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SELECTED ISSUES

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## Selected issue 2

# A gender perspective on drug use and responding to drug problems

### Relevance of gender-specific information in the drug field at European and international level

This selected issue explores how gender influences not only patterns and levels of drug consumption in Europe, but also how responses to drug problems are planned and implemented. This is an issue of acknowledged importance, with gender issues at the core of some of the key objectives of the EU drug action plan 2005–08, which highlights the importance of providing accessible and good-quality drug services <sup>(1)</sup>. Concerns in this area are not new: over two decades ago, a first call was made to European policymakers to pay more attention to gender-specific issues, with particular focus on women’s needs <sup>(2)</sup>, and this theme has been taken up in a plethora of research papers and articles. It is now accepted that understanding gender differences in drug-related behaviours is a critical requirement for developing effective responses <sup>(3)</sup>. Ensuring equality of access to services and sensitivity to gender-specific issues within services are two of the key themes for developing high-quality care in this area.

Clearly, the potential coverage of discussion on gender and drug use is considerable, and it is therefore necessary here to restrict attention to those aspects that are supported by gender-specific differences in data reported at a European level. The focus of this selected issue is on examining differences between men and women in relation to the prevalence of drug use, patterns of drug use and drug-related problems and exploring how these issues are reflected in gender-specific approaches to prevention, treatment and harm reduction. As with any comparative exercise at this level, there are limitations in the data available (see box on methodology). For example, the available epidemiological data do not always include a gender breakdown, and when data do exist, figures relating to women are sometimes low and difficult to interpret. It is also worth noting that

information on responses predominantly describes interventions designed for women because men are seldom explicitly targeted — despite increasing evidence that young males in particular may represent an important group for developing targeted, gender-specific interventions.

### Gender differences in drug consumption and drug-related problems

#### Gender differences in prevalence and patterns of drug use by type of substance

In general in Europe, drug use is considerably more common among men than among women, especially when regular, intensive or problematic use is considered. That said, some national research studies suggest that, based on some consumption measure, the gender gap may be narrowing in a few countries, at least in the case of some types of drug use. The differences in the European data on male and female reported drug use are explored in detail below. However, parity, or near parity, of drug use among males and females is found only in lifetime prevalence among school students, and even then only in a minority, albeit a significant one, of countries.

#### Cannabis

In Europe, the vast majority of young people who have tried an illicit drug have used cannabis, but there are considerable differences between countries. Lifetime prevalence of cannabis use among all adults (aged 15–64) ranges from less than 2 % in Romania to more than 30 % in Denmark (Figure 1). Males outnumber females in lifetime experience of cannabis use in most of the countries surveyed.

Among school students aged 15–16 years who have ever in lifetime experience of cannabis use, males outnumber females in most countries (Hibell et al., 2004), but ratios are low and vary only a little across Europe, ranging from

(1) Details of this can be found at [http://europa.eu/comm/employment\\_social/emplweb/news/news\\_en.cfm?id=136](http://europa.eu/comm/employment_social/emplweb/news/news_en.cfm?id=136)

(2) At the 1984 Ministerial Conference of the Council of Europe Pompidou Group; policy recommendations on ‘Women and drugs’ were later adopted at a European conference.

(3) The concept of bringing gender issues into mainstream society was clearly established as a global strategy for promoting gender equality in the platform for action adopted at the United Nations Fourth World Conference on Women, held in Beijing (China) in September 1995. The Beijing declaration states that if, gender perspectives are to be reflected in policies and programmes, then statistics related to individuals should be collected, compiled and analysed, and presented by sex and age to reflect problems, issues and questions related to women and men in society.

### Methodology

Differences between males and females are presented as ratios of prevalence among males and females. Ratios higher than 1 indicate more males than females, for example a ratio of 2 indicates twice as many males as females. Ratios lower than 1 indicate more females than males, so a ratio of 0.5 will indicate twice as many females as males.

Typically, three observational time frames are used for studies of illicit drug consumption. 'Lifetime use' is of limited value in assessing current drug use among adults (although it is considered to be a reasonable indicator among schoolchildren), but it can provide insight into patterns of use. 'Last year use' and 'last month use' reflect the current situation more accurately, with the latter weighted more heavily towards people who use the drug frequently.

The ESPAD school surveys provide prevalence data on school students aged 15–16 years in most EU countries and are a

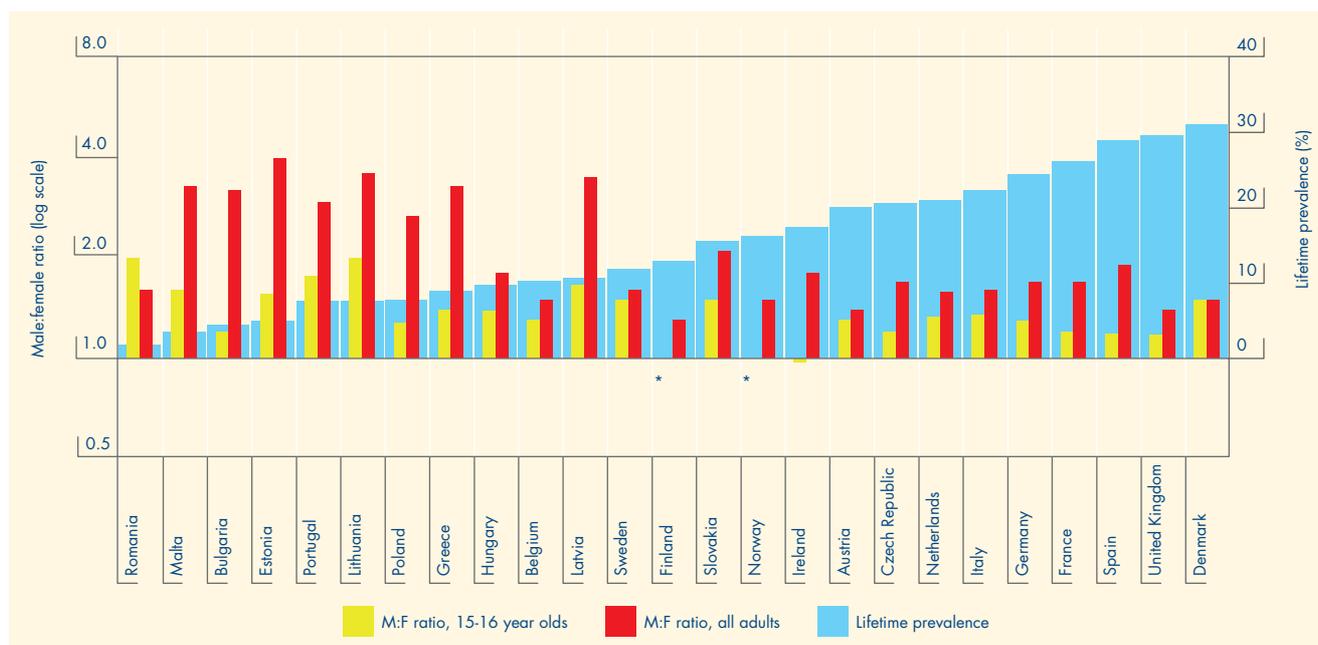
principal source of information for this group. Surveys conducted among other age groups are less homogeneous, and coverage and methods may vary. Full details of the available surveys and detailed notes on methodological issues can be found in the accompanying statistical bulletin. This analysis uses data from the 2003 ESPAD school survey.

Two different sources of treatment data are available. The total number of clients requesting treatment for drug use for the first time in one or more of five types of treatment centre (outpatient, inpatient, low-threshold agencies, general practitioners, treatment units in prison) provides a general overview and enables trends in gender differences among drug clients to be identified. Secondly, data regarding drug clients requesting treatment (including for the first time) in outpatient treatment centres are used to analyse patterns of drug use and to describe the socio-demographic characteristics of drug clients from a gender perspective. This analysis is based on data from the above sources collected in 2004.

