

**Women &
Substance Misuse:**
Drug Misuse & Women's
Health in Ireland

The Women's Health Council
Comhairle Shláinte na mBan



CONTENTS

1. Introduction	3
2. Prevalence	4
2.1. Women compared with men	4
2.2. Converging patterns among young people	5
2.3. Types of drugs	5
3. Factors Associated with Drug Misuse	10
3.1. Family background	10
3.2. Drug misusing partner	11
3.3. Age	11
3.4. Education & socio-economic statu	12
3.5. Violence & sexual abuse	12
4. Consequences of Drug Misuse for Women	13
4.1. Physical	13
4.2. Mental/Emotional	17
4.3. Social & interpersonal consequences	18
4.4. Effects of others' drug misuse on women – the burden of care	20
4.5. Drug related crime	21
5. Treatment Services in Ireland	22
5.1. Accessing treatment	22
5.2. Treatment options	22
5.3. Particular needs of women	24
6. Drug Misuse Strategy & Legislation in Ireland	28
6.1. Drug misuse strategy	28
6.2. Drug misuse legislation	29
7. Conclusions/Recommendations	30
7.1. Gender sensitive policy	30
7.2. Improving women's access to services	30
7.3. Area of particular concern: Prescription drug misuse	32
7.4. Health Promotion	33
8. References	34

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1. Introduction

Women have played an important role in highlighting the issues around the misuse of illegal drugs in this country. During the 1990s in Dublin's disadvantaged inner city areas women organised direct action campaigns and anti-drug marches, which prompted government action to tackle the drugs problem (Murphy-Lawless, 2002). Although women were the ones to take action on the area, at a societal level, drug misuse is a larger problem among men than women. A detailed look at the issue reveals a more complicated picture, however, in which the prevalence of drug use and related health and social consequences differ greatly between the sexes. In addition, changing patterns of drug misuse among young people mean that drug misuse may be becoming a larger problem for women than it has been traditionally.

The Women's Health Council, in line with its statutory instrument, has focused on the area of women and drug misuse in order to investigate current trends, examine the particular circumstances that lead to and result from drug misuse among women, and draw out the particular effects of drug misuse on women's health and well-being. The paper will examine the misuse of both legal and illicit drugs. The Council envisages that it will be of interest to policy and strategy makers, as well as health service providers and those with an interest in women's health.

2. Prevalence

Data on drug misuse in Ireland is gathered by a number of organisations. The National Advisory Committee on Drugs (NACD), established in July 2000 under the auspices of the Department of Tourism, Sport and Recreation, has conducted two general population surveys of drug misuse to date. It found that in 2006/7, 24% of people aged 15 to 64 years in this country reported taking illegal drugs during their lifetime. This represented an increase from 19% in 2002/3 (NACD & DAIRU, 2008b). Similarly, the proportion of young adults (15-34 years) reporting illegal drug use in their lifetimes increased from 26% in 2002/3 to 31% in 2006/7 (NACD & DAIRU, 2008b). Those in the younger age groups were more likely to misuse drugs, with lifetime use highest in those aged 25-34 years (34%), although last year and last month use was highest for those aged 15-24 years (15% and 6% respectively) (NACD & DAIRU, 2008b).

The Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB) maintains two national drug-related surveillance systems, focusing on drug and alcohol treatment data. Research recently published by the ADRU found that the prevalence of treated problem drug use among 15–64-year-olds living in Ireland increased by 15% between 2001 and 2006, from 372 per 100,000 of the population in 2001 to 426 in 2006 (Reynolds et al., 2008). However, the number of new cases entering treatment was found to be marginally lower in 2006 (74.8 cases per 100,000) than in 2001 (75.7 cases) (Reynolds et al., 2008).

2.1. Women compared with men

As stated in the introduction, drug use globally is an overwhelmingly male activity (EMCDDA, 2006). The 'typical' problem drug user profiled in the research is young and male, unemployed, with no stable home and a low level of education (Reynolds et al., 2008). General population data have shown that men are more likely to misuse drugs than women, with 29% of men reporting lifetime use of any illegal drugs compared to 19% of women (NACD & DAIRU, 2008b), and research on young people has shown that male students were much more likely to use illegal drugs than female students (Hope et al., 2005). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has noted, however, that the ratio of women misusing drugs compared to men increases as overall prevalence of drug use increases, although it is usually lower for the more illegal drugs and for recent or frequent patterns of drug misuse (EMCDDA, 2005).

Men also outnumber women among those attending services for the treatment of drug misuse; overall in Europe, women only make up 20% of the population availing of services (EMCDDA, 2005). However, research has shown that women experience particular barriers to accessing services (discussed in section 5.3) that hamper their participation; it may therefore be that women are underrepresented in the treatment population and there may be considerable unmet need in the area. Although men are more likely to misuse illegal drugs than women, for prescription drugs, such as tranquilisers and anti-depressants, women have

been found to predominate (NACD & PHIRB, 2009). This may imply that women's pathways to drug misuse are different to men's, or that they misuse drugs for different reasons. It may also mean that women have different experiences of drug use to men, and therefore also different health and social consequences around drug use. For example, research has shown that women who misuse drugs are more likely to engage in higher risk practices, such as injecting drugs, than their male counterparts, which would leave them open to a greater range of health risks especially if they share injecting equipment (EMCDDA, 2005, O'Brien & Dillon, 2001).

2.2. Converging patterns among young people

While traditionally more males than females misuse drugs, there have been indications in recent research that the gap in illicit drug use is narrowing among those in the younger age groups. EMCDDA figures for Ireland have shown that among school students, an equal ratio of 15-16 year old boys and girls have ever used cannabis, and, although more adult males than females have ever taken ecstasy, a slightly larger ratio of 15-16 year old girls than boys have repeatedly used the drug (EMCDDA, 2006). An Irish study of adolescent opiate use found that whereas during the 1990s males were more at risk of opiate misuse, now male and female teenagers are equally at risk (Fagan et al., 2008). These figures, which mirror the situation in the rest of Europe, would seem to suggest that the traditional gender gap in drug misuse is closing among younger people and it has significant implications for the future. If young women persist in using drugs in a similar manner to their male counterparts, it is likely that there will be an overall increase in the prevalence of drug misuse in the future, with knock on effects for treatment and rehabilitation services.

2.3. Types of drugs

Overall, cannabis is the most commonly misused drug in Ireland, followed by magic mushrooms, ecstasy, cocaine and amphetamines (NACD & PHIRB, 2008a, Hope et al., 2005). Among those in treatment for drug misuse, cannabis was the most common problem drug, followed by opiates and cocaine (Reynolds et al., 2008). Polydrug use (using more than one substance) has been identified as a growing problem, involved in 70% of cases entering or returning to treatment in 2005 (Department of Community Rural and Gaeltacht Affairs, 2007).

These population figures can mask important differences in patterns of drug misuse between men and women, however. While men predominantly use cannabis, opiates and cocaine, women are more likely to misuse stimulants and pharmaceutical drugs such as tranquillisers/sedatives and anti-depressants (EMCDDA, 2005, EMCDDA, 2006, NACD & PHIRB, 2009). In 2005, for example, a study of Irish students found that while 45.4% of male

students had used cannabis compared to 32.4% of females, equal proportions of both had misused tranquillisers (1.3%) (Hope et al., 2005). Figures from the HRB's National Drug Treatment Reporting System (NDTRS) showed that differences in the numbers of men and women treated for use of volatile inhalants and benzodiazepines were less pronounced than those for other drugs such as cocaine, cannabis and amphetamines (Reynolds et al., 2008). Most recently, figures published by the NACD indicated that women actually have higher prevalence rates for lifetime use of sedatives/tranquillisers and anti-depressants than men (NACD & PHIRB, 2009). Figures for the main types of drugs misused are examined in more detail below.

2.2.1. Cannabis

Cannabis is the most commonly used illegal drug in Ireland. The proportion of adults who reported using cannabis at some point in their life increased from 17% in 2002/3 to 22% in 2006/7 (NACD & DAIRU, 2008b). A higher proportion of men report using cannabis than women - 27% of men compared to 17% of women (NACD & DAIRU, 2008b). Among students, 22% of males said they had used cannabis ten or more times in the past year compared to 11% of females (Hope et al., 2005). However, as noted above, more recent figures have shown that among school students in Ireland, an equal ratio of 15-16 year old boys and girls reported ever having used cannabis (EMCDDA, 2006).

