

**Towards gender-sensitive prevention and treatment for  
female substance users in Belgium**

**Naar gender-sensitieve preventie en hulpverlening voor  
vrouwelijke middelengebruikers in België**

**Vers un traitement et une prévention sensible au genre pour  
femmes toxicomanes et alcooliques en Belgique**

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## LIST OF ABBREVIATIONS

ADIC: Antwerps Drug Interventie Centrum  
AIDS: Acquired Immune Deficiency Syndrome  
BHIS: Belgian Health Interview Survey  
BMC Medical Education: Bio Med Central Medical Education  
BP: Behandelprogramma  
CAD: Centrum voor Alcohol en andere Drugproblemen  
CGG: Centrum Geestelijke Gezondheidszorg  
CKG: Centrum voor Kinderzorg en Gezinsondersteuning  
DAWN: Drugs and Alcohol network  
EMCDDA: European Monitoring Centre for Drugs and Drug Addiction  
EU: European Union  
FEDITO: FEDération bruxelloise francophone des Institutions pour TOxicomanes  
FORT: Feministische Oefengroepen Radikale Therapie  
GDS: Global Drug Survey  
GTA: Grand Theft Auto  
HBV: Hepatitis B  
HCV: Hepatitis C  
HIV: Human Immunodeficiency Virus  
IAS: International AIDS Society  
IDU: Injecting Drug User  
KDO: Project Kinderen en Drugverslaafde Ouders  
KiDO: Kinderen van Druggebruikende Ouders  
KOAP: Kinderen van Ouders met een Alcoholprobleem  
KOPP: Kinderen van Ouders met Psychische Problemen  
MaPa: Opvoedingsondersteuning voor druggebruikende ouders  
MASS: Maison d'Accueil Socio-Sanitaire  
MSOC: Medisch Sociaal Opvangcentrum  
NFP: National Focal Point  
NIAAA: National Institute on Alcohol Abuse and Alcoholism  
NPS: New Psychoactive Substance  
PONDO: Perinataal ONdersteuningsnetwerk voor Druggebruikende Ouders  
OP+: Ontwenningprogramma voor druggebruikende ouders en hun kinderen  
OST: Opioid Substitution Therapy  
PTSD: Post-Traumatic Stress Disorder  
REITOX: Réseau Européen d'Information sur les Drogues et les Toxicomanies  
TC / TG: Therapeutic Community / Therapeutische Gemeenschap  
TDI: Treatment Demand Indicator  
UNDOC: United Nations Office on Drugs and Crime  
UNICRI: United Nations Interregional Crime and Justice Research Institute  
UZ: Universitair Ziekenhuis  
VAD: Vlaams expertisecentrum Alcohol en andere Drugs  
WHO: World Health Organization  
WIV-ISP: Wetenschappelijk Instituut Volksgezondheid - Institut scientifique de Santé Publique

## CHAPTER 1

# INTRODUCTION

*Julie Schamp, Griet Roets, Wouter Vanderplasschen*

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The basic arguments for distinguishing women's health practice, policy and research from generic or mainstream health practices, policy and research rest on increasing evidence of the pertinence of sex and gender in determining human health (Olfiffe & Greaves, 2011; Wizemann & Pardue, 2001). It issues a call for not only including gender in services across the continuum of care (Mrazek & Haggerty, 1994), but to include gender in thoughtful and transformative ways as well, so that gendered norms are changed for the better and health is improved for both men and women (Greaves et al., 2014).

### 1 Gender differences in substance use

Significant gender differences have been reported worldwide regarding the use and abuse of alcohol, prescription drugs and illicit substances (Back et al., 2010; Tang et al., 2012; Van Havere et al., 2009). For example, men and women tend to progress differently from first use to dependence and recovery (Tang et al., 2012). Regarding treatment, women tend to enter treatment with more severe substance abuse problems, including more physical, psychological, family and socio-economic problems (De Wilde, 2006; Kissin et al., 2014). Once in treatment they tend to do as well as men, or even better (International Narcotics Control Board, 2017), regarding treatment retention, completion and outcomes, although several predictors of poor treatment outcomes (e.g. unemployment, history of victimization, psychological distress) are more common among women (Greenfield et al., 2007).

Abundant evidence suggests that women are underrepresented in alcohol and drug demand reduction services (Greenfield et al., 2007). Treatment demand data show that men clearly outnumber women in alcohol and drug services ('gender gap'), although the male-to-female gender ratio differs between countries and treatment modalities and according to the primary substance of abuse (e.g. relatively more women contact treatment due to problems with alcohol and stimulant substances) (De Donder, 2014; Montanari et al., 2011). Previous research has shown that the underrepresentation of female substance users is particularly high in long-term residential services (e.g. therapeutic communities) (De Wilde, 2006; EMCDDA, 2006). Moreover, it is assumed that the number of female problem users in the population does not correspond with the proportion of women in alcohol and drug treatment, especially among women in the childbearing age (Montanari et al., 2011).

Gender aspects have mainly been studied and discussed in relation to treatment, while this phenomenon is scantily documented in prevention, harm reduction and other demand reduction services along the continuum of care (Mrazek & Haggerty, 1994). Moreover, women's perceptions regarding the gender gap in alcohol and drug demand reduction services are poorly documented and tend to differ greatly on contextual factors like the accessibility and availability of services (Montanari et al., 2011). Treatment entry may be complicated by various complex socio-cultural (e.g. social stigma) and socio-economic factors (e.g. poverty, educational attainment, social support), as well as system barriers like the accessibility and affordability of services, opening hours and absence of childcare. Also, provider- and clinical-level factors that help or hinder the process of connecting female substance users to substance related care are described. For example, primary care givers often fail to prioritize substance use to other comorbid health concerns, perceive a lack of coordination among primary care and mental health providers, and consider themselves as having insufficient knowledge regarding referring options (Abraham, 2017). Furthermore, gender has often been regarded as a dichotomous determinant of differences in treatment and population samples, whereas it interacts with many other variables like age, ethnicity, social status, etc. (Greenfield et al., 2007). Thus, help-seeking behaviours are profoundly affected not only by emotional and motivational factors, but also by diverse interlocking social factors, such as poverty, lack

of social and family support, immigration status, and loss of child custody (Gueta, 2016). In this regard, LeBel and colleagues argument that offender desistance requires ‘the will and the ways’ (2008, p. 136), referring to the need for internal motivation as well as situational opportunities and highlighting the interrelationship between them. Based on the intersectional nature of barriers and facilitators to treatment, it seems that a comprehensive theory concerning barriers should incorporate the sociocultural dimension by identifying special experiences at the crossroads of multiple marginality (Bowleg, 2012; Hankivsky et al., 2010).

## **2 Towards gender-sensitive initiatives**

The need for gender-sensitive prevention, treatment and harm reduction practices has been acknowledged in the EU Drugs Action Plan since 2005, since most services have been developed “through the lens of managing men, not women” (Ney et al., 2012). During the past decade, several gender-specific initiatives have been launched worldwide to address the needs of female substance users. Most of these are single-gender (women-only) projects, like residential mother-child programmes, women groups, case management for pregnant women, while others are mixed-gender practices which are sensitive to gender-related issues by providing parenting groups/classes or childcare services. As opposed to single-gender projects, mixed gender-sensitive programmes are often less visible and less well-known. Both types of gender-sensitive treatment prove to be effective, but vulnerable populations (e.g. pregnant women, women with double diagnosis, HIV-infected women) tend to benefit more from single-gender programmes (Greenfield et al., 2011). Still, the degree of gender-responsiveness – further called gender-sensitivity – widely varies between programmes and this has been shown to affect treatment outcomes (Kissin et al., 2014).

In Belgium, few empirical studies have focused on gender issues in drug demand reduction, except some studies among specific populations like women in drug-free therapeutic communities (De Wilde, 2006), female recreational substance users (Vander Elst, 2009), female sex workers (Decorte et al., 2012) and drug-addicted mothers in residential treatment (Vanderplasschen et al., 2015). A recent monograph of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) collected women’s voices in studies from all over Europe (2012) and pointed at stigma, parenthood, deprivation and abuse, role identity and self-awareness as key issues in developing gender-sensitive services. Similar themes were identified among women in recovery (Gueta & Addad, 2015; Neale et al., 2014). Recent evidence suggests that an intersectional perspective can inform a shift in policy and practice that brings forward social factors, for example, by rejecting drug policies that punish people of minority and low economic status and embracing cooperative and positive experiences to initiate recovery (Gueta, 2016).

However, the increasing normalization of substance use poses new challenges to the provision of gender-sensitive services, in particular in prevention, early intervention and harm reduction settings.

## **3 Gender-sensitivity: what’s in a word?**

While the term ‘gender-sensitive’ is often used generically (e.g. by the United Nations to address women's basic or special needs), other terms commonly used include women- or gender-responsive, women-focused, and gender-specific; the distinctions are not always clear (Grella, 2008; Tang et al, 2012). In the 1990s, the term ‘gender-responsive’ emerged in the international context of social interventions and institutions to represent the drive to achieve gender equality by consideration of the ways in which gender informs various social processes. The field of substance use treatment has similarly evolved to embody a focus on gender-responsive treatment (Bloom, Owen & Covington, 2003). Grella (2008) describes this progression as a series of paradigm shifts (see Figure 1.1), commencing in the 1960s with a generic treatment model considering the client as male. In the 1970s an increasing sensitivity to the issue of gender with regard to substance use and addiction is noted. This focus on gender differences logically leads in the 1980s to the development of separate treatment programmes for women in order to better address their needs, especially those related to pregnancy and parenting. In the 1990s and 2000s research reporting the effectiveness of women-specific treatment, leads to a

focus on developing gender-responsive treatment approaches that are fully informed by the treatment needs of women, such as trauma, relationships and strengths.

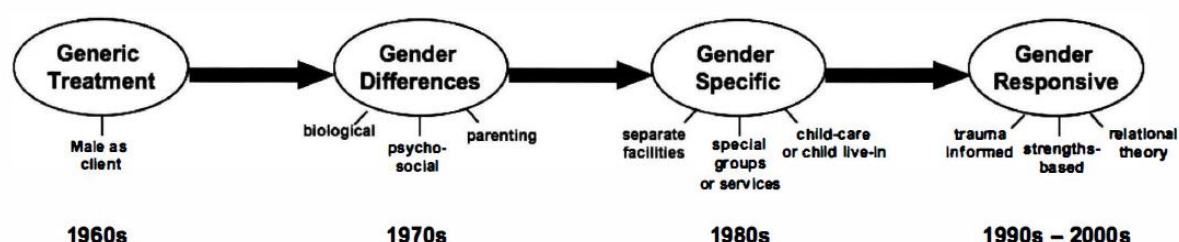


Figure 1.1 Evolving substance use treatment approaches (Grella, 2008).

Taking into account the latter findings, a gender-sensitive approach has been defined as a set of comprehensive, family-focused interventions which are provided in a strengths-based, relational and trauma-informed fashion within a safe and affirming environment (Grella, 2008; Tang et al., 2012). This means that in treatment for women, their context and family should be involved as much as possible. Also, women are to be looked upon as persons in relation to others, rather than as sole individuals. Moreover, treatment should be focused on women's strengths and trauma must be recognized and addressed as a vital part of the recovery of women. Thereby, it is essential that women feel safe and that recovery can be established in a positive and empowering climate.

Similarly in the field of health promotion, Pederson and colleagues (2014) introduce a framework for gender-transformative health promotion that builds on understanding gender as a determinant of health and outlines a continuum of actions to address gender and health (see Figure 1.2). Gender-transformative health promotion activities – a diverse set of communication, organizational, community and political practices that operate at multiple levels (Keleher et al., 2007) – produce health and social outcomes that contribute to gender equity and change gender norms (Kabeer & Subrahmanian, 1996). Several principles of gender-transformative health promotion interventions are identified, such as trauma-informed, empowering, strengths-based, harm-reducing, involving the social context, and a collaborative and relational approach. Taking all into account, these principles of action suggest that gender-transformative health promotion is both an outcome and a process.

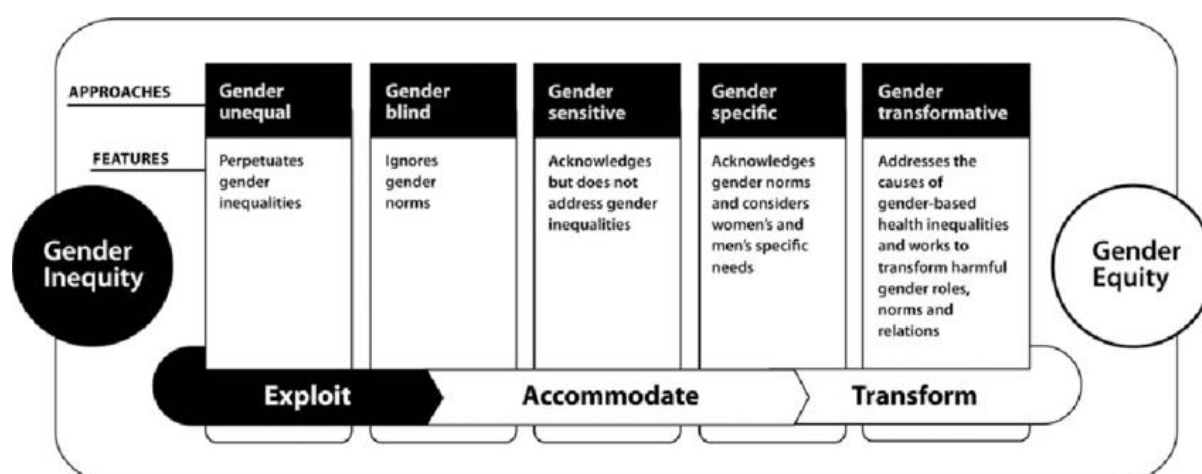


Figure 1.2 A continuum of approaches to action on gender and health (Pederson, Greaves & Poole, 2014 - Inspired by remarks by Geeta Rao Gupta, Ph.D., Director, International Center for Research on Women (ICRW) during her plenary address at the XIIIth International Aids Conference, Durban, South Africa, 12 July 2000: 'To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interactions

should, at the very least, not reinforce damaging gender and sexual stereotypes' (and see also World Health Organization, 2011)).

#### **4 Anti-essentialism as a fundamental base...**

In order to understand gender-sensitivity in alcohol and drug demand reduction services in Belgium, this research will rely on contemporary third wave feminist theory in which anti-essentialism is a central concern (Braidotti, 2013; Grosz, 2005). Prior to the '80's, feminist theorists argued that there were essentialist differences between men and women, and therefore they adhered to the idea that all women shared common and universal experiences and needs resulting from their oppression by men (Braidotti, 2013; Harding, 1986). In the 1980s and 1990s, however, this has led to heated feminist debates and controversies over essentialist claims, and early third-wave feminists rejected these essentialist assumptions (Braidotti, 1991; Butler, 1991; Gatens, 1991, 1996; Grosz, 1994; Haraway, 1991). Inspired by the early work of Simone De Beauvoir (1949), who argued that one is not born, but becomes a woman, anti-essentialist and intersectional notions of femininity were introduced (Braidotti, 2013).

Anti-essentialism implies that the modernist gaze of rationality and progression, resulting in the impossible separation of body and mind and the denial of 'corporeality', is rejected (Price & Shildrick, 1999). The underlying universalistic interpretations of subjectivities, underpinned by biological essentialism, are challenged, and the notion of 'corporeality' – or 'embodied subjectivity' – is introduced (Braidotti, 2013). From the perspective of third-wave feminist theory, rather than reducing the body to an unspoken being in Western societies, the body matters, and not just to women, as 'an open-ended, pliable set of significations, capable of being rewritten, reconstituted, in quite other terms than those which mark it, and consequently capable of re-inscribing the forms of sexed identity' (Grosz, 1994, p. 61). For these feminist theorists, the mind is always embodied or based on corporeal relations, and the body is always social, political and in-process rather than natural, referring to a non-unitary vision of the subject whose mind and body are intrinsically interrelated (Braidotti, 2013). From this point of view, the idea that embodied experiences of women should be seen as part of the household of emotions is challenged and bodily experiences and differences are perceived as being productive. The feminist embodied approach as a new way of knowing women substance users' needs to be established to maintain an anti-oppressive stance in which we complicate as well as theorise the concept of difference (Ettorre, 2015).

