. and Bloom B. E. (2003), "Gendered justice: women in the criminal justice system", in Bloom B. E. (ed.), *Gendered justice: addressing female offenders*, Carolina Academic Press, Durham, NC.

Crowley D. and Van Hout M. C. (2016), "Effectiveness of pharmacotherapies in increasing treatment retention and reducing opioid overdose death in individuals recently released from prison: a systematic review", *Heroin Addiction and Related Clinical Problems* Vol. 19, No. 2, pp. 25-42.

Currie J. C. (2001), *Best practices: treatment and rehabilitation for women with substance use problems*, Health Canada, Ottawa.

Degenhardt L. et al. (2017), "Global prevalence of injecting drug use and socio-demographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review", *The Lancet Global Health* Vol. 5, No. 12, pp. e1192-e1207.

DeHart D. D. and Moran R. (2015), "Poly-victimization among girls in the justice system: trajectories of risk and associations to juvenile offending", *Violence Against Women* Vol. 21, No. 3, pp. 291-312.

Department of Health (2017), "Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025", Department of Health, Dublin.

Department of Health (2021), *Mid-term Review of the national drugs strategy, Reducing Harm, Supporting Recovery and Strategic Priorities 2021-2025*, Drugs Policy and Social Inclusion Unit, Department of Health, Dublin.

Department of Justice and Equality (2017), "National strategy for women and girls 2017-2020: creating a better society for all", Stationary Office, Dublin.

Devlin A. M. and Wight D. (2021), "Mechanisms and context in the San Patrignano drug recovery community, Italy: a qualitative study to inform transfer to Scotland", *Drugs: Education, Prevention and Policy* Vol. 28, No. 1, pp. 85-96.

Donnelly S. and Morton S. (2019), "Creating organisational and practice change through the use of co-operative inquiry groups in healthcare settings", *Action Research* Vol. 17, No. 4, pp. 451-68.

Dugan E. et al. (2021), "Global prevalence of hepatitis C virus in women of childbearing age in 2019: a modelling study", *The Lancet Gastroenterology and Hepatology* Vol. 6, No. 3, pp. 169-84.

Edland-Gryt M. and Skatvedt A. H. (2013), "Thresholds in a low-threshold setting: an empirical study of barriers in a centre for people with drug problems and mental health disorders", *International Journal of Drug Policy* Vol. 24, No. 3, pp. 257-64.

EIGE (2020), "Gender budgeting: step-by-step toolkit. Guidance for mainstreaming gender into the EU Funds", European Institute for Gender Equality, Publications Office of the European Union, Luxembourg.

EIGE (2021), *Glossary & thesaurus*, European Institute for Gender Equality, available at <https://eige.europa.eu/thesaurus/overview>, accessed 4 February 2022.

El-Bassel N. et al. (2014), "Drug use as a driver of HIV risks: re-emerging and emerging issues", *Current Opinion in HIV and AIDS* Vol. 9, No. 2, pp. 150-5.

Elliot D. L. et al. (2008), "Long-term outcomes of the ATHENA (Athletes Targeting Healthy Exercise & Nutrition Alternatives) program for female high school athletes", *Journal of Alcohol and Drug Education* Vol. 52, No. 2, pp. 73-92.

EMCDDA (1999), *Outreach work among drug users in Europe: concepts, practice and terminology*, European Monitoring Centre for Drugs and Drug Addiction, Insights No. 2, Office for Official Publications of the European Communities, Luxembourg.

EMCDDA and CICAD-OAS (2010), *Building a national drugs observatory: a joint handbook*, European Monitoring Centre for Drugs and Drug Addiction and the Inter-American Drug Abuse Control Commission of the Organization of American States, Publications Office of the European Union, Luxembourg.

EMCDDA, Brotherhood A. and Sumnall H. R. (2011), *European drug prevention quality standards. A manual for prevention professionals*, European Monitoring Centre for Drugs and Drug Addiction, Manual No. 7, Publications Office of the European Union, Luxembourg.

EMCDDA (2015), *Comorbidity of substance use and mental disorders in Europe*, Insights No. 19, European Monitoring Centre for Drugs and Drug Addiction, Publications Office of the European Union, Luxembourg.

EMCDDA (2017), *An overview of the treatment demand key indicator (TDI)*, European Monitoring Centre for Drugs and Drug Addiction, available at https://www.emcdda.europa.eu/publications/methods/tdi-overview_en, accessed 4 February 2022.

EMCDDA (2019a), *European drug report 2019: trends and developments*, European Monitoring Centre for Drugs and Drug Addiction, Publications Office of the European Union, Luxembourg.

EMCDDA (2019b), *European prevention curriculum. A handbook for decision-makers, opinion-makers and policy-makers in science-based prevention of substance use*, European Monitoring Centre for Drugs and Drug Addiction, Publications Office of the European Union, Luxembourg.

EMCDDA (2020), *European drug report 2020: trends and developments*, European Monitoring Centre for Drugs and Drug Addiction, Publications Office of the European Union, Luxembourg.

EMCDDA (2021a), *Statistical Bulletin 2021*, European Monitoring Centre for Drugs and Drug Addiction, available at www.emcdda.europa.eu/data/stats2021_en, accessed 4 February 2022.

EMCDDA (2021b), *European drug report 2021: trends and developments*, European Monitoring Centre for Drugs and Drug Addiction, Publications Office of the European Union, Luxembourg.

EMCDDA (2021c), *Prison and drugs in Europe: current and future challenges*, European Monitoring Centre for Drugs and Drug Addiction, Insights No. 25, Publications Office of the European Union, Luxembourg.

Equality Network (2017), *LGBTI glossary*, Equality Network, Edinburgh.

Ervin S. et al. (2020), *Addressing trauma and victimization in women's prisons. Trauma-informed victim services and programs for incarcerated women*, Urban Institute, Washington, DC.

ESPAD Group (2020), "ESPAD Report 2019. Results from the European School Survey Project on Alcohol and other Drugs", EMCDDA Joint Publications, Publications Office of the European Union, Luxembourg.

Ettorre E. (2007), *Revisioning women and drug use: gender, power and the body*, Macmillan, York.

European Commission (2020), *EU Agenda and Action Plan on Drugs 2021-2025*, European Commission, Brussels.

Evans E. et al. (2013), "Explaining long-term outcomes among drug-dependent mothers treated in women-only versus mixed-gender programs", *Journal of Substance Abuse Treatment* Vol. 45, No. 3, pp. 293-301.

Evans-Lacko S. et al. (2018), "Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) surveys", *Psychological Medicine* Vol. 48, No. 9, pp. 1560-71.

Farnworth M. and Teske J. R. H. C. (1995), "Gender differences in felony court processing: three hypotheses of disparity", *Women and Criminal Justice* Vol. 6, No. 2, pp. 23-44.

Fazel S., Yoon I. A. and Hayes A. J. (2017), "Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women", *Addiction* Vol. 112, No. 10, pp. 1725-39.

Fernandez J. et al. (2006), "Low threshold: a future model for drug service provision? An evaluation of the model used in South Islington Drug Services", *Journal of Research in Nursing* Vol. 11, No. 1, pp. 42-6.

Fitzpatrick S. and Stephens M. (2014), "Welfare regimes, social values and homelessness: comparing responses to marginalised groups in six European countries", *Housing Studies* Vol. 29, No. 2, pp. 215-34.

Fleetwood J., Radcliffe P. and Stevens A. (2015), "Shorter sentences for drug mules: the early impact of the sentencing guidelines in England and Wales", *Drugs: Education, Prevention and Policy* Vol. 22, No. 5, pp. 428-36.

Focus Ireland (2019), "Annual report 2018. Challenging homelessness. Changing lives", Focus Ireland, Dublin.

Foxcroft D. R. et al. (2014), "Motivational Interviewing for alcohol misuse in young adults", *Cochrane Database of Systematic Reviews*, No. 8, CD007025.

Gadama L. et al. (2020), "'Prison facilities were not built with a woman in mind': an exploratory multi-stakeholder study on women's situation in Malawi prisons", *International Journal of Prisoner Health* Vol. 16, No. 3, pp. 303-18.

Gender Equality Commission (2015), "Gender equality glossary", Council of Europe, Strasbourg.

George S., Boulay S. and Galvani S. (2011), "Domestic abuse among women who misuse psychoactive substances: an overview for the clinician", *Addictive Disorders and their Treatment* Vol. 10, No. 2, pp. 43-9.

Gerassi L. B. (2018), "Barriers to accessing detox facilities, substance use treatment, and residential services among women impacted by commercial sexual exploitation and trafficking", *Behavioral Medicine* Vol. 44, No. 3, pp. 199-208.

Giacomello C. (2020), *Arbitrary detention and compulsory drug treatment in Mexico: a forsaken face of female incarceration*, Penal Reform International, available at www.penalreform.org/blog/arbitrary-detention-and-compulsory-drug-treatment-in-mexico, accessed 4 February 2022.

Gilbert P. A. et al. (2018), "Alcohol research with transgender populations: a systematic review and recommendations to strengthen future studies", *Drug and Alcohol Dependence* Vol. 186, pp. 138-46.

Gilliver C. (2018), "Trauma-informed care in response to adverse childhood experiences", *Nursing Times* Vol. 114, No. 7, pp. 46-9.

Gjoneska B. et al. (2021), "Citizen consultation on problematic usage of the internet: ethical considerations and empirical insights from six countries", *Frontiers in Public Health* Vol. 9, No. 268.

Goldsmith D. and Hillyard M. (2019), "The lack of focus on trans women in a themed issue of the International Journal of Drug Policy on sexualised drug use", *International Journal of Drug Policy* Vol. 68, pp. 1-2.

Gómez Rodríguez R. (2019), *Resignifying the Punts Liles. Learning experiences and new challenges to contribute to the elimination of sexist violence*, L'Associació Drets Sexuals i Reproductius, Barcelona.

Green B. L. et al. (2016), "Trauma experiences and mental health among incarcerated women", *Psychological Trauma: Theory, Research, Practice, and Policy* Vol. 8, No. 4, pp. 455-63.

Greenfield S. F. et al. (2007), "Substance abuse treatment entry, retention, and outcome in women: a review of the literature", *Drug and Alcohol Dependence* Vol. 86, No. 1, pp. 1-21.

Greenfield S. F. et al. (2010), "Substance abuse in women", *Psychiatric Clinics of North America* Vol. 33, No. 2, pp. 339-55.

- Greenwood R. M. (2016), *Novas community detox programme evaluation: fidelity, client and programme outcomes*, Novas, Limerick.
- Grella C. E. and Joshi V. (1999), "Gender differences in drug treatment careers among clients in the national Drug Abuse Treatment Outcome Study", *American Journal of Drug and Alcohol Abuse* Vol. 25, No. 3, pp. 385-406.
- Griffin K. W. et al. (2000), "Ethnic and gender differences in psychosocial risk, protection, and adolescent alcohol use", *Prevention Science* Vol. 1, No. 4, pp. 199-212.
- Guidicini P. and Pieretti G. (1995), *San Patrignano between community and society. A research on the biographic routes of 711 San Patrignano former guests*, FrancoAngeli, Milan.
- Gunnlaugsson H. (2013), *Fikniefnavandinn á Íslandi. Þróun neyslu, neyslumynstur og kostir í stefnumótun* [The substance abuse problem in Iceland. Development of use, patterns of use and possibilities in policy making], Félagsvísindastofnun Háskóla Íslands, Reykjavík.
- Ham L. S. et al. (2019), "Effect of alcohol intoxication on bystander intervention in a vignette depiction of sexual assault", *Journal of Studies on Alcohol and Drugs* Vol. 80, No. 2, pp. 252-60.
- Hanes M. (2017), "Road to recovery: road drawings in a gender-specific residential substance use treatment center", *Art Therapy* Vol. 34, No. 4.
- Harm Reduction International (2021), *What is harm reduction?*, available at www.hri.global/what-is-harm-reduction, accessed 4 February 2022.
- Harrop E. N. and Marlatt G. A. (2010), "The comorbidity of substance use disorders and eating disorders in women: prevalence, etiology, and treatment", *Addictive Behaviors* Vol. 35, No. 5, pp. 392-8.
- Hawkins J. D., Catalano R. F. and Miller J. Y. (1992), "Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention", *Psychological Bulletin* Vol. 112, No. 1, pp. 64-105.
- Hayes R. M., Abbott R. L. and Cook S. (2016), "It's her fault: student acceptance of rape myths on two college campuses", *Violence Against Women* Vol. 22, No. 13, pp. 1540-55.
- HERA (2018), *Strategic framework 2018-2022*, Health Education and Research Association, Skopje.
- Herbst J. H. et al. (2008), "Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review", *AIDS and Behavior* Vol. 12, No. 1, pp. 1-17.
- Hillenbrand E. et al. (2015), "Measuring gender-transformative change. A review of literature and promising practices", Working Paper, CARE USA.
- Hogle J. M. and Curtin J. J. (2006), "Sex differences in negative affective response during nicotine withdrawal", *Psychophysiology* Vol. 43, No. 4, pp. 344-56.
- Holly J. and Horvath M. A. H. (2012), "A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health", *Advances in Dual Diagnosis* Vol. 5, No. 2, pp. 59-67.

Hopkins R. (2017), *This is what life in prison is really like for women in South Africa*, Wits Justice Project, available at www.witsjusticeproject.co.za/investigative-journalism/this-is-what-life-in-prison-is-really-like-for-women-in-south-africa, accessed 4 February 2022.

Hser Y. I. et al. (1997), "Drug treatment careers. A conceptual framework and existing research findings", *Journal of Substance Abuse Treatment* Vol. 14, No. 6, pp. 543-58.

Huber A. (2016), *Women in criminal justice systems and the added value of the UN Bangkok Rules*, Penal Reform International, London.

Hunt G. and Antin T. (2019), "Gender and intoxication: from masculinity to intersectionality", *Drugs: Education, Prevention and Policy* Vol. 26, No. 1, pp. 70-8.

Hunt G. et al. (2019), "Queer youth, intoxication and queer drinking spaces", *Journal of Youth Studies* Vol. 22, No. 3, pp. 380-400.

Hunt J. (2012), *Why the gay and transgender population experiences higher rates of substance use – Many use to cope with discrimination and prejudice*, Center for American Progress.

Hurtig M.-C. and Pichevin M.-F. (1986), *La différence des sexes : questions de psychologie*, Tierce, Paris.

Hutton F. (2020), "Introduction", in Hutton F. (ed.), *Cultures of intoxication. Key issues and debates*, Palgrave Macmillan.

Hyde Z. et al. (2014), *The first Australian National Trans Mental Health Study: summary of results*, School of Public Health, Curtin University, Perth.

Hyman S. M. et al. (2008), "Severity of childhood trauma is predictive of cocaine relapse outcomes in women but not men", *Drug and Alcohol Dependence* Vol. 92, Nos. 1-3, pp. 208-16.

Ignjatova L. et al. (2016), "Towards gender specific tailored programmes", *Heroin Addiction and Related Clinical Problems* Vol. 18, No. 3s1, p. 38.

Ignjatova L. (2017), "Report on the assessment of drug dependence treatment quality standards for drug dependence treatment programs in the former Yugoslav Republic of Macedonia", Ministry of Health, North Macedonia.

Ignjatova L. et al. (2018), "Stigma and secrecy coping in individuals in treatment for substance dependence in Macedonia and Slovenia", *Heroin Addiction and Related Clinical Problems* Vol. 20, No. 10, pp. 38-9.

ILGA-Europe (2019), *ILGA-Europe glossary*, International Lesbian, Gay, Bisexual, Trans and Intersex Association, available at www.ilga-europe.org/resources/glossary, accessed 4 February 2022.

INCB (2016), "Annual Report 2016 – Chapter 1 – Women and drugs", International Narcotics Control Board, Vienna.

INCB (2017), "Report of the International Narcotics Control Board for 2016", No. E/INCB/2016/1, United Nations, New York.

Institute for Health Metrics and Evaluation (2017), *Global Burden of Disease Study 2017 (GBD 2017) data resources*, available at <http://ghdx.healthdata.org/gbd-2017>, accessed 4 February 2022.

Institute for Health Metrics and Evaluation (2019), *Global Burden of Disease Study 2019 (GBD 2019) data resources*, available at <http://ghdx.healthdata.org/gbd-2019>, accessed 4 February 2022.

Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz et al. (2017), "Encuesta nacional de consumo de drogas, alcohol y tabaco 2016-2017: Reporte de drogas", INPRFM, Mexico City.

Inter-American Drug Abuse Control Commission, Executive Secretariat (2020), *GENLEA handbook: strategies and good practices for strengthening gender equality in counterdrug law enforcement agencies*, General Secretariat of the Organization of the American States.

Irish Penal Reform Trust (2013), "Women in the criminal justice system – Towards a non-custodial approach", *IPRT Position Paper 10*, Dublin.

Irish Prison Service and the Probation Service (2018), *Irish Prison Service & Probation Service Joint Strategic Plan 2018-2020*, Department of Justice, Dublin.

Ivers J.-H. and Barry J. (2018), "An evaluation of the Parents under Pressure programme (PUP) at Coolmine", Trinity College Dublin, Dublin.

Iwamoto D. K. et al. (2011), "'Man-ing' up and getting drunk: The role of masculine norms, alcohol intoxication and alcohol-related problems among college men", *Addictive Behaviors* Vol. 36, No. 9, pp. 906-11.

Jackson A. and Shannon L. (2012), "Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky", *Maternal and Child Health Journal* Vol. 16, No. 9, pp. 1762-70.

James S. E. et al. (2016), "The report of the 2015 US Transgender Survey", National Center for Transgender Equality, Washington, DC.

Jego M. et al. (2018), "Improving health care management in primary care for homeless people: a literature review", *International Journal of Environmental Research and Public Health* Vol. 15, No. 2, article 309.

Johns M. M. et al. (2019), "Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students – 19 states and large urban school districts, 2017", *Morbidity and Mortality Weekly Report* Vol. 68, No. 3, pp. 67-71.

Jones L. et al. (2006), *A review of community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people*, National Collaborating Centre for Drug Prevention, Centre for Public Health, Liverpool John Moores University, Liverpool.