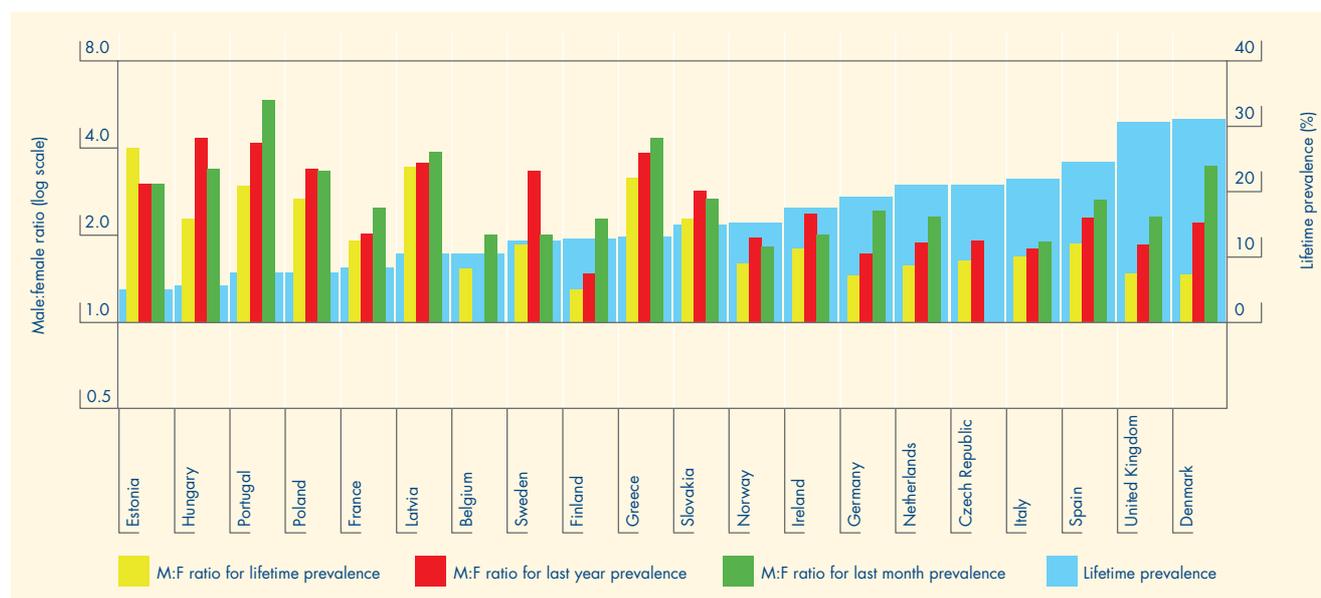
1.0 (signifying equality) in Ireland, Finland and Norway to 1.8 in Portugal. In contrast, gender differences in lifetime experience of cannabis use among all adults are typically higher and show considerably more variation between countries. Adult male to female ratios range from 1.3 in Finland to 4.0 in Estonia. Generally, the adult gender difference tends to be less marked in countries with relatively

high prevalence rates than in countries with low prevalence rates, the latter group including most of the new EU Member States (but excluding the Czech Republic and Slovenia), together with Greece and Portugal. However, in Finland, Sweden, Romania and Norway, where lifetime prevalence levels are also relatively low, male–female differences are minimal (Figure 1).

**Figure 1:** Male to female ratios for ever in lifetime use of cannabis among 15- to 16-year-old students and all adults (15–64 years)



NB: \*M/F ratios of 1 among students in Finland and Norway. Countries are ordered by increasing levels of lifetime prevalence among all adults (plotted on the right-hand axis). Male–female ratios are plotted on a logarithmic scale (left-hand axis). ESPAD figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg–Western Pomerania and Thuringia). Sources: 15- to 16-year-old students — ESPAD (2003 survey); all adults (15–64 years) — 2006 EMCDDA statistical bulletin.

**Figure 2:** Male to female ratios for ever in lifetime, last year and last month cannabis use among all adults (15–64 years)

NB: Countries are ordered by increasing levels of lifetime prevalence among all adults (plotted against the right-hand axis). Male–female ratios are plotted on a logarithmic scale (left-hand axis).

Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia).

In Belgium, no data are available for last year prevalence.

In the Czech Republic, no data are available for last month prevalence.

Source: 2006 EMCDDA statistical bulletin.

Among adult drug users, male predominance increases as the observation time frame is shortened from lifetime through last year to last month. Gender ratios for lifetime experience range from 1.3 to 4.0, with last year prevalence ratios being slightly higher, ranging from 1.5 in Finland to 4.3 in Hungary. In the case of last month prevalence rates, gender ratios are even higher, ranging from 1.8 in Norway to 5.9 in Portugal. However, these figures must be interpreted with care as random variation may be high because of the low numbers reporting last year and last month use (Figure 2).

Among 15- to 16-year-old school students, gender differences are considerably more marked among those who report 'frequent use' of cannabis (40 or more times during a lifetime) than in the case of lifetime or last year prevalence. Among the frequent use group, the prevalence among male students can be twice, three times or even, in one country, four times higher than in female students. Again, some caution is needed in interpreting these results because of the relatively small numbers of students reporting frequent use (Figure 3).

The most marked continuous increases in lifetime experience of cannabis among both male and female school students have occurred since 1995 in the Czech Republic, Estonia, Slovenia and Slovakia and since 1999 in France. Although these increases generally run in parallel among males and females in both adult and school student populations, in 2003 the strong male predominance in lifetime prevalence

for cannabis use among students was reduced in several countries where prevalence levels are either high or increasing (Figure 4). For adults, however, this is not the case, at least in countries where cannabis trend data are available. During the last decade, there have been increases in last year prevalence rates for cannabis use in Germany, Spain, France and the United Kingdom, yet the gender differences remain constant.

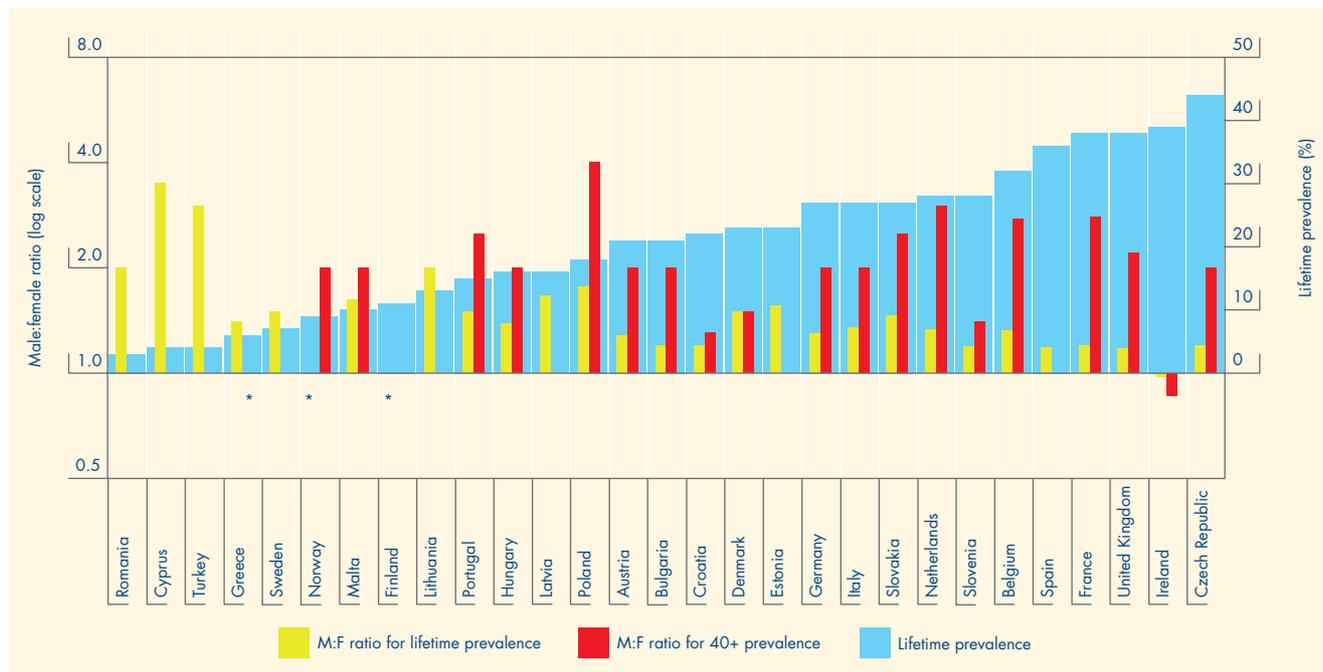
### Ecstasy

Overall prevalence rates for ecstasy use are much lower than those for cannabis, although there is considerable variation between countries and between population subgroups. Reported rates for lifetime prevalence range from 0.1 % among all adult females (15–64 years) in Sweden to 17.3 % among young adult males (16–34 years) in the United Kingdom (4).

Gender ratios in lifetime prevalence of ecstasy use vary more widely between countries than in the case of cannabis. In over half of the EU countries reporting data, lifetime experience of ecstasy use is approximately the same in 15- to 16-year-old female students as in male students of the same age. In the remaining countries, ecstasy use is higher in male students than in females, with ratios varying from 1.3 in France to 2.0 in Denmark, Greece, Italy, the Netherlands and Sweden. Likewise, among adults (15–64 years) in most of the EU countries surveyed, lifetime experience of ecstasy is