#### **5 ... along with an intersectional point of view**

Related to this discussion on anti-essentialism, Campbell and Ettorre (2011) have traced how ideas on addiction and related knowledge-making practices in research and treatment have made the addiction field resistant to awareness of intersectionality – the gendered, classed and racialized power differentials that structure the lives of drug-using women. They use the notion 'epistemologies of ignorance' (Tuana, 2004, 2006), to show that we must be concerned not only with knowledge-making but also ignorance. Indeed, multiple 'epistemologies of ignorance' work along gendered, sexualized, classed and racialized lines to make knowing 'what women substance users need' difficult to discern. There is a real need in the drug and alcohol field to acknowledge the pervasive 'epistemologies of ignorance' that exist.

Intersectionality addresses a central feminist concern about capturing the multiple interacting positionalities and subjectivities of women such as gender, race, class, sexual orientation, health and dis/ability, age, values, culture and individual biography (Connell, 2009; Davis, 2008). Third-wave feminist theory focuses on theorising the multiple subject positions of women, which allows us to engage critically with their subjectivity (Braidotti, 2013). From this point of view, the presumed consensus that we know what is typically good or bad for women is radically challenged, and an explicit focus is placed on the ways in which differences among women and men, and between women can be embraced (Davis, 2008).

From an essentialist point of view, prevention and treatment services have mainly been constructed in ways that women are perceived as radically different from men. The underlying assumption is that women need

specialised and targeted women-only services (Neale et al., 2014). From an anti-essentialist and intersectional point of view, the category of ‘women’ is no longer universally treated as homogeneous in substance use research, and some authors have started to highlight and examine the diverse needs, concerns, experiences and aspirations of women in substance use prevention and treatment services and the ways in which they can be offered the proper support in order to lead a good life (Neale et al., 2014).

## 6 GEN-STAR

This research is the result of a project investigating gender-sensitivity<sup>1</sup> in the field of drug demand reduction in Belgium, commissioned by the Belgian Science Policy (BELSPO) and the Federal Public Service for Health, Food Chain Safety and Environment (FOD Volksgezondheid/SPF Santé Publique).

By combining these theoretical perspectives and various research methods, we aim at providing a state of the art regarding gender-sensitivity in Belgian drug and alcohol services and at providing recommendations to further improve current practices. The overall aim of this study is to assess the availability of and need for gender-sensitive prevention and treatment approaches in Belgium and the obstacles and challenges that are experienced by female users<sup>2</sup> in utilizing these services. The objectives of the study are closely related to the following research questions:

- 1) Which type of single-gender and mixed-gender sensitive programmes are available in Belgium in the area of alcohol and drug demand reduction and what are the main features of these programmes?
- 2) Different terms are used to refer to gender-sensitive interventions, without clear distinction (Tang et al., 2012). How has this been conceptualised in the literature and in other European countries and to what extent can the identified programmes be considered ‘gender-sensitive’?
- 3) What are female substance users’ experiences and perspectives on good practices and barriers regarding alcohol and drug prevention and treatment? Which intersections have they encountered and what trajectories and critical events have they experienced as (un)helpful?
- 4) To what extent are women represented in various demand reduction modalities for alcohol and drug users in Belgium and which related characteristics affect their participation? Is the male-to-female ratio in treatment services comparable to the gender proportion in population and school surveys and among recreational substance users in nightlife settings?
- 5) What type and number of gender-sensitive services are needed to address female users’ needs appropriately along the continuum of care and which are the prerequisites for implementing such services?

To explore these issues more fully, this report is divided into different chapters, starting with an overview of the theoretical background of this study in this introductory chapter. Second, based on an online-survey and semi-structured interviews with programme coordinators, we introduce in detail the gender-sensitive approach in the alcohol and drug demand reduction services in Belgium. The specific gender-sensitive initiatives along the full continuum of care (Mrazek & Haggerty, 1994) and their geographical spread are articulated along with their main features, accomplishments and challenges. In line with the latter, we look at the international landscape of gender-sensitive alcohol and drug prevention and treatment services in the third chapter, without claiming to be exhaustive. Both the EMCDDA best practice portal as well as the Reitox national focal points are consulted to monitor specific interventions for women regarding prevention, harm reduction and treatment. In part four, we examine the male-to-female ratio for various substances in through secondary analysis general and specific population samples in Belgium. Also, gender differences in treatment demand data from various treatment

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<sup>1</sup> Gender refers to the socially constructed characteristics of women and men and is sensitive to different identities that do not necessarily fit into binary male or female sex categories (WHO, 2011). However, in the current research, gender and gender-sensitivity are specifically focused on the needs of women.

<sup>2</sup> The term ‘female users’ throughout the report is defined as women who use(d) or abuse(d) substances. Accordingly, ‘substance use’ covers the use and abuse of substances.

modalities for alcohol and drug users are explored. Next, we explore women's personal accounts of critical life events and experiences with services along the continuum of care through in-depth interviews. In addition, we intend to explore the obstacles and challenges that women experience when contacting alcohol and drug services. These challenges for further developing gender-sensitive alcohol and drug demand reduction services are analysed during discussion groups using the GPS Brainstorm toolkit. A number of points surface throughout this document: diverse levels of assignation of women's responsibility for change; various stigmatizing forces in society at large; and differing levels of knowledge regarding the influence and role of gender in drug demand reduction services. Finally, taking into account the previous findings, we address opportunities in going forward. We conclude with a proposition of potential options for pursuing changes in gender-sensitivity and alcohol and drug prevention and treatment in the wider spheres, and what influences might be shaping ongoing pressures and new opportunities for generating more gender-sensitive alcohol and drug prevention and treatment.

# GENDER-SENSITIVE INITIATIVES FOR FEMALE SUBSTANCE USERS IN BELGIUM

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## 1 Introduction

First, we aim to identify which type of single (women-only) and mixed gender-sensitive programmes are available in Belgium in the area of alcohol and drug demand reduction. In this study gender-sensitivity is measured in single as well as mixed-gender projects, since gender-sensitivity of mainstream alcohol and drug services is an important issue, also highlighted by the EMCDDA (2006). Therefore, the whole continuum of care is respected and prevention initiatives, as well as initiatives in early intervention, harm reduction, treatment and continuing care are included. In the second part of this chapter, the main features, accomplishments and challenges of these gender-sensitive programmes are highlighted.

## 2 Methodology

To identify all initiatives in Flanders, Brussels and the Walloon region that provide women-only services and/or mixed gender-sensitive services, we designed a short online questionnaire. In this survey we asked organisations whether their current way of working includes a gender-sensitive initiative or other specific gender-sensitive measures. Three regional umbrella organisations of alcohol and drug services in Belgium (VAD, Fédito Bxl and Eurotox) contacted all agencies in Flanders, Brussels and the Walloon region via e-mail with an introductory text and a web link to the questionnaire. Approximately 250 agencies were addressed and invited to complete the questionnaire in July and August 2016. 65 agencies completed the questionnaire of which 40 Dutch speaking and 25 French speaking organisations. Ten Dutch speaking organisations and eight French speaking organisations reported having a gender-sensitive initiative in their programme. After assessing the list of initiatives, it appeared that eight organisations offering a gender-sensitive initiative were not included. Consequently, these initiatives were contacted again by the researchers to be included in the research. It appeared that they initially did not receive of the questionnaire.

In order to establish the main features, accomplishments and challenges of the identified initiatives, all organisations offering single or mixed gender-sensitive services were contacted for a semi-structured interview. This interview was based on the information collected in the short online survey mentioned above and on the standardized instrument Tang and colleagues (2012) used in research on treatment for women and men in mixed-gender programmes. This instrument was adapted and integrated in the semi-structured interviews. Integrating a standardized instrument that assesses several aspects like organisational characteristics, physical environment, staff composition and training, women's services, child services, allows us to measure to what extent programmes offer gender-sensitive services in a Belgian context. The interviews were conducted with the project coordinator or the person responsible for the initiative. The content of the interviews focused on seven themes: respondent background, programme structure and philosophy, client/patient admission patterns, children services, staff competencies and training, programme challenges and programme costs. Interviews were performed on-site and took 90 to 120 minutes. A total of 26 interviews were conducted (16 Dutch speaking and 10 French speaking). The data were analysed thematically by the two project researchers according to the semi-structured interview guide. Descriptive analyses of the interview data focus on the type of services that are provided, the specific populations that are addressed and the number of women served in these programmes.

### **3 Mapping and spread of gender-sensitive initiatives for female users in Belgium**

Based on an analysis of the data collected through an online survey, this part of the report provides a general overview and classification of gender-sensitive initiatives in Belgium, followed by a more detailed description of these services and their geographical spread.

#### **3.1 Overview and classification**

Due to the diversity of gender-sensitive initiatives included in the project, and the differences between them, the initiatives are being analysed according to the setting (i.e. outpatient and residential) and according to the continuum of care (i.e. prevention – early intervention / harm reduction / low threshold / treatment – aftercare) (Mrazek & Haggerty, 1994). In Table 2.1 an overview of the gender-sensitive initiatives is provided which are further elaborated in 3.2 (cfr. *Infra*).

Many organisations offer several gender-sensitive services. For example, Centre Alpha offers health promotion actions for women as well as parental support for families with (a) substance abusing parent(s). Psychiatrisch Centrum Dr. Guislain offers a residential treatment programme for men and women, as well as a mixed-gender outpatient aftercare programme. Both programmes offer a women group for both the women in the residential programme as well as the women in the outpatient programme. Clinique Notre-Dame des Anges provides two residential treatment units for women only along with a women group as an outpatient aftercare programme.

Another notable finding is that only three organisations in Belgium report to take preventive actions specifically targeted at women regarding alcohol and drug use. One of which (i.e. the awareness raising parent group organised by CGG Houba Brussel) no longer exists due to an apparent lack of interest and attendance of the target group. Two other preventive gender-sensitive initiatives concern the spreading of informative and preventive folders and posters specifically addressing girls and young women in youth centres and schools or through social media. This might indicate an underreporting of gender-sensitive preventive actions, possibly due to ambiguity regarding the definition and interpretation of gender-sensitive prevention.

Table 2.1 *Gender-sensitive initiatives in Belgium (2016)*

Setting	Continuum of care	Organisation	Type of gender-sensitive initiative
Outpatient	Prevention	Centre Alfa	Women health promotion actions
		CGG Houba Brussel*	Parent group to raise awareness
		Logo Oost-Brabant	Folder 'Illicit substances and pregnancy'
	Early intervention	Centre Alfa	Service Parentalité
		Free Clinic vzw	PROject, Bubbels en Babbels, 'Vrouwenclub' (Activering)
	Harm reduction	Interstices asbl	Service Parentalité-Addiction
		Le Comptoir	Projet Boule de Neige
		MASS Bruxelles asbl	Women group (future)
	Low threshold	MSOC Gent	KDO-project
		MSOC Leuven*	MaPa-project
	Treatment	MSOC Oostende	KiDO-project
		Namur Entraide Sida asbl	Projet Salma
		Start-Mass	Groupe Maternité
	Aftercare	CGG Eclips	Women group
		CGG Vagga Antwerpen*	Women group
		Clinique Notre-Dame des Anges	Women group
		P.C. Dr. Guislain	Women group
		CAD Limburg	Women group
Residential	Treatment	Adic vzw*	OP+ Women group in mixed-gender treatment programme
	Aftercare	Centre de Cure et de Postcure Les Hautes-Fagnes*	Separate building for women, women group, anti-sexist rules, women housework group
		Clinique Notre-Dame des Anges	Two residential women-only units
		Hôpital Psychiatrique du Beau Vallon*	Residential women-only unit
		P.C. Dr. Guislain	Women group
		Psychiatrische Kliniek Alexianen	Groep B
		T.C. De Kiem*	Tipi Women group in mixed-gender treatment programme Umbrella activities with T.C.'s in Flanders
		T.C. De Sleutel*	Evening activity for women Umbrella activities with T.C.'s in Flanders
		T.C. De Spiegel	IRIS (e.g. separate hall for women, women group, female counsellor, women hour, separate living room) Umbrella activities with T.C.'s in Flanders
		T.C. Katarsis	PINK (e.g. women group, women leisure activity) Umbrella activities with T.C.'s in Flanders
		Trempoline	Kangourou Women activities, self-help group, seminars, work sector, life space

\* Added by the project researchers after data collection through an online survey.

### 3.2 Description of the organisations and implemented gender-sensitive initiatives

Adic vzw (Antwerps Drug Interventie Centrum) in Antwerp is a psychosocial rehabilitation centre for problem substance users. Its main goal is to treat these substance users so that they can be reintegrated in society in the most optimal way. Residential treatment, as well as outpatient support is provided. The gender-sensitive initiative of Adic vzw is a detoxification programme of eight to ten weeks for parents and their children (*OP+*, *Ontwenningsprogramma voor druggebruikende ouders en hun kinderen*). *OP+* is accessible/open to four single parent families (maximum six), in particular addicted mothers and fathers who are able to take care of their children independently. Besides detoxification, the programme aims to help parents gain short-term perspective on their problematic living circumstances, which they try to stabilize. Parents participate in an intense and structured programme, while the children go to day care or kindergarten. The programme encompasses detoxification, screening, observation and referral. Next to this, *OP+* works on the motivation of the drug or alcohol abusing parent and on the parent-child relationship. Although the programme is open to parents in general, 95% of the applicants seems to be mothers with (a) child(ren) and only 5% are fathers with (a) child(ren). The long-term residential treatment programme (*BP, Behandelingsprogramma*) is mixed-gender, but offers separate women group therapy sessions as well as men group therapy sessions, covering gender-specific themes and subjects.

Centre Alfa in Liège offers personal medical, psychological and/or social consultations. They focus on offering a support on parenting with home-based interventions and network collaboration. They also realize different types of health promotion actions nearby professionals and future professionals regarding “parenting and addictions”.

Centre de Cure et de Postcure Les Hautes-Fagnes in Malmédy is an institute specialized in the psycho-social rehabilitation for drug and alcohol users (licit and illicit). They have a part of the building reserved for women, women support groups (and men support groups), specific anti-sexist rules, a housework group (concerning for example cleaning and laundry issues) with a specific group for women to reinforce their own identity.

Centrum Geestelijke Gezondheidszorg (CGG) Eclips in Ghent offers specialised, outpatient treatment to children, youngsters, adults and elderly people with severe mental or psychiatric problems. The centre also features expertise in the field of drug prevention, addiction care, forensic care, suicide prevention and epilepsy. Team Addiction Care of CGG Eclips provides a relapse prevention group for women only with an alcohol problem. This women-only group offers a safe environment and a feeling of recognition among other women. Themes to which women often seem to easily relate to are addressed such as guilt and shame, stigma, partner and children, position of women, etc.

Centrum Geestelijke Gezondheidszorg (CGG) Houba Brussel is an outpatient service offering specialised and customised care for children, youngsters, adults and elderly people. In 2014, CGG Houba Brussel offered a group for parents of ethnic-cultural minorities in the context of education support. With this group CGG Houba Brussel wanted to raise awareness regarding substance use and addiction. Three sessions were organised, attended by maximum ten women each. The initiative was not repeated because of a lack of interest and attendance, and because of perceived sufficient knowledge among the target group.

Centrum Geestelijke Gezondheidszorg (CGG) Vagga Antwerpen offers specialised, outpatient treatment to children, adults and elderly people with severe mental problems or dysfunctions and to their environment. With regards to addiction, attention is put to both care and prevention actions. Within the latter, every two weeks two women groups are organised, one during the day and one in the evening, each for approximately ten women (with a maximum of 12 women). These are experience-driven groups centred around use, relapse prevention and themes that are present in the lives of women.

Centrum voor Alcohol- en andere Drugproblemen (CAD) Limburg in Hasselt organises prevention and outpatient treatment regarding alcohol, tobacco, licit or illicit substances, medication, gambling, gaming and internet. Along with numerous services and initiatives, CAD Limburg offers a (half open) therapy group for women with an

alcohol and/or medication dependency problem. The therapy group is once a month, each session takes approximately two hours and is costless. Women can enrol at any time after a welcome meeting with the responsible therapist(s). Women specific themes are addressed at the request of the women and feedback is given among the women.

The Clinique Notre-Dame des Anges (CNDA) is a psychiatric hospital in Liège. The two residential women units are reserved to women who consume alcohol. There is also an outpatient day-care centre with a talk group for women only (GTA: each person concerned or interested by the alcohol problem addiction can assist. They have the same group for men).