Jones L. et al. (2011), "Reducing harm in drinking environments: a systematic review of effective approaches", *Health and Place* Vol. 17, No. 2, pp. 508-18.

Jones M. S. (2020), "Exploring coercive control, PTSD, and the use of physical violence in the pre-prison heterosexual relationships of incarcerated women", *Criminal Justice and Behavior* Vol. 47, No. 10, pp. 1299-318.

Jouriles E. N. et al. (2018), "Bystander programs addressing sexual violence on college campuses: a systematic review and meta-analysis of program outcomes and delivery methods", *Journal of American College Health* Vol. 66, No. 6, pp. 457-66.

Jovanovski B. (ed.) (2020), "Annual report 2019", Health Education and Research Association, Skopje.

Kalant O. J. (1980), *Alcohol and drug problems in women*, Research Advances in Alcohol and Drug Problems, Vol. 5, Plenum Press, New York/London.

Kandall S. R. (2010), "Women and drug addiction: a historical perspective", *Journal of Addictive Diseases* Vol. 29, No. 2, pp. 117-26.

Kann L. et al. (2018), "Youth risk behavior surveillance – United States, 2017", *Morbidity and Mortality Weekly Report. Surveillance Summaries* Vol. 67, No. 8, pp. 1-114.

Karlsson M. E. and Zielinski M. J. (2020), "Sexual victimization and mental illness prevalence rates among incarcerated women: a literature review", *Trauma Violence and Abuse* Vol. 21, No. 2, pp. 326-49.

Kast K. A., Manella G. and Avery J. (2019), "Community as treatment: the therapeutic community model in the era of the opioid crisis", *Journal of Addictive Behaviors, Therapy and Rehabilitation* Vol. 8, No. 2.

Kcomt L. et al. (2020), "Healthcare avoidance due to anticipated discrimination among transgender people: a call to create trans-affirmative environments", *SSM – Population Health* Vol. 11, article 100608.

Kumpfer K. L., Smith P. and Summerhays J. F. (2008), "A wakeup call to the prevention field: are prevention programs for substance use effective for girls?", *Substance Use and Misuse* Vol. 43, Nos. 8-9, pp. 978-1001.

Lazarus J. V. et al. (2020), "Novel health systems service design checklist to improve healthcare access for marginalised, underserved communities in Europe", *BMJ Open* Vol. 10, No. 4, article e035621.

Lee J. H. et al. (2016), "Discrimination, mental health, and substance use disorders among sexual minority populations", *LGBT Health* Vol. 3, No. 4, pp. 258-65.

LeMaire K. L., Oswald D. L. and Russell B. L. (2016), "Labeling sexual victimization experiences: the role of sexism, rape myth acceptance, and tolerance for sexual harassment", *Violence and Victims* Vol. 31, No. 2, pp. 332-46.

Lenihan T. (2020), *Addressing the 105,000 increase in the global female prison population, ten years after the Bangkok Rules were adopted*, Penal Reform International, available at www.penalreform.org/blog/addressing-the-105000-increase-in-the-global-female, accessed 4 February 2022.

Leone R. M. et al. (2018), "Bystander intervention to prevent sexual violence: the overlooked role of bystander alcohol intoxication", *Psychology of Violence* Vol. 8, No. 5, pp. 639-47.

Leventhal A. M., Huh J. and Dunton G. F. (2014), "Clustering of modifiable biobehavioral risk factors for chronic disease in US adults: a latent class analysis", *Perspectives in Public Health* Vol. 134, No. 6, pp. 331-8.

Lindson N. et al. (2019), "Motivational interviewing for smoking cessation", *Cochrane Database of Systematic Reviews*, No. 7, CD006936.

Liquori O'Neil A. and Lucas J. (eds) (2015), *Promoting a gender responsive approach to addiction*, United Nations Interregional Crime and Justice Research Institute, Turin.

Lisansky Gomberg E. (1982), "Historical and political perspective: women and drug use", *Journal of Social Issues* Vol. 38, No. 2, pp. 9-23.

Lisansky Gomberg E., Raskin White H. and Carpenter J. A. (eds) (1982), *Alcohol, science, and society revisited*, University of Michigan Press, Ann Arbor, MI.

Livingston N. A. et al. (2017), "Ecological momentary assessment of daily discrimination experiences and nicotine, alcohol, and drug use among sexual and gender minority individuals", *Journal of Consulting and Clinical Psychology* Vol. 85, No. 12, pp. 1131-43.

Lonsway K. A. and Fitzgerald L. F. (1994), "Rape myths: in review", *Psychology of Women Quarterly* Vol. 18, No. 2, pp. 133-64.

Loughran H. and Broderick G. (2017), "From service-user to social work examiner: not a bridge too far", *Social Work Education* Vol. 36, No. 2, pp. 188-202.

Luzzati R. et al. (2016), "Prevalence of human immunodeficiency virus, hepatitis B virus, and hepatitis C virus infections among transgender persons referred to an Italian center for total sex reassignment surgery", *Sexually Transmitted Diseases* Vol. 43, No. 7, pp. 407-11.

Lynch S. M., Fritch A. and Heath N. (2012), "Looking beneath the surface: the nature of incarcerated women's experiences of interpersonal violence, treatment needs, and mental health", *Feminist Criminology* Vol. 7, No. 4, pp. 381-400.

Lyons T. et al. (2015), "A qualitative study of transgender individuals' experiences in residential addiction treatment settings: stigma and inclusivity", *Substance Abuse Treatment, Prevention, and Policy* Vol. 10, No. 17.

MacAfee L. K. et al. (2020), "Substance use treatment patient and provider perspectives on accessing sexual and reproductive health services: barriers, facilitators, and the need for integration of care", *Substance Use and Misuse* Vol. 55, No. 1, pp. 95-107.

MacArthur G. et al. (2018), "Individual-, family-, and school-level interventions targeting multiple risk behaviours in young people", *Cochrane Database of Systematic Reviews*, No. 10, CD009927.

Macaulay F. (2020), "Gendering drug policy", in Buxton J. et al. (eds), *The impact of global drug policy on women: shifting the needle*, Emerald Publishing, Bingley.

MacDonald S., Christophers L. and Morton S. (2020), *Issues and service access barriers for homeless women with complex issues: a scoping review*, University College Dublin, Dublin.

Manandhar M. et al. (2018), "Gender, health and the 2030 agenda for sustainable development", *Bulletin of the World Health Organization* Vol. 96, No. 9, pp. 644-53.

Manfré G. and Pollettini A. (2010), "*Beyond the community*". *Multidisciplinary study of retention in treatment and follow-up on former residents of San Patrignano*, available at http://sanpatrignano.org/pdf/oltre_comunita_eng.pdf, accessed 4 February 2022.

Martin F. S. and Aston S. (2014), "A 'special population' with 'unique treatment needs': dominant representations of 'women's substance abuse' and their effects", *Contemporary Drug Problems* Vol. 41, No. 3, pp. 335-60.

Martínez-Redondo P. and Luján-Acevedo F. (2020), *Hombres y adicciones. Intervención desde perspectiva de género*, UNAD, Madrid.

Mayock P. and Sheridan S. (2012), *Migrant women and homelessness: key findings from a biographical study of homeless women in Ireland*, Research Paper No. 2, School of Social Work and Social Policy and Children's Research Centre, Trinity College Dublin, Dublin.

Mayock P., Sheridan S. and Parker S. (2012), "Migrant women and homelessness: the role of gender-based violence", *European Journal of Homelessness* Vol. 6, No. 1, pp. 59-82.

Mayock P., Parker S. and Sheridan S. (2013), *Mapping homeless services for women in Dublin*, Dublin Region Homeless Executive, Dublin.

Mayock P., Parker S. and Sheridan S. (2015), *Women, homelessness and service provision*, Simon Communities in Ireland, Dublin.

McGee C. et al. (2015), *A scoping study of the implementation of routine enquiry about childhood adversity (REACH) – Blackburn with Darwen*, Center for Public Health, Liverpool John Moores University, Liverpool.

McLean Taylor J., Gilligan C. and Sullivan A. M. (1997), *Between voice and silence – Women and girls, race and relationship*, Harvard University Press, Cambridge, MA.

McNeil R., Guirguis-Younger M. and Dilley L. (2012), "Recommendations for improving the end-of-life care system for homeless populations: a qualitative study of the views of Canadian health and social services professionals", *BMC Palliative Care* Vol. 11, No. 14.

Mead M. (1950), *Male and female. A study of the sexes in a changing world*, Victor Gollancz, London.

Measham F. (2002), "'Doing gender' – 'doing drugs': conceptualizing the gendering of drug cultures", *Contemporary Drug Problems* Vol. 29, No. 2, pp. 335-73.

Measham F. and Brain K. (2005), "'Binge' drinking, British alcohol policy and the new culture of intoxication", *Crime Media Culture* Vol. 1, No. 3, pp. 262-83.

Menschner C. and Maul A. (2016), *Key ingredients for successful trauma-informed care implementation*, Center for Health Care Strategies, Inc. and Robert Wood Johnson Foundation.

Merchants Quay Ireland (2019), "Annual review 2018", Merchants Quay Ireland, Dublin.

Messina N., Bloom B. and Covington S. (2020), "Gender-responsive approaches for women in the United States", in Ugwu-dike P. et al. (eds), *The Routledge companion to rehabilitative work in criminal justice*, Routledge, London.

Meyer I. H. (2003), "Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence", *Psychological Bulletin* Vol. 129, No. 5, pp. 674-97.

Meyer I. H. et al. (2017), "Incarceration rates and traits of sexual minorities in the United States: National Inmate Survey 2011-2012", *American Journal of Public Health* Vol. 107, No. 2, pp. 267-73.

Miller J. B. (1991), "The development of women's sense of self", in Jordan J. V. et al. (eds), *Women's growth in connection – Writings from the Stone Center*, Guilford Press, New York.

Miller W. R. and Rollnick S. (2002), *Motivational Interviewing: preparing people for change*, Guilford Press, New York.

Ministerio de Sanidad, Servicios Sociales e Igualdad (2017), National Strategy on Addictions 2017-2024, Government Delegation for the National Plan on Drugs, Madrid.

Ministerio de Sanidad, Servicios Sociales e Igualdad (2018), Plan de Acción sobre Adicciones 2018-2020, Delegación del Gobierno para el Plan Nacional sobre Drogas, Madrid.

Ministry of Justice (2020), *Statistics on women and the criminal justice system 2019 – A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991*, National Statistics, London.

Mocroft A. et al. (2013), "Risk factors and outcomes for late presentation for HIV-positive persons in Europe: results from the Collaboration of Observational HIV Epidemiological Research Europe Study (COHERE)", *PLoS Medicine* Vol. 10, No. 9, article e1001510.

Morton S., Hohman M. and Middleton A. (2015), "Implementing a harm reduction approach to substance use in an intimate partner violence agency: practice issues in an Irish setting", *Partner Abuse* Vol. 6, No. 3, pp. 337-50.

Morton S. (2016), "Diversity and vulnerability: group work for women who have experienced IP, childhood trauma, and substance use", in Pelech W. et al. (eds), *Inclusive group work*, Oxford University Press, Oxford.

Morton S. and Hohman M. (2016), "That's the weight of knowing': practitioner skills and impact when delivering psychoeducational group work for women who have experienced IPV", *Social Work with Groups* Vol. 39, No. 4, pp. 277-91.

Morton S. and O'Reilly L. (2016), "Community based low threshold substance use services: practitioner approaches and challenges", Ballymun Youth Action Project, Dublin.

Morton S. and Curran M. (2019), "Fostering understanding, empowering change: practice responses to adverse childhood experiences (ACEs) and intergenerational patterns of domestic violence", Cuan Saor Women's Refuge.

Morton S. and O'Reilly L. (2019), "Challenges, relationship and outcomes in low-threshold drug services", *Drugs and Alcohol Today* Vol. 19, No. 2, pp. 113-22.

Morton S. et al. (2020), "Gender and Irish drug policy. Report submitted to the working group as part of the 'Implementing a gender approach in different drug policy areas: from prevention, care and treatment service to law enforcement' project", University College Dublin and Department of Health, Dublin.

Murphy L. et al. (2017), *Drug-related intimidation. The Irish situation and international responses: an evidence review, HRB drug and alcohol evidence reviews*, Health Research Board, Dublin.

Mutatayi C. (2019), "Female-oriented programmes in addiction care. Results from the Ad-femina survey", *Tendances*, OFDT, No. 130.

Najavits L. M. (2002), *Seeking safety: a treatment manual for PTSD and substance abuse*, Guilford Press, New York.

Nakitanda A. et al. (2020), "Hepatitis C virus infection in EU/EEA and United Kingdom prisons: opportunities and challenges for action", *BMC Public Health* Vol. 20, No. 1670.

National Women's Council of Ireland (2018), "The impact of homelessness on women's health", National Women's Council of Ireland, Dublin.

Neale J. et al. (2018), "Do women with complex alcohol and other drug use histories want women-only residential treatment?", *Addiction* Vol. 113, No. 6, pp. 989-97.

Nelson S. E. et al. (2012), "Moving ahead: evaluation of a work-skills training program for homeless adults", *Community Mental Health Journal* Vol. 48, No. 6, pp. 711-22.

Newcomb M. E. et al. (2020), "High burden of mental health problems, substance use, violence, and related psychosocial factors in transgender, non-binary, and gender diverse youth and young adults", *Archives of Sexual Behavior* Vol. 49, No. 2, pp. 645-59.

Niccols A. et al. (2021), "Preschool mental health: the Brief Child and Family Intake and Outcomes System", *International Journal of Behavioral Development* Vol. 45, No. 2, pp. 170-8.

Norman E. (1997), "New directions: looking at psychological dimensions in resiliency enhancement", in Norman E. (ed.), *Drug-free youth. A compendium for prevention specialists*, Routledge, New York.

Nougier M. and Cots Fernández A. (2021), "Punitive drug laws: 10 years undermining the Bangkok Rules", International Drugs Policy Consortium, London.

O'Carroll A. and Wainwright D. (2019), "Making sense of street chaos: an ethnographic exploration of homeless people's health service utilization", *International Journal of Equity Health* Vol. 18, No. 113.

Oakley A. (1972), *Sex, gender and society*, Maurice Temple Smith Ltd., London.

Obradovic I. (2017), "Perceptions, motives and trajectories associated with drug use in adolescents", *Tendances*, OFDT, No. 122.

Obradovic I. (2019), "Attitudes, représentations, aspirations et motivations lors de l'initiation aux substances psychoactives – Enquête ARAMIS", OFDT, Paris.

Observatorio Uruguayo de Drogas and Junta Nacional de Drogas (2019), *Personas, calle, consumos: dos estudios sobre uso de pasta base en Uruguay. Aproximaciones cuantitativas y etnográficas*.

OHCHR (2016), *Targeted and tortured: UN experts urge greater protection for LGBTI people in detention*, Office of the High Commissioner for Human Rights, available at www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20165&LangID=E, accessed 4 February 2022.

Olievenstein C. (1977), *Il n'y a pas de drogués heureux*, Robert Laffont, Paris.

Open Society Foundations (2011), "By women, for women – New approaches to harm reduction in Russia", Assessment in Action Series.

Otiashvili D. et al. (2013), "Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers", *International Journal of Drug Policy* Vol. 24, No. 6, pp. 566-72.

Palamar J. J. and Griffin M. (2020), "Non-consensual sexual contact at electronic dance music parties", *Archives of Sexual Behavior* Vol. 49, No. 3, pp. 909-17.

Penal Reform International (2016), "Reforming criminal justice responses to drugs – 10-point plan", available at https://cdn.penalreform.org/wp-content/uploads/2016/04/10-point-plan-Drug-policies-WEB_final.pdf, accessed 4 February 2022.

Penal Reform International and Human Rights Education Associates (2017), *Women in detention – Putting the Bangkok Rules into practice (e-course)*, Penal Reform International, available at www.penalreform.org/resource/women-detention-putting-bangkok-rules-practice, accessed 4 February 2022.

Penal Reform International, Linklaters LLP and International Drug Policy Consortium (2020), "Sentencing of women for drug offences", Penal Reform International, London.

Penal Reform International and Thailand Institute of Justice (2020a), "Global prison trends 2020", Penal Reform International, London.

Penal Reform International and Thailand Institute of Justice (2020b), "Special focus 2020 – Pull-out section – Alternatives to imprisonment", in Penal Reform International and Thailand Institute of Justice (2020a), "Global prison trends 2020", Penal Reform International, London.

Penal Reform International (2021), *Key facts*, Penal Reform International, available at www.penalreform.org/issues/women/key-facts, accessed 4 February 2022.

Penal Reform International and Thailand Institute of Justice (2021), "Global prison trends 2021", Penal Reform International, London.

Perry A. E. et al. (2019), "Interventions for female drug-using offenders", *Cochrane Database of Systematic Reviews*, No. 12, CD010910.

Pharis M. E. and Levin V. S. (1991), "A person to talk to who really cared: high-risk mothers' evaluations of services in an intensive intervention research program", *Child Welfare* Vol. 70, No. 3, pp. 307-20.

Pires C. et al. (2018), "Violência sexual e consumo de substâncias psicoativas: podem os contextos festivos ser educativos?", *ex æquo*, No. 37, pp. 143-58.

Pompidou Group (2017), "Introducing a gender dimension into drug policy – Synthesis report on violence, women and rape drugs", Pompidou Group, Council of Europe, Strasbourg.

Public Health England (2018), "Gender specific standards to improve health and wellbeing for women in prison in England", Public Health England, London.

Pyle S. (2019), *Equitable substance use disorder treatment for LGBTQ populations: research, tools, and resources for behavioral health providers*, CASAT OnDemand, available at <https://casatondemand.org/2019/12/19/4489>, accessed 4 February 2022.

Raleva M. and Ignjatova L. (2016), "Association between adverse childhood experiences and health risk behaviours such as smoking, use of alcohol and substance abuse in adolescence", *Heroin Addiction and Related Clinical Problems* Vol. 18, No. 4s1.

Reisner S. L. et al. (2015a), "Gender minority social stress in adolescence: disparities in adolescent bullying and substance use by gender identity", *Journal of Sex Research* Vol. 52, No. 3, pp. 243-56.