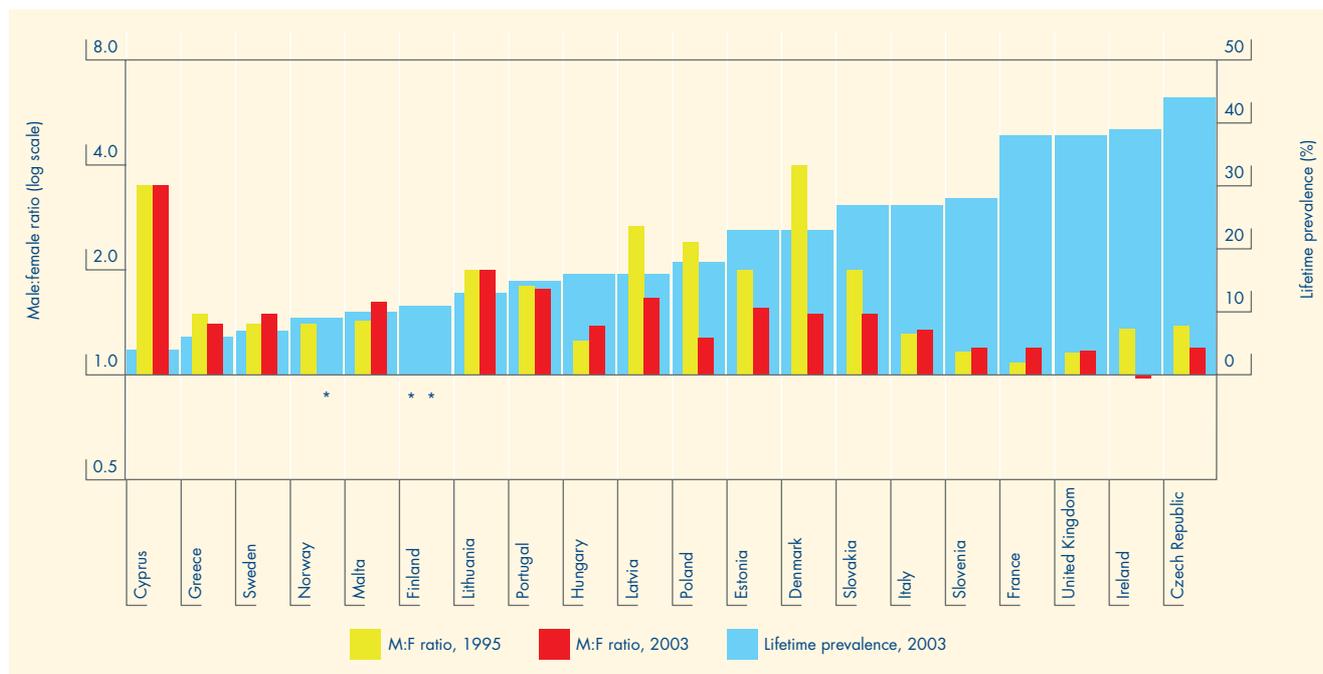
(4) See Tables GPS-8 and GPS-9 in the 2006 statistical bulletin.

**Figure 3: Male to female ratios for ever in lifetime or repeated (40 + in lifetime) cannabis use among 15- to 16-year-old school students**



NB: \*M/F ratios of 1 for lifetime prevalence in Finland and Norway, and for 40+ prevalence for Greece. Countries are ordered by increasing levels of lifetime prevalence among all students (plotted on the right-hand axis). Male-female ratios are plotted on a logarithmic scale (left-hand axis). Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia). In Spain, no data are available for 40 + times in lifetime use. In Cyprus, Sweden, Finland, Lithuania, Latvia and Estonia, ratios for 40 + prevalence could not be computed because of the existence of a zero prevalence. Source: ESPAD (2003).

**Figure 4: Male to female ratios for ever in lifetime use of cannabis among 15- to 16-year-old school students in the 1995 or 2003 rounds of the ESPAD survey**



NB: \*M/F ratios of 1 for both years in Finland and for 2003 in Norway. Countries are ordered by increasing levels of prevalence in 2003 (plotted on the right-hand axis). Male-female ratios are plotted on a logarithmic scale (left-hand axis). Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia). Source: ESPAD (1995 and 2003 surveys).

generally lower among females, with ratios ranging from 1.0 in Estonia to 6.0 in Poland (Figure 5). Thus, as for cannabis, gender ratios for lifetime prevalence progressively increase in higher age groups. However, overall prevalence rates for use of ecstasy are low, and therefore caution should be exercised in interpreting male to female ratios.

Since 1995, small but continuous increases in the lifetime use of ecstasy among school students have taken place in the Czech Republic, Estonia and Portugal. These have occurred largely in parallel among both male and female school students.

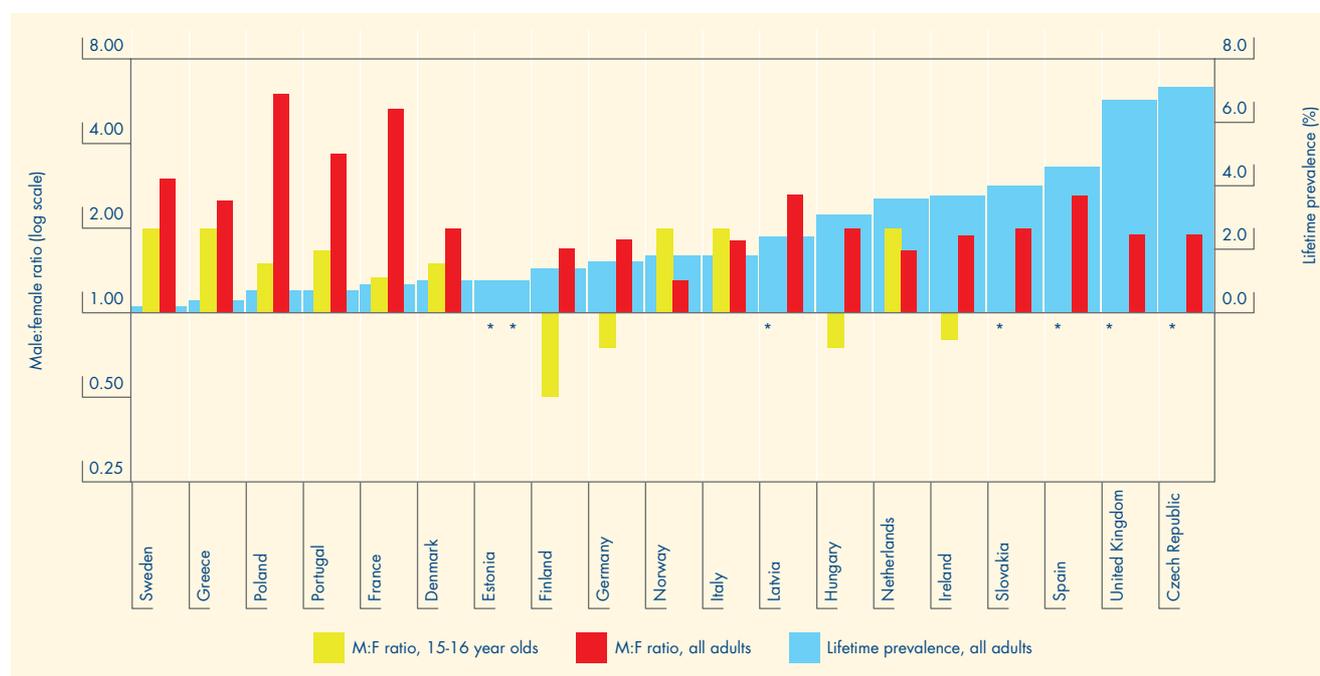
### Cocaine

Overall prevalence rates for cocaine use are very low among school students, and among adults are lower than those for cannabis and ecstasy use, although considerable variation exists between countries. Reported lifetime prevalence rates among young adults aged 15–34 years range from 0.1 % of females and 1.2 % of males in Lithuania to 7.1 % of females and 14 % of males in the United Kingdom <sup>(5)</sup>. Males outnumber females by a factor of two or more in most countries (Figure 6).

### Tranquillisers and sedatives

Tranquillisers and sedatives can be used both as legally prescribed medicines and illegally without a doctor's prescription. Comparable data on gender differences for this type of behaviour are not available from adult population surveys. However, among school students (aged 15–16 years) surveyed in the EU Member States, candidate countries and Norway by ESPAD, lifetime prevalence of the use of tranquillisers or sedatives without a doctor's prescription was markedly higher in females than in males in all countries (Hibell et al., 2004), with the exception of three Member States (Cyprus, Ireland and the United Kingdom) and Bulgaria, Turkey and Norway. Lifetime prevalence ranges from 1–2 % of females in Cyprus, Ireland, Germany, Austria and the United Kingdom to 18 % of females in Lithuania and 22 % in Poland. In the United Kingdom, more males than females use these drugs, but prevalence estimates for the use of this type of illicit substance are very low and the difference has to be seen in this context (Figure 7). Nevertheless, concerns about increased use of tranquillisers and sedatives by males have been expressed <sup>(6)</sup>.