Free Clinic vzw in Antwerp developed a specialised outpatient offer for people with severe dependency issues to illicit substances. From the perspective of harm reduction, different aspects of this complex matter are tackled. They have several services for divers target groups among substance users. The service *Activation (Activering)* wants to activate substance users in a neighbourhood in Antwerp through a variety of activities. One of these activities is the women club (*Vrouwenclub*), a women-only activity once a month with attention for specific themes and body care. The service *PROject* is an outpatient and gender-responsive care programme within substance treatment for female users and their child(ren). Three days a week during two hours women can come to an anonymous house for medical, social, mental or spiritual consultation. The service *Bubbels en babbels* focuses on families with young children of whom one or both parents has an illicit substance problem. Special attention goes to the needs of women since they are the majority of the clients of this initiative.

The service Kairos of the Hôpital Psychiatrique du Beau Vallon in Namur is an addiction group and a department of the rehabilitation service. The support is made by a multidisciplinary team. The purpose is the readaptation of each client to a professional, familial, social and affective life, through more adapted behaviours. They work with the therapeutic community model. This initiative is women-only.

The service Parentalité-Addiction of Interstices asbl in Brussels targets pregnant women and future parents who use substances and regroups the stakeholders of the parenting field. This multidisciplinary team wants to offer a safe and coherent structure with an early global support and a postnatal follow-up. This is a consultation space but also a welcome community area. The majority of the work is done at the mother's home and is constructed around the parents-children bond.

Le Comptoir in Charleroi offers a welcome area where sterile injection material for using substances is available as well as medical consultations. They organize some "Opérations Boule de Neige" only for women. Eight work sessions are organised during a period of two months to address the question of specific risks (sexual and linked to the injection of substances).

Lokaal Gezondheidsoverleg (Logo) Oost-Brabant in Herent near Leuven, aims at more quality of life and healthy years for everyone. They focus on prevention and disseminating methods, educational material and brochures. One of these brochures concerns the use of alcohol, tobacco and illicit substances during pregnancy and is addressed specifically at girls and young women. They try to reach as many girls and young women as possible through different channels (e.g. schools, youth association, social media, etc.) and they collaborate closely with umbrella organisations such as VAD and Vlaams Instituut Gezond Leven.

Maison d'Accueil Socio-Sanitaire (MASS) de Bruxelles asbl does not have a gender-specific initiative. They have personalized programmes adapted on the client's needs. They are particularly careful to the contraception question and the transmission of infectious diseases with women. They have community health groups and want to create a women group in the future. They mainly work to increase and to maintain the contact with the hidden population of substance users, to limit health, social and psychological harms related to substance use and improve their quality of life.

Medisch Sociaal Opvangcentrum (MSOC) Gent offers outpatient, low threshold, multidisciplinary treatment for users of illicit substances. The service KDO (children and drug addicted parents) is a free, voluntary and low threshold project for (ex-)drug addicted parents with children until the age of 12 and for pregnant women. They offer help in the environment of the client through home visits while looking for answers and solutions. Although the KDO project is open and accessible to men and women, the majority of the clients are women. The KDO project is open to clients of MSOC, as well as to non-clients.

Medisch Sociaal Opvangcentrum (MSOC) Leuven is an outpatient centre for youngsters and adults who have questions or difficulties with illicit substances. A multidisciplinary team offers a variety of services, one of which is the MaPa-project. This initiative is for free and discrete, and serves as education support for substance using parents. The team offers individual counselling, prenatal care and the extension of a social and professional supporting network. In reality women more than men make use of the MaPa-project. Besides that, PONDO is another gender-sensitive service of MSOC Leuven. PONDO is a supporting preventive network that cooperates with the substance using parent aiming at responsible parenthood, in which safety of the unborn child is the central concern. Also, MSOC Vlaams-Brabant regularly sets up actions regarding birth control (e.g. International Women Day, 'prikpil').

Medisch Sociaal Opvangcentrum (MSOC) Oostende operates from a harm reduction and low threshold perspective and offers medical, mental and social outpatient services for illicit substance users. The KiDO-project (children and drug addicted parents) offers outreaching, integrated and intensive support for substance dependent parents and their young children. More than 80% of the clients entering the programme are women. The KiDO-project is based in the same building as MSOC Oostende, but it welcomes clients of MSOC, as well as substance using parents that are not registered at MSOC Oostende.

The project Salma of Namur Entraide Sida asbl is a service of psycho-medical-social support for women of childbearing age and/or pregnant women who use psychoactive substance and their children. They offer an early and reinforced intervention and also a communication and articulation between the professional of the network. The work is mainly home-based.

Psychiatrisch Centrum Dr. Guislain in Ghent is a modern care facility that offers specialised treatment for diverse psychiatric problems. 'Opname 3' is the department for detox and treatment for men and women with problem alcohol and/or medication use, residential as well as outpatient. Once a week during one or two hours a women group is organised tackling specific themes of interest for women and offering woman friendly activities. Women and substance use and the associated challenges and experiences are also a vast and reoccurring subject in the relapse prevention group (which is mixed-gender).

The addiction team of Psychiatrische Kliniek Alexianen Tienen (Ter Dennen) offers a rehabilitation service for adults (men and women) who are dependent on alcohol, medication or illicit substances. They offer residential services as well as outreaching services. The residential treatment programme consists of four separate groups, one women-only group, two men-only groups and one mixed-gender group. The women-only group (six to ten weeks) guarantees a safe environment of recognition and respect, and opens the opportunity to discuss and process women specific themes and experiences.

The Start-Mass (Service Transdisciplinaire d'Aide à la Réadaptation des Toxicomanes – Maison d'Accueil Socio-Sanitaire) in Liège offers a '*Groupe Maternité*' which aims to reduce the risks around the future parents, substance use and maternity (lifestyle, prostitution, risks of transmission to infectious diseases, etc.). They also provide support and counselling during the pregnancy or abortion. This group constitutes a relay to other institutions from the social network who work on that topic (pregnancy and substance use).

Therapeutic Community (T.C.) De Kiem in Gavere provides differentiated support to people suffering from problems related to the use of illicit substances as well as to their social environment. The residential part of the programme includes an induction unit, a therapeutic community (TC), a mother-and-child unit and several re-

entry houses. The outpatient part of the programme includes two outpatient centres, prison work, a regional Outpatient service and parent groups. The T.C. of De Kiem is known as woman friendly maintaining two weekly women groups and monthly women days for the women of all four T.C.'s in Flanders. Besides that, they take part in a steering committee concerning women in the T.C. and they organise a conference about women in substance treatment every two years, together with the personnel of the other T.C.'s in Flanders. The Tipi is a separate dwelling near the T.C., meant for pregnant women and addicted mothers and their children up to six years old. Single fathers and their young children can be admitted too. Up to eight women (ideally six women) can be admitted with their children.

Therapeutic Community (T.C.) De Sleutel in Ghent focuses on people with substance problems and risk groups offering prevention, crisis management, outpatient and residential treatment, and employment opportunities in Flanders. For two years now they have a monthly evening activity for women of T.C. De Sleutel only, given by women who have successfully finished the programme. Besides that, they organise and participate in the monthly women days for the women of all four T.C.'s in Flanders. Also, De Sleutel takes part in a steering committee concerning women in the T.C. and organises a conference about women in substance treatment every two years, together with the personnel of the other T.C.'s in Flanders.

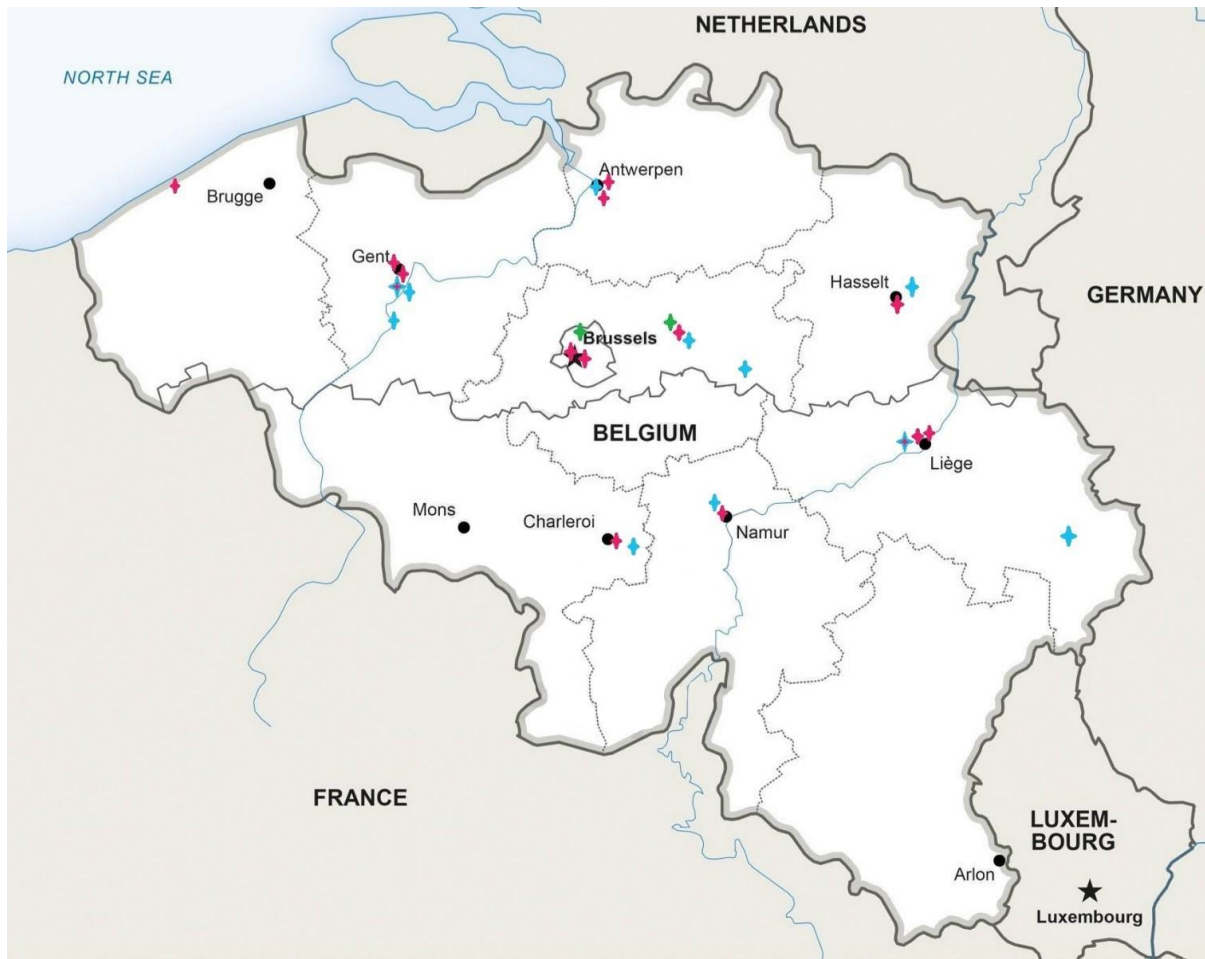
Therapeutic Community (T.C.) De Spiegel in Kessel-Lo is a treatment centre for people with a drug addiction, offering differentiated outpatient and residential treatment. They bring gender-sensitivity in their services through IRIS, a woman friendly approach to treatment responding to specific female needs in the residential programmes. There is for example a weekly women group, women receive a female counsellor, women can take a women hour, there is a small separate living room decorated by the women prioritising women using it (without the presence of men). Next to that, they help organise a monthly gathering of all the women of the four T.C.'s in Flanders, as well as take part in a steering committee concerning women in the T.C., and organise a conference about women in substance treatment every two years, together with the personnel of the other T.C.'s in Flanders.

Therapeutic Community (T.C.) Katarsis in Genk is a rehabilitation centre offering a residential, group oriented and highly structured programme for men and women with problem illicit substance use, with special notice for individual guidance. With the project PINK they want to give the women in Katarsis the attention and support they need. There is a weekly women group for all admitted women and a weekly women leisure activity. Next to that, Katarsis helps organise a monthly gathering of all the women of the four T.C.'s in Flanders, as well as take part in a steering committee concerning women in the T.C., and organise a conference about women in substance treatment every two years, together with the personnel of the other T.C.'s in Flanders. Finally, they value a women friendly basic attitude in the T.C. and take into account their family, partner, children and social network.

Trempoline in Châtelet is a therapeutic community for people who use substances. This is a three phase programme (welcome phase, community phase, social reinsertion phase). This is a mixed-gender centre with a specific programme for women. They also allow women to stay with young children (Kangourou). There is a self-help group for women coordinated by a woman, activities to create ties between women, and seminars (self-esteem, feminine sexuality, co-dependence, body image, emotions/feelings/guilt/shame and women identity). The women are together in a work sector, and they have a life space reserved for them.

### 3.3 Geographical spread

A closer look at the geographical spread of the gender-sensitive initiatives (see Figure 2.1) allows us to identify regions that lack gender-sensitive services. In the provinces West-Vlaanderen and Luxemburg no gender-sensitive residential treatment facilities are currently available, as well as no to very few outpatient treatment initiatives. Also, it is clear that all gender-sensitive initiatives are located in (or very near to) larger cities (e.g. Ghent, Antwerp, Liège, Namur, Charleroi, Brussels, Ostend, Hasselt), whereas very few initiatives are found in rural areas and smaller cities.



*Figure 2.1* Overview of gender-sensitive initiatives in Belgium: services for prevention (green), outpatient treatment (pink) and residential treatment (blue).

Source: GEN-STAR, 2016

## 4 Features of and challenges for gender-sensitive initiatives for female users in Belgium

In this part the results of the data collected through semi-structured interviews (n=26) with project coordinators of the gender-sensitive initiatives in Flanders, Brussels and the Walloon region are reported. Given the great diversity in gender-sensitive initiatives in Belgium, the report is split up by type of programme. Consequently, the prevention, outpatient and residential programmes are described separately. However, a similar approach and framework is used to analyse the different programmes, leading to an in-depth focus on several topics such as philosophy, admission requirements and support for children in services providing prevention, outpatient and residential programmes. Quotes of the interviews are added to the findings to highlight and illustrate the expertise of the field.

### 4.1 Gender-sensitive prevention initiatives

Three organisations report on currently or previously delivering a gender-sensitive prevention initiative (see Table 2.2). For Centre Alfa and Logo Oost-Brabant, this included the **dissemination of folders and posters** regarding alcohol and drug prevention specifically targeted at teenage girls and young women to widely inform and raise awareness among this specific target group. The prevention material is disseminated in a very proactive way through schools, the community, youth organizations, but also among pharmacists, gynaecologists, doctors and social media. For two consecutive years, CGG Houba Brussel organised an

informative **parent group** that wanted to raise awareness on substance use and addiction among young people with an ethnic-cultural minority background. The amount of interactions depended on the demand of the specific group. The group was open to all parents, though only women (mothers and grandmothers) attended the group.

Table 2.2 *Gender-sensitive prevention initiatives in Belgium (2016)*

Women health promotion actions	Centre Alfa
	Logo Oost-Brabant
Parent group to raise awareness	CGG Houba Brussel

An important remark made by Logo Oost-Brabant and CGG Houba Brussel is that the **general prevention campaign is male and white** and gender-sensitivity in prevention is necessary in order to reach girls and young women.

*“En ik denk soms bij, ja, waar we geen gender-sensitieve aanpak hebben, dat we dan toch meer jongens aanspreken dan meisjes. [...] Omdat we, denk ik, gewoon op de leefwereld van meisjes bijvoorbeeld niet ingaan. [...] De algemene, de neutrale campagne is mannelijk. Ja, mannelijk en blank.” (Prevention service A)*

*“And I sometimes think that, yes, where we don't have a gender-neutral approach, we appeal more to boys than girls. [...] Because, I believe, we just don't look more closely at the living environment of girls, for example. [...] The general, the neutral campaign is masculine. That's right, masculine and white.” (Prevention service A)*

All three initiatives report **difficulties to reach girls and young women**. Some prevention campaigns seem to be too specific and only reach a very small and specific population (e.g. the prevention campaign at high schools regarding smoking cigarettes while pregnant), while other campaigns are too general and do not appeal to specific target groups. Most gender-sensitive prevention campaigns concern topics that relate to girls and young women, like the use of contraception or pregnancy. However, gender-sensitive prevention campaigns regarding alcohol and drug use are harder to find.