Reisner S. L. et al. (2015b), "Substance use to cope with stigma in healthcare among US female-to-male trans masculine adults", *LGBT Health* Vol. 2, No. 4, pp. 324-32.

Reisner S. L. et al. (2016), "Global health burden and needs of transgender populations: a review", *The Lancet* Vol. 388, No. 10042, pp. 412-36.

Rimes K. A. et al. (2017), "Non-binary and binary transgender youth: comparison of mental health, self-harm, suicidality, substance use and victimization experiences", *International Journal of Transgenderism* Vol. 20, Nos. 2-3, pp. 230-40.

Rohrbach L. A. and Milam J. (2006), "Gender issues in substance abuse prevention", in Sloboda Z. and Bukoski W. J. (eds), *Handbook of drug abuse prevention*, Springer US, Boston, MA.

Roig Forteza A. (2020), "Metzineres: sheltering and empowering women who use drugs, survivors of violence", *Innovative approaches to drug policy and incarceration*, WOLA, No. 15.

Rollnick S. and Miller W. R. (1995), "What is motivational interviewing?", *Behavioural and Cognitive Psychotherapy* Vol. 23, No. 4, pp. 325-34.

Romo-Avilés N. (2018), "Drugs and gender", in Ronzani T. M. (ed.), *Drugs and social context*, Springer International Publishing AG, Cham.

Roze M. et al. (2020), "Post-traumatic stress disorder in homeless migrant mothers of the Paris region shelters", *International Journal of Environmental Research and Public Health* Vol. 17, No. 13.

Ruhama (2018), "Annual report 2017", Ruhama, Dublin.

Russell B. (ed.) (2013), *Perceptions of female offenders: how stereotypes and social norms affect criminal justice responses*, Springer Nature Switzerland.

- Sacks J. Y., McKendrick K. and Hamilton Z. (2012), "A randomized clinical trial of a therapeutic community treatment for female inmates: outcomes at 6 and 12 months after prison release", *Journal of Addictive Diseases* Vol. 31, No. 3, pp. 258-69.
- Saleeby D. (1997), *The strengths perspective in social work practice*, Longman, White Plains, NY.
- Salmon A. (2011), "Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship", *Critical Public Health* Vol. 21, No. 2, pp. 165-78.
- SAMHSA (2012), *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals*, Substance Abuse Mental Health Services Administration, Rockville, MD.
- SANPUD, Metzineres and Harm Reduction International (2019), "Harm reduction for women in prison", South African Network of People who Use Drugs.
- Savage M. (2016), "Gendering women's homelessness", *Irish Journal of Applied Social Studies* Vol. 16, No. 2.
- Scheim A. I., Bauer G. R. and Shokoohi M. (2017), "Drug use among transgender people in Ontario, Canada: disparities and associations with social exclusion", *Addictive Behaviors* Vol. 72, pp. 151-8.
- Schinke S. P., Fang L. and Cole K. C. (2008), "Substance use among early adolescent girls: risk and protective factors", *Journal of Adolescent Health* Vol. 43, No. 2, pp. 191-4.
- Schmidt R. et al. (2018), "New terrain: tools to integrate trauma and gender informed responses into substance use practice and policy", Centre of Excellence for Women's Health, Vancouver, BC.
- Schneider K. M. et al. (1995), "Evaluating multiple outcomes and gender differences in alcoholism treatment", *Addictive Behaviors* Vol. 20, No. 1, pp. 1-21.
- SeConS (2012), *Gender aspects of health and social risk of partners of injection drug users (IDUs)*, UNDP, Belgrade.
- Secretaría de Salud (2019), Programa Sectorial de Salud 2019-2024, Mexico.
- Secretaría de Salud (2021), Programa de Acción Específico de Salud Mental y Adicciones, Mexico.
- Sell N. M. et al. (2018), "Alcohol consumption and use of sexual assault and drinking protective behavioral strategies: a diary study", *Psychology of Women Quarterly* Vol. 42, No. 1, pp. 62-71.
- Senreich E. (2010), "Are specialized LGBT program components helpful for gay and bisexual men in substance abuse treatment?", *Substance Use and Misuse* Vol. 45, Nos. 7-8, pp. 1077-96.
- Shirley-Beavan S. et al. (2020), "Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain", *Harm Reduction Journal* Vol. 17, No. 13.
- Šimonović D. (2019), *Official visit to Bulgaria, 14-21 October 2019 by United Nations Special Rapporteur on violence against women, its causes and consequences. End of*

mission statement, Office of the High Commissioner for Human Rights, available at www.ohchr.org/FR/NewsEvents/Pages/DisplayNews.aspx?NewsID=25173&LangID=E, accessed 4 February 2022.

Small J., Curran G. M. and Booth B. (2010), "Barriers and facilitators for alcohol treatment for women: are there more or less for rural women?", *Journal of Substance Abuse Treatment* Vol. 39, No. 1, pp. 1-13.

Smedslund G. et al. (2011), "Motivational interviewing for substance abuse", *Cochrane Database of Systematic Reviews*, No. 5, CD008063.

Smiley A. et al. (2017), "Overdiagnosed but underserved – Trans healthcare in Georgia, Poland, Serbia, Spain, and Sweden: Trans Health Survey", *Transgender Europe*.

Smye V. et al. (2011), "Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: an intersectional lens in the Canadian context", *Harm Reduction Journal* Vol. 8, No. 17.

Spira M., Grossman S. and Wolff-Bensdorf J. (2002), "Voice and identity in a bicultural/bilingual environment", *Child and Adolescent Social Work Journal* Vol. 19, pp. 115-38.

Springer J. F. and Phillips J. (2007), "The Institute of Medicine framework and its implication for the advancement of prevention policy, programs and practice", Center for Applied Research Solutions (CARS), Santa Rosa, CA.

Stöckl H., Watts C. and Penhale B. (2012), "Intimate partner violence against older women in Germany: prevalence and associated factors", *Journal of Interpersonal Violence* Vol. 27, No. 13, pp. 2545-64.

Sullivan W. P. (1994), "Case management and community-based treatment of women with substance abuse problems", *Journal of Case Management* Vol. 3, No. 4, pp. 158-61; 183.

Sumnall H. et al. (2006), "Drug use prevention among young people – Evidence into practice briefing", National Collaborating Centre for Drug Prevention, Liverpool.

Surrey J. L. (1991), "The self-in relation: a theory of women's development", in Jordan J. V. et al. (eds), *Women's growth in connection – Writings from the Stone Center*, Guilford Press, New York.

Tarján A., Horváth G. and Stöver H. (2018), *European mapping of harm reduction interventions in prisons*, HA-REACT WP6, European Harm Reduction Conference, 21 November 2018, Bucharest.

Taylor O. D. (2010), "Barriers to treatment for women with substance use disorders", *Journal of Human Behavior in the Social Environment* Vol. 20, No. 3, pp. 393-409.

The Federal Council (2017), *National Strategy on Addiction and Action Plan 2017-2024*, Swiss Confederation, Bern.

The Yogyakarta Principles plus 10 (2017), "The Yogyakarta Principles plus 10 – Additional principles and state obligations on the application of international human rights law in relation to sexual orientation, gender identity, gender expression and sex characteristics to complement the Yogyakarta Principles", as adopted on 10 November 2017, Geneva.

Thomas N. and Bull M. (2018), "Representations of women and drug use in policy: a critical policy analysis", *International Journal of Drug Policy* Vol. 56, pp. 30-9.

Thomas R. E., Lorenzetti D. and Spragins W. (2011), "Mentoring adolescents to prevent drug and alcohol use", *Cochrane Database of Systematic Reviews*, No. 11, CD007381.

Thomasset C. (2018), "O medieval, a força e o sangue", in Vigarello G. and Alfaro J. (eds), *História da virilidade I – a invenção da virilidade. Da antiguidade às luzes* (1st edn), Orfeu Negro, Lisbon.

Thompson W. E. and Gibbs J. C. (2016), *Deviance and deviants: a sociological approach*, Wiley-Blackwell.

Timpson H. et al. (2016), "'Once you've been there, you're always recovering': exploring experiences, outcomes, and benefits of substance misuse recovery", *Drugs and Alcohol Today* Vol. 16, No. 1, pp. 29-38.

Tinkler J. E., Becker S. and Clayton K. A. (2018), "'Kind of natural, kind of wrong': young people's beliefs about the morality, legality, and normalcy of sexual aggression in public drinking settings", *Law & Social Inquiry* Vol. 43, No. 1, pp. 28-57.

Tirado-Muñoz J. et al. (2018), "Psychiatric comorbidity and intimate partner violence among women who inject drugs in Europe: a cross-sectional study", *Archives of Women's Mental Health* Vol. 21, No. 3, pp. 259-69.

Tompkins C. N. E. and Neale J. (2018), "Delivering trauma-informed treatment in a women-only residential rehabilitation service: qualitative study", *Drugs: Education, Prevention and Policy* Vol. 25, No. 1, pp. 47-55.

Torchalla I. et al. (2012), "Integrated treatment programs for individuals with concurrent substance use disorders and trauma experiences: a systematic review and meta-analysis", *Journal of Substance Abuse Treatment* Vol. 42, No. 1, pp. 65-77.

Tripodi S. J. and Pettus-Davis C. (2013), "Histories of childhood victimization and subsequent mental health problems, substance use, and sexual victimization for a sample of incarcerated women in the US", *International Journal of Law and Psychiatry* Vol. 36, No. 1, pp. 30-40.

Tuchman E. (2010), "Women and addiction: the importance of gender issues in substance abuse research", *Journal of Addictive Diseases* Vol. 29, No. 2, pp. 127-38.

Turner G. and Shepherd J. (1999), "A method in search of a theory: peer education and health promotion", *Health Education Research* Vol. 14, No. 2, pp. 235-47.

Turner S., Norman E. and Zunz S. (1995), "Enhancing resiliency in girls and boys: a case for gender specific adolescent prevention programming", *Journal of Primary Prevention* Vol. 16, No. 1, pp. 25-38.

Tyng C. M. et al. (2017), "The influences of emotion on learning and memory", *Frontiers in Psychology* Vol. 8, No. 1454.

UNAIDS (2021), "HIV and sex work", Fact Sheet Series, Geneva.

UNDAW and UNODC (2008), "Good practices in legislation on violence against women", UN Division for the Advancement of Women and United Nations Office on Drugs and Crime, Vienna.

UN General Assembly (1991a), "Basic principles for the treatment of prisoners: resolution/adopted by the General Assembly. Adopted at the 68th plenary meeting, 14 Dec. 1990", No. A/RES/45/111, United Nations, New York.

UN General Assembly (1991b), "United Nations standard minimum rules for non-custodial measures (The Tokyo Rules): resolution/adopted by the General Assembly. Adopted at the 68th plenary meeting, 14 December 1990", No. A/RES/45/110, United Nations, New York.

UN General Assembly (1998), "Political declaration on countering the world drug problem. Resolution adopted by the General Assembly", No. A/RES/S-20/2*, United Nations, New York.

UN General Assembly (2016), "United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela Rules). Resolution adopted by the General Assembly on 17 December 2015", No. A/RES/70/175, United Nations, New York.

United Nations (1955), "Standard minimum rules for the treatment of prisoners", United Nations, Geneva.

United Nations (2015), "Transforming our world: the 2030 agenda for sustainable development", No. A/RES/70/1.

United Nations (2020a), *Sustainable development goals. Goal 5: Achieve gender equality and empower all women and girls*, available at www.un.org/sustainabledevelopment/gender-equality, accessed 4 February 2022.

United Nations (2020b), "Gender equality: why it matters", United Nations, New York.

United Nations (2021), *What is domestic abuse?*, available at www.un.org/en/coronavirus/what-is-domestic-abuse, accessed 4 February 2022.

United States Sentencing Commission (2018), "Demographic differences in sentencing: an update to the 2012 Booker Report", *Federal Sentencing Reporter* Vol. 30, No. 3, pp. 212-29.

UNODC (2008), *Handbook for prison managers and policymakers on women and imprisonment*, Criminal Justice Handbook Series, United Nations Office on Drugs and Crime, Vienna.

UNODC (2009), *Handbook on prisoners with special needs*, Criminal Justice Handbook Series, United Nations Office on Drugs and Crime, Vienna.

UNODC (2011), "The Bangkok Rules. United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders, adopted by the General Assembly on 21 December 2010 in A/RES/65/229".

UNODC, International Labour Organization and United Nations Development Programme (2012), "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions", *Policy Brief*.

UNODC (2013a), *The international drug control conventions: Single convention on narcotic drugs of 1961 as amended by the 1972 protocol; Convention on psychotropic substances of 1971; United Nations convention against illicit traffic in narcotic drugs*

and psychotropic substances of 1988 with final acts and resolutions, United Nations Office on Drugs and Crime, Vienna.

UNODC (2013b), "International standards on drug use prevention", United Nations Office on Drugs and Crime, Vienna.

UNODC et al. (2014), "Women who inject drugs and HIV: addressing specific needs", *Policy Brief*, UNODC/UNW/WHO/INPUD.

UNODC (2016a), *Handbook on the management of high risk prisoners*, Criminal Justice Handbook Series, United Nations Office on Drugs and Crime, Vienna.

UNODC (2016b), "Addressing the specific needs of women who inject drugs. Practical guide for service providers on gender-responsive HIV services", United Nations Office on Drugs and Crime, Vienna.

UNODC (2016c), "Outcome document of the 2016 United Nations' General Assembly Special Session on the world drug problem. UNGASS 2016. Our joint commitment to effectively addressing and countering the world drug problem", United Nations Office on Drugs and Crime, Vienna.

UNODC (2017a), "World Drug Report 2017 – Global overview of drug demand and supply. Latest trends, cross-cutting issues", United Nations Office on Drugs and Crime, Vienna.

UNODC (2017b), "Guidelines on drug prevention and treatment for girls and women", United Nations Office on Drugs and Crime, Vienna.

UNODC (2018a), *Partnerships and funding*, United Nations Office on Drugs and Crime, available at www.unodc.org/unodc/en/donors/index.html, accessed 4 February 2022.

UNODC (2018b), *International standards on drug use prevention. Second updated edition*, United Nations Office on Drugs and Crime, Vienna.

UNODC (2018c), *DATAUNODC*, available at <https://dataunodc.un.org/>, accessed 4 February 2022.

UNODC (2018d), "World Drug Report 2018 – Women and drugs. Drug use, drug supply and their consequences", United Nations Office on Drugs and Crime, Vienna.

UNODC (2020a), "World Drug Report 2020 – Socioeconomic characteristics and drug use disorders", United Nations Office on Drugs and Crime, Vienna.

UNODC (2020b), "World Drug Report 2020 – Drug use and health consequences", United Nations Office on Drugs and Crime, Vienna.

UNODC (2020c), *Toolkit on gender-responsive non-custodial measures*, Criminal Justice Handbook Series, United Nations Office on Drugs and Crime, Vienna.

UNODC (2020d), "Executive Summary – World Drug Report 2020", United Nations Office on Drugs and Crime, Vienna.

UNODC (2021a), *Crime prevention and criminal justice*, available at www.unodc.org/e4j/en/secondary/criminal-justice.html, accessed 4 February 2022.

UNODC (2021b), "World Drug Report 2021 – Global overview: drug demand, drug supply", United Nations Office on Drugs and Crime, Vienna.

UNODC (2021c), "Gender mainstreaming in the work of UNODC. Guidance note for UNODC staff", United Nations Office on Drugs and Crime, Vienna.

UNODC and WHO (2020), "International standards for the treatment of drug use disorders. Revised edition incorporating results of field testing", World Health Organization and the United Nations Office on Drugs and Crime.

UN Secretariat (2010), "United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders (the Bangkok Rules): note/by the Secretariat", No. A/C.3/65/L.5, United Nations, New York. UN Women (2014), "A gender perspective on the impact of drug use, the drug trade, and drug control regimes. UN women policy brief", United Nations.

UN Women (2017), Strategic Plan 2018-2021, No. UNW/2017/6/Rev.1, United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women).

UN Women (2021), *Gender equality glossary*, available at <https://trainingcentre.unwomen.org/mod/glossary/view.php?id=36>, accessed 4 February 2022.

Vale Pires C. et al. (2019), *Ponto Lilás 2019: relatório de intervenção*.

Valencia J. et al. (2020), "Gender-based vulnerability in women who inject drugs in a harm reduction setting", *PLoS One* Vol. 15, No. 3, e0230886.

Valentine V. (2016), "Non-binary people's experiences in the UK", Scottish Trans Alliance, Edinburgh.

Valentine V. and Maund O. (2016), "Transgender inclusion in drug and alcohol services", Scottish Trans Alliance, Edinburgh.

van de Baan F. C. et al. (2021), "Prevalence of illicit drug use before imprisonment in Europe: results from a comprehensive literature review", *Drugs: Education, Prevention and Policy*, published online 8 February 2021.

van den Bergh B., Plugge E. and Aguirre I. Y. (2014), "Women's health and the prison setting", in Enggist S. et al. (eds), *Prisons and health*, WHO Regional Office for Europe, Copenhagen.

Van Havere T. et al. (2009), "The influence of age and gender on party drug use among young adults attending dance events, clubs, and rock festivals in Belgium", *Substance Use and Misuse* Vol. 44, No. 13, pp. 1899-1915.

Van Hout M. C. and Crowley D. (2021), "The 'double punishment' of transgender prisoners: a human rights based commentary on placement and conditions of detention", *International Journal of Prisoner Health*, published online 24 March 2021.

Van Hout M. C., Fleißner S. and Stöver H. (2021), "# Me Too: global progress in tackling continued custodial violence against women: The 10-year anniversary of the Bangkok Rules", *Trauma, Violence and Abuse*, published online 3 August 2021.

Vuattoux A. (2016), "Genre et rapports de pouvoir dans l'institution judiciaire : enquête sur le traitement institutionnel des déviations adolescentes par la justice pénale et civile dans la France contemporaine", submitted thesis, Université Paris 13 Nord, Paris.

Walitzer K. S. and Dearing R. L. (2006), "Gender differences in alcohol and substance use relapse", *Clinical Psychology Review* Vol. 26, No. 2, pp. 128-48.