2.2.2. Ecstasy

The NACD population survey in 2006/7 found that just over 5% of adults reported taking ecstasy at least once in their lifetime. Within this figure, twice as many men reported using ecstasy than women (NACD & DAIRU, 2008b). This reflects the pattern in the rest of Europe, but again, as mentioned above, in Ireland among school students a slightly larger ratio of 15-16 year old girls than boys reported repeatedly using the drug (40+ times during their lifetime) (EMCDDA, 2006).

2.2.3. Cocaine

Misuse of cocaine has increased in Ireland in recent years, with the proportion of adults who reported using cocaine (including crack) at some point in their life increasing from 3% in 2002/3 to 5% in 2006/7, while among those aged 15 – 34 years the proportion increased from 5% in 2002/3 to 8% in 2006/7 (NACD & PHIRB, 2008c). In line with this increase, the number of new cases in treatment who reported cocaine as their main problem drug also increased significantly, from 43 in 2001 to 342 in 2006 (Reynolds et al., 2008). Cocaine consignments in Ireland have also been found to have increased significantly (International Narcotics Control Board, 2008).

The most recent population survey found that in Ireland lifetime prevalence rate for cocaine powder and/or crack among men is twice that of women (7% compared to 3%). Compared to the previous survey carried out in 2003/4, these rates represented a significant increase

– the lifetime prevalence rate for any type of cocaine use among women was previously 1.6%. The average age at first use of cocaine powder was 21 for women, compared to 22 for men (NACD & PHIRB, 2008c, NACD & DAIRU, 2008a).

2.2.4. Opiates

Opiates, particularly heroin, have been in heavy use among drug misusers in Ireland for more than thirty years. Their use is especially associated with Dublin's disadvantaged inner city areas, where the 'opiate epidemic' is said to have peaked in the years between 1979 and 1983 (Dean et al., 1987), although Ireland still has a high prevalence of young opiate misusers compared to other European countries (Fagan et al., 2008). It was estimated that there were 14,452 opiate users aged 15-64 in Ireland in 2001 (Kelly et al., 2004). During the same time period, researchers found a statistically significant increase in the number of young women aged 25-34 using opiates. This trend seems to have continued, with reports of a greater number of female teenagers attending the Trinity Court Drug Treatment Centre for heroin misuse in 2005 (17 out of 19 teenagers were female) (Ring, 2005), and women being more likely than men to report use of "other opiates"¹ (8% compared with 5%) in the latest NACD prevalence study (NACD & DAIRU, 2008b). Figures from the NACD show clearly that women are now more likely to misuse opiates than men; they found that female lifetime, last year and last month prevalence rates for other opiates were at least double those of males (NACD & PHIRB, 2008a). The EMCDDA, in its most recent *Annual Report*, highlighted the fact that opioid drugs, mainly heroin, are the drugs most often associated with overdose (EMCDDA, 2008a).

2.2.5. Prescription drugs

The International Narcotics Control Board has stated that as the use of prescription drugs, such as sedatives or anti-depressants, has increased, so too has the misuse of these drugs, to the point that internationally prescription drugs are now the second most misused class of drugs after cannabis (Zarocostas, 2007). This issue is of particular concern for women as, although men outnumber women for use of most categories of illicit drugs, women have been found to predominate where prescription drugs are concerned.

Research carried out by the Women's Health Council in Ireland found that women were more likely than men to be taking prescription medicine, and that in the population overall, women in least well off socio-economic groups were the most likely to be taking prescription medication (Women's Health Council, 2008). In more specific research, women in Ireland report higher prevalence rates for lifetime use of sedatives or tranquillisers than men (13% compared to 8%), and also anti-depressants (13% compared to 6%) (NACD & DAIRU, 2008b, NACD & PHIRB, 2009). Research carried out by the Department of Health & Children's Benzodiazepine Committee found that use of benzodiazepines increased with

¹ The category 'other opiates' included Opium, Temgesic®, Diconal®, Napps, MSTs®, Pethidine, Dihydrocodeine, Buprenorphine, Morphine, Codeine, Kapake, Diffis, Dikes, Peach, Fentanyl, and Oxycodone.

age, reaching a peak in the late 60s and early 70s, with higher usage being found amongst females of all age groups (Department of Health & Children, 2002). It has been suggested that for some older women increasing physical ailments such as arthritis bring them into contact with prescription drugs which may be misused if not appropriately prescribed and monitored (The National Center on Addiction & Substance Abuse at Columbia University, 2006). In addition, the depression and anxiety that can accompany physical ailments may increase the risk that older women will misuse prescription drugs to alleviate their distress.

The higher rate at which women are prescribed tranquillisers, sedatives and anti-depressants when compared to men is a serious cause for concern. The Benzodiazepine Committee found that prescribing rates for males in 1999 and 2000 were 10.6% and 7.4% respectively, compared to 15.8% and 11.8% for females (Department of Health & Children, 2002). A community-based research project carried out in Ballymun in Dublin found that two-thirds of the benzodiazepines dispensed by community pharmacies in the area went to women (Ballymun Youth Action Project, 2004), with most believing that doctors prescribed the drugs 'to help women cope'. Worryingly, it has been found that women are twice as likely as men to have benzodiazepines prescribed to them for 'non-clinical' symptoms such as stress, grief, acute or chronic illness, physical pain or adjustment to a major life change and to have them prescribed for longer periods (Cormier et al., 2004, Ballymun Youth Action Project, 2004, Poole & Dell, 2005). The NACD also found associations between higher prevalence rates of tranquilliser and anti-depressant use and indicators of deprivation such as not being in paid work, lower levels of educational attainment, and long term dependence on state benefits (NACD & PHIRB, 2009). The WHC has previously shown that women are more likely than men to be represented in these categories (Women's Health Council, 2003, Women's Health Council, 2001, Women's Health Council, 2007).

Long term benzodiazepine use can lead to dependence, and research carried out in Canada found that women are more likely to become chronic users than men (Kermode-Scott, 2007). Although only small numbers of individuals currently present for treatment for problem benzodiazepine or other prescription drug use, the HRB has recommended that the impact of these drugs must be addressed within treatment and prevention services (Lyons et al., 2008). Given the higher prevalence rates among women, it is essential that such treatment services pay particular attention to women's needs and that women are targeted by any health promotion or prevention campaigns undertaken in this regard.

2.2.6. Polysubstance use

Recent figures have shown that in most cases where drug use is an issue, several substances are being used simultaneously (polysubstance use). For example, the majority of deaths directly due to drugs on the HRB's National Drug Related Deaths Index (NDRDI) showed polysubstance use, and the majority of people entering treatment for the first time between 2001 and 2006 reported problem use of more than one drug (Reynolds et al., 2008, Lyons et al., 2008). Overall, among new treatment cases between 2001 and 2006, 31% reported use of two substances, 23% reported using three substances simultaneously and 18% reported problem use of four or more substances (Reynolds et al., 2008). In Ireland, the NACD population drug survey of 2002/2003 found that polysubstance use (most commonly combining use of alcohol, tobacco and any illegal drug) was more common among men (2.65%) than women (1.2%) (NACD & DAIRU, 2007)².

Polysubstance use is problematic for a number of reasons, not least that it increases a person's risk of death or serious harm to health. It also increases the complexity of an individual's problems and needs, and it is associated with poorer treatment outcomes. As polysubstance use appears to be rising in Ireland, commentators have emphasised the need for treatment services that work in an integrated and flexible manner to manage all of the drug user's needs, addressing both alcohol and drug use at the same time.

² Results from the 2006/7 survey on this variable have not yet been published.

3. Factors Associated with Drug Misuse

'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 (EMCDDA, 2006).

When examining the issue of drug misuse among women, it is important to acknowledge that women are not a homogeneous population – they come from diverse backgrounds, with different socio-economic circumstances, ethnicities, religions, ages, and family backgrounds (Poole & Dell, 2005). These characteristics can all affect their likelihood of misusing drugs. When comparing women to men, it is essential to note the importance of the social network for women, as researchers have pointed out that initiation into drug use is rarely due to the intervention of a drug-pushing stranger; it usually happens in a familiar context with friends, relatives or neighbours playing an important role (Connolly, 2005). Regarding motivation to misuse drugs, the U.S. National Center on Addiction and Substance Use has stated that girls and women tend to use drugs (including tobacco and alcohol) to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex or lose weight. Given their different misuse and motivating patterns, women's treatment needs may therefore also be quite different to men's, with an increased emphasis on care and support as emotional and relational reasons are often at the crux of women's misuse of drugs (Poole & Dell, 2005, National Center on Addiction & Substance Abuse, 2003).