*“Bepaalde doelgroepen bereiken wij niet. Wij hebben soms het gevoel dat wij nog te algemeen, dat onze boodschappen nog te algemeen zijn en dat wij soms ook niet voldoende methodieken hebben.” (Prevention service A)*

*“We aren't reaching certain target groups. We sometimes have a feeling that we're too general, that our messages are still too generic and that we sometimes don't have sufficient methodologies.” (Prevention service A)*

Consequently, a gender-sensitive prevention campaign on alcohol and drug use needs to be **tailored** based on the message, design and dissemination channels. For example, girls and young women can better be reached through Facebook than through a traditional paper prevention campaign.

The **rationale behind the choice** to integrate a gender-sensitive initiative differs. First of all, the organisations are obligated by the government to differentiate in prevention campaigns. Next to being bound, the organisations note the fundamental belief that tailored prevention is of great value for girls and young women. Also, these initiatives help reducing the persistent and widespread taboo on women and alcohol and drug use.

Almost all staff members are educated in healthcare, but none of the initiatives includes or collaborates with experts by experience nor does the staff has had any **gender-specific formation** leading to specialized qualification or certificate of ability. However, the staff shows a great interest in the implementation of a gender-

sensitive approach in their functioning, and in a more general way a great reflexion on the topic, but their knowledge and understanding is more based on the field and their practice, rather than based on a theoretical framework. Once or twice a year staff members can attend a training or a seminar, but the offer of topics related to gender-specific themes are extremely rare. A lecture or seminar on multicultural issues and women and/or alcohol and drug use is sometimes offered, but topics such as parenting, human development, sexuality, trauma, sexual abuse and family violence in relation to women and/or substance use are seldom touched in trainings or conferences, despite the fact that they are presumed to be particularly valuable.

The main **challenge** for these initiatives is reaching their target group (i.e. girls and young women). As not every method, channel and design of health promotion interventions is suitable for reaching girls and young women, project coordinators of these services report that it remains an on-going challenge to find and apply the most relevant manner and characteristics. When it comes to financial assistance, participants report that they need more time and resources to integrate a gender-sensitive approach.

*“Het budget dat we toen hadden was genoeg voor die sensibiliseringsgroep, maar nu hebben we gewoon geen tijd en geen middelen om weer iets te doen rond gender-sensitiviteit.” (Prevention service B)*

*“At the time, the budget we had was enough for the awareness-raising group, but now we just don't have the time or resources to tackle gender-sensitivity issues.” (Prevention service B)*

### 4.3 Gender-sensitive outpatient initiatives

Eleven gender-sensitive initiatives in the field of early intervention, harm reduction, low threshold and/or aftercare were reported by nine substance use agencies in Belgium (see Table 2.3). In addition to this, one more organisation expressed the intention of starting up a gender-sensitive initiative in the nearby future. Six initiatives are located in the French speaking part of Belgium and six initiatives are situated in Flanders. Eight initiatives are intended for pregnant women and/or parents and their children. Their main activity and goal is to set up a network of professional support around substance using pregnant women and substance using parents with their children. Two initiatives are women groups that want to unite women once a week or two-weekly to inform them about the risks of substance use (e.g. the risks of injecting). One initiative focuses on building a network and safe environment for mothers and their children, and another one organises a monthly activity for women only, aiming at activating and stimulating women to undertake action and shift their attention to things other than substances.

Besides these initiatives, five aftercare gender-sensitive programmes are reported, four of which in Flanders and one in Wallonia. They all want to support women in their daily life and help them remain abstinent through offering a weekly or two-weekly women group. These single-gender groups focus on offering a safe place to female users to talk about their struggles and concerns.

Table 2.3 *Gender-sensitive outpatient initiatives in Belgium (2016)*

Case management for substance using pregnant women / parents with their children	Service Parentalité	Centre Alfa
	Bubbels en Babbels	Free Clinic vzw
	Service Parentalité-Addiction	Interstices asbl
	KDO-project	MSOC Gent
	MaPa-project	MSOC Leuven
	KiDO-project	MSOC Oostende
	Projet Salma	Namur Entraide Sida asbl
Case management for substance using mother and child	Groupe Maternité	Start-Mass
	PROject	Free Clinic vzw
Harm reduction group for women	Projet Boule de Neige	Le Comptoir
	Women group (future)	MASS Bruxelles asbl
Low threshold activation group for women	Vrouwencub	Free Clinic vzw
Aftercare women group	CGG Eclips	
	CGG Vagga Antwerpen	
	Clinique Notre-Dame des Anges	
	Psychiatrisch Centrum Dr. Guislain	
	CAD Limburg	

#### 4.3.1 *Programme structure and philosophy*

The eight gender-sensitive case management initiatives for parents and their children are **mixed-gender** programmes, meaning that both mothers as well as fathers can call upon these services. However, the case management initiative PROject (Free Clinic vzw) is single-gender and focuses on mothers and their children only. The case management initiatives for substance using pregnant women and mothers are primarily focused on women and pregnancy, but fathers can be involved. The harm reduction groups for women, the activation group for women and the aftercare women groups are **single-gender**. All the aftercare women groups are organized independently, except for the group in Psychiatrisch Centrum Dr. Guislain. They offer a mixed-gender outpatient programme with the (single-gender) women group as one aspect of the entire programme.

Most of the services **focus on the family and creating a parental identity**, but the harm reduction groups for women and low threshold activation women group **focus on the effects** of substance use and the role of women in society. The aftercare women groups aim at supporting women in their daily life and their intention to remain sober.

Looking at the position of these initiatives on the **continuum of care**, all the gender-sensitive initiatives discussed in this chapter have harm reduction and low threshold characteristics, whereas the five women groups have a clear aftercare strategy. Moreover, the case management projects for substance using parents and their child(ren) are recurrently used as aftercare services for parents that have completed a residential treatment programme.

*“Ge hebt bijvoorbeeld in Antwerpen, OP+, dus die, van daar komen er ook zeer veel mama’s nu, als nazorg hè. Dus mama’s die in Oost-Vlaanderen wonen, maar die dan daar een opname doen en dan zo een nazorgtraject bij mij hebben. Zo heb ik er ook nu vijf ofzo lopen.” (Outpatient service F)*

*“In Antwerp, for instance, you have OP+, so a lot of mothers are coming from there now, for aftercare, you see. So mums who live in East Flanders, but who go for treatment there and then*

*go through the process of aftercare with me. I now have about five clients like that.” (Outpatient service F)*

The general way to proceed with men and women in these programmes does not differ significantly. All male and female clients receive the same kind of **approach**, in which their therapy and guidance is defined and organized according to their personal situation.

*“Eigenlijk zijn wij hier over het algemeen wel van mening dat iedere persoon op zich verschilt. Dus we hebben ons efkes een periode bezig gehouden van ja, we willen toch ook weer dat vrouwen op een andere manier benaderd worden, maar onze visie is altijd geweest van ieder persoon is uniek. En in die zin bestaan er evenveel verschillen tussen mannen en vrouwen dan dat er binnen de mannengroep zelf zijn en binnen de vrouwengroep zelf. Voor ons is het belangrijk dat we bij iedere persoon die hier voor ons zit, dat we kunnen kijken naar wie zijt gij als persoon, niet als druggebruiker, maar dat we gaan benadrukken van voor ons zijt gij een persoon met inderdaad wel druggebruik, maar ge zijt ook ouder en ge hebt nog zoveel andere rollen in uw leven en we gaan vooral kijken wat is die combinatie en wat heeft een invloed op wat en hoe gaan we daar rond werken. En daarom vinden we dat belangrijk om voor iedereen een uniek verhaal te maken.” (Outpatient service G)*

*“Well, we actually generally believe that every person, in essence, is different. So for a while we had a period that we were eventually busy with, well, we really do want women to be approached in a different way, but our vision has always been that every person is unique. And in that sense there are as many differences between men and women as there are between men themselves, and between women themselves. For us, the important thing is that with every person who comes to us here, we can look at who is this as a person, not as a drug user, but at the same time we emphasise that, to us, you are a person who, sure, is a drug user and you are also parent and you have so many other roles in life, and we specifically look at the combination of all those things and at what has an impact on what and how we can work with these factors. And that's why we think it is important to create a unique story for everyone.” (Outpatient service G)*

Still, all these programmes acknowledge the presence of a **social stigma on women and substance use and the vulnerable position** these women are in. For that reason, they declare to pay special attention to women and their needs, aspirations and desires in the programme, that are often very specific and different from men. This approach varies from very practical applications and measures in their programme aligned to women (e.g. keeping track of the planning and timing of their use of contraception, bringing women to an appointment with the gynaecologist, integrating a more outreaching approach by visiting women at home instead of asking them to come to the organisation, etc.), to a more abstract mind-set and incorporated frame of reference among counsellors and health professionals.

*“Ergens moet je denk ik voor een stuk altijd wel gevoelig zijn voor de vrouw binnen de verslavingssector. Ik noem dat hier binnen het milieu. Omdat de vrouw vind ik toch altijd nog x aantal extra kwetsbaarheden heeft ten opzichte van de man in dat milieu. Vrouwen zijn in dat milieu vaak slachtoffer van geweld, seksueel misbruik, euh... [...] Dus allé, sowieso ben ik extra alert voor de vrouw binnen het milieu. En, ja, uiteraard trek je dat ook door in KiDO, ook naar de medische zaken hè. Een vrouw proberen we aan te moedigen om toch bijvoorbeeld een keer in een jaar naar de gynaecoloog te gaan. Ja, dat zijn dingen die je dan natuurlijk met de man niet doet. Maar dus ja, er zijn zeker een aantal eigenaardigheden of specifieke dingen waar dat je extra alert bij zijt wat dat de vrouwen betreft buiten de mannelijke populatie.” (Outpatient service H)*

*“Somewhere, I think, part of you always needs to be sensitive to the woman within the addiction field. Here, I call it within the scene. Because women, I believe, still have quite a few extra vulnerabilities compared to men in the scene. Yes, women in the scene are often victims of*

*violence, sexual abuse, umm... [...] So sure, I'm always paying extra attention to women in the scene. And, yes, of course you extend this to KiDO, as well as to the medical issues. We try to encourage women, for example, to go and see a gynaecologist at least once a year. And yes, these are obviously things you don't do with men. But, yes, there are definitely a number of peculiarities, or specific things you pay extra attention to with the women compared to the male population.” (Outpatient service H)*

The coordinators of aftercare single-gender therapy groups for women also report a certain **vigilance for delicate themes** among substance using women, such as the physical experience of their body, the relationships these women are in, their family and a history of sexual or physical abuse.

*“Bij de vrouwen ga ik heel veel belang hechten aan hun lichamelijke conditie. Niet dat dat bij mannen niet belangrijk is ze, of dat dat niet bekeken wordt ze. Ook hun functioneren binnen de relatie, binnen het gezin. Goh, heel veel vrouwen met een verslavingsprobleem hebben bijkomende problemen op diverse vlakken. Zo goed als eigenlijk altijd.” (Outpatient service L)*

*“With women, I attach a great deal of value to their physical condition. Not that this isn't important for men, or that this isn't looked at. Also their functioning in the relationship, within the family. Gee, a lot of women with addiction problems have additional problems on top of addition problems. It's almost always like this.” (Outpatient service L)*

The single-gender initiatives report the **freedom of speech among women** as an important aspect. Women feel more assured and safe to talk about certain sensitive topics such as substance use in relation to health problems, sexuality, pregnancy, parenthood and relationships.

*“Elles ont des préoccupations qu'elles veulent partager avec nous mais pas avec les autres hommes qui sont là et c'est souvent elles qui sont plus demandeuses d'espace, d'intimité avec les travailleurs. [...] L'aspect entre femme, un collectif, c'est quelque chose qui semble répondre à un besoin.” (Outpatient service D)*

*“They have concerns that they want to share with us but not with other men who are there and it is often the women who ask for more space, intimacy with the workers. [...] The aspect of being among women, a collective, is something that seems to meet a real need.” (Outpatient service D)*

Another important aspect that service coordinators of outpatient aftercare programmes mention, is the need for a **non-judgmental attitude towards female users and a possible relapse**. They report the importance of women being convinced of a zero tolerance practice once they enter the programme, but stress that a relapse is human. Moreover, judging women for relapsing might cause them to drop out the programme.

*“Die motivatie is belangrijk, om alcoholvrij door het leven te gaan. Of het al dan niet lukt maakt niet uit hè, dat is geen voorwaarde. Ze mogen hervallen zo vaak ze willen, maar ze moeten wel die overtuiging hebben.” (Outpatient service O)*

*“Being motivated to retain sober in life, that is important. Whether or not they achieve this, is not a prerequisite. They can relapse as often as they want, but they need to be convinced of that belief.” (Outpatient service O)*

In the initiatives primarily focusing on parenting, the majority of the clients are mothers with their children. All programmes except for the MaPa-project of MSOC Leuven report that only a **few fathers with their children enter the programme**. Nonetheless, participants report that a great place is reserved to fathers, because of the increased attention to parenthood of substance users the last couple of years.

*“On a beaucoup plus de femmes que d’hommes au service parentalité, pourquoi parce que: de un la parentalité dans nos sociétés est encore vue comme une affaire de femmes mais aussi parce qu’on répond aux besoins spécifiques des femmes, donc ça lève des freins pour que les femmes viennent. Mais il faut aussi laisser une place aux pères consommateurs de produits, d’où l’intérêt d’avoir intégré un père dans l’équipe. Une des peurs des femmes est que si les femmes consultent, leur conjoint les quitte, donc si on ne laisse pas une place au père, au conjoint ça risque de devenir un frein pour l’accès aux soins de la femme.” (Outpatient service A)*

*“We have many more women than men within the parenting service, why because: for one, parenting in our societies is still seen as a matter for women, but also because the specific needs of women are met, so it removes the obstacles that prevent women from coming. But it is also necessary to leave room for fathers who are consumers of substances, hence the interest of having integrated a father into the team. One of the fears of women is that if women consult, their spouse will leave them, so if we do not leave a place for the father, the spouse it risks blocking access to care for women.” (Outpatient service A)*

The **maximum age of the children in the programme** is approximately 12 years old, but is flexibly applied. Families with one child of 12 years old or older and the rest of the children younger than 12 can still enter the programme. Only when most or all children are older than 12 years old, the programme refers the family to other healthcare instances.

These initiatives are developed and being maintained out of different considerations. The **parental gender-sensitive initiatives are generated as an answer to an existing need**. They are developed as a result of the perception that the regular home counselling services, general practitioners and gynaecologists appeared to lack the necessary skills and know-how to work with substance using parents or pregnant women. Also, they appeared to be short of the acquired network and partnerships to secure follow up of substance using parents or pregnant women on a long-term basis, along with a lack of experience regarding counselling this group. Consequently, many substance using parents did not find the appropriate guidance and care. Next to that, male and female clients of the medical-social shelter appeared to no longer come to the service once they were pregnant or became parents, due to the strong social stigma on pregnancy and parenthood and substance use on the one hand and the service not being the most child-friendly place on the other hand.

*“Les femmes ne se tournent pas facilement vers les professionnels par peur du jugement.” (Outpatient service I)*

*“Women do not easily turn to professionals for fear of being judged.” (Outpatient service I)*

Another consideration in the development of these initiatives is the fact that **parents keep parental custody over their children longer when a pregnant woman or parent is supported** by the counsellor and/or professional network that has been established for them, according to some respondents. Parents struggling with substance use who are not supported by a professional network, risk that children are placed under foster care sooner. Next to this, the rationale of the health, education and development of the children is important in the subsistence of these gender-sensitive initiatives.

*“We weten als er geen hulpverlening voor de bevalling is, dat die kinderen heel snel geplaatst worden omdat dat dan misloopt en omdat er dan mensen, ik bedoel dan jeugdrechter van parket of politie, dan gewoon beslissingen nemen en dan hebben ze geen kansen gehad. Dus ge vertrekt echt vanuit het idee van ja we willen eigenlijk hetzelfde als u, zolang mogelijk dat gij voor uw kind kunt zorgen, maar we willen dan wel dat dat op een deftige, op een goede manier gebeurt en daarom dat we samen willen nadenken.” (Outpatient service G)*

*“We know that if there is no help before the baby is born, those children are quickly placed in foster care because it goes wrong and because there are people, I mean people like the youth public prosecutor or the police, who just make decisions and then they really haven't been given a chance. So you're really starting out from the basic idea that, well, we really do want the same as you do, that you can take care of your child as long as possible, but we want you to do this in a decent, in a good way, and that is why we want to think about it together.” (Outpatient service G)*

Service coordinators at the single-gender initiatives report the **unhealthy and often unsafe relationship between men and women** in the context of substance use as the main reason for developing the initiatives. Substance using women are often victimized through violence and forced to prostitution, which leads to traumatizing experiences, related to men. Besides that, they report that not all women-specific subjects are fit to talk through in the presence of men. The single-gender initiatives want to offer these women a safe place, without the risk of a confrontation with men and without being held back to speak freely.