- Wattanaporn K. A. and Holtfreter K. (2014), "The impact of feminist pathways research on gender-responsive policy and practice", *Feminist Criminology* Vol. 9, No. 3, pp. 191-207.
- Wegner R. et al. (2015), "Sexual assault perpetrators' justifications for their actions: relationships to rape supportive attitudes, incident characteristics, and future perpetration", *Violence Against Women* Vol. 21, No. 8, pp. 1018-37.
- Whitaker T., Ryan P. and Cox G. (2011), "Stigmatization among drug-using sex workers accessing support services in Dublin", *Qualitative Health Research* Vol. 21, No. 8, pp. 1086-1100.
- Whiteford H. A. et al. (2013), "Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010", *The Lancet* Vol. 382, No. 9904, pp. 1575-86.
- WHO (2011a), "Gender mainstreaming for health managers: a practical approach. Facilitators' guide", World Health Organization, Geneva.
- WHO (2011b), "Gender mainstreaming for health managers: a practical approach. Participants' notes", World Health Organization, Geneva.
- WHO (2015a), "HIV and young people who inject drugs", Technical Brief No. WHO/HIV/2015.10, World Health Organization, Geneva.
- WHO (2015b), "HIV and young transgender people", Technical Brief No. WHO/HIV/2015.9, World Health Organization, Geneva.
- WHO (2018a), "Memorandum of understanding between the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC)".
- WHO (2018b), "Global status report on alcohol and health 2018", World Health Organization, Geneva.
- WHO (2019a), "WHO global report on trends in prevalence of tobacco use 2000-2025", World Health Organization, Geneva.
- WHO (2019b), "Breaking barriers towards more gender-responsive and equitable health systems", World Health Organization, Geneva.
- WHO et al. (2019), "International guidelines on human rights and drug policy", WHO/HRDP/OHCHR/UNAIDS/UNDP.
- WHO and UNODC (2020), "International standards for the treatment of drug use disorders. Revised edition incorporating results of field-testing", No. License CC BY-NC-SA 3.0 IGO, World Health Organization and United Nations Office on Drugs and Crime, Geneva.
- WHO (2021a), "Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies 2016-2021: actions for impact", World Health Organization, Geneva.
- WHO (2021b), *Classification framework for gender responsiveness of policies and programmes*, available at www.euro.who.int/en/health-topics/health-determinants/gender/policy/classification-framework-for-gender-responsiveness-of-policies-and-programmes, accessed 4 February 2022.

Wincup E. (2016), "Gender, recovery and contemporary UK drug policy", *Drugs and Alcohol Today* Vol. 16, No. 1, pp. 39-48.

Wincup E. (2019), "Women as vulnerable subjects: a gendered reading of the English and Irish drug strategies", *Addictive Behaviors* Vol. 98, article 105995.

Wolff N., Blitz C. L. and Shi J. (2007), "Rates of sexual victimization in prison for inmates with and without mental disorders", *Psychiatric Services* Vol. 58, No. 8, pp. 1087-94.

Wolfson L. et al. (2021), "Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework", *Health and Social Care in the Community* Vol. 29, No. 3, pp. 589-601.

Wright R. (2004), "Care as the 'heart' of prison teaching", *Journal of Correctional Education* Vol. 55, No. 3, pp. 191-209.

Yamawaki N. et al. (2012), "Perceptions of domestic violence: the effects of domestic violence myths, victim's relationship with her abuser, and the decision to return to her abuser", *Journal of Interpersonal Violence* Vol. 27, No. 16, pp. 3195-3212.

Yaremenko L., Shulga L. and Varban M. (2015), *Gender and harm reduction – Basic concepts*, Alliance for Public Health.

Yi S. et al. (2017), "HIV prevalence, risky behaviors, and discrimination experiences among transgender women in Cambodia: descriptive findings from a national integrated biological and behavioral survey", *BMC International Health and Human Rights* Vol. 17, No. 14.

Zand D. H. et al. (2017), "Parenting self-efficacy and empowerment among expectant mothers with substance use disorders", *Midwifery* Vol. 48, pp. 32-8.

Zankowski G. L. (1987), "Responsive programming: meeting the needs of chemically dependent women", *Alcoholism Treatment Quarterly* Vol. 4, No. 4, pp. 53-66.

Zurhold H. et al. (2011), "What affects reintegration of female drug users after prison release? Results of a European follow-up study", *Journal of Offender Rehabilitation* Vol. 50, No. 2, pp. 49-65.

Appendix 1 – Examples of prevention, criminal justice and treatment and intervention projects

Prevention

“I want to know”, North Macedonia

The project

This project aims at the prevention of drugs and behavioural addiction, and is youth friendly, gender sensitive and focused on women, men and non-binary young people in North Macedonia. It is implemented by two youth centres for sexual and reproductive health attached to an association called the Health, Education and Research Association (HERA). They are located in the capital city Skopje in Vodno, municipality of Centar, and Šuto Orizari, a municipality predominantly inhabited by Roma. These centres are open every working day. In 2012, in addition to the existing services, a Counselling Service for Protection against Substance Use and Risks in Young People commenced in the youth centre in Vodno, and it is open Mondays, Tuesdays and Thursdays from 2:30 to 5:30 p.m. A few years later, a similar service was added to the youth centre in Šuto Orizari, where it mainly works with minors and is open Fridays from 1 to 4 p.m.⁹

Background and context to the intervention

The HERA was formed in January 2000 by six volunteers, medical students determined to do something about the lack of education on HIV/Aids and the lack of drugs and care for people living with HIV in North Macedonia. Shortly afterwards, the HERA expanded beyond HIV/Aids to cover a fuller range of sexual and reproductive health and sexual rights. In 2009, the HERA obtained full membership of the International Planned Parenthood Federation (IFRS), and its five-year strategic framework reflects its aspirations.

Over the years, the HERA has advocated for better policies on sexual and reproductive health because it believes in freedom of choice and diversity. The organisation provides free and confidential services for sexual and reproductive health and GBV because it believes that availability, accessibility and confidentiality are inseparable from the health of citizens. The HERA also provides education on sexual rights

9. Available at <https://hera.org.mk/servisi/?lang=en>, accessed 4 February 2022.

because strong citizenship and a sustainable democratic society are unattainable without comprehensive information and youth participation. The HERA empowers the marginalised because to be inclusive, society must rely on social justice.

Gender equality is still the HERA's guiding star today, and its commitment is unwavering because it believes that all people should enjoy their sexuality freely in society.

Youth centres provide the following free and confidential services:

- ▶ gynaecological services:
 - diagnosis of STIs;
 - administration of therapy and contraceptives;
 - planned parenthood counselling, unintended pregnancy prevention, bimanual examination, ultrasonography and pregnancy tests;
- ▶ dermatological examinations, including diagnosis and treatment of STIs;
- ▶ counselling for the prevention of STIs, HIV testing and counselling;
- ▶ information and counselling for social rights, administrative procedures and healthcare rights, including in crisis situations;
- ▶ counselling and support related to GBV, including domestic violence;
- ▶ psychosocial counselling: counselling about sexuality, sexual relations, relationships; puberty, peer relations, and conflicts, changes and crises during adolescence; psychological support in crisis management; counselling for child marriages and teenage pregnancy; behavioural counselling;
- ▶ peer education about HIV and sexual and reproductive health;
- ▶ legal assistance and support from a legal adviser and paralegals from the Roma community;
- ▶ distribution of condoms, lubricants and educational materials;
- ▶ counselling for drug use prevention (Counselling Service for Protection against Substance Use and Risks in Young People).

The organisation can act as a one-stop shop: young people can use more services when needed and professionals can easily refer clients from one service to another. The Counselling Service for Protection against Substance Use and Risks in Young People is financially supported by the City of Skopje and is mainly intended for young people from secondary schools in Skopje and their parents, but the friendly attitude towards young people attracts young people from other cities in the country as well as older youth. Other HERA services intended for youth refer clients to the counselling service, which is able to draw on the rich experience of three psychiatrists in the field of prevention and treatment of substance use and addiction.

Overview of the programme

The counselling service provides psychosocial counselling, care and support to young people and their parents for the prevention of drug use. It also offers services for early detection and early intervention and timely referral to health institutions as well as support to professionals involved in the education system to help them manage drug use among secondary school students. Twice a year, school teams are trained in teamwork, drug prevention and behavioural addiction, peer violence, cyber bullying

and problematic internet use. Universal, selective and indicated prevention targets vulnerable groups and individuals. Identity or health documents are not required to access the counselling centre and clients are registered with codes for anonymity and confidentiality. Psychiatric services are provided to groups or individuals who use substances, but also to those who do not use or are in a treatment programme.

The services are used by men, women, transgender, other; according to sexual activity, men who have sex with men or women who have sex with women; and according to sexual orientation, homosexuals, heterosexuals, bisexuals or transsexuals.

Psychiatrists that offer “off” and “online” drug/substances/behavioural dependence prevention services to young people, including non-binary persons, like other professionals in youth counselling centres, are specifically trained and continuously receive education from a civil association – ТрансФорма (Transforma) – of non-binary persons. Transforma is an initiative for the protection and promotion of the rights of transgender people in North Macedonia. Services are free and are provided face to face, by phone or via the internet. The attendance of girls and women is much higher compared to the rigid services in the public health system, where women tend to feel unsafe. Safety as well as anonymity attracts women to this service and helps them deal with the stigma associated with being a woman, and one who uses substances.

A large number of women visit the centre because they have an addicted partner and cannot cope, because they care for them but are also afraid of being influenced by the partner. The service works with them on motivation for change, assertiveness, communication skills, stress management, decision making and strengthening self-confidence. In some cases, in agreement with the client, the partner is included in the prevention activity and the service addresses their relationship, conflict resolution and communication skills, conducting MI with the partner to encourage a change in drug use patterns. Those women who as a result of abuse start using a substance are addressed individually, and in situations where there is auto-aggression they are referred to public health institutions, with managed transfers and facilitated access to institutions carried out by prior appointment and arrangement with employees to avoid any kind of trauma to the client. When necessary and possible, and in agreement with the client, the service involves parents, to whom psychoeducation for active listening without judgment is provided, as well as skills for clear, open and honest communication with their children, and an emphasis on the importance of time spent together, and so on.

In order to deliver preventive activities as well as early detection and intervention targeting non-binary young people who are at greater risk of substance use than their peers, substance prevention has been merged with services for anonymous and confidential testing for STIs and consultations with a gynaecologist and dermatologist. In this way, the stigma that a young person visiting a psychiatrist for drug use may experience is avoided. These young people are usually provided with individual, tailored services that cover the range of counselling, testing and health services; it is important for them to accept their own identities, address their trauma and stress, deal with violence, and build assertiveness and self-confidence.

Selective prevention is implemented in Šuto Orizari municipality, predominantly inhabited by Roma. These are mostly children who later join the education system.

The service works with young girls and boys in a mixed group to educate them on communication skills and assertiveness, and assess attitudes and beliefs about smoking, alcohol and drugs. Small groups of girls (usually two best friends) or individuals are counselled specifically on the topics of violence and the use of medication. Young girls often also want to be counselled individually about their love relationships, and their needs are met. Boys are provided with separate counselling regarding behavioural dependence (for example gambling).

Services offered to young people and their parents include:

- ▶ drug prevention services (verbal interventions, counselling, psychoeducation, individual psychosocial therapy, supportive treatment, family/marital psychotherapy, short psychotherapy sessions, prevention of relapse of substance use [also behavioural dependence], MI, verbal interventions with a parent, psychoeducation with a parent, supportive treatment with a parent, consultative telephone interventions with a parent, providing information on pedagogical psychological services, psychoeducation on pedagogical psychological services);
- ▶ referrals to healthcare institutions, other HERA services and other institutions.

Individual or group preventive activities focus on psychoeducation and information; normative beliefs; change of attitudes and beliefs and correction of misperceptions; as well as life skills, including rejection techniques.

Evaluation

The youth counselling centre uses an approach that ensures security, anonymity and confidentiality (without requiring personal client data). This is a very important approach to facilitate access to substance abuse prevention programmes for all, but especially for women regarding the double stigma of being a woman and one who uses substances. Stigma prevents young people, especially women, from seeking drug-related services at health facilities that require documentation and record patients. Many more women seek help at youth counselling centres than at rigid public health services, especially because they are not registered there, which women are afraid of doing. Gender-sensitive and non-judgmental and moralising approaches also attract vulnerable categories. Working with trauma and post-traumatic stress disorder with women in counselling centres, with careful transfers to the healthcare system when needed, and without added trauma, is a significant approach as well.

The approach of merging multiple services – a “one-stop shop” (for example with a gynaecologist and dermatologist and anonymous and confidential testing and counselling) – and meeting the poly-needs of women, men and non-binary young people is especially effective. If the centres are seen as providing more than just a drug service, if they are places where service recipients see that there are more people like them (that is the gender group to which they belong), non-binary young people and women in particular are likely to be attracted.

According to the HERA's annual report for 2019 (Jovanovski 2020), 47% of clients (young people or parents) who visited the Counselling Service for Protection against Substance Use and Risks in Young People were women, which is much higher than the percentage of women in public health programmes for prevention and

treatment of drug use and dependence – in Skopje this remains at up to 15% of the total number of patients in the capital while in other cities the proportion is even lower (Ignjatova 2017).

However, it should be borne in mind that not all clients using the counselling service use substances and are addicted to them – some are parents. This is in contrast to public health programmes where all women clients suffer from a dependence syndrome. According to the data from the service providers (that is the three psychiatrists), over an eight-year period (2012-20), 13 people of homosexual orientation, two of bisexual orientation, and one transgender (female to male) accessed services; three were female and 12 males, and only one was referred to an opioid maintenance treatment service. Of these, two were 15-19 years old, two were 20-24 years old, 11 were 25-29 years old and one was 35-39 years old. They presented with use of alcohol, benzodiazepines, cannabis and narcotics, but no one injected drugs; three reported that they did not use drugs but attended counselling related to anxiety, sadness, and the need to address the weight of secrecy, self-acceptance, acceptance by family or other reasons.

Addressing gender inequality

One-stop shop services within a youth counselling service, anonymity and confidentiality have proven to be a good practice to attract more young people, more female clients and more people of different genders, sexual activity and orientation. The approach of the services is friendly, non-judgmental, non-moralising, anonymous and confidential, and the activities are comprehensive, coherent and follow the needs of the clients. They do not address drugs exclusively as a problem, but work to strengthen the vulnerable population, and provide education, support, assistance, employment opportunities and more, which certainly contributes to the prevention of substance use.

However, public health prevention and treatment programmes for PWUD remain insufficiently sensitive to age and gender and are not attractive to these groups. Female patients experience existing public health programmes as unsafe and inadequate (Ignjatova 2017).

Wider context

The HERA's Strategic Framework 2018-22 aims at improving the sexual and reproductive rights of all citizens, especially marginalised communities, and to expand its influence in the field of sexual and reproductive rights and gender equality in North Macedonia, as well as in the wider region and throughout Europe (HERA 2018).

The TOP

The project

The school-based, selective prevention initiative that will be described below is part of a larger umbrella project called WeFree (www.wefree.it), which consists of different initiatives and formats created to adapt it to the different ages of the target group (children and adolescents aged 12-19). The initiative that is the subject of this document – the TOP – is aimed at boys and girls aged 15-17. This is often the period

when the search for personal and gender identity becomes crucial and the conflicts – with parents, adults and peers – that are part of this process need to be addressed and possibly positively resolved. It is school based and therefore it addresses mixed groups composed of girls and boys, but it is not gender neutral. On the contrary, the approach is gender sensitive because it focuses on the gender specificity of certain behaviours and issues. Like all the initiatives of the WeFree Project, the TOP is implemented all over Italy, islands included, in different formats and locations: within the Community of San Patrignano (SP), at schools, in theatres and similar spaces, and also online. During the Covid-19 pandemic these were switched to online activities.

Background and context

SP is a therapeutic community founded in 1978. Since then, it has provided, completely free of charge, more than 25 000 people with a home, the warmth of a family, medical and legal assistance, as well as the possibility to continue their studies, attend vocational training courses, learn life skills, build self-confidence and self-esteem, and be successfully reintegrated into society at the end of the process. But prevention has also always been part of its core mission. The WeFree project is based on SP's long experience of fighting marginalisation and helping people with substance use disorders recover. In particular, SP has welcomed more than 4 000 women and girls, and in the process learned a lot about gender differences in drug use patterns, treatment and recovery, and consequently on risk and protective factors. The prevention message is delivered by selected residents at the end of their recovery process, or by former residents: both are carefully educated and trained and are supervised during the activities by prevention experts. This is a peer education and emotionally based approach that seeks to foster the emotional identification of young people with those who carry out the intervention: for this reason, the group of facilitators should always be mixed by gender. The programmes are implemented with the support of funding accessed through participation in public calls from the Ministry of Education, the Ministry of Health, the Ministry of Labour and Social Policies, and the Department of Anti-Drug Policies, but also by collaborating with civil society: foundations, civic and voluntary organisations, and local stakeholders. In addition, schools have funds to invest in prevention activities and in projects aimed at developing transversal skills to be implemented in favour of their students.

Outline of the programme

This intervention innovatively merges the Ministry of Education's programmes for the development of soft skills and study and work orientation tools (PCTO), which are compulsory in the third and fourth year of high school, with information, elements and actions aimed at preventing, detecting and addressing teenage angst and drug use. Thus, substance use prevention is actively linked to planning one's future. The aim of the project is to identify drug use in its early stages and prevent the development of substance use disorders and simultaneously intercept adolescent problems that often affect quality of life to varying degrees. This includes:

- ▶ accompanying and offering tools to the whole group (male and female) to face and overcome difficulties generated by interpersonal/gender relationships;
- ▶ protecting and empowering girls, but also educating their male peers to respect them;

- ▶ promoting the well-being and consequent school success of young people;
- ▶ increasing self-confidence and self-esteem;
- ▶ preventing and addressing situations of youth discomfort and school drop-out;
- ▶ counteracting the development of problematic attitudes, addictions and bullying;
- ▶ empowering them to make well-considered decisions and stimulating interests, initiatives and greater openness among themselves and towards adults.

The identified risk factors may be problematic in their own right, or they may lead to and be combined with substance use, exponentially increasing the risk of developing major disorders and addictions. Early detection of these problems can prevent and avoid problematic developments.