Figure 5: Male to female ratios for ever in lifetime use of ecstasy among 15-16-year-old school students and all adults (15–64 years)

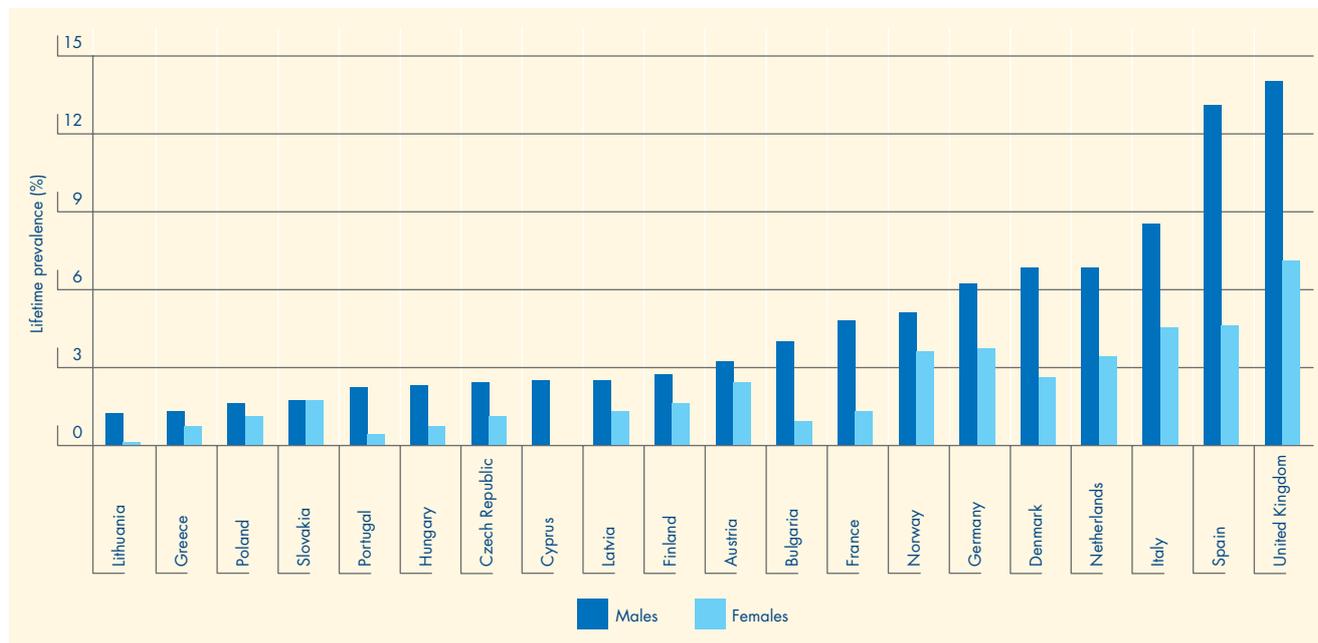


NB: \*M/F ratios of 1 for students in the Czech Republic, Spain, Estonia, Latvia, Slovakia and the United Kingdom and for all adults in Estonia. Countries are ordered by increasing levels of prevalence among all adults (plotted on the right-hand axis). Male–female ratios are plotted on a logarithmic scale (left-hand axis). ESPAD 2003 figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia). Sources: 15–16 year old students — ESPAD (2003); all adults (15–64 years) — 2006 EMCDDA statistical bulletin.

<sup>(5)</sup> Tables GPS-8 and GPS-9 in the 2006 statistical bulletin.

<sup>(6)</sup> German national drugs coordinator at [www.dw-world.de/dw/article](http://www.dw-world.de/dw/article) on 4 May 2006.

**Figure 6:** Prevalence of ever in lifetime use of cocaine among 15–34 year olds in the general population, by gender



Sources: Reitox national focal points.

**Figure 7:** Male to female ratios among 15–16 year old school students reporting ever in lifetime use of tranquillisers or sedatives without a doctor's prescription



NB: \*M/F ratios of 1 in Ireland, Cyprus, Bulgaria, Turkey and Norway. Countries are ordered by increasing levels of prevalence among all students (plotted on the right-hand axis). Male–female ratios are plotted on a logarithmic scale (left-hand axis).

Source: Figures for Germany are based on data from six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg–Western Pomerania and Thuringia). ESPAD (2003).

Data from the different rounds of the ESPAD school survey suggest no marked trend in the prevalence of tranquillisers or sedative use. A substantial increase, among female students, was reported only from Estonia.

**Alcohol**

In most countries, the vast majority (90 % or more) of 15- to 16-year-old students have drunk alcohol at least once, and a relatively high proportion report having had five or more drinks in one session during the last month. Prevalence of this more intensive pattern of alcohol use (sometimes referred to as binge drinking) ranges from 10 % of females in Turkey to 67 % of males in Denmark. This measure of potential problem alcohol use among 15- to 16-year-old students is higher than lifetime use of cannabis in all countries reporting data, with the exception of France (Figures 3 and 8).

Among school students aged 15–16 years, experience of drinking five or more drinks in one session in the last month is higher in males than in females, except in three countries (Ireland, the United Kingdom and Norway). In general, male predominance is lower in those countries where the prevalence of binge drinking is highest. The gender differential of intensive alcohol use ranges from 1 (signifying equality) or under in Ireland, the United Kingdom and Norway to 2.3 in Poland, and is broadly similar to that for cannabis.

**Polydrug use**

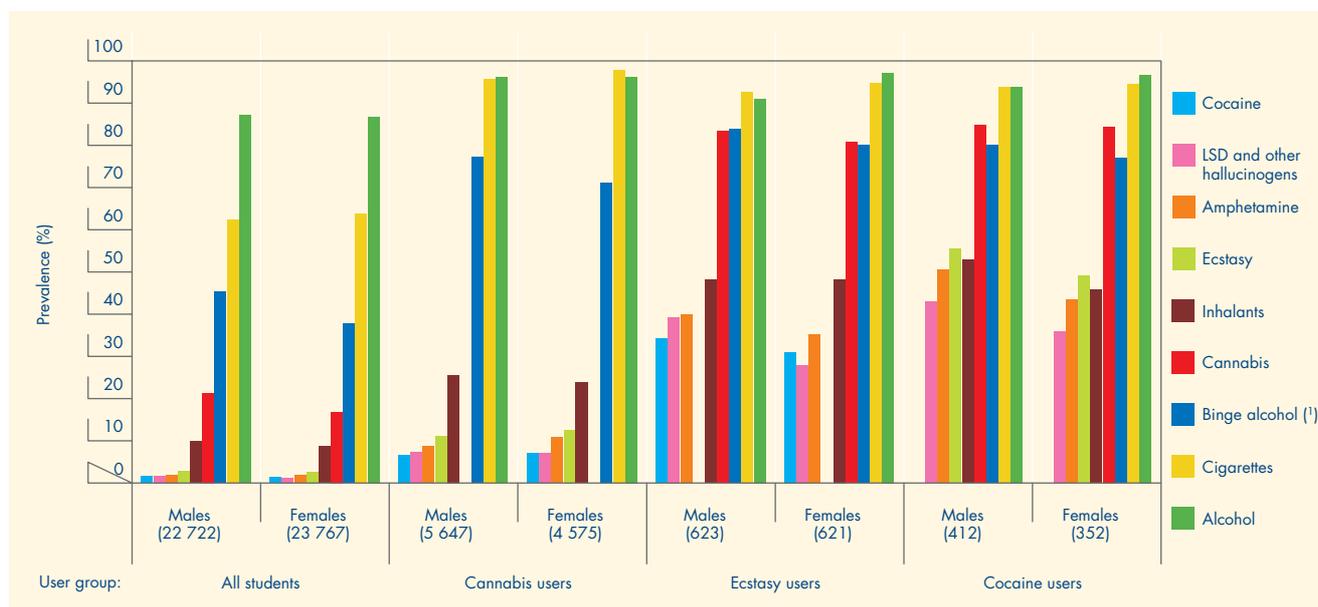
Analysis of data collected from the 15 European countries that participated in the 2003 ESPAD school survey shows that, in terms of patterns of substance use, gender differences are less marked than variations between different types of user groups. School students can be categorised into groups according to their lifetime experience of cannabis, ecstasy and cocaine, and these groups can then be compared with the general 15- to 16-year-old school student population (Figure 9). Compared with the general school student population, those with cannabis experience have a fourfold higher prevalence of other illegal substance use and a twofold higher prevalence of binge drinking. Among the group with ecstasy experience, the prevalence rates for use of cocaine and hallucinogenic drugs are more than 20 times higher than in the general school student population, and around five times higher than among those with cannabis experience. These data suggest that the more deviant/low-prevalence patterns of drug use among school students (ecstasy, amphetamine, hallucinogens, cocaine) cluster among a few individuals, and this pattern applies to both male and female students. It should be noted that lifetime use means ever having used each different drug and not necessarily use on the same occasion.

**Figure 8:** Male to female ratios for consumption of five or more drinks in one session during the last 30 days among 15- to 16-year-old students



NB: \*M/F ratio of 1 in Ireland.  
 Countries are ordered by increasing levels of prevalence of drinking five drinks in a row in the last month (plotted on the right-hand axis).  
 Male–female ratios are plotted on a logarithmic scale (left-hand axis).  
 Figures for Germany are based in six regions only (Bavaria, Brandenburg, Berlin, Hesse, Mecklenburg-Western Pomerania and Thuringia).  
 Source: ESPAD 2003.

**Figure 9:** Gender and the use of psychoactive substances by different user groups — ever in lifetime prevalence of use of nine psychoactive substances among 15- to 16-year-old students in 15 European countries



(1) Binge drinking is defined as consuming five or more drinks in a row.

NB: User groups are defined as those who have lifetime experience of the substance. Total numbers for the 15 ESPAD countries are given in brackets.

Lifetime prevalence rates are the average for 15 countries (Germany, Greece, France, Italy, Lithuania, Hungary, Malta, the Netherlands, Slovenia, Slovakia, Finland, Sweden and the United Kingdom together with Norway and Croatia, where ESPAD experts provided individual drug use data).

Source: ESPAD experts.