3.1. Family background

Lack of cohesive and supportive family life seems to be one of the most significant predisposing factors to drug use among women. A report published by the British Home Office found that parental discipline, family cohesion and parental monitoring were key predictors of drug use, and large family size and low parental age were also linked to adolescent drug misuse (Frisher et al., 2007). A study of a sample of Irish drug users published in 1980 found that the cohort was characterised by a high level of familial problems, such as separation from parent before the age of 16, poor parental relationship, paternal alcoholism, maternal psychiatric disorder, vague or erratic disciplinary code, or the death of a parent before the individual was 16 (Carr et al., 1980). Similar findings were made in a more recent study of young opiate users, which found that many came from a 'dysfunctional' family, with 52% having childhood involvement with social services (Fagan et al., 2008). A family history of substance misuse was also found to be common. Irish research on pregnant opiate users found that these women tended to have poor family relationships, or come from families with a history of alcohol misuse, drug abuse and/or psychological problems (Farrell, 2001). It has been suggested that girls are more responsive than boys to parental influences on substance use; Irish research has found that parental disapproval and 'bonding' to family (particularly to parents) tend to act as restraining factors in substance use (Grube & Morgan, 1990). In addition, American research has found that the worse a girl's relationship with her

parents, the earlier she will begin drinking alcohol and the greater her likelihood of misusing drugs (The National Center on Addiction & Substance Abuse at Columbia University, 2006).

3.2. Drug misusing partner

Internationally, research has found that a woman's partner has an important influence on her drug use. Women are more likely than men to have been introduced to drugs by a partner, and overall, women who misuse drugs are far more likely to be living with a drug misusing partner than are their male counterparts (Farrell, 2001, Dorman et al., 1997, Woods, 1994, O'Neill & O'Connor, 1999, Fagan et al., 2008, UNODC, 2004). Some researchers went so far as to say that it was 'extremely rare' to find a drug-using woman living with a non-drug using man, even though many drug using men live with women who do not use drugs (Woods, 1994). Most recently, Fagan et al (2008) found that a large proportion of the young female opiate users they studied were in relationships with older male heroin users. Women in a long-term relationship with a drug user may lack the partner support which is an important factor in presenting to and remaining in treatment (Hedrich, 2000), and the relationship may also create difficulties around recovery and living in a drug-free environment. It is therefore a significant concern regarding the challenges it can pose for women's treatment and rehabilitation.

3.3. Age

Illicit drug misuse is generally more common among younger people – those in the 15-24 year age group are more likely to report last year and last month use of illicit drugs than those in other categories, for example (NACD & DAIRU, 2008b). Internationally, it has been found that women tend to start misusing drugs at a slightly later age than their male counterparts (Hser et al., 1987). In Ireland, however, women have been found to have a slightly lower average age than men for starting to use cocaine (21 for women compared to 22 for men) (NACD & PHIRB, 2008c), and the average age at which both males and females started using cannabis was 18 years (NACD & PHIRB, 2008b). Regarding treatment, international data have shown that the highest proportions of females in drug treatment are under 20 years and over 39 years (EMCDDA, 2005). The types of drugs for which women are being treated differs according to age; those under 20 are most likely to be misusing amphetamine-type stimulant drugs, while those in the older age groups are more likely to misuse sedatives or prescription drugs. This suggests a pattern of recreational use of illicit drugs during youth, with a heavier reliance on prescription drugs among older women. In Ireland, women tend to present for drug treatment at a younger age than their male counterparts (Geoghegan et al., 1999, O'Brien & Dillon, 2001).

3.4. Education & socio-economic status

Early school leaving is a common pattern among drug users, both male and female, and perhaps as a result, unemployment is also the norm. A recent Irish study of 86 adolescent opiate users in treatment found that early school leaving was common, and 57% reported that they had never been in employment after leaving school (Fagan et al., 2008). An earlier study of Irish drug users revealed similar findings; the average age for school leaving among those studied was 16 and 63% were unemployed at the time of the study. Recently, the Health Research Board has found that rates of employment are highest among those in treatment for use of 'recreational' drugs like ecstasy, cocaine and amphetamines, while those who used drugs such as opiates and benzodiazepines had the lowest rates of employment (Reynolds et al., 2008).

Research has shown that women who misuse drugs often have higher educational levels than their male counterparts (EMCDDA, 2005), perhaps because they are on average older when they start to use drugs. Women are less likely than their male counterparts to be employed in the labour market, however, which could be explained by the higher proportion of female drug users who live with and care for children. Looking at those in treatment for drug misuse, the EMCDDA has found that a higher proportion of women are economically 'inactive' and that unemployment rates are more than 10% higher among women than among male drug users in treatment (EMCDDA, 2006). This is a significant finding, as research has shown that being employed seems to have a protective effect to some degree; it has been found that drug users in employment use their main problem drug less frequently and report better treatment outcomes than their unemployed counterparts (Keane, 2007).

3.5. Violence & sexual abuse

For women, drug misuse seems to be strongly linked with having experience of violence and/or sexual abuse. Research has shown that a large proportion of women with substance use problems are victims of domestic violence, incest, rape, sexual assault and child physical abuse (Cormier et al., 2004, Roberts & Vromen, 2005, Woods, 1999, UNODC, 2004). The National Center on Addiction & Substance Abuse at Columbia University has found that girls who report having experienced physical or sexual abuse are twice as likely to smoke, drink or use drugs as those who were not abused (National Center on Addiction & Substance Abuse, 2006, National Center on Addiction & Substance Abuse, 2003). One explanation for the higher levels of drug use among women who have been abused is that drugs may be used as a way of coping with the pain, both physical and mental, of such experiences (Poole & Dell, 2005, National Center on Addiction & Substance Abuse, 2006, Roberts & Vromen, 2005, TSA Consultancy, 2005).

4. Consequences of Drug Misuse for Women

Misuse of drugs can cause both health and social problems, including chronic ill health, mental health difficulties, and relationship problems, as well as indirect effects on those around the user. Although women are generally less likely than men to misuse drugs, the impact of drug use on their lives, and particularly on their health, is often disproportionately high. One of example of this is provided by research carried out by the Merchants Quay Ireland drug treatment service, which found that, in spite of the fact that they had a shorter history of drug use and shorter injecting careers, female drug users were more likely than their male counterparts to report a range of physical and mental health complaints (Cox & Lawless, 2000). Commentators have also suggested that women may progress to problematic drug use and dependency more quickly than men (Cox et al., 2008).

4.1. Physical

Women have been found to be particularly vulnerable to the negative physical health effects of drug use, even at the generally lower levels of drug misuse which women engage in compared to their male counterparts. Researchers have shown that even low levels of substance use are associated with more serious health consequences for women and girls (Poole & Dell, 2005).

4.1.1. Death

People who misuse drugs are far more likely to die prematurely than their non-drug using peers. The EMCDDA has found that mortality among drug users is up to fifty times higher than that of the general population (EMCDDA, 2008a). Death can occur as a result of a number of causes including overdose, medical consequences of drug use, accidents due to being under the influence of drugs and infections contracted as a result of injecting drugs (Long et al., 2005, Cassin & O'Mahony, 2006). The HRB's National Drug Related Deaths Index recorded a total of 2442 drug related deaths during the years 1998 to 2005, of which 1553 were directly drug related deaths (poisonings) and 889 were indirectly drug-related deaths. Women made up 32.9% of deaths by poisoning, and 16.3% of indirectly drug-related deaths (Lyons et al., 2008).

As men are more likely to misuse drugs than women, it is unsurprising that most drug-related deaths in all EU countries are male. 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 (EMCDDA, 2006). In a twenty-year follow up on a study of 55 pregnant opiate users in Ireland, Whitty and O'Connor found a particularly high mortality rate, with 53% of the women (n=29) deceased. The researchers stated that the mortality rate was almost three times that of the general drug using population and many times higher that what would be expected in a non-drug using population (Whitty & O'Connor, 2007).

Opiates are the drugs most likely to be responsible for deaths by poisoning. However, given women's high prescription and use rate, it is essential to note that benzodiazepines, often in conjunction with an illicit substance, have been implicated in more deaths than any other drug (Lyons et al., 2008). The National Suicide Research Foundation has stated that there is a need to consider restricting the availability of minor tranquilisers, as they are involved in more than 40% of intentional drug overdose acts (National Suicide Research Foundation, 2008).