*“We willen ook die veiligheid wel creëren om dan als vrouwen onder elkaar echt wel over hun problemen te kunnen praten. Als moeder, als vrouw, als dochter, als, ja, noem maar op. Ik denk dat dat niet zou lukken moesten daar een hoop mannen bijzitten om dan echt zo die vrouwgerichte zaken te gaan bespreken.” (Outpatient service N)*

*“We also want to create that sense of safety to help women really be able to talk about their problems with one another. As a mother, as a woman, as a daughter, as, well, you name it. I think that this wouldn't work - really talk about the issues that concern the women - if there were also a whole heap of men sitting with them.” (Outpatient service N)*

In line with the latter, the single-gender women group initiatives account for a **drop-out of women in mixed-gender groups** because they do not feel comfortable standing alongside men in a group. As an attempt to find an answer to this, single women groups have been developed.

*“Wij hebben hier al heel lang nazorg groepen, maar dat waren vroeger eigenlijk gemengde groepen, mannen en vrouwen werden daar in toegelaten. Maar het bleek eigenlijk dat de vrouwen zich niet zo comfortabel voelden in die groepen en daar snel mee ophielden. Ik heb daar wat literatuur rond opgezocht, maar ik vond daar niet zoveel over. En dan heb ik vernomen dat men in [residentieel programma] eigenlijk al lang met vrouwengroepen werkt. En dan ben ik daar eens op bezoek geweest om eens te kijken hoe ze daar werkten. En dan hebben we eigenlijk de beslissing genomen om hier ook met vrouwengroepen te starten. Sindsdien is dat eigenlijk geïnstalleerd en zitten die groepen zo goed als steeds volledig vol.” (Outpatient service L)*

*“We have actually had aftercare groups here for a very long time, but these used to be mixed groups, you know, men and women were both admitted. But it turned out that the women didn't feel very comfortable in those groups and quickly stopped coming. I looked up some literature on the subject, but couldn't find very much. And then I was told about [residential programme], where they have been working with women groups for quite some time. And then I went to visit the hospital to learn more about how they worked there. Then all of us sat down together and decided to start working with women groups here, too. This has actually been the set-up since then and now those groups are almost always full.” (Outpatient service L)*

Another reason for integrating a more gender-sensitive approach is the ascertainment that the **number of women in outpatient services has increased** the last couple of years.

*“We vinden dat toch eigenlijk wel een interessant item en een meerwaarde ook wel voor onze afdeling, omdat we ook wel zien dat er meer en meer vrouwen in opname komen. Als ik hier begon,*

*ja, waren er minder vrouwen, twee-drie vrouwen in een mannenafdeling eigenlijk hè. Maar dat is eigenlijk wel veranderd, hebben we wel gezien.” (Outpatient service N)*

*“We really find this to be an interesting item and an added value for our department, too, because we also see that more and more women are coming to us for treatment. When I started here, yes, there were fewer women, maybe two or three women in a men's ward, really. But that has really changed, we have noticed.” (Outpatient service N)*

The **capacity** of the gender-sensitive initiatives depends on the financial resources the project can rely on and accordingly the number of professionals working for the project. For the case management services, the number of clients varies from six to seven clients and their family in Groupe Maternité (Start-Mass) up to 70 to 80 families in Service Parentalité-Addictions (Interstices asbl). The harm reduction and low threshold initiatives vary from ten to twelve women in the Vrouwenclub (Free Clinic vzw) to 500 substance users in the Projet Boule de Neige (Le Comptoir) of which one third are women.

The gender-sensitive case management initiatives for parents and pregnant women are very often collaborating with different organisations and services in order to set up a **network of professional help** for each client. Initiatives working with pregnant women for example, have partnership with hospitals, which are providing the equipment and required help for perinatal follow-up. In this regard, L'hôpital Saint-Pierre in Brussels and L'hôpital de la Citadelle in Liège are developing a maternity ward for women who are consuming substances (i.e. le service Coala).

*“We hadden zoiets van we moeten zo vroeg mogelijk in de zwangerschap zorgen dat er een netwerk komt rond die zwangere. En dan is er dus PONDO gecreëerd, een samenwerkingsverband tussen MaPa, CKG De Schommel, Kind en Gezin, Parel van UZ Leuven en het vertrouwenscentrum Kindermishandeling. Dus we werken met vijf vaste partners en het idee is dat we een soort van adviesgroep willen zijn. [...] Een gezin komt één keer tot daar zo vroeg mogelijk in de zwangerschap. Het is een beetje de bedoeling dat zij hun situatie uitleggen, maar het is vooral bedoeld om preventief na te denken en om samen vanuit onze algemene kennis, vanuit ieder zijn expertise mee te kijken naar dat gezin en alle bezorgdheden en kwaliteiten op tafel te leggen om dan samen tot een plan te komen.” (Outpatient service G)*

*“We thought like, we need to make sure there is a network for women who are expecting a child as early on in the pregnancy as possible. And so PONDO was established, which is a collaborative initiative between MaPa [family support for drug-using parents], CKG De Schommel [Centre for Childcare and Family Support], Kind en Gezin [Child and Family], Parel van UZ Leuven [Pearl of UZ Leuven] and the Vertrouwenscentrum Kindermishandeling [Child Abuse Trust Centre]. So we work with five permanent partners and the idea is that we want to be a kind of advice group. [...] A family can go there, once, as early as possible in the pregnancy. The general idea is that they explain their situation, but the underlying purpose is to preventively think about the matter at hand and to collectively use our knowledge, from each person's own expertise, to examine that family and to bring the concerns and qualities to the table, and subsequently set out a plan together.” (Outpatient service G)*

The **theoretical or philosophical background** of these initiatives is often based on different frameworks. Most project coordinators report assertive community treatment and case management to be a source of inspiration, supplemented by a perspective of harm reduction and low threshold, free access to healthcare and a strive for global support (i.e. psychological, social and medical support). Free Clinic vzw reports to apply an existential framework and the theory of presence. Further, it adopts different techniques, one of whom is working with role models.

*“Momenteel, ik blijf dat waardevol vinden, is het dat existentiële denkkader. Dus echt wel werken op die vier gebieden, het sociale, het psychologische, het lichamelijke en het spirituele. Er zijn ook wel wat technieken, dus heel erg vanuit de presentietechniek. Waarbij dat ik bedoel dat we heel erg werken ook vanuit die rolmodellen. Vrouwen komen, worden ontvangen in een huiselijke sfeer [...] en er is dus een niet-gestructureerde groepswerking waarbij vooral de psychologe en de verpleegkundige, maar als ik tijd heb ook, aanwezig zijn.” (Outpatient service B)*

*“At the moment, I keep seeing the added value in this, it is the existential framework. In other words, really working on those four areas: the social, the psychological, the physical and the spiritual. There are also different techniques, for example working specifically from the social presence technique. What I mean by this is that we really work from those role models. Women arrive, are welcomed in a homely, comfortable atmosphere [...] and we therefore have a non-structured group dynamic in which the psychologist and nurse in particular, but also myself if I have time, are present.” (Outpatient service B)*

#### 4.3.2 Client admission patterns

All the outpatient gender-sensitive initiatives strive to **help** women and their families **as soon as possible after their request** for help. The majority of their clients has a first contact with a counsellor or team member within a few days. Service Parentalité (Centre Alfa) and the aftercare women groups sometimes struggle with waiting lists.

**Few clients are declined** from the case management programmes. The reasons for these rare refusals are the distance to the living place of the client, the age of the children (i.e. too old) and the kind of problem and request. When the problem is too invasive in all areas of life or when there is a severe domestic problem, the case management initiatives refer the clients to more specialized care. Occasionally, the safety of the counsellors cannot be guaranteed which also leads to referral of the client to other services.

The aftercare women groups report that the women groups are not open to just anyone. The women enrolled in these programmes are well **screened and monitored before being admitted** to the programme. They allow women who are in a somewhat stable position, who show a rather long-term engagement and who endeavour zero tolerance in their lives. Their motivation to enter the women group is crucial. Also, a severe comorbidity of psychotic, suicidal or other mental disorders can be a reason for refusal.

*“Op zich werkt het hier zo dat elke vrouw die hier binnenkomt begint met individuele therapie. De vrouwengroep en de mannengroep staan niet rechtstreeks open naar buiten toe. Dat is eigenlijk een extract van de mensen die we hier in begeleiding hebben. Dat is een voorwaarde. Andere vrouwen laten we eerst op intake komen, eigenlijk is de afspraak daar ook, iedereen begint met een individueel traject. En als die vrouw stabiel genoeg is om zich aan afspraken te houden, als zij overtuigd is van de nultolerantie en als zij bereid is om minstens zes keer te komen naar de groep, dan mag ze komen. [...] Dan hebben we daar nog een tussendrempel in, namelijk dat ik eerst nog eens apart een intake doe. Dus er zijn wel wat tussenstappen omdat we ook absoluut willen voorkomen dat die groepen een duiventil zijn. [...] Ge kunt geen groepsveiligheid organiseren als er elke keer weer een nieuwe bij zit.” (Outpatient service O)*

*“Basically, the structure here is that every woman who comes to us starts with individual therapy. The women group and the men group are really not open to the outside. So it's actually an extract of the people we are treating here. That is really one of the conditions. We get other women to go through an intake process first, but the deal there, too, is that everyone starts with individual therapy. And if that woman is stable enough to stick to the agreements, if she fully agrees with the zero tolerance and if she is prepared to come to the group session at least six times, she is welcome. [...] Then we have an extra step in between, where first I conduct another intake separately. So there are definitely some intermediate steps, because we absolutely want to avoid*

*that the groups have a 'come and go as you please' character. In a therapy group, the idea is not for people to 'check it out' to 'see if they like it'. [...] You can't organise group safety if there are new people joining the group every time." (Outpatient service O)*

The most frequently reported **motivation** for the women enrolled in case management initiatives is **custody of their children**. In all initiatives except for Le project Boule de Neige (Le Comptoir), a lot of the mothers or future mothers that are enrolled in the programme (50 to 95%) want to either maintain or regain custody of their children by joining the programme. For clients in the aftercare women groups this depends on the age of the women. However, the topic of the parental role, the development of the children and the bond between parents and children is always a central concern and one of the main focuses.

Women in aftercare women groups are often **referred** to by general practitioners, the psychiatric department of hospitals, the individual counselling trajectory of the organisation or their own initiative. Female clients of case management initiatives are often referred to by MSOC's, the psychiatric department of hospitals, general practitioners or health specialists, while male clients more likely tend to find their way to the programme through an intervention of police and/or justice. A smaller part of the female clients is referred to these initiatives by child welfare services. Participants report that generally the clients of these outpatient initiatives live in the same city or the neighbouring villages or districts. Hence, another important referral source is the "word of mouth" in the network of female users, or because they already know the structure and the work done there.

*"Et on se rend compte que ce n'est pas par le biais du comptoir ou du travail de rue, de première ligne, qu'on touche vraiment les femmes enceintes, c'est plus par les professionnels qui vont nous les renvoyer et qui sont un peu perdus quand ils se retrouvent dans cette situation." (Outpatient service I)*

*"And we realise that it's not over the counter or through street work, the front line, that we really reach out to pregnant women, it's more through professionals who will refer them to us and who are a little lost when they find themselves in this situation." (Outpatient service I)*

The initiatives report a **change in the referral source** on the one hand and an **increase in the amount of referrals** on the other hand during the last few years. This is due to the fact that the longer the initiatives exist and become integrated in the field of (drug demand) healthcare, the more organisations and health specialists get to know the initiative. Also, digitalizing the initiatives (i.e. websites, social media) leads to more fame and publicity.

*"Er zijn wel een aantal diensten die ons nu verschrikkelijk goed beginnen te kennen. We hebben bijvoorbeeld van KiDO een bureau in het Huis van het Kind en dat is naast het lokaal van de regioverpleegkundigen. Die regioverpleegkundigen kennen ons, wij kennen hen. En regelmatig springen wij dan een keer binnen bij elkaar. [...] En dan merk ik wel van ja, dat is toch wel veranderd. We krijgen veel doorverwijzingen van zulke diensten, gelijk Kind en Gezin, OCMW. Terwijl in het begin heb ik ze voornamelijk zitten werven hè, onze cliënten. [...] Ik denk ook dat de bekendheid van het project, ze horen meer en meer van ouders of van gezinnen van 'Ah, ik zit in KiDO, ik word daar begeleid', of 'Ik heb gehoord van KiDO, weet jij wat dat is?'. Onze bekendheid is de laatste jaren wel toegenomen door een mix van factoren, inderdaad door onze werking, maar ook door wat dat Petra zegt, dat zij ook een stuk lobbyt." (Outpatient service H)*

*"There are a couple of services that are getting to know us really well now. For example, through KiDO [Kids of Drug-using Parents] we have a desk in the Huis van het Kind [House of the Child], which is right next door to the regional nurses' room. The regional nurses know us, and we know them. And we regularly knock on each other's door for things. [...] And yes, then I notice that, sure, that has changed. We get quite a few referrals from these services, Kind en Gezin [Child and Family], OCMW [Social Services]. While, at first I was mainly recruiting them, our clients. [...] I also*

*think that the awareness of the project, you know, I mean, they're hearing more and more from parents or from families, like 'Ah, I'm in KiDO, I'm getting help there', or 'I've heard about KiDO, do you know what it is?'. Awareness of who we are has increased in recent years through a mix of different factors, of course because of the way we work, and by what Petra says, the fact that she is lobbying for us." (Outpatient service H)*

Despite an observed increase regarding the number of registrations in the case management programmes, their service and offer is **not abundantly known** yet in the field of drug demand reduction and general healthcare as an alternative for residential treatment, not among clients nor among counsellors.

*"Wij worden niet overbevraagd hè. [...] Nee, ik denk dat het aanbod niet goed genoeg gekend is. Ja en, natuurlijk als het aanbod niet gekend is, is die vraag er ook niet hè. Noch de potentiële patiënten, noch de hulpverleners kennen dat aanbod voldoende." (Outpatient service B)*

*"We aren't being overrun, though. [...] No, I think our services aren't known well enough. Yes and, of course, if the services aren't known, the demand isn't there either, you know. Neither the potential clients, nor the social workers know enough about the services." (Outpatient service B)*

Therefore, the initiatives emphasize the **need to disseminate** their programme extensively, that is through both clients, health workers and different organisations using different channels.

*"In de loop van de jaren zijn wij ons gaan voorstellen aan bijvoorbeeld OCMW's, Kind en Gezin, allé zo, andere partnerorganisaties. Maar eigenlijk is het vaak toch via het werken met cliënten waar dat ook andere hulpverleners bij betrokken zijn... Ja, maar dat is een traag proces hè. Zeker als ge niet heel veel cliënten hebt. Maar dat is eigenlijk, ik denk dat dat het meest duurzame is uiteindelijk. En dan ook, ja, bijvoorbeeld wat helpt, ik gaf dan ook lezingen over druggebruik in het algemeen aan apothekers en dan vertel je natuurlijk ook iets over waar je werkt en ja, dat werkt ook." (Outpatient service B)*

*"Over the years, we have introduced ourselves to organisations like OMCW [Social Services], Kind en Gezin [Child and Family], and, you know, other partner organisations. But in actual fact, it's through working with the clients where other aid services are also involved... Yes, but that's a slow process, you know. Especially if you don't have many clients. But it is actually, I think, the most sustainable way in the long run. And then, yes, what also helps, I used to give lectures about drug use in general to pharmacists, and then you also tell them a little about where you work and, you know, that works too." (Outpatient service B)*

#### 4.3.3 Children services

All project coordinators of the gender-sensitive case management initiatives in the research report providing certain **facilities for children** in their service. There is for example a place with some toys reserved for them to play, a room for baby care with all necessary utilities and equipment, baby milk formula and a baby bottle heater. Most of the equipment (e.g. toys, diapers, presents, baby clothing, change cushions, baby bottle heaters, etc.) comes from gifts or sponsoring since there is no specific amount of money retained for this.

Preferably the child(ren) is (are) not present during a parent's meeting with a counsellor. It happens regularly though that parents bring their children to the programme or a consultation. In this case there is **no childcare** or recorded procedure available, but an effort will always be done to allocate a staff member to look after the child(ren) for the time being.