## Conclusions

Underlying trends in gender can be ascertained only by taking a broad look at the considerable variation in the data for different countries and drugs. However, patterns are detectable; for example, gender equality in cannabis use and binge alcohol use increases with increasing prevalence of use, and generally prevalence rates are lower for serious illegal, recent or frequent drug use. The explanations may lie in lifestyle influences that are intrinsically related to gender or age, or in the ever-changing factors that determine the stages of developing drug fashions across Europe. Detailed analysis of differences in male and female drug use can yield important information about changing lifestyles in relation to patterns of drug use and about the potential efficacy of drug prevention and drug treatment services for different client groups. If young females are increasingly likely to experiment with drugs in the same manner as their male counterparts, the likely impact on future drug use trends must be determined. It is necessary to identify the different influences of each sex on overall trends in order to understand their direction and develop appropriate responses. Also, the markedly higher proportion of female to male students who have used tranquillisers or sedatives without a doctor's prescription and possible increases in male use of these substances merit future research attention.

## Gender differences in development of drug-related problems

### Treated population

Males far outnumber females among drug treatment clients. As some research studies have suggested that there may be barriers to service uptake by women, an important question, but one that is difficult to answer, is the extent to which women are underrepresented in the treatment population compared with the population of those who could be considered in need of treatment. In 2004, data from all types of treatment centres from which data are available suggest that among drug clients asking for treatment for the first time males outnumber females by a ratio of 4 to 1 (ratios of 3.9 for new clients and 4.0 for all clients) (7) (8).

Gender ratios among drug clients vary greatly between countries but are generally higher in the southern European countries than in northern countries. In 2004, the highest proportions of female clients were in the Czech Republic, Finland and Sweden, and the lowest were in Italy, Cyprus and Turkey. These differences to some extent reflect differences between countries in data coverage, as well as differences in structural factors such as the organisation of treatment services and in cultural and social factors such as the distribution of clients according to primary drug for which they seek treatment.

(7) See Table TDI-41 in the 2006 statistical bulletin.

(8) Methodological limitations should be considered when reading the data because of the partial data coverage in some Member States and the low numbers often reported for female clients in the smaller countries.

From 1999 to 2004, the gender distribution among new drug clients seeking treatment did not change to any great extent; the proportion of males increased in eight countries, decreased in three countries and remained stable in the remaining 13 countries <sup>(9)</sup>. Where increases in the gender ratio were observed, the principal reason is likely to be an increase in cannabis and cocaine users, who are mainly males, among first-time clients.

Data from outpatient treatment centres offer a more detailed picture of gender differences among drug treatment clients. In the treatment centres from which data were available, the gender ratio in 2004 was 3.6 for new drug clients and 4.3 for all clients <sup>(10)</sup>.

Gender ratios vary according to the primary drug for which drug users present for treatment. Most of the care provided by drug treatment services is aimed at opioid, cocaine and cannabis users, among whom males far outnumber females. The male to female ratio among new clients is especially high for cannabis (6.0) and cocaine (5.8), but lower for opioids (3.5), amphetamines and ecstasy (2.1); the only drugs for which female clients outnumber males are hypnotics and sedatives (0.9), but the limitations of the low numbers of clients reported have to be taken into account <sup>(11)</sup>.

Most people, both men and women, attend drug treatment services on their own initiative as self-referrals; the only gender differences regarding referral routes relate to the criminal justice system and health or social services. Male clients are more likely than females to have been sent for treatment by police and the criminal justice system (22.2 % of males and 10.6 % of females), whereas female clients are more likely than males to come to treatment via health and social services (27 % of males and 36 % of females seek treatment through health or social services, general practitioners or other drug treatment centres) <sup>(12)</sup>.

Among clients new to treatment, the women are usually younger than the men. New female drug clients requesting treatment for opioid and cocaine use are, on average, two years younger than males, while those requesting treatment for stimulants are an average of four years younger. Exceptions here are females asking for treatment for the use of hypnotics, sedatives or hallucinogens, who tend to be older than their male counterparts, although the numbers on which this conclusion is based are very low <sup>(13)</sup>, and cannabis clients, among whom the average age of

both males and females is around 23 years. Overall, the proportion of female clients is higher in the younger age groups <sup>(14)</sup>.

Among new drug clients in outpatient centres in the European countries that provide data, males and females report a similar age at onset of drug use; only among users of hypnotics and sedatives is the age at onset higher in females (29.2 years) than in males (25.1 years), but it should again be borne in mind that figures for clients being treated for use of hypnotics and sedatives are very low <sup>(15)</sup>. If age at first entering drug treatment is lower among females, but age at first use is similar to that of males, as is the case for some drug types, then this suggests that females achieve earlier access to treatment than males do (this point is taken up in the next section).

Among new treatment clients, males more often report severe patterns of drug use than females: higher male to female ratios are found among new clients using drugs daily (for all drugs except cannabis and hypnotics) than among those using less frequently <sup>(16)</sup>; and among new clients who use opioids the male to female ratio among injectors is higher than average <sup>(17)</sup>.

Describing drug users seeking treatment provides important insights into gender ratios among those in treatment services, but the mechanisms that drive the treatment demand process must remain speculative without some type of careful comparison of drug users who come for treatment at a given point and those who do not. More analysis, including time trends, is required to better understand how gender impacts on drug treatment demand.

### Non-treated population of problem drug users

Problem drug users who have no contact with treatment or other drug services constitute a 'hidden population', for which gender-related data are rarely available. Problem drug use (PDU) estimates that include both the treated and non-treated population are available by gender in only a few countries.

In Greece and Estonia (Uuskula et al., 2005), the available PDU estimates suggest a higher proportion of males among the non-treated population than among those in treatment. In contrast, in Finland, the proportion of males is higher in the observed treatment population than in the hidden population. However, as these are results from modelling studies that may

<sup>(9)</sup> See Table TDI-6 in the 2006 statistical bulletin.

<sup>(10)</sup> See Table TDI-21 in the 2006 statistical bulletin.

<sup>(11)</sup> See Table TDI-21 in the 2006 statistical bulletin.

<sup>(12)</sup> See Table TDI-29 in the 2006 statistical bulletin.

<sup>(13)</sup> See Table TDI-28 in the 2006 statistical bulletin.

<sup>(14)</sup> See Table TDI-42 in the 2006 statistical bulletin.

<sup>(15)</sup> See Table TDI-30 in the 2006 statistical bulletin.

<sup>(16)</sup> See Figure TDI-8 in the 2006 statistical bulletin.

<sup>(17)</sup> See Figure TDI-7 in the 2006 statistical bulletin.

depend on different assumptions, they should be interpreted with caution and the data do not provide us with any insight into the European picture as a whole. See Table 1 for a summary of the data from the three studies.

A study analysing 'latency period to treatment' (time between first use and first drug treatment) in three large European cities (Amsterdam, London, Rome) found that latency period was shorter in females than in males (EMCDDA, 2002). On average, among opioid users who request treatment, females request treatment 1.5–2 years earlier in their drug career than males. This difference was found in all three cities studied. After controlling for other variables that might have influenced the length of latency period (age, route of administration and ethnicity), gender remained significant in two of the three cities. The reasons for this are unclear, but it might be that female opioid users progress more rapidly to a level of problems that lead them to treatment, that they are directed to treatment by their social environment more rapidly than males or that other mechanisms lead them to seek treatment earlier.

### Mortality and drug-related deaths

In all EU countries, most drug-related deaths <sup>(18)</sup> are male. The proportion of female drug-related deaths ranges between 7 % and 35 %. The lowest proportions are found in Greece, Italy, Cyprus, Portugal and Romania, and the highest proportions are in the Czech Republic (where most deaths are associated with prescribed medicines), Poland, Finland and the United Kingdom.

The lower proportions of females among cases of drug-related deaths correlate with the lower proportions of females among problem drug users (in particular opioid users). However, due to the scarcity of data, it is difficult to compare gender breakdown for drug-related death and gender breakdown of problem drug use in each country. In most countries, the proportion of males among drug-related deaths is higher than the proportion of males among treatment clients <sup>(19)</sup>, but possible biases in the data make them difficult to interpret.

Notable differences have been detected between the genders in trends in drug-related deaths in the EU-15 Member States (for which the most complete set of data is available). Whereas the number of male deaths progressively increased from 1990 to 2000, followed by a clear decrease (30 % by 2003), the number of reported deaths among females remained relatively stable over the same period, ranging from 1 700 to 2 000 per year with only a 15 % decrease since 2000. This may imply that interventions (treatment and harm reduction) do not reach women to the same extent as men, or it may be an indication of differences in the prevalence of opioid use or in risk factors between the genders.

The mean age of male and female cases of drug-related death was similar in 12 countries. In seven countries, the mean age was higher among females, especially in Belgium, Ireland, Finland, the United Kingdom and Bulgaria. In contrast, in Cyprus, Latvia and Malta, the mean age was lower among females.

Among the EU population aged 15–39 years, the average rate of mortality caused by drug overdose in females is about nine per million, compared with 48 per million in males. However, gender differences in proportional mortality (the percentage of all deaths that can be attributed to any specific condition) due to drug overdose are lower (4 % for males against 2 % for females) because general mortality is lower among females. In Denmark, Luxembourg and Norway, drug-related deaths account for 8–10 % of mortality among females; in Austria, Slovenia, Sweden and the United Kingdom, this figure is between 4 % and 5 %.