All the initiatives also involve students' teachers and educators, in order to offer guidance and strengthen the alliance and competences of all the actors operating within the educating community. Key terms are "awareness" and "responsibility": awareness of the consequences of our actions on ourselves, others and the environment, and responsibility as not a burden to be avoided, but a positive opportunity to grasp. This approach could alleviate the sense of powerlessness and frustration that young people often experience.

Core elements and structure of the activities are as follows:

- ▶ the intervention is addressed to mixed groups of 35-45 students at a time;
- ▶ the narration of the life story of one of our trained and supervised residents (or former residents) is the emotional key – these follow precise guidelines and/or scripts prepared in collaboration with communication experts, playwrights, psychologists, toxicologists and educators;
- ▶ this session is accompanied with and followed by modules that can be diversely combined up to a total of 51 hours, divided into in-school training, online workshops, activities at SP and at school, and independent research;
- ▶ the activities are supervised by staff that include young trained residents and peer tutors from SP and teachers as school tutors, as well as a pedagogue, a social designer and a social entrepreneur who offer specific lessons and background information and accompany the whole process;
- ▶ students are protagonists – actors rather than passive recipients of the programme – staff members act only as facilitators of the activities.

During the activities, facilitators stimulate them so they can progressively learn and gain experience in extracurricular areas: personal knowledge and respect; empathy, behavioural attitudes and peer education; group management, team working and leadership skills; the ability to express ideas and lead discussions; and improving debate and communication skills. Participants are also helped to build their ability to identify the causes of a problem and propose relevant solutions. They can experience first-hand the complexity of gender dynamics in a protected environment and be guided and supported by staff to identify solutions. Subsequently, students independently research and contextualise the data using links to authoritative national and international resources that are provided to give them insights into both scientific

and sociocultural aspects, and to explore gender issues related to drug use. The outputs of the project are the production of proposals, actions and a search for cultural, sporting and leisure activities in their area. They share their experiences and acquired competences with all students in their schools, in their capacity as Tutors for Orientation and Prevention. Similar formats are used to create ad hoc training for the educational community of teachers, educators and parents.

Evaluation

The emotionally-based approach is supported by studies that have shown that emotions directly influence processes of learning and memory in the brain (Tyng et al. 2017). Many authors have proposed explanations for how peer education works (for example social learning theory, role theory, critical consciousness) (Turner and Shepherd 1999). In order to evaluate the efficacy and effectiveness of the TOP, a questionnaire is administered to participants, students and teachers. In particular, the efficacy of the project is explored across: empowerment; health, well-being and quality of life; social commitment; relationships with others; and orientation and training. The outcomes are very positive in terms of long-term behavioural changes, self-confidence and increased relational capacity, with a higher level of meaningful changes in girls. Furthermore, project participants become more interested in socially-oriented professions.

Addressing gender inequality

The project integrates gender-sensitive education as a founding element of its structure, and aims to be gender transformative. The crucial mechanisms that enable gender awareness and education are the dynamics within the group – the interactions between genders – that take place outside the normal passive routine they experience during lessons at school, through the support and contribution of facilitators. Gender issues are discussed and analysed during the activities to raise awareness of the fact that they often cause suffering and conflict, and the reason for this is a lack of knowledge, acceptance and mutual understanding. In the first module, the group is involved in a brainstorming session to define what youth malaise is and to identify the youth problems that students consider most important, starting from personal experience. A safe space to express their opinions and emotions is offered, avoiding any judgment and encouraging everyone to express their ideas and discover personal interests, aptitudes and talents. At this time, gender differences are highlighted and students together with their tutors focus on those they feel are closest to their experience. This approach is particularly stimulating and empowering for girls because they finally find a space that is conducive to their free expression, and not oppressive. The progressive phases of the project's implementation imply a gradual, concrete and growing awareness of the importance of overcoming pre-established gender patterns by assuming roles far from the socially accepted norm. Girls and boys and non-binary people achieve a better knowledge and acceptance of themselves and of each other, and meet on a level of greater maturity and mutual recognition. They learn from each other about flexibility, adaptation and inclusion, and recognise diversity as a value. The end result is an increase in self-confidence and self-esteem – which according to the evaluations is particularly evident in girls and those who are most vulnerable – with a growing awareness and responsibility

towards their peers and society (social awareness is particularly lacking in boys). Thus, by improving the well-being of young people and overcoming gender conflicts, substance use decreases along with the discomfort that causes it. During project development, supervisory staff observe interactions and can detect and report signs of significant problems. Special attention is paid to girls: eating disorders, self-harm and depression can be signs of dysfunctional/abusive families and are quite common. Separate moments for girls can be created if the facilitator identifies this need, and the female staff members supervise these moments. Further referrals and indicated prevention activities can be implemented whenever necessary by the school tutors. The challenge of this project is that in order to be replicable in its complexity, the staff required should include different professionals, but also recovered people, as the story of their personal experience is the emotional key to start the process.

Wider context

The project aims at contributing to the achievement of Sustainable Development Goal 3, good health and well-being; Goal 4, ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; and in particular Goal 5, achieve gender equality and empower all women and girls.

It also refers to the UNODC/WHO International Standards on Drug Use Prevention (UNODC 2018b) and to the latest recommendations regarding women and girls (UNODC 2017a). The pandemic has forced the implementation of prevention activities in a “new” online mode, and this has opened up exciting possibilities. The project is also working with recorded videos, and for question-and-answer sessions and debates has a number of former residents who have been educated and trained as prevention professionals. More students can be reached, including in remote cities, and this is a positive consequence of the pandemic that will most probably be maintained and extended in the future.

Ponto Lilás, Portugal

The project

Ponto Lilás (Lilac Point), Porto, Portugal is a GBV prevention and harm reduction outreach intervention.

Background and context

Festivals, parties, nightlife and other convivial and drinking environments are very relevant space-times in post-modern lifestyles and Western-based urban identities. These events promote a culture of intoxication (Measham and Brain 2005) where alcohol plays a central role in socialisation, leisure and sexual dynamics among youth and young adults. However, gender norms intersect with social norms for alcohol and other drugs use, penalising women in gendered ways. Alcohol and drug use in public spaces are traditionally considered social and pleasure-oriented masculine behaviours, and women who engage in these practices tend to be sexualised and, consequently, exposed to GBV. In this sense, the feminisation of party, festival and nightlife environments is an important gender equality indicator supporting emancipatory dynamics and the experimentation of alternative identities of femininity

and masculinity. However, these are not neutral, nor sexism-free, environments. On the contrary, the old gender norms and gender double standards are alive and well and are adapted to women's participation in these male-dominated space-times.

In their public lives, women are exposed to sexual harassment and other forms of sexual violence and vigilantism with regard to their behaviours. These gender and power dynamics are exacerbated in nightlife, particularly among the more mainstream environments that strongly adhere to more traditional gender norms. These spaces tend to promote the hyper-sexualisation of female bodies and normalise sexual harassment as acceptable behaviour in these spaces. Women who participate in these settings have to accommodate sexual harassment, and reconcile intoxication with self-vigilance, self-control and protective behaviours as part of their leisure experiences. Additionally, rape myths reproduce a victim-blaming culture that considers women responsible for the violence they may suffer. Gender double standards for alcohol and other drug use are also visible in the evaluation of a sexual violence situation: the same behaviour (alcohol or other drugs use) is used to blame the victim ("she didn't self-control") and excuse the perpetrator ("he couldn't control himself"). Considering this, prevention and harm reduction interventions in nightlife must move beyond gender-neutral approaches focused on individual drug use behaviours and health risks. Sexism and structural gender inequalities aggravate drug-related harms and cause gender-specific risks, so it is crucial to implement gender-aware interventions in the drug field.

Accordingly, a strategic and transdisciplinary partnership involving four Portuguese organisations designed an outreach pilot intervention project to respond to sexism and sexual violence at a large-scale college event in Porto. This group involved a university (the Faculty of Education and Psychology of the Portuguese Catholic University), an NGO promoting harm reduction at large-scale festivals and urban nightlife environments (Kosmicare), a community-based rape crisis centre (Centro EIR – UMAR) and the community-based project Preventing and Combating Dating Violence in higher education (UNI+ project – Plano I Association). The project lacked dedicated funding, but came about as a result of the sheer will of these organisations to respond to the rape culture deeply embedded in the leisure dynamics of college cultures.

The project was named Ponto Lilás, and was based on the methodology of Puntos Lila, created by several organisations and feminist collectives to respond to sexual violence at large-scale festivals and holidays and nightlife events in Spain (Gómez Rodríguez 2019). The choice of name was intentional – it sought to create a new service identity at events. If Red Cross services struggle to manage health emergency situations, Ponto Lilás emerges as a frontline service to prevent and respond to GBV at these events.

In Portugal, Ponto Lilás was implemented during an eight-day, large-scale college festival – Queima das Fitas 2019, well known for the sexist and rape culture it promotes and for the incidents of sexual violence alleged to take place during or after the event. The project was also implemented during a three-day urban festival – NOS Primavera Sound 2019 – but the data presented here refer to the intervention in Queima das Fitas 2019. Before the festival was suspended due to the Covid-19 pandemic, the project team was expecting specific financial support from the Porto Academic Federation to implement Ponto Lilás during Queima das Fitas 2020.

Transgender and non-binary people are also disproportionately affected by GBV and, from an intersectional perspective, this tends to be aggravated if the victims have consumed alcohol or other drugs. However, since the intervention described was designed mainly for women, the analysis here focuses mainly on women's experiences.

Outline of the project

Ponto Lilás is an outreach project created to prevent and respond to sexual violence and other forms of GBV at large-scale festivals. Specifically, it aims to:

- ▶ raise awareness and carry out informal education for gender equality, prevention of GBV, bystander intervention, harm reduction, and safer alcohol and drug use patterns;
- ▶ respond to crisis situations regarding sexual violence and other forms of GBV, drug and drinking-related health crises, or increased social vulnerability;
- ▶ refer service users struggling with trauma and psychological discomfort related to sexual violence to rape crisis centres or health services.

In terms of structure, this project was built on two central axes, communication and outreach intervention.

1. Communication

- ▶ The campaign slogan "I don't allow your harassment! Ponto Lilás – your safe zona at Queima das Fitas" underpinned the communication and educational materials of the project (for example leaflets, posters, bracelets and other gifts).
- ▶ A partnership with the Collective Transport Society of Porto (STCP) saw 260 buses bearing campaign posters in the course of a week, on routes taking in the universities and Queima das Fitas festival areas.
- ▶ A strategic partnership with the media partners, NGOs and other partners helped disseminate campaign materials.
- ▶ The creation of a profile on Instagram supported dissemination of project materials and activities, while also monitoring and denouncing sexist content related to the event circulating online (during the event, it is common to record women engaged in sexualised performances or activities and post them on social media to harass them online), and establishing an online communication platform for event attendees.

2. Outreach intervention

- ▶ An infostand was set up in a strategic area of the festival, managed by a team of specialised professionals, volunteers and peers. This outreach space worked as a safe zone and provided frontline responses for cases of sexual violence and other forms of GBV, serving as a place to raise awareness and educate for gender equality and safer drinking and drug use patterns.
- ▶ A patrol team, inspired by a bystander intervention approach, was set up for early detection, interruption and referral of sexual violence situations, and to target other forms of GBV and people in alcohol- or drug-use-related states of vulnerability. The team was composed of six specialised

professionals – four working to prevent GBV and two with experience in implementing harm reduction, targeting people who use drugs in festival nightlife environments – as well as 16 volunteers (peers and specialised professionals).

Ponto Lilás was implemented on all eight days of Queima das Fitas 2019, remaining open from 9:30 p.m. to 6:00 a.m.

Evaluation

The evaluation of the project included process and impact evaluation, with data compiled in the evaluation report of this project (Vale Pires et al. 2019).

- ▶ Process evaluation was based on an occurrences sheet (description of incidents), overview sheet (affluence, type of interaction, topics, situations and referral), feedback report, and ethnographic tool to be filled in by all professionals and volunteers involved in the project. The team contacted 2 099 people during the eight days of intervention at Queima das Fitas 2019. The team intervened in eight GBV situations, involving physical aggression between heavily drunk couples, and received 11 complaints of GBV that resulted in referrals to social services.
- ▶ Impact evaluation was based on a web survey disseminated online on social media, two weeks after the intervention. There were 101 respondents (88.1% women and 8.9% men) who came into contact with Ponto Lilás during Queima das Fitas, of which 89.1% considered the project very relevant, with 52.6% who were “very satisfied” with the intervention of the team.

Following several complaints from Ponto Lilás and other stakeholders, the Porto Academic Federation closed three bars during the festival with heavily sexist practices and established penalties and fines for bars with sexist approaches. The Federation also decided to regulate the event in order to discourage commercial sexist practices that contribute to the rape culture imagery of the event. However, since the 2020 edition of the festival was suspended because of the Covid-19 pandemic, it is not certain if this commitment will be sustained for the next edition of Queima das Fitas by the management that will be in place.

Addressing gender inequality

This intervention is gender aware, since it responds to the gender-specific risks women face when participating in public spaces or engaging in recreational drinking or drug use. It is focused on women as victims of sexual violence and other forms of GBV. However, it is important to state that GBV in public spaces also affects transgender and non-binary people and, for this reason, it is important to expand this initiative to include also the specific needs of these groups.

Wider context

This intervention intersects with GBV, drug use and festival environments. In this sense it contributes to gender equality and gender mainstreaming in the drugs field, and to the prevention of GBV that affects women’s participation in public and leisure spaces.

Criminal justice

The HOPS, North Macedonia

The project

The HOPS delivers free paralegal services for marginalised groups such as PWUD, sex workers and their families in North Macedonia, focusing on drug users of all genders. Legal advisory services are provided from two drop-in centres (Dunja and Šuto Orizari) by phone, and if necessary in the field.

Background and context to intervention

The HOPS first began to provide pro bono legal services to support sex workers in 2002-03 at the request of social workers in the field. The need to provide legal services to vulnerable categories such as sex workers, including sex workers who use drugs, was then recognised, and the organisation began seeking funding to establish a legal service.

The legal service was officially established in November 2004, in the programme for sex workers, only in the field and once a week, as there was no day centre for sex workers. At first it took time to gain the trust of the clients, but once this was achieved everyone started to share their legal problems, past and present. Since May 2005, a legal service has been operating once a week in the harm reduction programme for drug users (of all genders). Until 2008, the following legal services were provided, financially supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria: counselling and information, referral to institutions if necessary, accompaniment, and preparation of legal documents (complaints, requests, lawsuits, etc.). Since 2008, the organisation has received financial support for litigation of strategic cases and documentation of serious violations of the human rights of sex workers and drug users from the Foundation Open Society – Macedonia (FOOM). Until 2008, the services of one legal adviser were available; from 2008 to 2012, a lawyer and legal adviser provided services; and from 2012 onwards three lawyers have been available.

Since March 2020, the HOPS legal service has been registered to provide free legal aid to sex workers and drug users in accordance with the Law on Free Legal Aid. This should be funded by the Ministry of Justice of North Macedonia, but so far this has not been implemented.

The paralegals for sex workers started working in 2015 with the support of the FOOM, and in 2020, along with the paralegals for PWUD, were supported by the EU-European Instrument for Democracy and Human Rights project Access to Justice for the Most Marginalised. The paralegals are from the communities themselves, and are trained to provide basic information on rights violations, discrimination, violence, and health and social services. There are eight paralegals from the group of sex workers, and five from the PWUD group. In 2020, three paralegals were engaged, of which one was a woman. In 2021, through a Eurasian Harm Reduction Association project on the rights of women who use drugs for GBV, a study on GBV against women who use drugs was conducted. Through this project, free legal aid was provided with a special focus on women who use drugs and are victims of GBV, and three paralegals were hired.

Programme overview

The HOPS offers legal services in a friendly, non-judgmental environment, including free legal assistance for the vulnerable groups of drug users, sex workers and their families. This ranges across several areas: human rights, criminal law, civil and economic law, family law, misdemeanours, administrative law, discrimination and others. The services are provided in the form of advice, referrals, preparation of documents, access to institutions and procedures, and representation before the competent courts for strategic cases where there is a serious violation of human rights and discrimination. The HOPS also documents cases of human rights violations (which is an important tool for data collection), monitors trends in human rights violations, analyses and creates advocacy arguments to improve the situation, and prepares shadow reports to those produced by international bodies and organisations.

Specifically, free legal aid includes: initial legal advice on the right to use free legal aid; general legal information and advice; assistance in filling out forms, including forms issued by an administrative body in an administrative procedure for social protection; and preparation of complaints to the Commission for Protection against Discrimination and to the Ombudsman, as well as requests for protection of freedoms and rights to the Constitutional Court of the Republic of North Macedonia. Paralegal support consists of advising, informing and motivating hard-to-reach PWUD and sex workers to exercise their rights through peer education. Within the project Access to Comprehensive Care for Women who Use Drugs in Cases of Violence, the HOPS conducted the study “Gender-based violence against women who use drugs”. A round table was held to promote the research with representatives of relevant institutions and civil society. Researchers presented findings and recommendations for better systemic management of GBV, especially when it comes to women who use drugs. Harm reduction and psychosocial treatment and care are also provided on a sessional basis.

Evaluation

The HOPS provides services for PWUD and sex workers to protect their rights, with a special focus on health, socio-economic rights, and protection against discrimination, torture and GBV. According to the annual report for 2020, the two drop-in centres in Dunja and Šuto Orizari, in the field and by phone, provided a total of 837 legal services for 95 different clients who use drugs. Of these, 76 clients were men and 19 clients were women, and 33 were of Roma nationality.

In 2020, regarding discrimination due to addiction and unequal treatment based on health status, eight cases of people using drugs were registered who received legal services, of which three were women, one was a child and four were men. Regarding the violation of the right of access to health insurance and healthcare and discrimination, three cases were registered, of which two involved women: one pregnant and one in prison.

In 2020, the daily centre for support of sex workers (including sex workers who use drugs) and their families, in the field and by phone, provided a total of 896 services to 79 different clients. Of these, 17 were men and 62 were women, and 45 were of Roma nationality (<https://hops.org.mk>, accessed 8 February 2022).