4.2.2. Blood-borne viruses

Injecting drug use has been identified as a major risk factor for blood borne viruses, including HIV, in women (Poole & Dell, 2005, Reynolds et al., 2008). This is particularly the case because women have been found to be more likely than men to share used injecting equipment (Farrell, 2001, Dorman et al., 1997). Women's risk is also higher, however, because they are more likely to have sexual partners who also inject drugs, and often do not use condoms with their partners (Dorman et al., 1997). Not practising safe sex is especially dangerous for women, since they have a higher risk than men of contracting sexually transmitted infections due to their much larger area of mucous membrane (EMCDDA, 2006). Injecting drug use has also been linked with involvement in prostitution, something which further increases women's risk of contracting HIV/AIDS and other sexually transmitted infections (EMCDDA, 2006, Poole & Dell, 2005). Two of the most common blood-borne viruses found among drug users are HIV and Hepatitis C.

HIV

The total number of HIV infections reported in Ireland up to the end of June 2008 is 4,951. The latest figures show that there were 170 newly diagnosed HIV infections reported in Ireland during the first two quarters of 2008, 38.2% of which were female. For adults, the mean age at HIV diagnosis among females was 33.9 years, while it was 37.9 years among males. Where the probable route of transmission was known, injecting drug use was implicated in 11.8% of cases (Health Protection Surveillance Centre, 2008). The follow-up report to a study of pregnant opiate users in Ireland found a high incidence of HIV infection and HIV-related mortality; over half the women tested positive for HIV, and 17 of the total 55 women in the study were found to have died as a result of HIV and complications of the disease (Whitty & O'Connor, 2007).

Hepatitis

The EMCDDA has stated that infectious diseases such as hepatitis A, B and C are an important health consequence of drug addiction, particularly where injecting drug use is concerned. Hepatitis C is particularly common among Irish injecting drug users (O'Brien & Dillon, 2001). It is a blood-borne viral infection that affects the liver; it can cause liver failure, cirrhosis and hepatocellular carcinoma, although new drug therapies meant that it is now possible to treat disease successfully in many people (Health Protection Surveillance

Centre, 2009a). The majority of new cases of the disease are related to injecting drug use and to sharing of injecting equipment (EMCDDA, 2004, Reynolds et al., 2008, Healy et al., 2000), although it may also be passed on through unprotected heterosexual contact with an infected partner (Healy et al., 2000). Research has also found that hepatitis C is also more common among non-injecting drug users than in the non-drug using population (Scheinmann et al., 2007). A high prevalence of hepatitis C has been found among those injecting drugs for less than two years in Dublin (53.1%), and among new treatment clients 84% of injecting drug users tested seropositive for hepatitis C (EMCDDA, 2004). Although women accounted for a smaller proportion than men of cases of hepatitis C, it is worth noting that on average female cases are younger than their male counterparts (Health Protection Surveillance Centre, 2009b).

In order to prevent/minimise the spread of infectious diseases such as hepatitis C and HIV, the EMCDDA has recommended harm reduction measures including screening, counselling and education, methadone maintenance treatment, and needle and syringe exchange programmes (EMCDDA, 2004).

4.2.3. Fertility issues

A woman's fertility can be affected by drug use, through its affect on her menstrual cycle. It has been found that dependence on heroin or other opioid drugs can produce amenorrhoea and menstrual irregularity (Bell & Harvey-Dodds, 2008, Whittaker, 2003), and smoking marijuana has been associated with disruption of the ovulatory function (Mueller et al., 1990). Cocaine use has been associated with infertility caused by tubal abnormalities, although the researchers stressed that this area requires further research (Mueller et al., 1990). Where menstruation is irregular because of drug use, women may be at higher risk of unintended pregnancy, and may not be aware that they have become pregnant straight away. One study of British female drug users found that almost three-quarters reported an unplanned pregnancy (Bell & Harvey-Dodds, 2008). Treatment with methadone or buprenorphine for opiate users has been found to reverse the illicit drug effects on the menstrual cycle quite quickly, so it is essential to advise women entering treatment of the risks of becoming pregnant (Bell & Harvey-Dodds, 2008).

4.2.4. Drug use in pregnancy

Drug misuse during pregnancy is not common. In a study by one of Dublin's three maternity hospitals, only 4.57% of all pregnant women between from 1999-2005 reported having used illicit drugs in pregnancy (Barry et al., 2007). The majority of women in the study who reported drug use were found to be on methadone, which suggests that most were in treatment rather than misusing illicit drugs. This is an important point, as drug problems are often associated with a chaotic lifestyle. This can mean that women do not access maternity care as soon as is recommended, and that they do not attend antenatal care as often as non-drug using women (Whittaker, 2003).

In Scotland, research has shown that the majority (71%) of live babies born to drug misusing women were full-term and of normal birth weight (Drug Misuse Information Scotland, 2008). However, drug misuse can have serious effects on obstetric and pediatric morbidity and mortality. Misuse of drugs in pregnancy has been associated with increased rates of low birth weight, pre-term delivery, Sudden Infant Death Syndrome (SIDS) and Neonatal Abstinence Syndrome (NAS) (Whittaker, 2003). Low birth weight is the effect common to the misuse of most drugs in pregnancy. It has been linked with the use of cannabis (possibly because it is smoked in a mixture with tobacco), opioids, and cocaine. Benzodiazepine use may increase the risk of cleft palate, reduce brain development and affect long-term outcomes for the baby, as well as causing withdrawal symptoms in newborns that can be severe and prolonged. Cocaine use is reported to increase the risk of placental abruption, intrauterine growth restriction (IUGR), underdevelopment of organs and/or limbs, miscarriage and stillbirth, and pre-term delivery. Opiate use is associated with IUGR, pre-term delivery, SIDS and most commonly with NAS; abrupt withdrawal of opiates has been associated with miscarriage, stillbirth and pre-term labour. The effects of using ecstasy, amphetamines, hallucinogens or solvents have not yet been documented to a significant extent in the literature (Whittaker, 2003).

Studies in Ireland have confirmed that the babies of drug using women are more likely to be delivered prematurely, and to have lower average birth weights (Thornton et al., 1990, Barry et al., 2007). In the Coombe Hospital study in Dublin, the highest rates of low birth weight were found among the babies of heavy smokers and users of illicit drugs - 16.6% babies of drug-using mothers weighed less than 2500g, compared to 5.1% of infants born to mothers who reported no illicit drug use during pregnancy (Barry et al., 2007).

It is important to note that women who misuse drugs during pregnancy may be an especially vulnerable group with a multiplicity of needs in many areas. A study of a sample of pregnant opiate users in Dublin found that by 20-year follow-up more than half of the 55 women had died, mainly from HIV related illnesses. The authors stated that the high mortality rate demonstrated that these women were a particularly high risk group with poor outcomes (Whitty & O'Connor, 2007). It should also be noted that pregnancy outcome is the result of many interlinked factors including genetics, physical and psychological health, nutrition, health and social care, social deprivation and other environmental influences as well as the effects of drug use (Whittaker, 2003). Commentators have pointed out that many of the obstetric problems associated with substance misuse, including low birth weight and increased perinatal mortality, are also associated with social deprivation, poor antenatal care, and poor maternal health and nutrition (Mounteney, 1999). It is therefore essential to ensure that pregnant drug users can access specialised, integrated care services that will take all of their needs into account. Pregnancy is often a time of new beginnings for women with drug misuse issues, and a prompt that encourages them to tackle their substance use (Cox & Whitaker, 2009). Harm reduction approaches, which do not judge women but encourage them to reduce their use of drugs, may therefore present the best method for securing a healthy outcome for both the woman and her baby.

4.2.5. Other

In addition to the physical consequences of drug misuse outlined above, women are also at risk of complications from injecting drugs such as abscesses, infections, blood clots, deep vein thrombosis, endocarditis, septicaemia and gangrene (which can result in the loss of limbs) (Cassin & O'Mahony, 2006, Whittaker, 2003, Merchants Quay Ireland, 2007). One study which highlighted women's vulnerability to these problems was carried out at the Merchants Quay Project in Dublin in the late 1990s. It found that women were more likely than men to report abscesses, to have problems finding an intravenous site (suggesting damage to veins), and to suffer from weight loss (Geoghegan et al., 1999).

4.2. Mental/Emotional

The United Nations Office on Drugs and Crime has pointed out that women with substance use problems have higher rates than men of concurrent psychiatric disorders, particularly post-traumatic stress disorder and other mood and anxiety disorders (UNODC, 2004). Research has shown that as many as two-thirds of women with substance misuse problems may have a concurrent mental health problem such as depression, post-traumatic stress disorder, panic disorder and/or an eating disorder (Cormier et al., 2004). The National Center on Addiction and Substance Use in America has noted that stress is a common precursor for substance use in women of all ages, and that girls who are susceptible to depression and anxiety are at particularly high risk of developing substance use disorders (National Center on Addiction & Substance Abuse, 2006). Strong links have been found between drug misuse and depression, and it has been suggested that there is a bi-directional relationship between the two – i.e., that depression is a reason for, as well as a product of, drug misuse (Needham, 2007). Women in the general population have been found to be twice as likely as men to suffer from depression (Women's Health Council, 2005), and it may therefore be an important pathway to substance misuse for them, as well as being a significant consequence.