In cohort studies of opioid users, mortality rates are usually higher for males. This could be because there is a higher proportion of injectors among males or because males are more likely to exhibit high-risk behaviour (for example, higher frequency of injection; use of higher dosages; polydrug use, in particular including alcohol; injecting alone) or to be in high-risk situations (e.g. incarceration). However, the excess mortality of female opioid users in comparison with the

**Table 1. Male to female ratio among observed drug users and in estimates of the hidden population (capture–recapture method)**

	Observed population	Male/female ratio — observed population	Hidden population	Male/female ratio — hidden population
Greece	3 770	5.3	15 429	6.6
Estonia	3 024	6.0	10 777	10.0
Finland	4 097	3.5	14 117	2.1

Sources: Greece: data from treatment agencies; Estonia: estimates injecting drug users obtained from the HIV reference laboratory, police arrests, overdoses and drug treatment; Finland: data from treatment, driving under the influence of drugs, criminal report file and a register of infectious diseases.

<sup>(18)</sup> Drug-related deaths refer to those deaths caused directly by the consumption of one or more drugs. These deaths are known as 'overdoses', 'poisonings', 'drug-induced deaths' or 'acute drug deaths'.

<sup>(19)</sup> See Figure TDI-9 in the 2006 statistical bulletin.

general female population is higher than the corresponding figure for males. The lower general mortality of young females in part explains why females who use opioids increase their risk of dying to a greater extent than males do.

### Infectious diseases

A breakdown of the most recent available seroprevalence data by gender shows that female intravenous drug users (IDUs) are more vulnerable to HIV infections<sup>(20)</sup> and sexually transmitted infections (STIs) than are male IDUs. The likely reasons for such a gender difference include both social factors, e.g. female IDUs are much more likely to be involved in sex work than males are (Platt et al., 2005), and biological factors, such as women's higher risk of contracting genital infections owing to the much larger area of mucous membrane exposed. It is less clear whether women are at an increased risk of contracting these infections as a result of injecting; however, female IDUs are likely to be more often in a vulnerable position when attempting to protect themselves from infection within IDU partnerships and networks (Gollub et al., 1998).

Data available from Belgium, Estonia (2005), Spain (2002), France, Italy, Luxembourg, Austria, Poland and Portugal (all 2001) provide a total sample of 124 337 males and 20 640 females tested for HIV, mostly in drug treatment centres or other drug services. Overall HIV prevalence was 13.6 % among males and 21.5 % among females. Differences by country are marked, with the highest female preponderance being in Estonia, Spain, Italy, Luxembourg and Portugal; in contrast, in Belgium, HIV prevalence is higher among males. It is possible that these gender differences reflect different transmission patterns, for example differences in the relative contribution of sexual transmission, as mentioned above. On the other hand, variations in selection mechanisms resulting in spurious differences related to gender cannot be ruled out. For example, if female IDUs are tested more frequently than their male counterparts (e.g. as part of pregnancy care or screening for STIs) then infections among female IDUs may be detected more often.

In contrast to HIV, median seroprevalence for hepatitis C virus (HCV) is very similar in male and female IDUs: 58.1 % in males and 56.4 % respectively. It is known that sexual transmission of HCV is very difficult compared with transmission of HIV, and therefore infection among IDUs will probably almost exclusively be the result of sharing needles/syringes and other injecting paraphernalia. Thus, the contrasting findings for HIV and HCV suggest that the large gender difference in HIV seroprevalence is more likely due to differences in (exposure to) sexual risks in males and females

rather than to a gender difference in rates of detection of existing infections.

### Social correlates and consequences

#### Drug-related crimes

In most reporting countries<sup>(21)</sup>, women commit between 9 % and 15 % of drug law offences; the figure is lower in the Czech Republic (4 %) and higher in Lithuania and Romania (25 % and 20 % respectively). Against a background of an increase in the number of drug law offences reported in Europe in recent years, the proportion of women among drug law offenders has grown.

Regarding the substances involved in drug offences, in Belgium, Luxembourg and the Netherlands, women are more likely than men to be reported for cocaine or heroin offences, and, in the United Kingdom, female offenders screened in the framework of the NEW-ADAM<sup>(22)</sup> research programme show higher rates of positive opioids tests. Among Italian juveniles passing through juvenile justice services, girls (4 % of all juveniles concerned) are more likely than boys to admit to polydrug use; cannabis is the main substance used by 81 % of boys and by 59 % of girls, whereas opioids are the main substance used by 27 % of girls but by only 7 % of boys.

When it comes to convictions for drug law offences, the proportion accounted for by women ranges from 4 % to 14 %. Some countries (Spain, Italy, Austria and Sweden) report that women are less likely to be convicted than men, but Germany, in contrast, reports the opposite: crimes committed by women more often lead to convictions because, compared with drug law offences committed by men, those committed by women are more often associated with other punishable acts.

Information on gender differences among prisoners sentenced for drug law offences is scarce. Nonetheless, a few countries (Belgium, the United Kingdom) report that women who commit drug offences are more likely than men to be incarcerated. In addition, Spain and Ireland both point out that, as the number of women involved in drug trafficking (mainly as drug couriers) increases, so does the number of women in prison, as well as the average length of their sentence.

#### Social conditions of problem drug users

The social characteristics of problem drug users vary by gender, often to some extent reflecting broader gender differences in the general population. Studies of women with drug problems suggest that, compared with their male counterparts, they may suffer disproportionately from a range

<sup>(20)</sup> See Figure INF-3 (Part v) in the 2006 statistical bulletin.

<sup>(21)</sup> Belgium, the Czech Republic, Germany, Spain, France, Ireland, Italy, Latvia, Lithuania, Luxembourg, Hungary, Malta, the Netherlands, Austria, Portugal, Slovakia, Finland, Sweden, the United Kingdom, Romania and Norway.

<sup>(22)</sup> The New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) research programme interviews arrestees and examines voluntary urine tests to establish the prevalence of drug use.

of problems. Some evidence of this is found in data on drug treatment attendees.

Compared with male drug users in treatment, a higher proportion of female treatment clients are economically inactive (a group that includes housewives, pensioners and invalids); in addition, unemployment rates are more than 10 % higher among female drug users in treatment than among male drug clients <sup>(23)</sup>.

Living conditions also differ between female and male drug users: a high proportion of male drug treatment clients live in institutions, whereas a relatively high proportion of female clients live with children, either with or without a partner. In every country, women are relatively overrepresented among drug clients living with children: the gender ratio among the drug treatment population as a whole is 3.6, compared with a gender ratio among drug clients living with children of 1.1. Among drug users, as in the general population, women are the main providers of childcare <sup>(24)</sup>.

### International comparisons between Europe and other regions

Men are more likely than women to use illicit drugs. This is the case in the European Union, as shown by EMCDDA data, and it appears to be a worldwide phenomenon. Despite the use of different reporting systems and research methods internationally, for the purpose of comparison, it is worthwhile looking at the gender differences in drug use that are reported in countries outside Europe.

In the USA, males are more likely than females to use, abuse and be dependent on alcohol or illicit drugs <sup>(25)</sup>. According to the 2003 SAMHSA National Survey on Drug Use and Health, 15.2 million females (12 %) and 19.8 million males (17 %) used an illicit drug during the last year. In the 2002 National Survey on Drug Use and Health, among the population aged 12 or older, 6.4 % of women compared with 10.3 % of men reported last month illicit substance use; and this male to female ratio of 1.6:1 has remained fairly constant throughout the 29-year history of the survey (NSDUH, 2004). In Canada, overall, men are nearly twice as likely as women to report use of any illicit drug. In the 2004 'Canada's alcohol and other drugs survey', 18.2 % of men and 10.2 % of women reported using cannabis in the last year (Adlaf et al., 2005). In Australia, the use of illicit substances is more common among men than among women (41.3 % versus 34.2 % in 2001), except in the youngest age group (UNODC, 2004).

Data from several other countries indicate that, throughout much of the world, drug use remains an overwhelmingly

male activity. In China, where reported drug use is still very low despite a large increase during the 1990s, the lifetime prevalence of illicit substance use was 0.57 % in women and 2.58 % in men. Rates of use over the previous 12 months were 0.48 % for women compared with 1.80 % for men. In a rapid assessment survey conducted in 14 cities in India during 2000–01, the mean proportion of the sample of substance abusers who were female was 7.9 %. A similar assessment of drug use carried out in the Islamic Republic of Iran in 1999 estimated that only 6 % of the 800 000–1 200 000 substance users were women. A study of heroin users in one Kenyan coastal town estimated the ratio of male to female heroin users to be 20 (UNODC, 2004).

However, there are also signs that substance use among women is increasing rapidly. Official statistics from Russia reveal that the annual number of women registering for the first time with a diagnosis of drug addiction increased 10-fold over the period 1993–99 in the Russian Federation as a whole and 16-fold in Moscow.

Data from the treatment sector show that, in some regions of the world, women represent between 10 % and 30 % of the treated population <sup>(26)</sup>.