That year, legal advisers documented 14 cases of GBV against sex workers (including sex workers who use drugs) and violations of sex workers' rights, including one femicide (of a sex worker who used drugs). From these documented cases, four sex workers were motivated to initiate appropriate proceedings with the HOPS team or partner organisations (such as Transforma, a CSO for the protection and promotion of the rights of transgender people in North Macedonia, and Margin Coalition, a CSO that promotes protection and respect of the fundamental human rights of marginalised communities, with a focus on LGBTI persons, drug users, people living with HIV, sex workers and marginalised women – see case reviews at <http://coalition.org.mk/za-nas?lang=en>, accessed 8 February 2022).

Addressing gender inequality

A survey conducted by the HOPS in 2016 of 142 men (56.8%), 100 women (40%) and eight transgender people (3.2%) showed that PWID and sex workers in North Macedonia face 10 times more non-trivial legal problems compared to the general population (Cekovski and Dimitrievski 2018). At the same time, low legal literacy, mistrust in institutions and systemic discrimination, among other factors, prevent citizens of these communities from seeking protection of their rights and the administration of justice in an institutional way. This confirms their high vulnerability, as well as the need to improve access to information, legal advice and protection. Women who use drugs are much more likely to face problems with their families and partners compared to other subgroups. Most sex workers and PWID have unstable relationships with intimate partners, which are often interrupted due to poor financial status and prison sentences, but also due to violence suffered, mostly by women. WWID are much more likely to have problems with their minor children. The qualitative part of this research also describes the judgmental attitudes of health professionals towards pregnant women and mothers who inject drugs: they may advise them to give up their child for adoption or to a monastery. These women are often told that they will not be good mothers, and even health professionals may comment that such women should not be allowed to have children. With regard to sex work, drug-injecting sex workers face more problems if they are women.

Due to the lack of trust in institutional protection mechanisms, legal aid is often sought from citizens' associations that offer harm reduction services for drug use and support for sex workers. Legal advisers from the HOPS provide free advocacy in strategic cases of human rights violations against sex workers and drug users, representing clients not just before the courts in North Macedonia, but also before the European Court of Human Rights. One such example is a complaint to the European Court of Human Rights for sex workers (some of them PWUD) for violation of their rights under three articles of the European Convention on Human Rights (Articles 3, 5 and 8). Through peer education, paralegals inform and motivate hard-to-reach PWUD and sex workers to exercise their rights.

Wider context

The country recognises the need to include a gender perspective in drug policies and recognises the vulnerability of different gender groups. Free legal aid for vulnerable groups is recognised by the state but also by international organisations that support projects in this field. Co-operation between governmental institutions, CSOs

and international organisations is increasing, and activities for the preparation of documents/protocols related to this topic are planned. Some of the above projects involve more countries, such as Access to Comprehensive Care for Women who Use Drugs in Cases of Violence, which is part of the regional project Sustainability of Services for Key Populations in Eastern Europe and Central Asia implemented by the Alliance for Public Health, in a consortium with 100% Life (All-Ukrainian Network of PLWH), the Central Asian HIV Association and the Eurasian Key Populations Health Network, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Treatment and intervention

Comunità San Patrignano Società Cooperativa Sociale, Italy

The project

The following paragraphs describe a treatment intervention: a recovery and social reintegration-oriented centre, which is residential, drug free and long term. SP welcomes people in a way that is free of age, gender, social, ethnic or religious discrimination. The community has always been gender-inclusive: the first resident was a young woman. Since the very beginning, a mixed group of residents have raised awareness about the differences between women and men not only in drug use patterns but also in the treatment approaches and recovery tools on offer.

Background and context to the intervention

SP was founded in 1978 by Vincenzo Muccioli with a group of volunteers willing to make a concrete contribution towards addressing social issues. In the late 1970s, Italy had been hit by a heroin epidemic responsible for more than 1 000 overdose deaths per year. It was an unknown emergency: psychiatric clinics or prisons were not appropriate places for people with drug use disorders. In that period, some private and mostly faith-based communities were set up. SP was secular and at that time resembled a hippie commune rather than a therapeutic community: a huge number of people came from all over Italy asking for help. The founders decided to offer their help totally free of charge for the residents and their families. The volunteers that flanked Vincenzo were not professionals in the field of drugs: they learned how to intervene by doing, and received guidance directly from the people they were helping, who were the real protagonists of their recovery pathways. Occasionally, residents decided to stay on and give back. They accessed formal education opportunities and gained degrees in different areas, qualifying as psychologists, medical doctors, nurses, sociologists, professional educators or social workers. Currently, the staff of SP is mostly composed of former residents. The funds for SP's sustainability come from donors and from some activities that were implemented primarily to train people and offer them job skills, besides life skills, for their future social reintegration. Over 40 years later, SP is still free of charge for residents and their families. More than 60% of its revenues come from its activities, and the rest from donations. SP runs two centres for young people (females and males under 18 years) and 10% of the available places for adults are at the disposal of the public services for drug users, which pay a monthly fee for them. Professionals from the accounting and commercial

sectors and collaborators such as psychotherapists and psychiatrists (specialised in trauma care) make up the complement of staff. SP's trauma-informed approach is particularly relevant for women and girls.

Overview of the programme

Since 1978, SP has welcomed more than 25 000 individuals suffering from substance use disorders, including over 4 000 women and girls – a third of these, mothers with children. SP's approach is totally individual focused. The aim is to provide a place and space for their personal and professional growth, helping them build a drug-free life and also assisting their social reintegration following completion of the programme. The community invests in formal, non-formal and informal education and job training as possible ways of supporting residents to lead independent and meaningful lives. Unlike most residential centres that admit only men or only women, SP admits both women and men, with no age limit. This was a choice based on the need to create a “micro-society” within the community similar to the society to which people are expected to return at the end of their recovery process. Moreover, this co-existence of different genders, even if it can create some management difficulties, makes it possible to do fundamental work on gender relations, which are often severely compromised by the period of addiction. It allows the promotion of respect in a concrete way, in daily life: the community becomes a gymnasium where people train to live according to their values and feelings with respect for themselves and others. In order to be able to work properly in this direction, from the very beginning, SP had to consider and put in place the processes and elements needed to address different gender needs, accounting for age differences.

Evaluation

In 1994, independent studies carried out by the Department of Sociology at the Alma Mater Studiorum – University of Bologna (www.sanpatignano.org/en/about-us/sociological-research, accessed 9 February 2022), certified a success rate of 72% among the 711 former residents who were available to participate in the research (Guidicini and Pieretti 1995). In 2005, a new study that also included hair strand analysis of participants showed a higher success rate in women than in their male peers (Manfré and Pollettini 2010). A new study published in 2019 analysed the therapeutic community model as a viable answer to the opioid epidemic crisis in the US (Kast, Manella and Avery 2019).

Addressing gender inequality

In order to be able to accommodate women and men of any age at the same time, and offer them effective recovery options, SP implemented the following elements and progressively added further organisational provisions:

- ▶ progressively developing the structure of the programme based on peer support and mutual help, wherein older residents, by gender, act as tutors to newer residents;
- ▶ creating dedicated, safe housing for women, as well as for mothers with their children, as well as for minors;
- ▶ organising after-school and daily care facilities for children with the purpose of allowing their mothers to attend vocational training courses, and have

time for themselves and for interactions with peers, all crucial aspects of the recovery process;

- ▶ providing not only life skills but also job skill opportunities in order to empower residents, women in particular, towards successful social reintegration and an independent and meaningful life;
- ▶ parenting programmes for mothers and fathers;
- ▶ psychological support or psychotherapy experts in specific fields will be recruited shortly: most residents have experienced trauma that is at the root of their drug-related problems, or played a part in triggering more severe problems.

SP possesses data that show that abuse in childhood, bullying and GBV often occur for women. Substance use disorders and mental health issues are frequent consequences that need to be addressed. SP treats traumas mainly through cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) and, if necessary, short-term psychopharmacological therapy. Helping residents to overcome trauma and to recognise and accept their sexual/gender identity means empowering them, and giving them cultural and personal tools to cope with possible future discrimination: it has been shown that this makes their social reintegration easier and helps prevent relapse. It may be said that SP's methods reflect the theoretical framework of the six guiding principles of a trauma-informed approach (CDC 2020) even though when it began there were no theoretical guidelines in this regard. SP did not begin with a procedure in place or a list of techniques to deploy: its success has been the result of constant attention, caring awareness and sensitivity that were and are present at the organisational level. These days, the most compelling challenge involves respecting the whole spectrum of gender identities and sexual orientations, in order to not allow them to become a source of suffering and discrimination. In fact, the community is divided into different vocational training departments whose members share rooms, according to their biological sex. The interactions and the complex dynamics in play among room-mates during these social moments are fundamental and unavoidable steps in the recovery process. Guaranteeing admission to anyone and everyone remains the goal of SP.

Wider context

SP is unique in the national and international scenario, as most therapeutic communities welcome only men; if they do welcome women, they do it in totally separated facilities. SP has consultative status with the UN's Economic and Social Council (ECOSOC) and is part of the Civil Society Forum on Drugs, a European Commission expert group. Many people got to know SP and its specific characteristics relevant conference presentations. As a consequence, many centres around the world have been inspired by the work of SP and have introduced elements of its methods into their interventions or even created new centres following the SP model. SP shares its experience through study visits and, since 2014, has hosted a one-week seminar (three times a year), for scholars, governmental delegations, students and professionals in the social field within its community, with experienced residents as tutors for the daily activities and staff members as lecturers for the theoretical aspects. A study has been produced by a participant of one of these sessions (Devlin and Wight 2021).

18ANO, Greece

The project

The 18ANO programme is for those who use drugs, located within the Drug Dependency Unit of the Psychiatric Hospital of Attica in the centre of Athens. It takes referrals from the whole country. It has a counselling station, a residential in-patient unit and a social rehabilitation unit. It runs a two-year, drug-free residential treatment programme for women who use drugs only, irrespective of sexual orientation and drug of choice. Most women who use drugs are polydrug users: the drug of choice may be heroin, cocaine, amphetamines, *sisa*, cannabis, other stimulant drugs, alcohol, prescribed medications or a combination of all. Women who abuse only alcohol are referred to another unit. In addition, women who use drugs with a dual diagnosis are also accepted (unless the woman has a serious mental problem that needs to be addressed first and the referral is for the psychiatric hospital).

Background and context

The Drug Dependency Unit of the Psychiatric Hospital of Attica, known as 18ANO, is the primary drug-free treatment programme for substance abusers of the National Health System of Greece. It was founded in 1987 by a group of health professionals (psychiatrists, psychologists, nurses, social workers) who all shared the belief that drug addicts are not criminals or mentally disturbed individuals and that addiction is not solely a medical condition but rather a more complicated psychosocial problem. The theoretical framework that helped shape the intervention was Claude Olievenstein's thesis that "[i]n order for drug addiction to evolve a meeting must take place between a personality with psychic deficiencies with a drug in a specific sociocultural moment, at a critical period of the family in question" (Olievenstein 1977). In other words, for treatment to succeed one must take into account all four parameters.

For a decade, the programme was mixed: men and women addicts lived together in a safe therapeutic environment for six or seven months in the 18th unit of the hospital and participated together in all the therapeutic groups (mainly psychotherapy groups, drama therapy groups, gymnastics, art therapy groups and occupational therapy groups). Then they all followed a social rehabilitation phase of a year on an outpatient basis. The main goal was to uncover the reasons behind their drug addiction and give them the opportunity to focus on their strengths and on solutions that were masked by the self-harming behaviours of drug using. All participants agreed on the following rules: no drugs were accepted, and sexual activity and violent behaviour were prohibited throughout the therapeutic process.

However, the overrepresentation of men in the Drug Dependency Unit (that is 15-20 men versus 3-5 women) raised many questions, along with the underrepresentation of women who used drugs, the high drop-out rate of women after engaging in a sexual relationship with other men in treatment, the great difficulty women underwent in sharing experiences of victimisation in the psychotherapeutic groups, and the problematic power dynamics that developed among the men seeking the attention of the few women. The unit's clinical evidence in relation to women who use drugs, oversaw research that shed light on the different needs of women (Schneider et al. 1995; Sullivan 1994) and the Pompidou guidelines on the subject

provided the incentive to create, in 1997, a specialised treatment programme for women who use drugs. It was and still is funded by the Psychiatric Hospital of Attica and the Ministry of Health.

Outline of the programme

The idea behind the development of this intervention was to provide a safe environment for addicted women so that they are able to build trust with female health workers (professionals along with ex-addicts as role models) in women-only psychotherapeutic groups. The aim of these groups is for women to share experiences of both their substance-using years and the years prior to their first drug use, and to receive support from each other. The opportunity is provided for women to have their own space and time to be the centre of attention, where power dynamics or sexism have no place. The programme is based on the relational theory, which encompasses the merger of intrapsychic and interpersonal perspectives. A woman's sense of connectedness to others is considered central to her growth, development and definition of self (Miller 1991; Surrey 1991) so the quality of interpersonal relationships that she will form with other women and the therapeutic personnel may determine whether she will remain in treatment and may be a better predictor of improvement than concrete services received (Pharis and Levin 1991).

Women with problematic substance use (regardless of the drug of choice) stay for a period of seven months in an in-patient residential unit where they focus through various therapeutic groups on the psychological aspects and reasons behind their drug use. All women who use drugs share a) vulnerabilities in self-regulating emotions; b) problems with self-esteem (that is they have a low evaluation of personal capability and in effect feel helpless and unable to address or change these); c) an inability to connect to others without the assistance of drugs; d) experiences of extreme stress due to adverse childhood experiences; and e) traumatic experiences, mainly of a physical and sexual nature, prior to and during the years of drug addiction. A high percentage have felt victimised and feel they deserve what they have been experiencing in the course of their drug use.

The main therapeutic tool used by the unit to deal with these difficulties is group psychotherapy, which is run by trained clinical psychologists once a week in 1.5-hour sessions. The group works as a special forum for these problems and provides corrective emotional experiences for the women so they can find relief for their pain and opportunities to change and grow. It also works as a laboratory for women to learn how to express anger and aggressiveness and to experiment with constructive aspects of their character. They learn to talk about their sexuality, identify their own needs, and develop an ability to make their own life decisions.

Another group that takes place in parallel, once a week, is a semi-directed, psycho-educational group that focuses on the issue of gender, and especially the feelings participants may have about being a woman. It focuses on the awareness of negative emotions/feelings women who use drugs may have, such as jealousy, envy and competition when in relationships. Recognising the existence of such feelings and being able to accept them as normal actually reinforces the inner source of control, and the women accept and retain personal responsibility. Early family dynamics are discussed and the women realise little by little, for instance, that they were given

fewer opportunities than their male siblings from a very young age due to the way they were socialised, not because they were unworthy. Eventually they realise that they deserve to achieve their goals and proceed to self-realisation.

Other groups focus on educating women who use drugs in taking care of their bodies, learning how to care for themselves by cooking for each other, and engaging in physical activity as a mood booster and a way to prevent relapse and learn how to attend to their physical problems. In parallel, they are given all the medical attention needed for the physical problems they may have as a result of drug abuse, notably infectious diseases, neglected dental problems, other pathological symptoms, and concrete help for any social problem they may have experienced.

The intervention is implemented by a group of women health professionals who share a common philosophy despite their varied expertise. This therapeutic team follows the strengths perspective principle, taken from social work literature (Saleeby 1997). Emphasis must be on the strengths women who use drugs possess, not on their weaknesses and pathologies. One must connect with them, recognising that they have managed to survive despite the problems they face (in many cases extreme stress due to adverse childhood experiences) and thus acknowledging that they are survivors and specialists in their own lives. Drug addiction is only a survival strategy, and they must be helped to realise their competences and resources, natural abilities and capabilities. All the nursing staff have been trained in the technique of MI (Miller and Rollnick 2002) in order to be able to comprehend the complex process of behaviour change, moving through resistance and ambivalence.

The women then undergo social rehabilitation, for a year, on an outpatient basis. They are helped to have their own voice and start engaging in healthy relationships. One of the main relapse prevention goals of the unit is to provide housing. The women have the opportunity to stay in a hostel of the unit throughout the third phase. Since the beginning of the intervention, there has been an important increase in the demand rate (in 2004 there was a 12% increase); the drop-out rates, especially in the first trimester of the therapeutic programme, have fallen; and the age of women seeking help has changed (more younger women ask for professional help now).

Evaluation

There have been a number of research protocols studying the population of women who use drugs that seek to better understand their complicated lives, and they have been published in Greek journals, especially the well-known academic journal "Τετράδια Ψυχιατρικής". A presentation was made by Maria Sfikaki on 23 November 2001 at an international seminar of the ITACA Greek department entitled "Contemporary needs of substance users and their therapeutic approaches" with the subject "Female addiction: myth or reality? The clinical experience of the Drug Dependency Unit of the Psychiatric Hospital of Attica".

Addressing gender inequality

This programme was considered gender sensitive because it was developed not through the assumption that women who use drugs are vulnerable, but was based on the belief that they have specific needs that have to be addressed separately, due to the position they find themselves in to survive within the drug-using population,

and because of internalised stereotypical standards of male/female behaviour they carry from their families of origin. Societal perceptions in relation to the “proper” way for a woman to behave are reflected in all the personal histories of women who use drugs. Sexual victimisation is a huge topic that is addressed thoroughly in the treatment programme.

Wider context

Working with women who use drugs is very difficult. They are reluctant to engage with treatment, they suffer from marked impulsivity and they trust nobody. But once they do engage with treatment, their prognosis is better than that of men. A future goal is to educate addicted men on gender issues and help them think out of any binary categorisation. In the phase of social rehabilitation there is the opportunity to do so. In addition, educating other health professionals on gender issues is of crucial importance.

Family Associate, Serbia

The project

Family Associate is a pilot project first delivered in 2013-15 through the co-operation of the United Nations Children’s Fund (UNICEF), the Ministry of Labour, Employment, Veterans and Social Affairs of the Government of the Republic of Serbia, and the Novak Djokovic Foundation, which provided initial funds for its implementation in four cities in Serbia: Belgrade, Kragujevac, Novi Sad, and Nis. The project is aimed at caring for children in particularly vulnerable families and social groups. One of its primary goals is to strengthen the parenting role by helping parents acquire new knowledge and skills in parenting, enhance their life skills, and improve their relationships, with an emphasis on gender concerns.