The case management initiatives are most often **monitoring and evaluating the child(ren)'s behaviour and development through observations** done by a psychologist and/or a social worker. If a specific follow up is needed, all services prefer to refer the child(ren) to other services, specialized in the request for help. Some

organisations also report that it is not an ideal situation to have both the parent and the child(ren) as a client since there may occur conflicts of interest.

*“Notre travail c’est d’évaluer les compétences parentales pour voir si les besoins des enfants sont remplis, donc bien sûr. Pour voir cela on va évaluer le développement des enfants, donc on va faire une observation très attentive des enfants, c’est la psychologue et l’éducateur qui s’en occupent. La pédiatre aussi donne son regard, la sage-femme et on fait ponctuellement des tests de développement pour voir objectivement où en est l’enfant par rapport à son développement, est-ce qu’il a un retard? Est-ce qu’il ne faudrait pas faire une stimulation plus appropriée à l’enfant? Donner des recommandations plus précises, donner un soin médical, comme de la kiné, voir une logopède. Donc on a une équipe pluridisciplinaire qui regarde particulièrement le développement de l’enfant, que ce soit psychologique ou psychomoteur.” (Outpatient service A)*

*“Our job is to assess parenting skills to check if children's needs are met, so of course. To check this we will evaluate the children's development, so we will make a very careful observation of children, it is the psychologist and the educator who take care of it. The paediatrician also gives her input, the midwife and development tests are carried out from time to time to see objectively where the child stands in relation to his or her development, is development delayed? Shouldn't we give the child more appropriate stimulation? Give more specific recommendations, provide medical care, such as physiotherapy, speech therapy. So we have a multidisciplinary team that looks particularly at the development of the child, be it psychological or psychomotor.” (Outpatient service A)*

The project coordinator of Service Parentalité (Centre Alfa) reports some exceptions when it concerns certain cases. If the parent for example has difficulties with trusting other services or if the child's follow up is directly linked to substance use, the healthcare path of the child(ren) is mainly coordinated or closely followed up by the case management initiative itself.

*“Parfois il faut mettre des mots sur la consommation, et c’est important de pouvoir lui expliquer que son parent est héroïnomane ou cocaïnomane et ça pose un problème tant à la famille qu’aux intervenants en général. [...] On s’est rendu compte que c’était un sujet tabou et donc on a mis en place un outil qui est un livre. Ce n’est pas une thérapie, c’est juste qqz séances. Deuxième cas de figure, des adolescents qui ont besoin de faire une thérapie et se pose justement beaucoup de questions par rapport aux produits. Troisième situation, quand un enfant vit une problématique directement en lien avec la consommation de produits, c’est par exemple le placement, le placement subit, l’incarcération du parent, l’entrée en traitement ou le décès du parent. Ça va être plus facile pour nous de répondre aux difficultés propres à ces enfants-là.” (Outpatient service A)*

*“Sometimes you have to put words on consumption, and it's important to be able to explain to them that their parent is a heroin addict or cocaine addict, and that's a problem for both the family and the community at large. [...] We realised that this was a taboo subject and therefore we put in place a tool in the form of a book. It's not a therapy, it's just a few sessions. Secondly, there are teenagers who need to undergo therapy and there are a lot of questions about the substances. Thirdly, when a child experiences a problem directly related to the consumption of products, this can be, for example, the child being put into care, suddenly, the incarceration of the parent, the entry into treatment or the death of the parent. It will be easier for us to respond to the difficulties of these children.” (Outpatient service A)*

Project coordinators of both harm reduction groups for women and the low threshold activation group for women do not consider their programme as a place to welcome children. As such they do not reckon that services for children are appropriate in their programme. However, all aftercare women group initiatives in Flanders report to have a **KOAP-service** (*Kinderen van Ouders met een Alcoholprobleem*) in their organisation. This service offers support to children of parents with an alcohol addiction problem. The main objective is to

expand their resilience in individual or group prevention oriented therapy and diminish possible harm in the development of the children.

*“Dat is iets dat we hebben zien opkomen, dat is het hele KOPP/KOAP-project. KOPP, Kinderen van ouders met psychische problemen en dan is ook de beweging gekomen naar kinderen van ouders met een alcoholprobleem. Daar is ondertussen een hele, ja, toch wel mooie dienst rond uitgewerkt. Enerzijds in de [straat], dat is de Kinderen- en Jongerendienst die een groepsprogramma uitwerkt. Maar er is daar ook een individueel aanbod.” (Outpatient service K)*

*“This is something we saw coming, that's the whole KOPP/KOAP project. KOPP, in English ‘Children from Parents with Psychological Problems’, and then there is also the movement that focuses on children from parents with alcohol problems. Now a whole, well, actually very good aid service has been worked out based on this. On the one hand, in the [street], that's the Child and Youth Services, they are working on a group programme. But there is an individual therapy offer as well.” (Outpatient service K)*

These **services for children are developed because of a growing belief in a contextual framework**. Not only the female clients are suffering and struggling, but so is their environment. In recent years the attention of counsellors has broadened and the children of substance using parents have been appointed to be a more central concern. Also, often problems with children are reported by female clients which was formerly hardly or even not explicitly mentioned. In addition, the last couple of years family member of female clients are more requesting to be involved in the treatment.

*“Ik denk dat er doorheen de jaren veel meer oog gekomen is voor kinderen van ouders met afhankelijkheidsproblemen omdat er de laatste vijf à tien jaar enorm veel rond gebeurd is, wat daarvoor niet het geval was. Dus die kinderen zijn echt in beeld gekomen door al die initiatieven. Maar ja, helaas zijn al die initiatieven altijd projectgeld en hè. Maar het heeft wel een verandering teweeg gebracht zo op de hulpverleners op de werkvloer. In die zin dat er toch een tendens is de laatste tien jaar waar dat je dan echt therapeuten had die zeiden van ‘Ja maar, daarvoor komt die mama niet bij mij in begeleiding, ik moet werken rond haar hulpvraag, ik ga toch niks vragen over de kinderen?!’. Dat dat echt wel volgens mij enorm veranderd is.” (Outpatient service O)*

*“I think that, over the years, children from parents with dependency problems are getting more attention because so much has happened on that subject in the last five to ten years, which wasn't the case previously. So those kids have really become more visible through all those initiatives. But yes, unfortunately those initiatives always depend on project funding, right? But it has still brought about a change for the social care workers at the workplace. In the sense that there has been a tendency in the last ten years that you had therapists who would say ‘Yes, but that's not why the mother comes to me for treatment, I need to concentrate on her question for help, I'm not supposed to ask about the children, am I?!’. That is something I believe has really changed.” (Outpatient service O)*

In most initiatives there are **no additional costs** to be paid by the client for the monitoring and evaluation of the child(ren). In Service Parentalité (Centre Alfa) however this issue depends on the financial situation of parent(s), but project coordinators report that money is never a cause to stop the process or cease necessary actions.

#### 4.3.4 *Staff competencies and training*

Participants report that **all staff members** of the gender-sensitive initiatives have a **mental health treatment license**. Considerably few to no staff members have an addiction counselling certification and only one of the initiatives has a staff member currently in recovery him/herself as part of their team. Nonetheless, integration of the latter in these programmes has been nominated by the interviewed project coordinators as an added value for both clients and counsellors. Most teams are multidisciplinary and consist of different professions and

specializations. The most frequently reported specializations are in trauma and PTSD, and issues with regard to childhood, parenthood and perinatal care. Generally, the staff shows a great interest and reflection on gender-sensitivity in the context of alcohol and drug use, but their knowledge and understanding is mainly based on field observations, rather than theoretical or philosophical background.

Regarding training of staff members, most initiatives provide, sponsor or endorse continuing **education** or specific training for clinical staff up to six times a year, either as an in-service or out-service initiative. These learning opportunities are highly appreciated by staff members, but lack a specialized perspective. Training concerning female users in particular is very rare, especially training concerning specific topics in association with female users is scarce.

*“Sowieso inderdaad zijn er heel weinig opleidingen specifiek naar de vrouw gericht. Tenzij dat het gaat over zwangerschappen ofzo, gewoon omdat dat, jah, gewoon vrouwspecifiek is hè. Die indruk heb ik wel, als dat rond zulke thema’s gaat, ja, dan inderdaad heb je specifieke opleidingen, maar als dat rond andere problematieken gelijk dubbeldiagnose gaat, dan wordt er geen onderscheid gemaakt tussen mannen en vrouwen.” (Outpatient service H)*

*“At any rate, there are indeed very few studies that specifically focus on women. Unless it’s a study on pregnancies or something, just because that’s, well, specific to women, you know. I do get that impression, if these topics are discussed, yes, then you do have specific studies, but when it looks at other issues such as double diagnosis, then there is no distinction made between men and women.” (Outpatient service H)*

Some initiatives report the rare occurrence of a seminar focused on women and addiction care, but state that sometimes the content is not enough in-depth, satisfying or useful in their practice.

*“Ja, er worden ooit wel eens studiedagen geregeld voor de vrouwvriendelijke hulpverlening, maar dan krijg je gewoon ja, een overzicht over dat de verslaving bij vrouwen anders in elkaar zit dan de verslaving bij mannen, en welke initiatieven dat er zijn in België, die dan hun project uitleggen. Ik ben ooit eens geweest, en wat was dan hun specifieke aanbod voor vrouwen, goh, dat ze één keer per week een vrouwenuurtje kregen dat ze hun haar eens mochten föhnen of verven of ... En dan dacht ik ‘Ja, als dat uw vrouwvriendelijk aanbod is’. Ik kwam toen eigenlijk met honger terug thuis. Dat ik dacht ‘Ja, is dat nu vrouwvriendelijke hulpverlening?’.” (Outpatient service O)*

*“Sure, seminars are sometimes organised to promote woman-friendly aid, but then you just get, well, a summary of reasons why addiction is different for women than for men, and what initiatives are available in Belgium, who then explain their own projects. I’ve been there once, and what was their special service for women? Gee, that they had one hour a week for women where they were allowed to blow-dry or dye their hair, and so on. And then I thought ‘Well, if that’s your woman-friendly way of working...’. I actually came home feeling empty inside, thinking ‘Really? Is that woman-friendly aid?’.” (Outpatient service O)*

Nevertheless, these topics are particularly relevant for clients in these initiatives and programme directors report a **need for training** touching these themes. It concerns for example training programmes including current theories of women’s development, unique characteristics of women with mental health and substance use issues, the role of co-occurring other mental health problems in women’s recovery (such as depression, anxiety disorders, PTSD, eating disorder), the impact on cultural issues on treating women, women’s sexuality, sexual orientation and related issues, the effect on women of trading sex for drugs or money to buy drugs, the role of trauma and issues of re-traumatizing women, sexual abuse, family violence, community supports available for women, and the role of parenting or caretaking in recovery.

*“Ik denk dat dat heel nuttig is. Allé bijvoorbeeld, hoe noemt die, die triple P, daar komt dat ook in aan bod. Dus dat is ook iets dat wij ook doen, één van onze medewerkers heeft die opleiding gevolgd om dat te kunnen toepassen. Dat doe je wel niet jaarlijks natuurlijk hè. Maar dat blijft nuttig die dingen. Tools in die dingen zijn altijd verrijkend.” (Outpatient service B)*

*“I think that it's very useful. You know, for instance - what's it called again? - that Triple P, that's covered there as well. So that's something we also do; one of our colleagues has done the course to be able to apply it. It's not something you do every year, of course. But it's still useful, those things. Tools and such are always enriching.” (Outpatient service B)*

Almost all initiatives hold at least once a week a **formal staff meeting**, case conferences or treatment planning meetings where the clients progress is reviewed. Only Groupe Maternité (Start-Mass) where the social worker is working alone, and Projet Salma, that only has two staff members who share the same office, do not have weekly formal staff meetings. Next to the formal moments there are a lot of informal meetings according to the needs, contexts and difficulties the team faces. Also, most of these services organize interventions or regular team monitoring each month or once every couple of months to offer support to staff members.

All initiatives have a **policy** regarding matching clients and counsellors by gender. Although it is usually not defined in a strict protocol, the counsellors and social workers are highly sensitive to requests from (female) clients and make an effort to meet those needs. In the Projet Boule de Neige (Le Comptoir) the doctor who works with the women group is a woman, which is really important to them.

#### 4.3.5 Programme challenges

For all the gender-sensitive outpatient initiatives, except for the aftercare women groups, one of the most important programme challenge areas are financial resources, more specifically **limited reimbursement and funding**. Staff members have to make restricted choices regarding how to spend their budget and every cent spent needs to be evaluated. Attempting to get grants is not included in the workload of staff members and is very time and energy consuming, without the certainty of success.

The second difficulty that most programme directors report regards the facilities of the programme. They report **insufficient space and/or old or run-down buildings**, but also the difficulty to keep the building repaired and maintained.

**Finding and keeping qualified staff** is reported to be a challenge as well for most of the initiatives, due to staff turnover, low staff salaries and the unfeasibility to value the seniority, and the difficulty to find qualified staff and the most accurate profiles.

A few aftercare initiatives indicate that it is sometimes hard to **keep the programme at full capacity** due to resistance of clients towards a specific counsellor or a lack of therapy compliance. The latter is often a result of limited mental capacity of the client involved, poor self-care or not prioritizing the group and therapy. Most of the aftercare initiatives though have no difficulty keeping the programme at full capacity.

Some services point out the difficulty to **meet the clients' needs**, especially needs of female clients such as assuring emotional and physical safety and tackling medical issues. It is an on-going challenge for these initiatives to provide tailored care and help.

*“Ja, tegemoetkomen aan de behoeften van patiënten blijft een uitdaging. Dat moet ook een uitdaging blijven zodat je jezelf steeds blijft in vraag stellen en probeert om een aanbod eigenlijk beter af te stemmen en dat is belangrijk. Je wil kwaliteit blijven bieden hè.” (Outpatient service L)*

*"Yes, meeting the needs of clients remains a challenge. It should also continue to be challenging so you can keep questioning yourself and try to actually align a specific service better, and that is important. You want to keep offering quality, you know." (Outpatient service L)*

*"La difficulté réside dans le fait de prendre en compte le genre sans oublier le reste, ou l'autre genre sinon on peut faire pire que bien." (Outpatient service A)*

*"The difficulty lies in taking into account the gender without forgetting the rest, or the other gender otherwise we can do more harm than good." (Outpatient service A)*

In this regard project coordinators strive to break through the **persistent social stigma** of substance use among women and parents that still stands in other (general and specialized healthcare) services.

*"Ik denk dat het nog altijd moeilijk is om een druggebruiker die ouder is te gaan verdedigen en daar voor een stuk een volwaardige ouder in te zien. Voor ons is dat niet moeilijk, wij weten dat dat gebruikers zijn, maar bij ons is dat niet het eerste dat er uit springt. Wij gaan in eerste instantie kijken naar hoe ga je om met je kind, geraak je er om de kinderen naar school te brengen, is dat huis een beetje proper, krijgt dat kind aandacht, wordt dat gestimuleerd, ... Omdat dat toch belangrijk is voor dat kind. [...] Terwijl bij andere diensten het druggebruik meestal wel op het voorplan staat. De mensen een stuk als mens laten zien, of als ouder laten zien, dat blijft een zware uitdaging." (Outpatient service H)*

*"I think it's still hard to defend a drug user who is a parent and then also to see them sort of like as a full-fledged parent. For us it isn't that hard, we know they are drug users, but this isn't the first thing we look at. In the first instance, we look at how you deal with your child, whether you're able to bring the children to school, check that the house is reasonably clean, if the child is getting enough attention, whether the child is being stimulated, and so on. Because that's what's important for the child. [...] While with other services the substance use is usually at the forefront. Show the people as a human, or as a parent, that is still a huge challenge." (Outpatient service H)*

Some organisations describe the presence of the husband or male **partner** at the programme instead of the substance using woman herself as another challenge. This demands a certain creativity of the staff to find ways to get in touch or direct contact with the woman herself.