In Ireland, a study of the health status of female drug users found that the majority of participants reported that they had at least one psychological health complaint in the three months prior to the study, most commonly depression (Lawless, 2003). The Health Research Board has noted the particularly high rates of depression among drug users, citing studies which have shown that users are at greater risk of suicide than the population who do not use drugs (Lyons et al., 2008). This risk may be heightened among women, as research has shown that women (80%) are more likely than men (65%) to overdose on drugs as a method of deliberate self-harm (National Suicide Research Foundation, 2008). A study of adolescent opiate misusers in Ireland revealed that young women were more likely to report past suicidal behaviour than their male counterparts (Fagan et al., 2008).

4.3. Social & interpersonal consequences

'Social exclusion affects more women than men, with female drug users suffering from twofold discrimination both as drug users and as women (EMCDDA, 2006).

Perhaps because drug misuse is less common among women than men, women who use drugs often experience more stigma than do their male counterparts (Poole & Dell, 2005, Woods, 1999, Hedrich, 2000, UNODC, 2004). Use of drugs may impact on a woman's social and personal life in different ways to those of a male drug user. For example, the stigma attached to drug misuse can have implications for a woman's housing situation. Drug use (classed as 'antisocial behaviour') can be a reason for a woman being asked to vacate public housing; private landlords are selective about tenants and often drug users and women with children are not welcome; and many homeless shelters prefer not to provide accommodation for drug users because of their unpredictable, chaotic behaviour (O'Neill & O'Connor, 1999, Woods, 1999). Similarly, women as the partners of drug users may also face stigma and difficulties in accessing housing.

In addition, women's drug misuse may have wider social and interpersonal consequences for their families, and particularly for their children. In Irish society women still form the majority of primary carers for children and older relatives (Women's Health Council, 2003, Women's Health Council, 2007, Women's Health Council, 2002). The chaotic lifestyle associated with drug misuse may mean that women are not present to play this key role in supporting and caring for the family. Research has found that the children of mothers with substance misuse problems are less likely to remain with their birth mother, more likely to show developmental delay, and are significantly more at risk of abuse and neglect than the general population (Keen et al., 2000). As a group, the children of drug misusing parents also perform less well academically and in terms of social adjustment (Keen & Alison, 2001).

'Taken overall, there can be no doubt that parental drug misuse is a very important factor in preventing many children from achieving physical, mental and emotional health' (Keen & Alison, 2001).

Parental misuse of drugs can also be an important influence on children's behaviour around drugs. Children have been found to be more likely to misuse drugs in situations where their parents misuse drugs, where there is prolonged or traumatic parental absence, failure to communicate on an emotional level, and chaotic or disturbed family members (UNODC, 1995). The latest ESPAD report for Ireland found that while emotional support and care from parents influences children's substance (mis)use, parental monitoring, where children felt that their parents were 'keeping an eye' on their activities, was more important still (Morgan & Brand, 2009). If the parents themselves are misusing drugs, this monitoring is less likely to occur. It is important to note, however, that there is much evidence to suggest that interventions aimed at treating parental drug problems can have a stabilising influence

on the user herself, and this can in turn improve family functioning (Keen & Alison, 2001). The particular needs of women around treatment for drug misuse will be discussed further below.

In addition to the effects of drug misuse on the woman's family, it can have other social and interpersonal on the woman's own life. In particular, drug misuse also leaves women vulnerable to exploitation and victimisation, as described below.

4.3.1. Prostitution

Prostitution seems to be both a consequence of and a pathway into drug misuse for women. The EMCDDA has pointed out that female drug users, particularly those on heroin, are often involved in prostitution, but it is not always clear drug use leads to prostitution or vice versa (EMCDDA, 2006). Some commentators have speculated that the high price of illicit drugs encourages some drug users into providing sex for money or sex for drugs to support their habit (Cassin & O'Mahony, 2006, Woods, 1999). Research carried out in Ireland has found that the majority of women drug users working in prostitution report becoming involved for economic reasons, in order to 'make money for drugs' (Cox & Whitaker, 2009, O'Neill & O'Connor, 1999). Research has also found that female drug users in prostitution were younger, neglected their health more and were less likely to use medical services than non-drug using women working in prostitution; overall, the researchers described women drug users working in prostitution as 'a marginalised group within a marginalised group' (O'Neill & O'Connor, 1999). Research has also identified drug and alcohol use as a survival mechanism for women working in prostitution. An Irish study found that women reported habitually getting drunk or stoned or using prescription drugs in order to work, using drugs and alcohol to numb the pain of prostitution (TSA Consultancy, 2005). Recent research published by the NACD found that although women's drug use enabled them to minimize the distress associated with the work and to work longer hours, working while 'stoned' increased the risk of engaging in unprotected sex and of being unable to assess the potential dangers of a situation (Cox & Whitaker, 2009).

4.3.2. Vulnerability to assault/victimisation

High rates of victimisation have been found among substance misusing women (Cormier et al., 2004). The EMCDDA has pointed out that drug-facilitated sexual assaults are most easily perpetrated against women whose drug and alcohol use make them particularly vulnerable (EMCDDA, 2008b). The use of central nervous system depressants, in particular, has been linked with vulnerability to sexual assault; this category of drugs includes alcohol and benzodiazepines (such as flunitrazepam or Rohypnol). However, recreational drugs such as ecstasy, amphetamine, cocaine and ketamine can also be disinhibiting and if taken with alcohol can cause drowsiness and loss of consciousness which can leave women in a vulnerable position (EMCDDA, 2008b). In any discussion of sexual assault, however, it is crucial to note that while substance misuse can increase a woman's vulnerability, this

should not deflect attention or blame from the perpetrator, suggest that the perpetrator's responsibility for the assault is reduced in any way, or suggest that the woman is somehow to blame for the attack.

4.4. Effects of others' drug misuse on women – the burden of care

As the Women's Health Council pointed out in *Promoting women's health; A population investment for Ireland's future*, although more women are now taking part in the paid labour force, women are still primarily responsible for providing care to the members of their families and others in their communities (Women's Health Council, 2002). This means that, for the most part, it is women who assume responsibility for the care and management of substance misusers in the family. This can place women at risk of violent and abusive behaviours, and it can also mean that they have to assume sole financial responsibility for the family. The negative implications for the physical and mental health of women in these situations are clear.

A study of workers in the drug treatment and social work fields in Dublin highlighted the fact that when there is a need to find alternative care arrangements or support for a woman drug user or her children, it is other women within the kinship system – aunts, sisters, mothers and grandmothers – who are called upon (Woods, 1999). The same holds true for male drug users; the vast majority of those interviewed for NACD's research on the experiences of families seeking support in coping with heroin use were parents, specifically drug users' mothers (Duggan, 2007). Thus when the Government noted in the National Drugs Strategy 2001-2008 that the families of problem drug users 'have the potential to be key to the rehabilitative effort', and are 'a valuable resource in terms of childcare' (Department of Community Rural and Gaeltacht Affairs, 2007), the gender dimension of these policy statements should be highlighted. In practice, it is usually the drug user's mother, wife, girlfriend, sister, aunt, or grandmother who will provide this care and support, in most cases at some cost to her own health and well-being.

4.5. Drug related crime

The EMCDDA has found that in most countries, women commit between 9% and 15% of drug law offences and that they make up between 2% and 8% of the prison population of Europe (EMCDDA, 2006). In 2004, 6757 people were prosecuted for drug offences in Ireland, of whom 500 (7.4%) were women (Connolly, 2006). The overall number of women prosecuted for drug offences each year has remained stable since 1998.

Crime and drug use are inextricably linked. An early study of Irish drug users found that 51% of the sample had been convicted of a crime, with drug-related non-violent crimes (e.g. stealing, housebreaking, vandalism, forging cheques, obtaining things by false pretences) contributing most to the increase in criminality subsequent to drug misuse (Carr et al., 1980). Similarly to British research which found that women prisoners and ex-prisoners most often reported becoming involved in crime to fund a drug habit (Roberts & Vromen, 2005), an exploratory study of drug use among Irish prisoners found that women were more likely to have become involved in crime after they started misusing drugs (Dillon, 2001). Men in the same study were more likely to have been involved in crime prior to their drug use.