Background and context

Many countries have developed intensive support services and programmes for families in crisis. Intensive Family Preservation Services (IFPS) are applied in many European countries (for example the Netherlands, Germany, Finland) and are realised in different ways and under various names across the UK, the USA and Australia. The service is based on the belief that separating a child from their family and placing them in a home or foster family is stressful and painful. It leads to the severance of relationships with people close to children. Likewise, living in a dysfunctional family is a risk factor for drug abuse and violence. Therefore, the principle is always to strengthen the natural family, whenever possible, through different kinds of support.

Current socio-demographic characteristics of women who use drugs show that they belong to one of the most vulnerable social groups and that their socio-economic position is extremely unfavourable. Their overall education level is deficient, and many live in deprived areas. This deprivation may be manifested in an inability to provide for the basic needs of the household and housing conditions that are often lacking some of the primary necessities, among others. The gender aspects of health and the social risks of injecting drug partners mean that only 15.5% of all respondents are employed (SeConS 2012), indicating widespread exclusion from the labour market.

The key factors influencing the role of a woman drug addict in a family, partnership or in society are lack of parental care and supervision; experience with and exposure to different forms of violence (psychological, physical and sexual); substance abuse problems within the family; life on the streets and exposure to sex work, delinquency and peer pressure; curiosity or submissiveness concerning the impact of people from family and peer networks; and lack of awareness and knowledge regarding the risks and consequences of drug use. All these factors are heavily influenced by gender-specific roles. Gender roles are learned during childhood and are often characterised by women's subordination to male figures. Internalisation of gender roles in which women are in a submissive position, with little or no power, influences the reproduction of gender inequality in respondents' future lives. It leads to greater exposure of women to the risk of initiation into drug use and relationships with partners who are injecting drug users, generating social and health risks.

Outline of the programme

A Family Associate regularly visits families in the programme and provides practical support in resolving everyday challenges, family disagreements and other problems. The family co-worker is also a kind of "bridge" between the family and the community and helps, for example, in enrolling young children into kindergarten or daycare, collecting administrative documents to secure financial support for the family, involving family members in treatment, and engaging children in creative or community sports activities.

Beneficiaries of the Family Associate are families with children who are facing extreme poverty; single parents with children; families experiencing challenges related to mental health, drugs or alcohol addiction; or families where a child or parent is living with a disability. In other words, these are families facing multiple deprivations, where there is the risk of neglecting the specific needs of children, in which case social workers and other authorities can provide the right support.

Some of the families have severe problems related to alcohol and drug misuse by parents, embedded in complex contexts including, most prominently, inter-generational abuse, low maternal self-esteem, high levels of violence, and poverty. These are related to very high levels of concern about children's risks, including children experiencing physical abuse, those born in withdrawal from drugs, those experiencing severe neglect, or those witnessing violence in the home. Therefore, early interventions help parents and children onto a safer path to a drug and violence-free life.

Evaluation

Outstanding results have been achieved by the programme; in the first 10 months of launching the pilot project, the programme helped 325 families, 545 adults, and 791 boys and girls (as of July 2014). Data on the progress of families show that the service achieves its purpose: it improves the capacity of the family to provide security and the right conditions for the child's development in the family environment.

The Family Associate service has the effect of keeping children with their families. The service prevents the neglect and abuse of children in the family by improving family relationships, parenting skills, educational outcomes, and children and parents' (physical, mental and emotional) health with particular reference to gender

differences and sensitivity. The children are safer; the family develops a new routine and establishes boundaries in family relationships; parents have increased self-confidence. Family members improve life skills and acquire a positive attitude towards life, and they can cope with the stress that leads to financial difficulties. The relationship between families and other services is improving – they have learned how to use other help services.

Addressing gender inequality

In addition to the burden on women using drugs in providing for their household while also obtaining funds for drugs, gender inequalities are also evident in other aspects of household life and intimate partner relationships. Firstly, women are almost exclusively responsible for the household and childcare. Secondly, the research indicates that women are systematically exposed to domestic violence and violence against women. Physical, sexual, economic and psychological violence dominate partner relationships to the extent that violence is “normalised” in many cases. Thirdly, male domination in the drug market puts women who are injecting drug users themselves in a position where they are dependent on their partners to procure drugs, especially if they have not already developed their networks. Finally, injection drug use practices produce a range of additional risks.

The outcomes after one year of the project with regard to family behaviour may be divided into three groups.

1. First group: there were apparent changes for the better, including much-reduced substance use leading to other benefits and positive changes for the family. Violent partners leaving (or dying) was also a standard feature. Here, the Family Associate was able to motivate families to accept treatment and support. The project also facilitated contact with the health sector keeping in mind the gender needs of service users, especially women and mothers; helped find environmental resources and organised support for drug-addicted mothers; and performed the role of advising and educating mothers.
2. Second group: there was partial improvement characterised by fluctuation between better times and increased difficulties. Since the referral, there have been clear improvements, but the mothers find it difficult to sustain them for various reasons (that is, mixed outcomes).
3. Third group: these families had severe and multiple problems over a number of years. This included a strong intergenerational element with children now becoming involved in crime or sex work, or having their children taken into care. There was little reduction in drug or alcohol problems (that is, poor outcomes).

Wider context

To avoid or overcome these social adversities, social welfare institutions have to be effective, and women living under these conditions have to view them as systems of support. However, research findings show that respondents experience these institutions more as a threat than an asset. One of the most obvious implications is that local authorities should experiment with developing services based on this pilot project, which offers families a real chance to change, reduces the need for care and achieves substantial cost savings, particularly if they are considered over

a more extended period, and if savings related to reduced health and other social costs are taken into account. It is recommended that the Centres for Social Affairs incorporate this kind of project in their routine practice.

Metzineres, Barcelona, Catalonia, Spain

The project

Metzineres is an integrated harm reduction programme for women. It provides shelter for women who use drugs and have survived violence. It is based in Barcelona.

Background and context

Metzineres was created to respond to the specific barriers women who use drugs face. The project is based on harm reduction, human rights and gender mainstreaming approaches. Created in 2017, Metzineres is currently a non-profit co-operative funded by the Open Society Foundation (<https://metzineres.net>, accessed 9 February 2022). It is the only service in Catalonia offering a safe shelter environment and harm reduction response to women who use drugs.

Outline of the programme

Metzineres is implemented by an all-female transdisciplinary team whose goal is to “create and share flexible responses characterised by direct and immediate access and tailored to each woman’s particularities, in keeping with their expectations, concerns, curiosities, interests, and needs” (Roig Forteza 2020).

Metzineres was also covered in a publication about Covid-19 and PWUD published by the Pompidou Group of the Council of Europe and the Correlation Network (2021). The programme has adapted its interventions to the new pandemic context. It has retained a holistic approach and included the risks of airborne coronavirus infection in the information it provides, and implemented a workshop for neighbours on how to administer Naloxone in order to respond to their perceptions of injecting heroin use during lockdown. In addition, the programme began producing its own protective masks for clients and to provide support to those infected by Covid-19.

Evaluation

Metzineres receives around 20-30 visits per day, and has supported more than 200 women, 10% of whom are trans (Roig Forteza 2020). Most clients are around 30-49 years old, and they face intersecting inequalities: 73% report problems with their drug use; 21% are sex workers; 36% have mental health problems; 66% are homeless; 33% were previously incarcerated; 45% live with HIV; and 54% live with hepatitis C. All of them report histories of violence (intimate, family and institutional violence). As a result of participating in the programme, the clients report using less drugs and improving their physical, emotional and mental health; they are also more likely to spend time in health and care networks and make use of other shelters.

A qualitative study conducted with Metzineres clients (Shirley-Beavan et al. 2020) also demonstrated that harm reduction services designed specifically for women can mitigate some of the barriers (violence and stigma-related) they face when accessing healthcare services, including those working in the drugs field.

It also demonstrated that these approaches can reduce the marginalisation of its users by empowering them and reinforcing their solidarity.

Addressing gender inequality

Metzineres has an all-female team composed of health and social professionals with expertise in drugs and gender mainstreaming. They promote a safe shelter environment to deal with the intersecting barriers women who use drugs face: stigma and structural violence, GBV, criminalisation and lack of female-specific services (ibid.). In this sense, they offer a programme drawing on intersectional feminism, harm reduction, and human rights and person-centred approaches. Through a community-based and tailored response, Metzineres aims to increase the access and adherence of women who use drugs to health and social care services; to reduce stigma (including self-stigma); and to increase solidarity and empowerment. With a client-centred approach, the programme can also provide holistic, personalised and gender-responsive support. It champions a participatory approach, involving clients in all phases of programme implementation (design, implementation, monitoring and evaluation).

Metzineres is more than a service; it is a community centre since it also seeks to establish relations with its neighbours in order to decrease the stigma towards their clients and also create a stronger and more responsive neighbourhood (Correlation and Pompidou Group 2021). In terms of remaining challenges, Shirley-Beavan et al. (2020) point out the existence of structural barriers that penalise women who use drugs and that are only possible to overcome through policy and social changes.

CAARUD L'Échange and CAARUD "Réduire les Risques", France

The projects

The interventions described here are low-threshold, women-sensitive interventions aiming to improve the access of women who use drugs to care and support by creating trust and an alliance. This (fragile) relationship is not yet a therapeutic alliance but is intended as a way to prepare them to engage in care and social insertion.

In France, some drug treatment centres or low-threshold services have developed interventions with the general aim of creating a favourable climate for women who are addicted to drugs (licit or illicit) to resort to help services and possibly engage earlier with treatment. These are usually run by NGOs or hospital services, with a risk and harm reduction mission. The "women reception time" approach implemented by CAARUD L'Échange and CAARUD "Réduire les Risques" (RLR) are illustrations of these frontline initiatives.

CAARUD L'Échange's "women reception time", open exclusively to women who use drugs, with or without their children, takes place every Wednesday from 10 a.m. to 1 p.m. at their centre in Nancy, north-east France. CAARUD RLR is exclusively dedicated to women who use drugs from Monday to Friday, in the afternoons and on Tuesday mornings, in Montpellier, south France.¹⁰

10. CAARUD L'Échange contact details: Ms Vera Fon Sing, Ms Delphine Streit-Chevalier, caarud.lechange@agu54.org. CAARUD RLR contact details: Ms Monique Douguet, monique.douguet.rlr@free.fr, secretariat@reduirelesrisques.fr.

Background and context

Women are more likely than men to face negative social representations and attitudes about their problematic drug use or drug dependence. Women who are addicted to drugs are widely perceived as the antithesis of the dominant female and maternal models. Women themselves have often internalised these derogative social representations, which explains their reluctance to disclose their needs for care or risk reduction equipment. This is particularly true for mothers who fear a referral to child protection services or even a court decision to separate their children from them because of their addiction. Often, this reluctance to refer to help services also draws on difficult personal experiences with and a lack of trust in social and health institutions. In addition, women who use drugs have often experienced domestic violence from family members or intimate partner(s) that has fostered psychological vulnerability and trauma. There is a high rate of psychiatric morbidity among women who are addicted to drugs. All these kinds of barriers explain why women resign themselves to asking for help at a late stage, in a crisis situation.

To prevent these situations, low-threshold services like CAARUD L'Échange and CAARUD RLR have developed more adapted responses, if not specific to women with or without children. Both NGOs implement these activities with annual funding support from their respective Regional Health Agency. CAARUD L'Échange's activities followed a national call in 2010 for applications for the development of gender-sensitive action in addiction, launched by the French interministerial body defining drug policies (MILDECA) and the Ministry of Health.

Outline of the programme

Both initiatives aim at creating a relationship of trust between women who are addicted to drugs and staff members – to reassure women in a favourable environment with a friendly and informal ambience – in order to facilitate self-care and help them to deal with health issues. However, under this similar general aim, the two centres implement different conditions of delivery, with different advantages.

Two staff members of CAARUD L'Échange run the “women reception time” on Wednesdays, when only women can visit the drop-in centre, with or without their children. On a regular basis, small group workshops are proposed to the women, the theme varying according to staff resources and abilities, available partnerships and the women's requests. The centre welcomes a mostly urban population, Nancy being the provincial capital.

At CAARUD RLR, the entire staff is dedicated to women, who come with or without their children, on weekdays. The exclusive reception of women during the week results in a smaller number of clients than if reception were permanently mixed, but it allows more time to be devoted to each case. The centre is open to a mixed clientele under 25 years old on Monday mornings only. This mixed clientele may be informed of and referred to a social inclusion programme (TAPAJ). CAARUD RLR addresses a peri-urban and urban population in a high-density population area (because of a milder climate).

All regular risk reduction activities in the mission of a CAARUD are offered to women referred to the women-sensitive service, such as free, anonymous and confidential

support, individual professional counselling, provision of harm reduction equipment, needle exchange programmes, advice about safer injection and safer drug use, HIV and hepatitis C rapid diagnostic tests, pregnancy tests, assistance in accessing social rights, and the provision of a health and hygiene space with a shower, laundry, nursing care, and so on. Further, various intermediate objectives may be considered.

Addressing women who are reluctant to refer to help services, for the many reasons mentioned above, requires first of all the raising of awareness about the availability of women-oriented drug services, following which incentive services and activities should be proposed that induce them to visit and return to the centre.

One incentive is to respond to women's immediate needs, for instance by providing stopgap solutions (for example food parcels, snacks, clothes, sanitary pads, hygiene products), emergency housing, support for administrative procedures (for minimum social allowances), bridging with partner services or practitioners dealing with gynaecological or maternity issues, support for intimate or family violence (through NGOs or the police), and nursing care services. Since February 2020, CAARUD RLR social workers have directed 10 to 12 women to an emergency shelter with 30 spaces reserved for women, without going through the general emergency shelter service (SAMU Social).

The low-threshold approach may help to find new ways of addressing women's vulnerabilities and needs that may deviate from mainstream professional practices. Some proposed activities may seem detached from the issue of drug addiction, such as attending events (for example going to the theatre or to a movie) or organising outings; offering the women breakfast or a snack; offering sessions of sophrology, relaxation or other physical activities; or proposing peer workshops for cooking (for example cooking cold, low-budget cooking or cooking with no household electrical appliances), sewing (for example customising clothes), knitting, make-up (with a socio-aesthetician), and health and safer sex education. However, these are also trust-building approaches. They are variously delivered year-to-year by the two NGOs, depending on the funds available, staff abilities, the partnerships developed and women's requests. Work takes place within the framework of an extended partnership, not only with the usual social and health services – including hospitals and other drug-specialised addiction services – but also with less mainstream services and professionals (see “Addressing gender inequality”). This wider range of partners may include, for instance, local NGOs that work on parenting assistance, help women who are victims of violence, and help people to control their aggression, as well as the police, gynaecologists, social workers, sophrologists, dieticians and socio-aestheticians.

Each initiative has its own advantages. With CAARUD L'Échange, women can alternate between “women reception time” and the occasional workshops on Wednesday mornings, and mixed reception during the rest of the week. The alternation allows them to keep in touch with the reality of regular reception, where it is necessary to adjust to the masculine presence and deal sometimes with men's aggressive or hegemonic attitudes. With CAARUD RLR, the exclusive reception of women allows for a continuously reassuring environment and more time to devote to each case. The exclusive reception of women was made possible thanks to a close partnership with another CAARUD in a large city nearby to which men are referred for medical-social support.

Evaluation

Activity reports (in French) provide more details on programme outputs. Staff report that the offer of women-sensitive interventions allows them to reach women with whom they would not have come into contact through the mixed reception, as confirmed by women visiting CAARUD L'Échange. Both centres are identified by their female clients as an entry point for all types of requests and needs, including those not related to addictions. The centres therefore rely on a strong partnership network, wider than that for men, to direct these women to the appropriate interlocutors.

Addressing gender inequality

The rationale of the low-threshold, women-sensitive approaches as developed in these examples is, on the one hand, to respond to emergency situations and the main structural and psychological barriers that limit women's access to appropriate risk reduction and treatment, such as fear of stigmatisation, trauma and psychiatric morbidity. On the other hand, they seek to address psychological vulnerabilities, such as low self-esteem. They respond to the crisis situation of women who are addicted to drugs and are often in a very precarious situation by providing them with emergency housing, stopgap solutions or medical referrals.

To circumvent women's reluctance to refer to drug risk reduction services, especially when based on their fear of stigmatisation, first contact often involves call-in assistance (for example food parcels, clothes or hygiene product distribution) and peer promotion. Once contact is firmly established and a reassuring environment provided, then the drug-related framework may be gradually reintroduced. Women are informed about such women-sensitive approaches through posters in the centres and their partner services, through flyers distributed during outreach patrols, and also through word-of-mouth from former participants. Activities may target the development of domestic abilities. They may smoothly call to mind relegated concerns by motivating women to take pleasure in doing something, to take time for themselves, to reinvest in their relationship to their bodies, and to improve their self-image. Some pathways may seem to reflect a stereotypical image of women (for example cooking, sewing, make-up), but they are nevertheless rather well accepted and often requested by the women themselves, as a way to reconnect with the normalised image of a woman. The subtle balance between the necessary and the "superfluous", at least in appearance, makes it possible to delicately initiate an alliance.

Accompanying women often requires a very reassuring first contact as women ask for more (psychological) support than men. This is related to experiences of frequent violence and trauma. Low-threshold, women-sensitive approaches take into consideration the trauma and psychiatric burdens of women by implementing a respectful approach with the help of specialised NGOs or services, for instance in the fields of psychiatric support, psychological support, GBV, prostitution issues and parenting assistance. In addition, the two centres welcome children accompanying the women so they can access their services even if they do not have alternative childcare in place.

Wider context

The described interventions are two examples of a range of initiatives developed in France. According to the national survey Ad-femina, carried out in 2018 in France, four out of 10 institutions engaged in drug risk reduction or drug treatment reported previous experience with specific women-oriented support (Mutatayi 2019) – addressing issues related to pregnancy, the mother–child bond or, as in these two examples, women’s needs and expectations.