Gender differences in drug use patterns can also be discerned, despite considerable differences in figures and methodology between regions; generally, men predominantly use cannabis, opioids and cocaine, whereas women more often use stimulants and pharmaceutical drugs. Among older women, the highest rates of pharmaceutical drug use are in North America and Europe. Numerous international studies report the same finding — that women are more likely to use and abuse prescribed psychoactive drugs such as painkillers, sleeping pills and tranquillisers (Cormier et al, 2004). Indications of an increase in female use of methamphetamine are reported in some countries (e.g. Canada).

Women who use drugs, especially heroin, are often involved in prostitution and are likely to engage in unsafe practices and to share injecting equipment. In the USA, 47 % of all women diagnosed with AIDS are injecting drug users, and a further 19 % report having sex with users who inject drugs (NIDA notes, 2000). The Australian Institute of Criminology reported that there is a strong link between women's drug use and crime, especially prostitution and property crime: the prevalence of drug use is high among sex workers and women who commit property crime but it is not known whether drug use leads to crime and prostitution or vice versa.

Gender appears to be an important variable affecting the link between personality and substance use (Adalbjarnardottir

<sup>(23)</sup> See Table TDI-40 in the 2006 statistical bulletin.

<sup>(24)</sup> See Table TDI-14 in the 2006 statistical bulletin.

<sup>(25)</sup> In the USA, unlike Europe, data on drug use concern both alcohol and illicit drugs.

<sup>(26)</sup> See results from the 2004 annual expert meeting on treatment demand indicator (<http://www.emcdda.europa.eu/?nnodeid=6437>).

and Rafnsson, 2001). Male drug users still outnumber females, except in the case of tranquillisers and sedatives, for which the opposite is true. Indications that the gap in illicit drug use between males and females is narrowing, especially among younger age groups, are reported from many regions worldwide. However, more consolidated research is needed internationally in order to elucidate the differences in patterns of drug use among males and females.

## Gender-specific approaches in responses to drug use

### Prevention: universal and selective prevention for boys and girls

In all Member States, gender-related prevention work remains uncommon. This is somewhat surprising as it is well known that girls and boys experience different developmental problems during adolescence and have different resources at their disposal to cope with these problems. Moreover, at least in the case of prevention, gender specificity usually equates to interventions for girls; only very rarely are specific prevention actions targeted at boys, despite their known higher risk of both using drugs and developing problems (Butters, 2004). Boys may in fact represent a good target for this sort of approach as they may be more susceptible to social influence (Szalay et al., 1996) and because they appear to have a higher threshold for seeking help (Schmidt, 2001). Although currently underdeveloped, gender-specific preventive interventions for boys therefore represent an important area for research and a potentially valuable area for service development.

Several studies provide evidence of the need to adopt a gender-specific approach in preventive intervention in terms of content, setting and practice. For example, Schinke (1994) found that interventions are more effective if their content takes account of gender: in the case of young men, effective interventions include improving social skills and, in particular, assertiveness in the social environment, whereas helpful techniques in young women focus on facilitating expression, reducing tension and teaching effective control techniques.

For effective prevention, the setting should also be different for women and men; according to reports from some Member States, women prefer settings that allow informal exchange and extroverted forms of expression, such as small workgroups. Reflection on personal experience and role images (including that of the trainer) are considered important, as is the gender of the contact person, which should be a woman for girls and a man for boys. Often, the

effects of the programmes are longer lasting (Lillehoj et al., 2004) and more pronounced for girls ([www.eu-dap.org](http://www.eu-dap.org)).

For young people at high risk, family supervision is a more consistent protective factor for girls than for boys (and helps to reduce opportunities for girls to use substances). Schools are more likely to provide self-help tools and protection against substance use for high-risk girls than for high-risk boys. And substance use among boys is affected more by risk conditions in their neighbourhood (Sale et al., 2005).

For girls, the programmes that are most effective in sustaining positive effects on substance use prevention after their completion focus on behaviourally orientated life skills. In contrast, methods of delivery that involve interaction with peers or adults are particularly effective in boys (Springer et al., 2004).

In practice, gender-specific prevention projects (in Germany, Austria and the Nordic countries) mostly take the form of separate workshops or seminars for girls and boys in order to encourage positive body image, identity development, self-reliance and action competence and to avoid the reiteration of gender stereotypes. Belgium and Denmark report that gender-specific projects are mostly found within the vocational education system, where social problems such as drug use are more frequent. In one Danish scheme 'many boys felt a sense of relief at being able to break down the barrier and talk about their own experiences, feeling that they were not the only ones with these problems. At the start of the project, the girls' relations with each other at the schools were, in most cases, rather delicate. ... but during the project a stronger sense of solidarity was created among the girls.' Several school programmes in Germany (Sign) and Austria (*Selbst sind de Kids, Eigenständig werden, I luag uf mi*) take gender-specific aspects into account. The German/Austrian project 'Step by step' <sup>(27)</sup> also takes into account gender-specific differences, e.g. training teachers to recognise the early signs of drug use in boys and girls.

Ethnicity and gender are targeted together in interventions in Belgium, Luxembourg and the Netherlands. In Belgium, the 'Tuppercare' project targets women from the Turkish and Moroccan communities. Key women in the community host meetings of family members and friends at which prevention workers of the same ethnic origin can provide information about sensitive issues such as drug use. A joint Dutch-Luxembourgish peer-to-peer education project ('Chebbab' in Nijmegen) involving young Moroccan men <sup>(28)</sup> in a socially vulnerable position has proved to be successful. Fifteen young Moroccan men provided peer education about cannabis use to other Moroccan young men. In 2004, the 'Chebbab' project resulted in the production of a manual for the peer education method entitled *Youth with*

<sup>(27)</sup> See <http://eddra.emcdda.europa.eu>

<sup>(28)</sup> A relatively high proportion of migrant young people in Dutch cities, men more than women, appear to belong to a socially vulnerable group with a multiplicity of problems, including drug problems.

a message (*Jeugd met een boodschap*) (Kroneman et al., 2003). However, three other pilot studies in the Netherlands involving Antilleans and Turks failed; because of the stigma attached to drugs in these cultures, non-using peers were unwilling to be associated with drugs.

Tobacco campaigns in Germany and in France use gender-specific target messages, e.g. the contradiction between seduction and the effects on beauty or between addiction and the quest for freedom.

In recreational settings in the Netherlands, gender appears to be a less significant factor affecting drug use than age and music preference ([www.unitydrugs.nl](http://www.unitydrugs.nl)). However, Calafat et al. (2003) highlight the moderating 'partying skills' of female party-goers and suggest that female consumption behaviour in recreational settings should be promoted as a model for prevention.

### Gender-specific approaches to drug treatment

Treatment facilities are usually organised around the needs of opioid addicts, who are mainly men. Those treatment interventions that do have a gender-specific component are mainly targeted to women's needs and, in particular, to pregnant drug users or women with children. Thus, in practice, gender-specific treatment often means treatment targeted towards women drug users.

Most European countries report having at least one treatment unit or programme exclusively for women or for women with children. In recent years, the introduction of high-quality management at drugs agencies seems to have played a role in several countries in achieving a higher target group specialisation, although coverage of gender-specific service provision appears to be low and is often limited to major urban centres. The most common types of gender-specific intervention include case management approaches that facilitate the mediation of care for pregnant drug users, services that specifically address the mothers and fathers of small children and specially designed outreach projects targeted at sex workers.

### Gender difference in treatment access, completion and outcome

The structural, social, cultural and personal barriers to treatment that women can face are summarised in the UNODC toolkit on substance abuse treatment and care for women, bringing together case studies and lessons learned (UNODC, 2004). The literature reviewed here shows that, among individuals with substance use problems, women are more likely than men to have a partner with a substance use problem; childcare responsibilities; severe problems at the beginning of treatment; trauma related to physical and sexual abuse; and concurrent psychiatric disorders.

Research on gender differences in the access, duration, completion and outcome of treatment suggests that generalisations on gender cannot easily be made (EMCDDA, 2005). In some analyses, women are reported to be more likely than men to access treatment; the reasons for this may be related to the existence of specific services offered to women or to the fact that women need treatment more than men if they are pregnant or if they have children. In other studies, women are reported to seek treatment proportionately less often than men because of the associated social stigma.

There is not enough information about gender differences in treatment duration, completion and outcome in Europe to draw any firm conclusions. For example, a German analysis of outpatient treatment data reports that men require a shorter treatment duration and have a better outcome, whereas, in Slovakia, among clients of a methadone programme, the success rate was higher for women than for men.

More research is needed to better understand gender differences in all treatment processes; the analysis should take into account differences in the clients' characteristics, their patterns of drug use and the differences between the types of treatment offered (for example outpatient/inpatient; medical/counselling).

### Interventions for pregnant women

Outpatient and low-threshold facilities increasingly provide basic medical care as well as sexual healthcare, contraception advice, free infectious disease testing and treatment and pregnancy testing.

Pregnant drug users are defined as a priority group, and they are given preferential access to drug treatment. Integrated quality care for pregnant drug users is being increasingly provided across Europe. Staff support women in gaining access to a range of appropriate services. Case management and the mediation of care are critical components of accessibility and quality of services — objectives noted in the EU action plan.