The types of crime drug misusing women become involved in are often different to those of their male counterparts. The ROSIE study found that among its participants, women were more likely than men to have committed an acquisitive crime (e.g. shoplifting), while men were more likely to be involved in drug dealing (Cox et al., 2008). A study of women on remand in the Dochas Centre in Mountjoy Prison, Dublin, found that the most common crimes committed by women were drug possession, theft from a shop and handling stolen goods (Comiskey et al., 2006). In a related dimension, a study of the prison population of Ireland published in 2000 found that 51% of male and 69% of female prisoners reported being under the influence of drugs when they committed the offence for which they were serving a sentence (Hannon et al., 2000).

5. Treatment Services in Ireland

5.1. Accessing treatment

There are a number of interesting differences between men and women accessing drug treatment services. Women do not misuse drugs at the same rate as men, but it has been found that they present for treatment earlier than their male counterparts (O'Brien & Dillon, 2001). Among users of opiates, it has been found that women request treatment one and a half to two years earlier in their drug career than men (EMCDDA, 2006), and that women overall tend to present for treatment at a younger age than men (O'Brien & Dillon, 2001, Geoghegan et al., 1999). European figures have shown that new female clients needing treatment for opioids and cocaine use are on average two years younger, and for stimulants are four years younger than their male counterparts. The reasons for this are not completely clear, but it might be that women progress more rapidly to a level of problems with drugs that lead them to treatment or that they are directed to treatment by their social environment more rapidly than males (EMCDDA, 2006, Cox et al., 2008). It should be noted, however, that male and female clients generally access treatment for cannabis use at roughly the same age, and women requesting treatment for the use of hypnotics, sedatives or hallucinogens tend to be on average older than their male counterparts (EMCDDA, 2006), perhaps reflecting the overall age-related trends for use of these drugs.

One further noteworthy gender difference in use of drug treatment services is the finding that men are more likely to have been sent for treatment by police and the criminal justice system than women (22.2% of males vs. 10.6% of females). Women are more likely to have accessed treatment through health and social services - 36% of females seek treatment through health or social services, general practitioners or other drug treatment centres compared to 27% of males (EMCDDA, 2006).

5.2. Treatment options

Treatment for drug misuse in Ireland is provided by both statutory and non-statutory services, and in a range of settings including residential centres, community-based addiction services, GP services and within prisons. Public clinics are usually based in community health centres or local health offices, and addiction counselling is offered in many day hospitals. Community care services also offer therapy for families, couples and groups, as well as the individuals affected. Private treatment services, run by charities and private limited companies, are also available. Referrals to most residential programmes can come from a doctor, social worker, the courts and probation services, community nurses or workplaces, and costs for some private programmes are covered by the GMS or social welfare payments.

Although some services exist which provide treatment for drug misuse alone, for the most part treatment services deal with both alcohol and drug misuse (Health Promotion Unit, 2006). This is particularly the case in areas outside Dublin (Carew et al., 2009) where services are more likely to be integrated. Within Dublin, services are slightly more fragmented with

a small proportion of services offering treatment for alcohol alone or drug misuse alone, although a few services offer treatment for the misuse of alcohol and/or prescription drugs. There is a wide variation in the numbers and types of treatment services across the country, with the greatest concentration of services in Dublin, as might be expected given its greater population density. A directory of drug and alcohol services published by the Health Promotion Unit in 2006 listed forty-two drug and alcohol treatment services for Dublin (not including HSE satellite clinics), whereas there were no dedicated services available in Leitrim (clients had to travel to Sligo town), Offaly (travel to Port Laoise) or Cavan (travel to Monaghan or Sligo) (Health Promotion Unit, 2006).

A four tier model of drug treatment service provision was recommended by the Working Group on Treatment of under 18-year-olds presenting to Treatment Services with Serious Drug Problems (Department of Health & Children & HSE, 2005), and was also endorsed to by the HSE Working Group on Residential Treatment & Rehabilitation (Corrigan & O'Gorman, 2007). Under this model, tier one services are aimed at those starting to experiment with drugs or alcohol and consist of drug-related information and advice, screening and referral to specialised drug treatment services. They are provided in general healthcare settings, education, social care or in criminal justice settings. Tier two services are provided for people with problems resulting from drug or alcohol misuse and include drug-related prevention, brief intervention, counselling, and harm reduction delivered through outreach, primary care, pharmacies, criminal justice settings, and community- or hospital-based specialist drug treatment services. Tier three services are for those experiencing substantial problems as a result of drug or alcohol use and are mainly delivered in specialised structured community addiction services as above, as well as in primary care settings such as Level 1 or Level 2 GPs, pharmacies, prisons, and the probation service. Services consist of community based specialised drug assessment and coordinated, care-planned treatment including psychotherapeutic interventions, methadone maintenance, detoxification and day care. Finally, tier four services, for those experiencing severe problems as a result of drug or alcohol misuse, consist of intensive interventions through day or inpatient hospitals, including residential specialised drug treatment in dedicated inpatient or residential units/wards, or in general psychiatric wards. Continuity of care and aftercare is important and it is recommended that treatment services be linked to residential rehabilitation units and halfway house accommodation (Corrigan & O'Gorman, 2007)³.

According to official figures, the majority of the 68,754 cases treated between 2001 and 2006 attended outpatient services (68%) (Reynolds et al., 2008). Gender differences have been noted in the setting for drug treatment; men are more likely to receive treatment at residential or low-threshold services, while women are more likely to present to non-residential or GP services for treatment (O'Brien & Dillon, 2001)⁴. This may be partly due to the

³ Personal communication from Ms Alice O'Flynn, Care Group Manager—Social Inclusion, HSE, 20th April 2009.

⁴ It should be noted that the response to people who misuse drugs by GPs/primary care teams will be similar to that of any other primary care patient; they will be treated on an equal footing and not segregated or discriminated against in any way.

fact that residential services are generally more focused towards men (Corrigan & O'Gorman, 2007). Currently there is only one residential treatment centre in Ireland that incorporates childcare facilities. Ashleigh House, run by the Coolmine Therapeutic Community, is a residential rehabilitation service for women that offers 'family places' for children, and includes a qualified childcare worker on staff, play areas for children, and parenting support. It was successfully piloted in 2008, and at the time of writing had one woman and her pre-school child in treatment.⁵ However, women may also have a preference for treatment in non-residential settings due to their childcare responsibilities; female drug treatment clients are far more likely to be living with children than their male counterparts (EMCDDA, 2005).

Drug treatment options include medication (detoxification, methadone reduction, substitution programmes and psychiatric treatment), brief intervention, counselling, group therapy, family therapy, psychotherapy, complementary therapy, and/or life-skills training (Department of Community Rural and Gaeltacht Affairs, 2007, Reynolds et al., 2008). A combination of methods is usually used as the most effective way to treat drug misuse. In 2006, 51% of people entering treatment for problem drug use received counselling, 39% received methadone substitution, 17% received a brief intervention, 14% attended medication-free therapy and 36% received more than one initial treatment intervention (Reynolds et al., 2008).

5.3. Particular needs of women

...sex differences and gender influences affect women's and men's use of and response to substance use, and their treatment needs are correspondingly different (Poole & Dell, 2005).

In their study of adolescent opiate users, Fagan et al noted that complete abstinence may not be the sole aim; rather users may be 'seeking relief from the overall chaos and instability in their lives' (2008:50). The same may be true for women who misuse drugs; therefore it is useful to note that the researchers recommended that treatment services be flexible and multidisciplinary in nature, and that they should be able to use a range of bio-psycho-social interventions to help treat and stabilize drug users (Fagan et al., 2008). Since women and men can have quite different experiences and issues around drug misuse, a gendered approach to treatment must be adopted so that women's and men's needs are dealt with in the most appropriate manner possible. As emotional and relational reasons are often at the crux of women's misuse of drugs, services for women may require an increased emphasis on care and support (Poole & Dell, 2005, National Center on Addiction & Substance Abuse, 2003).

⁵ Personal communication from Mr. David Madden, Manager of Coolmine Therapeutic Community Ashleigh House, 23rd April 2009.