*"On a une difficulté: on a un monsieur qui vient souvent ici et il est déjà venu avec madame, donc on l'a déjà vue une fois ici, mais après madame on ne l'a voit plus. [...] Et il faut qu'on insiste. "Et Nathalie, elle ne vient plus?" Et on a plus accès à madame, c'est monsieur qui vient pour madame, mais on sait que madame existe. Alors, après pourquoi ça se passe comme ça, c'est leur popote, c'est leur histoire. Mais après voilà c'est comme ça que ça se passe parfois et la femme ne vient pas, ou rarement." (Outpatient service D)*

*"We have a problem: we have a man who comes here often and he has already come with a woman, so we've seen her once here, but after that she's never been back. [...] And we have to insist. "And Nathalie? Why doesn't she come any more?" And we have no more access to the woman, it's the man who comes instead of her, but we know that the woman exists. So what? Why is it happening like that? It's their mess, it's their story. But that's how it is sometimes and the woman doesn't come, or rarely." (Outpatient service D)*

Some initiatives report to find it challenging to **manage a mixed-gender facility**. MaPa-project (MSOC Leuven) notes that female clients often are faced with resistance from their partner. In order to successfully provide the necessary care for these women, it is important that the women's partners are involved in the process and that they are convinced of the need for help and the added value of the assistance the service is offering.

*"Ik weet niet of ik voorstander ben van een programma voor de twee, enfin, om mannen en vrouwen op te splitsen. Hoewel ik het project van Free Clinic, ken je dat? Dat vind ik wel een geweldig gezellig project. Maar ik denk dat de uitdaging in het werken met vrouwen vooral er in ligt dat ook de mannen moeten mee zijn in het verhaal. En als we mannen en vrouwen opsplitsen weet ik niet of dat altijd mogelijk is." (Outpatient service G)*

*"I don't know if I'm a fan of a programme for the two, in other words, to separate men and women. Although I have heard about the Free Clinic project. Do you know it? I think that's an incredibly cosy project. But I believe the biggest challenge in working with women is getting the men on board with the process. And if we separate the women from the men, I don't know if that's always possible." (Outpatient service G)*

Additionally, the involvement of **children** brings along a greater responsibility for staff members which can be a supplementary challenge on an emotional level.

*"Gérer la parentalité c'est plus compliqué, on est parfois dans des situations qui mettent à mal notre travail, notre déontologie, nos représentations. Il y a une prise de risques, je pense que quel que soit le service quand on travaille avec des enfants, on a toujours une difficulté supplémentaire, une responsabilité." (Outpatient service A)*

*"Managing parenting is more complicated, we are sometimes in situations that undermine our work, our ethics, our representations. There is a risk taking, I think that whatever the service when working with children, we always have an additional difficulty, a responsibility." (Outpatient service A)*

For services that are not located in a hospital it is challenging to have prenatal or **perinatal services** available. They try to counter this by cooperating with different services in the environment.

Finally, the **client satisfaction** is to be seen by all initiatives as an on-going challenge. They report the necessity to retain a continuous vigilance and critical state of mind in order to offer the best feasible care and keep the client as content as possible.

#### 4.4.1 Programme costs

Generally, the initiatives report that the **available budget is quite limited**. Most initiatives can only just bear the costs for their programme, but do not have the possibility to go further and elaborate certain aspects. Creativity, innovation and entrepreneurship by the staff are been cut short by financial constraints. Although most initiatives recognize that there is a need for more gender-sensitive programmes in the drug demand reduction field.

*"Un espace particulier serait vraiment utile. Les femmes seraient preneuses et demandeuses. Dans le milieu associatif à Charleroi, il n'y a qu'une structure qui s'occupe et développe un espace personnel pour les femmes, c'est un centre d'accueil de jour pour personnes précarisées, sans-abris. Malheureusement dans leur public, ils ont mis la restriction que là-bas ils ne travaillent pas avec des usagers de drogues. Et j'entends les femmes parler de ça et dire "Oui, mais nous on ne peut pas y aller". Certainement qu'elles seraient heureuses, c'est dur d'être toujours en minorité dans un monde d'homme. Dans la rue, la seule identité féminine c'est surtout à des fins commerciales." (Outpatient service D)*

*"A specific space would be really useful. Women would be for it and make use of it. In the Charleroi associative community, there is only one organisation that cares for women and runs a personal space for women, it's a day centre for people in need, homeless. Unfortunately, they are strict about the people they accept, they don't work with drug users. And I hear women talking about it*

*and saying, "Yes, but we can't go there." There's no doubt that they would be happy, it's hard to be always in the minority in a man's world. On the street, the only female identity is mainly for commercial purposes." (Outpatient service D)*

The initiatives receive **funding from different sources**. Most gender-sensitive outpatient initiatives in Flanders obtain funding from the Flemish government whether or not supplemented by financing from the host city or private organisations. In addition to this, CGG Vagga Antwerpen asks for a small contribution of the female clients. Psychiatrisch Centrum Dr. Guislain receives no funding and is fully dependent on initiatives of the women to collect some budget. The programmes in Wallonia are subsidized by the Cocof, the Walloon Region, Viva for Life or ISOSL (*Intercommunale des Soins Spécialisés de Liège*). Service Parentalité-Addiction (Interstices asbl) depends in part from the Hôpital Saint-Pierre for some facilities, like the access to computers or internet and gynaecological consultations. The Projet Boule de Neige (Le Comptoir) is supported financially by Modus Vivendi.

#### 4.5 Gender-sensitive residential treatment initiatives

Eleven organisations offer (a) residential gender-sensitive service(s) (see Table 2.4).

Table 2.4 *Gender-sensitive residential treatment initiatives in Belgium (2016)*

Adic vzw	Residential treatment programme for parent and child(ren) (OP+)
	Women group in mixed-gender residential treatment programme (BP)
Centre de Cure et de Postcure Les Hautes-Fagnes	Separate building for women
	Women group
	Anti-sexist rules
	Women housework group
Clinique Notre-Dame des Anges	Two residential women-only units
Hôpital Psychiatrique du Beau Vallon	Residential women-only unit (Kairos)
Psychiatrisch Centrum Dr. Guislain	Women group in mixed-gender residential treatment programme
Psychiatrische Kliniek Alexianen	Residential women-only treatment programme (Groep B)
T.C. De Kiem	Residential therapeutic community for parent and child(ren) (Tipi)
	Women group in mixed-gender therapeutic community
	Umbrella activities with T.C.'s in Flanders
T.C. De Sleutel	Evening activity for women in mixed-gender residential programme
	Umbrella activities with T.C.'s in Flanders
T.C. De Spiegel	IRIS (i.e. separate sleeping hall for women, separate living room for women, women group, female counsellor, women hour)
	Umbrella activities with T.C.'s in Flanders
T.C. Katarsis	PINK (i.e. women group, women leisure activity)
	Umbrella activities with T.C.'s in Flanders
T.C. Trempline	Kangourou
	Women activities
	Self-help group
	Seminars
	Work sector
	Life space

Five initiatives are psychiatric hospitals, two of which are a mixed-gender residential programme including a women group: Centre de Cure et de Postcure Les Hautes-Fagnes and Psychiatrisch Centrum Dr. Guislain. Kairos is a women-only unit in Hôpital Psychiatrique du Beau Vallon and Psychiatrische Kliniek Alexianen is a long-term women-only residential programme. Clinique Notre-Dame des Anges reserves two units for women in their residential programme.

Next to that, five therapeutic communities in Belgium report to integrate gender-sensitive initiatives in their programmes. T.C. De Kiem has a long-term residential programme for parents and their child(ren) (Tipi) as well as a women group in their mixed-gender programme. T.C. De Sleutel organizes a monthly evening activity for their female residents given by women who have successfully finished the programme. T.C. De Spiegel has a well elaborated set of measures and activities for female residents in their mixed-gender programme, named 'Iris'. These comprise a separate sleeping hall and living room for women, a weekly women activity, the possibility to see a female counsellor and a weekly leisure activity for women only. As the latter, T.C. Katarsis has a well elaborated set of measures and activities for female residents in their mixed-gender programme, named 'Pink'. They have a weekly women group and a weekly leisure activity for women only. Also, they adopt a women friendly ground attitude and pay much attention to the context of female residents. Furthermore, all female residents of the four Flemish T.C.'s can attend the umbrella activities that are organized monthly by and for the female residents and counsellors of the T.C.'s. Trampoline offers different gender-sensitive measures and a service for mothers and their children.

Finally, Adic vzw offers a long-term residential programme for parents and their child(ren) and integrates a women group in their mixed-gender long-term residential programme.

#### 4.5.1 Programme structure and philosophy

There are eight **mixed-gender** structures: Centre de Cure et de Postcure Les Hautes-Fagnes, Adic (OP+ and BP), Psychiatrisch Centrum Dr. Guislain, T.C. De Kiem (Tipi and T.C.), T.C. De Sleutel, T.C. De Spiegel, T.C. Katarsis and Trampoline. Three programmes are **women-only**: Kairos (Hôpital Psychiatrique du Beau Vallon), Clinique Notre-Dame des Anges and Groep B (Psychiatrische Kliniek Alexianen).

There are five gender-sensitive therapeutic communities in Belgium – TC. De Kiem, T.C. De Sleutel, T.C. De Spiegel, T.C. Katarsis and T.C. Trampoline – and one long-term residential gender-sensitive initiative (Adic vzw). Next to that there are four psychiatric hospitals who offer a residential gender-sensitive programme for drug addiction, one of which is situated in a psychiatric hospital, but works with the principles of a therapeutic community (Kairos of Hôpital Psychiatrique du Beau Vallon). Although the programme of Centre de Cure et de Postcure Les Hautes-Fagnes, Kairos (Hôpital Psychiatrique du Beau Vallon) and Trampoline is similar to a long-term residential treatment programme in Flanders, they define themselves as an aftercare programme. Clinique Notre-Dame des Anges is a treatment centre as well as an aftercare centre.

The general **therapeutic and psycho-pedagogical approach** in the residential gender-sensitive programmes is similar for men and women, but there are some aspects specifically oriented at female residents, such as places accessible for women only, activities for women only, talking about topics that are the specific interest of women or specific rules.

*“De globale aanpak verschilt niet, allé, de grote lijnen zijn hetzelfde, maar er gaat toch meer oog zijn voor die noden van vrouwen. Hè, zo wat ik juist zei, met die partners enzo, je moet daar rekening mee houden dat dat heel moeilijk voor hen is om daarvan los te komen en zich daartoe te verhouden.” (Residential service J)*

*“The general approach does not differ, no. The broad lines are the same, but the focus will be more on the needs of women. You know, like I was just saying, about the partners and such, you need to bear in mind that it's extremely difficult for them to break loose and relate to it.” (Residential service J)*

The initiatives mention a couple of **trends and evolutions** in the field and in the organisations. Some centres notice that the population that signs up for the residential programmes is getting younger. Also, some centres report more complex problems among female users due to polyconsumption (alcohol and cannabis, alcohol and prescription drugs, ...). Further, the female clients are more disadvantaged and vulnerable than a few years ago.

*“Ik merk gevoelsmatig dat er heel wat meer ouders uit de armoede komen. Allé, als ik dat zo heel plastisch uitdruk, in het begin van ons programma hadden we nog heel wat cliënten die in orde waren met hun uitkering, hun mutualiteit, en meer en meer krijgen nu wij ook te horen van oei, die hebben helemaal nog geen kindergeld aangevraagd. Dus dat eigenlijk hun sociale administratie een beetje een rompslomp is. Dat er meerdere terreinen precies zijn aangetast dan in het begin van onze opname.” (Residential service A)*

*“I notice that there are many more parents out there who are living in poverty, I think. Well, if I explain it that graphically, when our programme first started we still had quite a few clients who had their social benefits organised, their mutuality, and now we're hearing more often things like, oh dear, they haven't even applied for childcare benefits yet. So, in other words, their social administration is a bit of a mess. The fact that more areas have been affected than when they first came to us for treatment.” (Residential service A)*

The development of three **long-term residential services for parents and their children** is another major change in the drug demand reduction field in Belgium (i.e. Tipi (De Kiem vzw), OP+ (Adic vzw) and Kangourou (Trempline)). They have been generated because some women did not find the way to addiction care due to their parental responsibilities. Consequently, the purpose of these initiatives is to allow more women to get the treatment they need. These programmes offer parents the opportunity to receive treatment for their problem use whilst being a parent for their children. Young children until the age of 12 years old can join their parents in these facilities. The programme is open to parents, so both fathers and mothers are welcome. In reality it only exceptionally occurs that fathers join the programme with their children. Mostly mothers are entering the programme with their children. This could be explained by the – in most cases – more caring role of mothers and by the stereotypes and roles that are assigned to men and women in our society and still maintained.

*“Omdat we merken dat de vrouw vaak nog de opvoedende rol voor zich neemt. Je merkt dat toch dat qua opvoedingstaken de mama nog altijd meer taken op zich neemt dan de papa, waardoor dat bij hen dan de keuze snel gemaakt is van, ja, de vrouw komt in opname bij [name residential parent-child programme]. En de vader gaat dan naar een gewoon ontwenningprogramma. Wat we ook wel merken, vind ik, dat bijvoorbeeld vanuit jongerenwelzijn ook heel vaak toch nog heel hard naar de mama wordt gekeken. Bijvoorbeeld als jongerenwelzijn betrokken is bij een gezin merken we dat vaak inderdaad de mama bepaalde afspraken moet nakomen zoals bijvoorbeeld de jeugdrechter en dat papa gemakkelijker op de achtergrond verdwijnt.” (Residential service A)*

*“Because we are noticing that women often still take on the child-raising role. You notice that, in terms of upbringing, the mother still takes on more tasks than the father, which means that the choice is easily made for the mother to admit herself at OP+, and the father then simply goes into a regular rehab programme. Another thing we are noticing, I think, is that youth welfare, for instance, focuses particularly hard on the mother of the child. As an example, if youth welfare is involved with a family, we see that it is often the mother who is responsible for adhering to certain agreements, for instance the youth courts, and that the father disappears into the background.” (Residential service A)*

Regarding the general **philosophy**, one of the most important ideas in all gender-sensitive residential programmes is to find a balance between offering individualised care and help on the one hand and respecting the healing effect of a group of women on the other hand. Project coordinators from all programmes believe in the positive aspects of living in a group. It reinforces the bond between women and creates a sense of belonging

to a group of women, which enhances the empowerment of female residents. In this regard the FORT-technique (*Feministische Oefengroepen Radikale Therapie*) is mentioned more than once as a background model. This piece of rather grey literature stands for feminist practice groups on the basis of radical therapy. These are self-help groups where women help each other to take responsibility for their own lives. An important aspect is that they learn to make a difference between personal life problems and problems that seem personal, but are in fact socially determined. In single-gender programmes the focus is on a group of women, whereas in mixed-gender programmes the healing effect of a group of women is obtained by a women group.

*“Vanuit het feminisme toch een beetje denk ik hoor, is dat toch wat gegroeid. Wel, die vrouwengroepen die wij nu hier doen, zijn oorspronkelijk, komen vanuit de FORT-technieken vanuit het feminisme. [...] Feministische oefentherapie of radicale oefentherapie, ik weet het niet precies. Het draait erom dat ge aan de hand van rondjes vrouwen eigenlijk de mogelijkheid geeft om zelf aan die vrouwengroep, allé, in handen te nemen. Dus dat ze niet afhankelijk worden van een staf lid. [...] Daar zitten toch wel een beetje de methodieken van het feminisme in. [...] De vrouwengroepen zijn eigenlijk daaruit een beetje ontstaan hoor.” (Residential service I)*

*“This has grown a little bit from feminism, I think. Well, these women groups we organise here now are originally based on the so-called FORT technique from feminism. [...] Feminist exercise therapy or feminist radical exercise therapy, I don't know exactly. The whole point is that you give women the chance to take the lead of the women group themselves by talking to each other. So without depending on a staff member. [...] There is definitely a little bit of the feminist methodology in this. [...] The women groups actually sort of originated from that, you know.” (Residential service I)*

Generally, the philosophy behind the gender-sensitive programme is **eclectic**. Often used frames of reference are behavioural therapy, systemic therapy, the 12-steps plan, acceptance and commitment therapy, motivational enhancement therapy, feminism, mindfulness and therapies that are focused on dealing with addiction problems. Similar to the therapeutic communities in Flanders, the three aftercare centres in Wallonia are inspired by the therapeutic community model, but each centre has his own specificities. Centre de Cure et de Postcure Les Hautes-Fagnes for example prefers to work in a quite early stage with socio-professional reinsertion and a familial/social environment.