In most countries, the preferred treatment for opioid-dependent pregnant women is substitution therapy, particularly if discontinued opioid use would be detrimental to the mother or child or if the mother is already in substitution treatment. Research concerning the substitution drug of choice is inconclusive (Lejeune et al., 2003; Jones et al., 2005; Fischer et al., 2006); however, there is consensus that substitution treatment is beneficial to both mother and child. In some countries, e.g. Belgium, France and Sweden, the primary aim of maternity care for drug users is usually abstinence.

Pregnant drug users receive priority treatment in Member States in order to meet their specific needs. The concern is to monitor these women regularly throughout pregnancy

and during the postnatal period in order to ensure that the health of the mother and child remains as good as possible and to support the mother and child relationship. Pregnant opioid addicts require individual counselling and therapy that is quick to implement. In Belgium, a case management approach is adopted. In Greece, a special unit has been created in Thessaloniki to cater for the needs of pregnant women who are turned down by other services. In Ireland, treatment centres refer pregnant clients to midwives to ensure a consistent care plan. In Sweden, maternity care centres have a very high coverage; they refer pregnant drug users to treatment, and studies have shown particularly positive treatment outcomes for pregnant addicts. Research has shown the benefits of centralising care in special units that have access to comprehensive information about the social and medical consequences of substance abuse.

### Drug-using parents and child care

Although pregnant women are often the focus of attention, this service may not always continue when the child is born. In many countries, services have been developed mainly for mothers and their children and, in some cases, for families. 'Vulnerable people — addicted mothers and their children' <sup>(29)</sup> is a European project with participation from Belgium, Germany, Greece, Italy and the Netherlands, assisting mothers and their children up to four years old. It has produced a manual which combines the experiences and methods applied by the project partners with recommendations and models for practical use. Courses and training in parenting skills are also available in France, Luxembourg and Portugal, and guidelines for the integrated assistance of pregnant drug users and those with children were developed in 2005 for the Venice region and presented to the other Italian regions as a model (Provoid project) <sup>(30)</sup>.

Outpatient treatment centres, e.g. in the Czech Republic, Ireland, the Netherlands, Portugal and the United Kingdom, provide childcare and specific sessions on parenting skills together with drug treatment. In several countries, such as Belgium, the Czech Republic, France, Italy, Malta and Portugal, therapeutic communities have special provisions for mothers or parents with children. In Luxembourg, a collaboration network involving services for the psychomotor rehabilitation of children, family social services, homes for women and children, hospitals and schools has been set up.

Prison sentences are particularly difficult for drug-using mothers; often, their children are placed in foster homes, but several countries (the Czech Republic, Ireland, Hungary, Slovakia and Sweden) report that assistance is given to maintain the emotional bonds between mother and child. One prison in Belgium has a special unit for mothers with children up to two and a half years old. There is at least one prison in Portugal with a special unit for mothers with

children under four years old; in Slovakia, pregnant women and mothers of children less than one year old cannot serve a prison sentence.

Although there is usually a focus on motherhood — often in the absence of a stable partner — one Swedish study has looked at the importance of fatherhood for addicted men. Many of these fathers want to take part in raising their children, but the social authorities see them only as addicts, even though they consider the fathers to be important in their children's lives.

### Interventions in the criminal justice system

Although there are far fewer female than male prisoners, with women making up between 2 % and 8 % of the prison population in Europe, this is not to women's advantage. Women prisoners are often placed in a unit that is annexed to a male prison, and there may often be a lack of services specifically targeted to women's needs in areas such as medical services, treatment of drug dependency, work and training. This is reflected in the information available to the EMCDDA, with reports revealing that only four countries (France, Portugal, Slovakia and Sweden) have projects specifically for drug-using female prisoners.

#### Quartier Intermédiaire Sortantes

The Quartier Intermédiaire Sortantes is a pre-release unit for female prisoners with drug-use-related problems from three French prisons (Fleury-Mérogis, Versailles and Fresnes). Based at Fresnes, near Paris, it was established in 1997 and prepares prisoners with drug and/or alcohol problems who are in the last month of imprisonment for life after release. The day programme is voluntary and run jointly by internal and external staff, who provide information and advice on a variety of topics, including health issues (e.g. health promotion, healthcare, harm reduction/transmission of STDs, body awareness) and support networks (e.g. re-establishing links with family and children; agencies that offer support to sex workers) as well as training in the day-to-day skills required for life outside prison (household tasks, cooking, managing finances). The use of external experts in this programme is strongly geared to creating links that the women can use on their return to the community. The services provided at QIS are funded by the Direction Générale de la Santé and by the MILDT (Interdepartmental mission for the fight against drugs), and are currently under evaluation. Promising results were achieved during the first two years of operation: only 10 % of women who attended the programme, compared with 40–50 % of the rest of the prison population, returned to prison.

<sup>(29)</sup> <http://www.vulnerablepeople.org/>

<sup>(30)</sup> [www.venetosociale.it](http://www.venetosociale.it)

## Harm reduction approaches to female problem drug users

There is a trend among low-threshold agencies to reorient their services and opening hours to respond better to the needs of female problem drug users. Specialised low-threshold agencies providing health promotion services to female problem drug users, and targeting sex workers in particular, are reported by Belgium, Germany, Greece, Luxembourg, the Netherlands and Finland. This work usually takes the form of street outreach services to provide information and advice, particularly about safer sex, but also to distribute sterile injecting equipment, condoms and lubricants and to make referrals to other health, social and treatment services. There is some provision, although much less, of such health promotion services to male sex workers, but these services are not usually targeted specifically at drug users.

## Conclusions

There are marked differences between the genders in almost all aspects of the drug phenomenon. Males far outnumber females among drug users in all European countries and for most types of drugs. Similar findings are reported in other regions of the world, and in terms of numbers men remain the major consumers of both illicit drugs and services for those with licit drug problems.

Some indications of a narrowing gap between men and women in drug use have recently been reported, in particular among younger people in higher prevalence countries. However, a narrowing of the gender divide is not generally apparent in other data sets, and this remains an important area for further scrutiny and research. Certainly, it would be a worrying observation if women were beginning to adopt the same drug consumption patterns as men, as this would result in a considerable expansion of both the size of the European drug problem and the demand for services.

From the European data presented here, we can identify some overall patterns of differential participation in drug use between the genders. Southern countries tend to report higher male to female ratios than do countries in the north of Europe. The highest proportions of men are found among users of cannabis and cocaine, and the highest proportions of women among users of tranquillisers, sedatives and pharmaceutical drugs, and this is generally reflected in the data on the population in drug treatment.

Far more males than females die as a result of drug use. However, there are signs that the moderate overall decrease in drug-related deaths observed since 2000 is more marked among males than it is among females. The reasons for

this are unclear but there is clearly a need to ensure that intervention measures targeting drug overdose are sensitive to the needs of both genders.

Research evidence has suggested that barriers may exist to service uptake by women and that addressing childcare issues is an important element of developing women-friendly services. Women appear to be more likely to access treatment earlier in their drug-using career. Why this is the case remains unclear, although for some women pregnancy and motherhood can be strong motivators for entering treatment and reducing or quitting the use of drugs, again emphasising the importance of this issue in considering treatment opportunities for women.

The proportions of male and female drug users testing positive for hepatitis C are similar, although HIV seroprevalence is higher among female (20 %) than among male drug users (13 %). Females represent between 9 % and 15 % of drug law offenders in the European countries, but there are indications of an increased involvement of women in drug-related crimes in recent years. Social exclusion affects more women than men, with female drug users suffering from twofold discrimination both as drug users and as women.

Even though growing attention is being paid to specific gender needs in drug-related interventions, in practice, gender-specific prevention projects are the exception rather than the rule.

Gender-specific treatment is usually targeted at pregnant drug users and women with children. In most, but not all, European countries there is at least one treatment unit for women only. Drug users in prisons have access to gender-specific resources in only a few countries. Harm reduction agencies in several countries are implementing interventions that specifically target female drug users, especially in the context of their involvement in sex work and related individual and public health risks.

Although drug use has often been treated as a non-gender-specific issue, data show that prevalence of drug use, problem drug use and related health and social consequences differ greatly between the genders. Men and women characteristically have different histories of drug use, from initiation to exit. The reasons for those differences are complex and are related to a mix of social, physiological and personal factors.

Further research is clearly needed to describe and interpret the role of gender in drug use and its associated problems. As a starting point, policymakers, professionals and scientists must always take gender into consideration in the planning of research, analysis, interventions and policy in this field.

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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of the European Union's decentralised agencies. Established in 1993 and based in Lisbon, it is the central source of comprehensive information on drugs and drug addiction in Europe.

The EMCDDA collects, analyses and disseminates objective, reliable and comparable information on drugs and drug addiction. In doing so, it provides its audiences with an evidence-based picture of the drug phenomenon at European level.

The Centre's publications are a prime source of information for a wide range of audiences including policymakers and their advisors; professionals and researchers working in the field of drugs; and, more broadly, the media and general public.

The annual report presents the EMCDDA's yearly overview of the drug phenomenon in the EU and is an essential reference book for those seeking the latest findings on drugs in Europe.