An important issue that has been identified regarding treatment services for women is the fragmented nature of service provision. The need for integrated services during pregnancy has already been mentioned above, but this holds true for all drug misusing women, who often have a multiplicity of needs rather than just one problem. Drug using women working in prostitution, for example, have been found to 'move more or less continuously through social, mental health and healthcare agencies, homeless hostels, drug and alcohol services and the prison system' (Cox & Whitaker, 2009). Research has concluded that, in order to prevent women being lost through loopholes in the system, there is a need for greater co-operation, collaboration and communication between agencies providing services (Comiskey et al., 2006). Treatment programmes often do not provide women who misuse drugs with the full range of services they may need, including prenatal and gynecological care, contraceptive counselling, childcare, job training, advice and support around housing, and counselling for sexual and physical abuse. Given the chaotic nature of the lives of those misusing drugs, and the problems this creates around connecting with services, it is important that services are co-ordinated to avoid presenting women with a confusing array of appointments and services and losing them from the system entirely (Keen & Alison, 2001).

In providing services, greater awareness is needed of the gender-specific issues that can lead to substance misuse, and it is essential that a gendered approach is taken in all services provided. Staff must be aware of the particular pathways and background factors that lead to women misusing drugs, so that their needs can be fully addressed. In some cases providing female counsellors and other workers may be helpful as many women substance users have previously experienced problems with men (Painter et al., 2000, UNODC, 2004). Support groups and one-to-one counselling have also been suggested as methods which particularly appeal to women and encourage them to attend treatment services (Farrell, 2001, EMCDDA, 2006).

Two areas have been identified as being particularly important in ensuring that women's needs are adequately provided for by treatment services.

5.3.1. Childcare

Research has found that entering treatment may be more problematic for drug using women than for men. This is both because women often experience a greater stigma attached to their drug use, but also because women are more often responsible for children than their male counterparts (Poole & Dell, 2005, EMCDDA, 2005, EMCDDA, 2006, Painter et al., 2000, Cox et al., 2008). In Ireland, women users are more likely to be lone parents (Farrell, 2001). A study of workers in the drug treatment and social work fields in Dublin found that those interviewed said that it was rare to meet a woman drug user who was not a mother – the vast majority female drug users accessing social work and drug treatment services had children (Woods, 1999).

Being responsible for children can mean that it is difficult for women to attend for treatment (UNODC, 2004). Studies in Ireland have found that while parents (mostly women) often wanted to take active steps to address their drug use, they were unable to do so as they did not have access to regular childminding arrangements (Moran, 1999, Butler & Woods, 1992). Women may also be reluctant to attend for treatment as they fear that their drug misuse may cause them to be labelled 'unfit mothers' and that their children will be taken into care as a result (Butler & Woods, 1992, Farrell, 2001, Bell & Harvey-Dodds, 2008, Painter et al., 2000, Hedrich, 2000, UNODC, 2004).

However, it has also been suggested that having children, and particularly becoming pregnant, may be an important reason that women decide to attend for treatment (Bell & Harvey-Dodds, 2008, Whittaker, 2003, EMCDDA, 2006). It is therefore extremely important that treatment services are made accessible to women by taking their childcare needs into account. Crèche facilities are essential, as they encourage women to attend for treatment by providing for women's practical childcare needs, but also by signalling the service's acceptance of women's situations (Moran, 1999). Both drop-in and full-day crèches are needed so that women can participate in all types of treatment (including more intensive treatment and rehabilitation) and to facilitate access to training and employment opportunities (Moran, 1999, Woods, 1999).

Action 54 of the National Drugs Strategy called on the Health Service Executive to consider, as a matter of priority, how best to integrate childcare facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting (Department of Tourism Sport & Recreation, 2001). In addition, the Working Group on Drugs Rehabilitation identified the lack of childcare services as a significant barrier to accessing treatment for women and reported that drugs-related services, including residential services, should have access to an appropriate level of childcare services and facilities. It therefore recommended that the HSE, in conjunction with the Office of the Minister for Children, should decide on how best to integrate childcare facilities with treatment and rehabilitation services and subsequently progress the matter (Department of Community Rural and Gaeltacht Affairs, 2007). The report of the HSE Working Group on Residential Treatment & Rehabilitation did not refer to providing childcare as part of rehabilitation services; it recommended the investigation of "innovative approaches such as providing the necessary supports so that family members can act as short-term foster parents" (Corrigan & O'Gorman, 2007).

5.3.2. Pregnant drug users

Across Europe, pregnant drug users are defined as a priority group and are given preferential access to drug treatment (EMCDDA, 2006). However, chaotic lifestyle and fear of stigma can often mean that these women do not attend for antenatal care as frequently or as early as is recommended. For these and related reasons, a specialist Drug Liaison Midwife (DLM) service was established in 1999 in Ireland, to liaise between the three Dublin maternity hospitals and drug treatment services (Scully et al., 2004, Scully et al., 2001). The DLM provides support to the women around their drug use and their general health, and can refer women to social services, local genito-urinary infectious diseases clinic or hepatology clinic, if they are HIV or Hepatitis C positive. In 2007, a total of 96 women were referred to the HSE Dublin Mid-Leinster Drug Liaison Midwife (Coombe Women & Infants University Hospital, 2008). Seventy-eight of these women delivered 79 babies (one set of twins) in the Coombe Women & Infants University Hospital, of whom 76 were live births. Of the 76 live babies, 46% had to be admitted to the Special Care Baby Unit and 30% needed treatment for NAS (neonatal abstinence syndrome). 36% of the women attending the Drug Liaison Midwife were Hepatitis C positive and 8% were HIV positive, with one new diagnosis made from booking bloods. The Drug Liaison Midwife service was found to help lessen the stigma for drug-misusing women, and improved the relationships between the women and the obstetric and drug services (Scully et al., 2004, Scully et al., 2001). However, it is important to highlight that the services provided to pregnant drug misusers often do not continue beyond the birth, effectively leaving such women, who may be in a heightened state of vulnerability after the birth, and their babies without specialist support (Keen & Alison, 2001). Services to drug misusing mothers need to be continued beyond birth to ensure the best possible outcome for both the mother and her child(ren).

6. Drug Misuse Strategy & Legislation in Ireland

6.1. Drug misuse strategy

Ireland's most recent national strategy on drugs, *Building on experience: National Drugs Strategy 2001-2008*, was published in 2001 by the Department of Tourism, Sport and Recreation. The Department of Community, Rural and Gaeltacht Affairs currently has responsibility for co-ordinating the implementation of the National Drugs Strategy, and a number of structures also exist to implement and deliver the National Drugs Strategy. These are the National Advisory Committee on Drugs (NACD); the National Drugs Strategy Team, made up of members from government departments and agencies involved in the drugs field as well as representatives from the community and voluntary sectors; the Regional Drugs Task Force; and the Local Drugs Task Forces.

Four areas were highlighted in the Strategy as being crucial in any attempt to address the problem of drug misuse:

1. Reduction in the supply of drugs. The main work in this area is carried out by the Department of Justice, Equality & Law Reform, the Gardaí, the courts, the prisons service, and the Probation and Welfare services. A Dial to Stop Drug Dealing scheme has also been developed, to provide a confidential and anonymous way for people to pass on information on drug dealing in their community.
2. Prevention of drug use. This heading covers education and awareness programmes provided by the Health Promotion Unit of the Department of Health & Children, awareness and education programmes run in schools by the Department of Education and Science, and education programmes run by the Gardaí and Local Drugs Task Forces in schools and the community.
3. Drug treatment, covering rehabilitation and risk reduction. Addiction counselling, detoxification programmes and methadone treatment programmes are essential components of this area, as well as the services provided in prisons for drug misusers. Fas also runs programmes aimed at helping reformed drug users get back into the workforce.
4. Research. As included above, the NACD produces a variety of research on the area and advises the the government on drugs policy issues, while the Alcohol and Drug Research Unit of the HRB oversees the National Drug Treatment Reporting System and National Drug Related Deaths Index, and also produces a range of research on drug use and drug-related issues.

Several documents have been produced since the Strategy was published, including a report on implementing the Strategy (Department of Community Rural and Gaeltacht Affairs, 2004), a progress report (Department of Community Rural and Gaeltacht Affairs, 2005b), a mid-term review which looked at progress and added eight new actions (Department of Community Rural and Gaeltacht Affairs, 2005a), and a report examining the area of rehabilitation carried out under the auspices of the Strategy (Department of Community Rural and Gaeltacht Affairs, 2007).

An important point to note about the Strategy is that, unlike its predecessors, it focused exclusively on 'problem drugs' – opiates – and did not address substances such as alcohol, prescription drugs and over-the-counter drugs (Pike, 2008). This meant that its recommendations, in common with those in the second report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, focused on young people living in disadvantaged areas and groups vulnerable to drug misuse such as prisoners (Ministerial Task Force, 1997). Viewed through a gendered lens, this approach gives rise to obvious concerns for women, as it effectively ignores areas where women's drug misuse has been found to be higher than men's.