Cuan Saor Women’s Refuge, Ireland

The project

The Cuan Saor Women’s Refuge in County Tipperary, Ireland, provides a range of domestic violence support and intervention services for women and their children at risk of or experiencing domestic violence, including for women who are using substances.

Background and context

Cuan Saor was originally developed as a community response to domestic violence – providing counselling, information and support to women in the locality. In 2001, the organisation was expanded to include the provision of refuge accommodation for women and their children. Services offered include refuge, support and advocacy; a helpline; support for children; court accompaniment; and outreach. In recent years in Ireland, many practitioners and researchers have recognised that for a significant number of women, experiences of domestic violence often co-exist with substance use, either by the perpetrator, the survivor, or both. Despite this growing recognition of the co-occurrence of these two issues in women’s lives, many agencies in Ireland, as in other jurisdictions, continue to focus on one issue or the other, with domestic violence service providers often excluding women from residential service provision if they are known to be actively using substances. Likewise, substance use agencies have recognised the existence of domestic violence in women’s lives, but have been resourced to primarily address drug or alcohol use.

Furthermore, agencies and practitioners have little evidence on women’s experience of effective intervention strategies, and the challenges and barriers to women seeking safety. Recent years have seen an increased recognition of trauma histories, intergenerational issues of compromised parenting, substance use and domestic violence, and infant mental health (IMH) across the domestic violence service landscape in Ireland. These trends have also been reflected in the rise of complex cases presenting at Cuan Saor’s service site in Clonmel, County Tipperary, and 10 years ago the organisation began to develop specific responses to women who were experiencing domestic violence and using substances, as well as conducting further research and intervention development on trauma histories and responses.

Cuan Saor is state funded by Tusla (Child and Family Agency) and the Court Support Service is funded by the Commission for the Support of Victims of Crime (CSVC) through the Department of Justice. Fundraising and donations are used for maintenance, upgrading the service, and therapeutic interventions for women and children.

Overview of the project

The organisation has sought to build comprehensive and effective responses to women experiencing domestic violence who are also using substances through the following process:

- ▶ organisational policy development;
- ▶ practice development for all staff;
- ▶ attending to inter-agency and partnership relationships.

Responses to women using substances include routine enquiries about substance use, support to identify the impact of substance use, consideration of triggers, harm reduction strategies and referrals, and support for detox, stabilisation, treatment or OST. Women who are actively using substances may be accommodated within the refuge (shelter). Intervention is also focused on supporting mothers to retain care of their children, obtain supervised access or obtain unsupervised access, with an aim of addressing aspects of compromised mothering. Safeguarding of children is key, and the agency employs a dedicated childcare worker to ensure and oversee the needs of any child/children. Inter-agency relationships are vitally important in ensuring service delivery for women experiencing domestic violence and substance use, and actions have included training swaps between agencies (domestic violence and substance misuse) and developing referral pathways between key agencies, as well as in-reach between relevant entries where appropriate.

Evaluation

Cuan Saor has engaged in a 10-year process of developing practice, policy and inter-agency relationships in order to improve its responses to women who are using substances and experiencing domestic violence. This process has involved many challenges, from staff concerns to complex client issues that have required a deep level of staff, team and organisational reflexivity. The outcomes of this work include:

- ▶ actively engaging and working with women who are using substances, including encouraging disclosure and focusing on harm minimisation and safety;
- ▶ accommodating women who are actively using drugs and alcohol within the refuge;
- ▶ building supportive and resilient relationships with relevant agencies, including substance misuse services, the Homeless Action Team and the social work department in regard to dual issues;
- ▶ piloting an outreach clinic at the Health Service Executive (HSE) Substance Misuse Drop-In service in the grounds of South Tipperary General Hospital;
- ▶ recognition of expertise on these dual issues within inter-agency settings;
- ▶ significant increases in staff confidence and skills in addressing substance use in women's lives, particularly how it interrelates with their experience of domestic and/or sexual violence;
- ▶ design and implementation of consistent messaging to all service users that substance use can be addressed within the service, by way of posters, leaflets and harm minimisation information being made widely visible.

The organisation has engaged in a number of projects to consider, explore and document the process of service delivery and outcomes and these are documented in reports and peer-reviewed journal articles (Donnelly and Morton 2019; Morton 2016; Morton and Hohman 2016; Morton, Hohman and Middleton 2015).

Addressing gender inequality

The service is specifically for women and seeks to address inequality through specific practical, economic, educational and therapeutic support. An example is the provision of a psychoeducational group work programme that seeks to future-proof women from abusive or manipulative relationships, as well as support them in their educational and therapeutic journey (Morton and Hohman 2016). Childcare is provided or childcare costs covered to ensure women can participate or engage with support or interventions. The organisation also advocates for positive change for women at inter-agency, community and structural levels, such as within the child protection and welfare process and in relation to social welfare and housing entitlements.

Wider context

While there is ongoing recognition of the intersectionality of substance use and domestic violence for women, there have been limited initiatives to provide integrated responses and care. In addition, there is ongoing recognition of the role of trauma and trauma histories within women's substance use initiation and trajectories. Cuan Saor has demonstrated the mechanisms and actions that can be undertaken to provide support that encapsulates a greater range of women's needs, and is now continuing work to integrate greater trauma-informed responses into their work with women and children (Morton and Curran 2019).

Coolmine Ashleigh House, Ireland

The project

Coolmine Ashleigh House in Dublin, Ireland is the only mother-and-child residential service in Ireland. It is a female-only residential service therapeutic community that provides a minimum of six months of residential treatment to women (with or without children), followed by a two-month integration and five-months of aftercare. The service operates with a multidisciplinary team, both internally and externally, in close collaboration with:

- ▶ the HSE;
- ▶ the Probation Service;
- ▶ a consultant psychiatrist/visiting medical officers;
- ▶ community clinicians and prescribers;
- ▶ drug liaison midwives;
- ▶ public health nursing;
- ▶ Tusla/children and family social workers;
- ▶ local authorities/homeless service providers;
- ▶ community drug teams/peer addiction/homeless agencies nationally.

Background and context

Coolmine is committed to creating pathways to treatment and addressing the blocks and barriers experienced by individuals trying to access treatment. In operation since the 1980s, it is built on the belief that everybody should have the opportunity to overcome addiction and have a meaningful and productive life.

One of the barriers identified in the 2000s was women's inability to access treatment due to aversion to placing their children in the care system in order to gain treatment. Lack of childcare options in addition to homelessness and addiction issues resulted in these women forming a very "hidden" population with limited opportunities for treatment. This often resulted in women and children continuing to reside in high-risk environments in order to avoid monitoring organisations, causing them to become more marginalised and vulnerable and often compounding their substance use.

In 2008, Coolmine responded to this need by developing a mother-and-child programme in its already existing women's residential programme. Currently, Ashleigh House supports single women, mothers, expectant mothers and mothers accompanied by their children. An integral part of the service is the on-site, dedicated Early Years and Pre-school Service for children up to the age of five years for all parents participating in the programme. Mothers can feel safe in the knowledge that while they are engaging in the treatment programme, their child is being looked after in a safe, secure, caring and nurturing environment. Ashleigh House supports up to 24 women at any one time (10 of these are mother-and-child places).

The women entering Ashleigh House have a distinct set of support needs that can include homelessness, criminal justice issues, child welfare and protection issues, mental illness, trauma, physical health issues, financial issues, unemployment and educational needs that require support. Due to the complex nature of the service, the staffing model is based on a multidisciplinary support team and is funded via a number of stakeholders including the Department of Health, HSE Social Inclusion, the Probation Service and the South Inner City Drug and Alcohol Task Force.

Outline of the programme

Ashleigh House is grounded in the therapeutic community approach to treatment. As such, it operates on the belief that the substance is merely the symptom and addiction cannot be treated in isolation from often highly complex support needs. It therefore adopts a holistic approach to treating women and responds to these needs through an intense case management system.

Ashleigh House is grounded in the belief that women can recover and be responsible for their own recovery, serving to assist women to not only end their dependence on substances but on services and people. This is achieved through a "community as method" model, where the women themselves are responsible for the running of the community, act as co-facilitators in all group therapy and are considered to be the "experts" in their own recovery.

The first service offered to women is a safe and secure residential environment in the form of six-month minimum residential placement with 24-hour staffing that can assist them in accessing the support they require. This can be and is

often extended, based on the woman's needs. The average length of time for a mother-and-child placement is 8.5 months. This long-term placement allows the women to remove themselves from often high-risk environments, develop trusting and positive relationships with both peers and staff, and begin their journey of recovery.

Treatment in Ashleigh House comprises an intense residential programme and involves a number of wraparound services that address the distinct needs of the women attending. The women receive the following support:

- ▶ group therapy;
- ▶ one-to-one key working;
- ▶ one-to-one psychotherapy/counselling;
- ▶ case management;
- ▶ peer support;
- ▶ 24-hour staffing for emotional and practical support;
- ▶ childcare support;
- ▶ mental health support from a visiting psychiatrist;
- ▶ nursing and GP support;
- ▶ housing support, with service level agreements developed with housing providers;
- ▶ methadone detox if required;
- ▶ advocacy;
- ▶ education and career support.

While Ashleigh House acknowledges and recognises that the women it works with are not only mothers, but also individuals seeking recovery, parenting support was an area identified as requiring attention by both the women and staff. A core element of Ashleigh House is the PuP programme. This strength-based approach to parenting aims to improve parental and child functioning by supporting parents to develop positive and secure relationships with their child. PuP is an attachment-based programme that combines psychological principles relating to parenting within a case management model.

Evaluation

Research into the PuP programme to date has demonstrated that it produces enduring change in high-risk families impacted by problem substance use and associated complex needs. In other words, it breaks the generational cycle. Trinity College, Dublin, and Griffith University, Brisbane, published an independent evaluation of PuP in Coolmine in September 2018 (Ivers and Barry 2018). It showed that:

- ▶ 92% of the high-risk families were retained in, and completed, the PuP programme;
- ▶ 100% remained drug and alcohol-free following the programme intervention;
- ▶ post-intervention depression, anxiety and stress levels were significantly reduced;

- ▶ mindful parenting scores evidenced a significant increase, indicating an increased, and more consistent, parental understanding of their emotional state and that of their child;
- ▶ child behaviour and/or parental perception of their child's behaviour improved.

A longitudinal study carried out by Coolmine found that women entering residential treatment had a distinct set of needs, including higher levels of depression, histories of physical and sexual violence, lower perceived well-being, and higher reported feelings of guilt and shame and obligations to family and care responsibilities. It also found that while women found completing treatment accompanied by a child to be very challenging, they would not have accessed treatment if their child could not have accompanied them (Babineau and Harris 2015).

Addressing gender inequality

Childcare for children under five years of age as a major block to treatment is addressed by Coolmine on entry to treatment. However, these barriers remain on exit from treatment. Access to education, employment opportunities, housing and aftercare support services remain a challenge for many of the women, who often settle for minimal support on exit from treatment. Advocacy from both Coolmine and other women-specific services is ongoing. For example, many of the women cannot access childcare places as most were homeless prior to entry and would not have their names on waiting lists for these placements.

Stigma remains a key feature of gender inequality for women with present or past substance abuse histories. This compounds feelings of shame and guilt and fractured community and family relations, often leaving women at high risk of relapse. Shame and guilt are key features of group therapy in Ashleigh House. Coolmine is committed to helping to reduce the stigma associated with female substance misuse through very active approaches, including open days to Ashleigh House, visible social media campaigns highlighting recovery and individual clients, attendance at conferences and seminars (outside of the addiction sector), presentations to Tusla, and an open-door policy for families and statutory agencies involved with the women's care.

The SAOL project, Ireland

The project

The SAOL is a community project focused on improving the lives of women affected by addiction and poverty, based in the North Inner City of Dublin.

Background and context

The SAOL is an integrated programme of education, rehabilitation, advocacy and childcare. The SAOL project's ongoing commitment to the women, children and community members of the North Inner City continues to develop, responding to the changing needs of the women who participate in the project with creativity and commitment. The SAOL has worked over the last 26 years to promote the needs of female drug users and their children. The project seeks to highlight the many extra difficulties that challenge women who use drugs, including the stigma attached to

being a mother who uses drugs, fears about the impact drug use might be having on their children, as well as fears about losing their children because of their drug use. While all of these are reasons that can attract women to treatment, they are also reasons why women tend to stay away from sources of help. The SAOL feels that a strong and confident voice is required to shout out that female drug users have needs that are not always recognised or met by the services they attend. The project is currently funded through a range of government funding streams (including the HSE, the Department of Employment and Social Protection, and the Probation Service) and specialist project grants, including a three-year commitment from Rethink Ireland for the Domestic Abuse / Violence Is Never Acceptable (DAVINA) project.

Outline of the programme

The project provides a number of support and intervention services as well as in-house childcare to enable women with children to engage and participate. At present, services include a community employment scheme for women; the Brio peer-training education programme for women using substances and involved in criminal behaviour; aftercare services; and the DAVINA domestic violence support programme, specifically for women who use substances and experience domestic violence. The SAOL has an extensive aftercare programme that is aimed at women who do not “fit into” day programmes and need more flexibility in their programmes because of their responsibilities. There is a drama group, a poetry group and a choir that sings around the inner-city community. Finally, there is also a small full-time crèche that cares for 11 children, all of whom are living in homes where there is addiction (and often homelessness).

The SAOL also delivers shorter-term creative and educational projects, depending on funding and resources. Since its inception 26 years ago, it has sought to provide services that are gender transformative for women by providing interventions to address poverty in women's lives, and by challenging, through multiple creative and advocacy means, the many structural inequalities women may be facing.

Evaluation

Recently, the SAOL produced a report on an anti-stigma training programme that was evaluated by Trinity College Dublin (Comiskey et al. 2021), according to which “it was very clear that the co-design procedure was respected. There was clear evidence of a shared understanding, of equal power distribution, the use of tools within the process to ensure all participated and the space was deemed safe and open”.

The SAOL works closely with University College Dublin on its Professional Masters in Social Work (PMSW) course and this has resulted in a number of peer-reviewed journal articles and conference presentations, including:

- ▶ “From service-user to social work examiner: not a bridge too far” (Loughran and Broderick 2017);
- ▶ “Putting relationships first in social work” (Broderick et al. 2019);
- ▶ “Object poverty: presentation from IASW National Social Work Conference 2019”, by Gary Broderick, Ray Hegarty, Jane McNicholas, SAOL project participants.

The SAOL was awarded the AONTAS Star Awards for adult education in 2017 and 2021. The project's Service Level Agreement with the HSE requires an annual process evaluation.

Addressing gender inequalities

As noted, this project was developed 26 years ago on the basis that women faced specific and gendered barriers to recovery from problematic substance use. All the interventions provided are based on the belief that responses need to recognise and address these gender issues, particularly poverty, in order for women to sustain recovery from problematic use. Challenging the stigma that women may face is key, particularly if they are mothers. The SAOL has developed a number of programmes (for example Reduce the Use, RecoverMe and Solas sa SAOL) that were designed specifically for women but for which it now provides training and free access to the resource for others. These programmes are now used in many services around Ireland.

The SAOL regularly promotes International Women's Day and during the week around 8 March hosts an event called Talk Time that brings together women who use substances and attend other addiction services for a conversation around what it means to be a woman in early recovery. The SAOL is a strong supporter of trauma-informed practice/care and uses the "Seeking Safety" approach (Najavits 2002) in its groups. The project is currently working with the HSE's Dual Diagnosis programme to find a way to run "Seeking Safety" for women in centres around Dublin. On the streets of the North Inner City, the SAOL's choir brings a presence that challenges the idea that women in recovery must be hidden and quiet.

A number of challenges in sustaining and developing the service and interventions remain.

- ▶ Project funding is cyclical and often short term, which limits expansion and the longer-term delivery of shorter, innovative interventions or projects.
- ▶ The structural inequalities women are dealing with are significant, particularly in relation to housing and employment. This can be severely limiting for women, especially those who are mothers.
- ▶ Access to reasonable and sustainable childcare outside of the SAOL is a major impediment to education and employment progression for women in recovery from problematic substance use. The project is exploring increasing the provision of childcare but financial, planning and building constraints are making this very difficult. The SAOL is also conscious that services for primary school children living in families where recovery from addiction is happening need to be radically improved.

Wider context

The SAOL has been working with women for 26 years, and it was a milestone when women were recognised as an at-risk group within the 2017-25 National Drug Strategy. Wider acknowledgement of the specific needs of women is slowly spreading, and the introduction of trauma-informed practices in services is helpful. The SAOL's work on stigma is leading the project into work with the UK through the National Health Service, as well as more local, community and national structures within Ireland.

Key is an involvement in professional social work training programmes at Maynooth University and University College Dublin, and the SAOL accepts students on placement from social work, community work and education training programmes. The project's involvement in creative forms of presentation and representation is also a vital part of its work with women and it works closely with the National Theatre of Ireland and Poetry Ireland, in the belief that involvement with the arts changes cultural perceptions. The SAOL works with the Irish American Writers and Artists association in New York and the Saint Pat's for All Parade, where it is represented every year.

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In its efforts to place human rights at the heart of drug policies, the Pompidou Group has decided to pursue further the work already undertaken towards integrating a gender dimension into drug policy by developing a handbook covering different drug policy areas.

It seeks to promote gender sensitivity in drug responses as essential leverage to reduce health inequities and to respect human rights, especially the rights to diversity and dignity for women, men and non-binary people.

The publication begins with an overview of epidemiological evidence on gender-based differences in drug use and related consequences.

The handbook aims at providing policy makers and practitioners in the drug field with evidence-based and operational recommendations to develop and implement policies and interventions that better integrate specific gender needs (gender-sensitive approach) and support more gender equity (gender-transformative approach) for people concerned with the provision of drug-related prevention and care (risk and harm reduction, treatment, reintegration), including in the criminal justice system.

Faithful to the Pompidou Group's objective of ensuring a link between research, policy and practice, this handbook first explores theoretical views about gender and drug policy, draws on available scientific knowledge and presents recommendations and examples for practice. It is based on extensive debate and a consensus of experts from 13 countries and various professional backgrounds, for cross-cultural relevance.

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The Council of Europe is the continent's leading human rights organisation. It comprises 46 member states, including all members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.



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