A wide-ranging consultation process on the National Drugs Strategy 2009-2016 was held during 2008, and the new strategy is due to be published in 2009⁶.

6.2. Drug misuse legislation

The main legislation for bringing criminal charges for drugs offences is the Misuse of Drugs Act 1977 and the Misuse of Drugs Act 1984 (Citizens Information, 2008). These were introduced in direct response to the rising level of opiate use - Dublin's 'opiate epidemic' – in the late 1970s and early 1980s (Dean et al., 1987). Together with the Misuse of Drugs Regulations 1988, the legislation puts controls on cultivation, licensing, possession, administration, supply, record-keeping, prescription-writing, destruction and safe custody of drugs (European Legal Database on Drugs, 2004). The Misuse of Drugs Acts have been further added to and amended by the Criminal Justice Acts 1984, 1996, 1999, 2006 and 2007.

The main drug offences under which criminal charges are brought are possession of controlled drugs, and possession of controlled drugs for the purposes of supply. It is also illegal to grow cannabis plants or opium poppies, to forge or fraudulently alter a prescription, and to attempt to commit an offence covered by the legislation or to help someone else commit an offence. It is also illegal to occupy or control any land, vehicle or vessel which is used for activities such as the manufacture, importation or supply of a controlled drug.

The penalties for drugs offences most commonly consist of fines and/or imprisonment, with the size of the fine and length of sentence related to the severity of the offence. In some cases, however, rather than imposing a prison sentence or fine, the Court can order a person to undergo treatment for drug misuse, and can also order him/her to complete an education or training course to improve job prospects, facilitate social rehabilitation or reduce the likelihood of him/her committing further drugs offences. It can also order a person to be detained in a specialised custodial treatment centre (Citizens Information, 2008).

⁶ Personal communication, Department of Health & Children, 06.04.09.

7. Conclusions/Recommendations

It is clear from the research that drug misuse is an issue for women, albeit in different ways and for a smaller proportion of women compared to men. Although, as for alcohol, the gender gap may be closing for younger women, research indicates that overall women have different patterns of drug misuse than men - of particular note here is the concentration of women among misusers of prescription drugs. Women's pathways into drug misuse are also distinct from those of men, and their social circumstances appear to be particularly disadvantaged when compared to those of their male counterparts. For these reasons, the Council has put forward the following recommendations regarding women and drug misuse.

7.1. Gender sensitive policy

'It is now accepted that understanding gender differences in drug-related behaviours is a critical requirement for developing effective responses' (EMCDDA, 2006:21)

After examining the research, the Women's Health Council has concluded that any policy or strategy being developed in the area of drug misuse must pay attention to gender. It is clear that drug misuse affects women and men in distinct ways. A gendered policy/strategy response is therefore essential in order to address the gender differences in patterns, types and pathways into of drug misuse. In addition, in order to fully address the circumstances of drug misuse among women, it is essential that the misuse of prescription drugs is included in policy/strategy, and that prescribing patterns are also reviewed in this regard. When making recommendations around treatment and rehabilitation, the gender dimension of caring for drug users – particularly where it is proposed to use drug users' families in the rehabilitation effort - should be recognised. Given the increasing polysubstance use problems coming to light, the WHC supports the recent decision by Government to integrate alcohol and drug misuse in a single policy/strategy on substance misuse.

Recommendation 1: The Women's Health Council recommends that gender should be integrated into the core of any new National Drugs or Substance Misuse Strategy being developed.

7.2. Improving women's access to services

Research has indicated that women who misuse drugs experience particular barriers to accessing treatment, central to which is childcare. Women are more likely to be the primary carers for children than their male counterparts and therefore often prioritise their children's care over their own need for treatment. Women are also more likely to be in a long-term relationship with a drug user than their male counterparts, which may mean that they lack partner support for presenting to and remaining in treatment (Hedrich, 2000). The

increased stigma attached to being a woman and misusing drugs is also an important factor to consider, particularly where women fear that their children will be taken away if drug misuse is disclosed. It has been found that crèche facilities encourage women to attend for treatment, both by providing for women's practical childcare needs, but also by signalling services acceptance of women's situations (Moran, 1999). It is therefore extremely important that drugs-related services, including residential services, should have access to childcare services and facilities.

Recommendation 2: The Women's Health Council recommends that, in line with the recommendations made in the National Drugs Strategy 2001-2008 and the Report of the Working Group on Drugs Rehabilitation, the HSE should develop and implement a strategy to provide childcare facilities as part of treatment and rehabilitation services as a matter of priority.

An important issue that has been identified regarding treatment services for women is the fragmented nature of service provision. Given the chaotic nature of the lives of those with substance misuse issues, and the problems this creates around connecting with services, it is important that services are co-ordinated to avoid presenting women with a confusing array of appointments and services and losing them from the system entirely (Keen & Alison, 2001). Although the need for integrated services during pregnancy has been highlighted, the same need holds true for all substance-misusing women. In this regard, it is important to note that the services provided to pregnant drug misusers often do not continue beyond the birth, effectively leaving such women, who may be in a heightened state of vulnerability after the birth, and their babies without specialist support. Services to drug misusing mothers need to be continued beyond birth to ensure the best possible outcome for both the mother and her child(ren). In addition, in order to prevent women being lost through loopholes in the system, there is a need for greater co-operation, collaboration and communication between agencies providing services (Comiskey et al., 2006).

In designing services for substance misusers, it is important to note that women's needs may be quite different to men's, and as such services may need to respond differently to both. As emotional and relational reasons are often at the crux of women's misuse of drugs and/or alcohol, services for women may require an increased emphasis on care and support (Poole & Dell, 2005, National Center on Addiction & Substance Abuse, 2003). Female support groups and one-to-one counselling have been suggested as methods of encouraging women to attend treatment services (Farrell, 2001, EMCDDA, 2006), and providing female counsellors and other workers may also be helpful as many women substance users have previously experienced problems with men including sexual abuse and violence (Painter et al., 2000, UNODC, 2004).

Recommendation 3: The Women's Health Council recommends the development and implementation of integrated substance misuse treatment and support services that take gender into account.

7.3. Area of particular concern: Prescription drug misuse

Given the higher rate at which women both use and are prescribed tranquillisers or sedatives and anti-depressants in Ireland, it is essential that women are fully informed about the properties of the drugs and their potential negative effects. It is particularly important that women are made aware of the fact that benzodiazepines, often in conjunction with an illicit substance, have been implicated in more deaths than any other drug. In November 2008, the HSE ran a health promotion campaign to mark European Antibiotic Awareness Day, to emphasise the importance of taking antibiotics only when they are really needed. A similar campaign should be developed to address prescription rates to and use of tranquillisers or sedatives, and anti-depressants among women.

Recommendation 4: The Women's Health Council recommends that a health campaign should be developed and run to address rates of prescription and use of prescription drugs (tranquillisers/sedatives and anti-depressants) among women.

Much research has already been carried out in Ireland covering the area of drug misuse, particularly by the HRB and the NACD, and all data currently being recorded by the HRB and NACD is disaggregated by gender. However, more research is needed on the area of misuse of prescription drugs in order to fully understand women's drug misuse. Although the NACD has recently published data on the prevalence of tranquilliser/sedative/anti-depressant use in Ireland, it would be useful to set such figures in the context of women's lives, and to examine prescribing patterns for these drugs.

Recommendation 5: The Women's Health Council recommends conducting detailed gender specific research on the prescribing and use of prescription drugs such as tranquillisers/sedatives and anti-depressants in Ireland.

7.4. Health Promotion

The Women's Health Council believes it is essential that women are educated about the gender differences associated with drug misuse use, particularly the finding that women are susceptible to more negative health consequences at lower levels of drug misuse than men. Such education should also include information on the effects of drug use during pregnancy. Education initiatives should be targeted at school aged children and young women, as age of initiation can be key in determining the outcomes for women's lives and health. It is also important that parents are educated and aware about the particularly important role they can play in influencing their daughters' behaviour around drugs and alcohol. Innovative approaches to conveying the information to adults will need to be developed, perhaps in community settings.

Recommendation 6: The Women's Health Council recommends that education on the particular effects of drug misuse for women should be included in the SPHE programme, as well as in education programmes for community settings.

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The **Women's Health Council**
Comhairle Sbláinte na mBan



Block D, Irish Life Centre
Abbey Street Lwr, Dublin 1

Phone: +353 1 878 3777

Fax: +353 1 878 3710

Email: info@whc.ie

www.whc.ie