*“Notre projet par rapport aux femmes est plus étendu, il y a une volonté par rapport aux femmes, au-delà du service Kangourou, le service a surtout aidé à faire venir des femmes. Mais on a d'autres femmes qui sont là et qui ne font pas partie du service. Quand on travaille la notion de genre on travaille de manière transversale. C'est vrai qu'à Kangourou ils vont surtout travailler la parentalité mais tout ce qui est la partie femme est travaillé dans un groupe spécifique, à travers les différentes phases du programme. [...] mettre quelque chose en place pour créer un noyau et un groupe d'appartenance. C'est compliqué, souvent il y a une femme dans un groupe de 20 hommes.” (Residential service K)*

*“Our project in relation to women is more extensive, there is a real motivation to do something for women, beyond the Kangaroo service, the service has mainly helped to bring in women. But we have other women who are there and who are not part of the service. When we work on the notion of gender we work in a transversal way. It's true that at Kangaroo they will mainly work on parenting but everything that concerns women is tackled in a specific group, through the different phases of the programme. [...] put something in place to create a nucleus and a group to which they belong. It's often complicated, there is one woman in a group of 20 men.” (Residential service K)*

All the gender-sensitive residential initiatives look beyond the end of substance use. They apply a more **global perspective** on the general well-being of a person and want to offer a place where each resident can learn to

live without substance use again. The trajectory of each resident being personalized according to the particular context and background, and with specific objectives for each resident.

The gender-sensitive approach in the residential programmes has been implemented as a result of diverse **reasons**. Firstly, the coordinators of the programmes report that outpatient services indicated that a lot of women in their programmes were in **need** of a residential programme. Notwithstanding, female users were missing in residential programmes and the women who were enrolled in the programme dropped out rapidly. The main cause for this seemed to be the male character of the programmes, focusing on a fixed daily structure, a strict hierarchy, a lot of sports, rather hard confrontations, etc.

*“Omdat er geen vrouwen waren, ja, er kwamen geen vrouwen in therapeutische gemeenschappen, of heel weinig. Dat is eigenlijk de reden geweest dat er is nagedacht van ‘how ma deze werking is eigenlijk heel mannelijk en wij moeten toch iets doen als wij ook willen dat vrouwen een kans maken om aan een drugprobleem via een therapeutische gemeenschap te werken’. Dat is een beetje de reden geweest. Het heeft natuurlijk een heel mannelijk karakter hè, met de hiërarchie, dat werken in een structuur, dat confronteren, veel sporten, ... Het heeft een zeer mannelijk karakter. [...] Vrouwen bleven hier niet of kwamen maar niet. En dat is een beetje de reden geweest hè. Het mannelijk karakter wat aanpassen.” (Residential service I)*

*“Because there were no women, yes, no women came to therapeutic communities, or very few. That was actually the reason why we started thinking ‘this way of working is actually very much targeted to men and we really should be doing something if we also want to give women a chance to work on a drug problem through a therapeutic community’. That was kind of the reason. Of course, it has a very masculine character, doesn't it, with the hierarchy, working within a structure, that confrontational aspect, a lot of sports, etc. It's all very masculine. [...] Women didn't stay or didn't come at all. And that was kind of the reason, you know. Adapting the masculine character a little.” (Residential service I)*

Next to the male character of the residential programmes, another reason for the drop-out of female users can be found in the fact that substance use among women often co-occurs with **traumatic experiences** such as sexual abuse, violence, prostitution, etc. These traumas are directly linked to men and may retain women from entering a mixed-gender programme, the presence of men being experienced as intimidating and threatening. By integrating a gender-sensitive approach (e.g. an anti-sexist policy, a separate hallway or living reserved for women only), they want to protect the female residents in the centre and secure the feeling of being safe.

*“La plupart des femmes avaient vécu soit des violences conjugales, des violences de rue, ou des abus sexuels. C'est assez clair, et donc qu'est-ce qu'on fait? Par exemple, si on laisse les groupes de parole libre thérapeutique homme-femme, les hommes dominaient les femmes, on pouvait discuter tant qu'on voulait, au bout d'un moment se réinstallaient "les jeux relationnels" extérieurs. Vous aviez quelques mâles dominants qui eux-mêmes avaient été violents, ils répliquaient ça ici. Une des premières choses qu'on a mis en place c'est des groupes spécifiques femmes. Autre chose qu'on a rapidement mis en place c'est des règlements très stricts dont tous les résidents sont au courant d'emblée dès qu'ils rentrent, à propos des gestes ou des propos sexistes. [...] On a très rapidement compris que si on voulait garder des femmes qui avaient vécus des situations difficiles, il fallait d'abord les protéger des hommes ici à l'intérieur. Aucuns propos sexiste, raciste, homophobe, aucunes menaces ni intimidations. On est très raide à ce niveau-là.” (Residential service B)*

*“Most women had experienced either domestic violence, street violence, or sexual abuse. It's pretty clear, so what do we do? For example, when we still had the therapeutic free discussion groups open to men and women, the men would dominate the women, we could discuss as much as we wanted, after a while the external "relational games" would return. You had some dominant*

*males who themselves had been violent, they were retaliating here. One of the first things we put in place is women-specific groups. Another thing that we quickly put in place is very strict regulations that all residents are aware of as soon as they enter, about sexist gestures or remarks. [...] We quickly realized that if we wanted to keep women who had experienced difficult situations, we first had to protect them from the men here inside. No sexist, racist, homophobic comments, no threats or intimidation. We are very strict about this.” (Residential service B)*

Also, as mentioned above, coordinators of both outpatient and residential services report several cases of women that did not enter residential treatment because of their **children**. They feel responsible for their education and/or they do not have a place for them to go to on a long-term basis. Consequently, they did not receive the proper treatment that they needed including the risk of their substance use getting out of hand and custody of their children being taken. By creating a programme for parents and young children, the drug demand reduction field wants to offer these women an alternative.

Further, the two women-only centres in Wallonia (i.e. Kairos (Hôpital Psychiatrique du Beau Vallon) and Clinique Notre-Dame des Anges) are historically two centres reserved for women, because they were originally managed by Catholic sisters. However, they noticed over time the therapeutic interest of a specific treatment initiative for substance using women. They observed that the women came more easily and stayed longer because of the absence of men in the programme.

*“Une prise en charge qui est spécifique pour les femmes apporte quelque chose qui n'existe pas ailleurs. Le problème de la dépendance est aussi un problème principalement de personnalité dépendante, il y a bien sûr le produit qui a son incidence sur les gens, mais il y a aussi un besoin affectif, un besoin de se rassurer, [...] par expérience, les centres mixtes pour personnes dépendantes, ben on voit se former des couples très rapidement après deux ou trois jours et pouf. [...] Je pense que le fait de ne pas avoir de mixité, permet aux dames, sans doute aux hommes aussi, de se recentrer sur leur problématique personnelle, et pas trouver vite un expédient à leur problématique de solitude, de manque affectif.” (Residential service D)*

*“Treatment that is specific to women brings something that does not exist elsewhere. The problem of dependence is also a problem mainly of dependent personality, there is of course the substance that affects people, but there is also an emotional need, a need to reassure oneself, [...] from experience, the mixed-gender centres for dependent people, well we see couples get together very quickly after two or three days and poof. [...] I think that not having a mix allows ladies, probably men too, to refocus on their personal problem, and not quickly find an expedient to their issue of loneliness, lack of affection.” (Residential service D)*

Most gender-sensitive programmes reserve some **beds** for women. Trempoline for example gives priority to Kangourou places, while Centre de Cure et de Postcure Les Hautes-Fagnes practices positive discrimination for women entrance when there are few women enrolled in the programme. In doing so they want to return the balance of men and women in the group so that it is more peaceful and easier to handle. They also have a partnership with the Clinique Reine Astrid of Malmédy (six beds) which is in charge of the detox phase. Katarsis has one room of four beds reserved for women only.

Considering the **capacity**, the gender-sensitive residential programmes have between 14 to 40 available places per initiative. The number of beds for women being different for each facility.

#### 4.5.2 Client admission patterns

In general, more than 95% of all referred women have been **admitted** to the programmes, whereas around 75% could be admitted at Kairos (Hôpital Psychiatrique du Beau Vallon) and Psychiatrische Kliniek Alexianen. In each facility, there often is a waiting list. The main reasons for being unable to admit female clients are linked with clients' motivations that are not clear or insufficient and the co-occurrence of a severe psychological disorder.

Also, when a female client is awaiting a ruling and is most likely to be sentenced, she can be declined from the programme.

*“Wanneer er teveel anti-sociale elementen zijn die voor ons programma niet hanteerbaar zijn, en wanneer de co-morbiditeit een psychotische stoornis betreft, kunnen ze niet in het groepsprogramma.” (Residential service F)*

*“When there are too many antisocial elements that are not manageable for our programme, and when the co-morbidity concerns a psychotic disorder, they can't be a part of the group programme.” (Residential service F)*

In some of the initiatives, a high proportion of women are **referred** for treatment by social services such as OCMW, Welzijnshuis, SAJ (Service d'Aide à la Jeunesse), Planning Familiaux, CPAS (Centre Public d'Action Sociale). Other initiatives report that women come out of personal initiative or arrive through care services, ambulatory centres, general practitioner and psychiatrists. Programmes for parents and their child(ren) state that a substantial amount of mothers is referred for treatment by the child welfare system. Some gender-sensitive initiatives notice a significant difference in referral sources and patterns for men compared to women clients. Men are often referenced by police and/or justice than women.

In most gender-sensitive programmes, a rather small part of the female residents **lives** in the same community or within 40 kilometres of the facility. Katarsis, OP+ and Clinique Notre-Dame des Anges welcomes at least half to three quarter women from further away from the facility.

In almost all programmes three quarter to all women of those who have children, have **reunification** with their children as a primary goal of treatment or at least keep or establish some kind of relationship with them. In the parent-child programme they wish to keep custody of their children by entering the programme. In Centre de Cure et de Postcure Les Hautes-Fagnes this accounts for only 50% of the women, while in Psychiatrische Kliniek Alexianen this applies to few to no female clients.

*“Bij ons is dat [het doel] niet zozeer hereniging, maar wel zo, als ze niets gaan doen, hè want bij ons zijn ze normaal nog samen. Allé, soms wel ze, als omwille van een tijdelijke crisissituatie de kinderen tijdelijk uit huis zijn geplaatst en dat de kinderen wel mee in opname mogen komen eenmaal ze bij ons in opname zijn, dat wel. Maar bij de meeste is het eigenlijk meestal een drive van ‘Ik wil niet dat ze mijn kinderen afpakken, want het is vijf voor twaalf en ik moet er nu iets aan doen, want anders...’.” (Residential service A)*

*“With us it [the goal] isn't so much a reunification, but it is if they do nothing, you know, because with us they are usually still together. Sure, sometimes, if the children are taken into care for a while because of a temporary crisis situation and the children are allowed to visit the parents once they have been admitted to us, then yes. But with most of them it is actually usually a motivation, like ‘I don't want them to take away my kids, because time is running out and I really need to do something now, because otherwise...’.” (Residential service A)*

#### 4.5.3 Children services

There are four residential programmes that allow **children to enter the programme** with one of their parents (i.e. Tipi (De Kiem), OP+ (Adic vzw), Kangourou (Trempline) and Centre de Cure et de Postcure Les Hautes-Fagnes). The maximum age of the children is from four to six years old and the number of children is limited to three to four, both depending on the programme. OP+ makes an exception for children up to 12 years old provided that they can go to school in Antwerp.

These initiatives provide different **services** to the parent's children. All programmes have specific agreements with day care external to the centre, as well as a school in the close environment of the facility. Depending on

the age of the child, he or she spends the day in the day care or school. The remainder of the time, the parent takes care of the child and takes full responsibility in engaging in his or her parental role. Staff members of the centre rarely have conversations with the children. They are there to support the parent in their parental role. In that regard, they refrain from organizing activities for children during holidays. Instead, they support women in looking for and organizing activities themselves. They also cooperate with for example a local paediatrician, *Kind en Gezin, Centra voor Kinderzorg en Gezinsondersteuning (CKG)* and *Office de la Naissance et de l'Enfance (ONE)* for younger children and with *Centra voor Geestelijke Gezondheidszorg (CGG)* for older children. They also offer to the parent information on for instance punishing and rewarding, and the different stages in a child's development. Next to that, they provide the possibility for parents to engage in video home/interaction training where parent and child are being filmed while interacting. Afterwards, the video is being looked at with a counsellor.

*“Wat we intern hebben is video interactie training. Dus dat wil eigenlijk zeggen, moeders en kind worden gefilmd in een bepaalde setting, meestal is dat een maaltijd of in bad doen. En dan wordt daar naar terug gekeken samen met de moeders zonder kind. De bedoeling is dat de begeleiding daar bij zit, maar die zegt niks, maar dan ook niks negatief. Maar niks hè. [...] De bedoeling is dat je dat laat zien en dat je die vrouw dat zelf laat zeggen. Dat ze daar zelf toekomt om te horen van ‘Amaj, ik ben scherp, ik kan geloven dat hij verschiet’. [...] Dat is altijd het uitgangspunt en dat werkt ook heel goed. Dus die moeders eigenlijk zelf laten kijken naar hun, maar niet beschuldigend hè, want dan doen ze dat niet meer, dan doen ze dat niet graag meer. Je kan hen ook niet verplichten. Ze moeten daar ook instappen en naar vragen. Wij bieden het aan, maar ze moeten dat willen doen. [...] Dat doen we veel hè.” (Residential service G)*

*“What we do internally is video interaction training. This works as follows: mother and child are filmed in a specific setting, usually it's dinner or bathing the child. And then we look back at the video together with the mother, without the child. The idea is to have the care worker present, but that person doesn't say anything, but also says nothing negative. Nothing at all, you know. [...] The idea is that you show the video and that you let the woman do the talking. That she realises things herself and to hear ‘Oh my god, I'm being very harsh, no wonder he's scared’. [...] That's always the basic principle and it works really well. So you are really letting the mothers watch themselves, but not accusatory you know, because then they don't do it any more, then they don't want to do it anymore. You can't force them either. They need to get on board and ask about it. We offer it, but they have to want to do it. [...] We do that a lot, you know.” (Residential service G)*

There is no specific **staff** for the children in the centres and all the **costs** involving children (e.g. childcare, school, clothes, etc.) are for parents themselves. Each situation being different, it is hard to estimate a total cost, but it is often substantial for the parent. However, as the majority of the parents in treatment in Wallonia has a Service de l'Aide à la Jeunesse (SAJ) or Service de Protection Judiciaire (SPJ) file, they often receive help for childcare costs.

Kairos (Hôpital Psychiatrique du Beau Vallon) and Clinique Notre-Dame des Anges do not have a children service. However, the first has a psychiatric department that welcomes mothers with their children. In an **exceptional** case, a client can stay there for a while with his/her child.

*“Le service réhabilitation n'est pas un service qui pourrait accueillir les enfants. Beaucoup de cas assez lourds. C'est impressionnant pour des petits bouts. On a accepté une fois, une maman avec son enfant pendant 15 jours, on n'avait pas d'autres solutions, et la dame en avait vraiment besoin, mais ce sont des cas exceptionnels. On a deux endroits spécialement créé pour les mères et enfants à l'hôpital le familial comme on appelle ça. Avec un encadrement, des éducateurs et SAJ si il faut.” (Residential service D)*

*“The rehabilitation service is not a service that could accommodate children. There are a number of very heavy cases. It's too much for young children. We accepted once, a mother with her child for 15 days, we had no other solution, and the lady really needed it, but these are exceptional cases. We have two places specially created for mothers and children in the hospital, the ‘familien’ as we call it. With coaching, educators and the youth assistance service if necessary.” (Residential service D)*

Clinique Notre-Dame des Anges and Katarsis think that having a department for children would be a **plus** for their programme and for substance using parents with their children, more particular for mothers with their children.

In contrast to the four residential parent-child programmes, the other residential treatment services in Belgium cannot accept children to join their parents in treatment. Nevertheless, they value the parent-child bond as a central subject in their programme and offer some **services** for the client's children. Psychiatrische Kliniek Alexianen integrates a KOAP-service in their programme. In the period of eight weeks of residential treatment the programme offers the possibility of one or two consultations with children of clients in a manner that is comprehensible for the children. De Spiegel provides parent groups and allows visits from children of clients. They have a separate room available for these visits which is decorated in a child-friendly way. Katarsis has a well elaborated set of implementations for working with the family and children of parents in treatment. They have a room for children for example where a child can stay for one night in an exceptional situation, and a family room with a kitchen and play room where parents can stay with their children during visits. The number of visits has increased over the last years, as well as the number of phone calls (i.e. on a daily basis). Different activities are organized with parents and their children (e.g. a visit to a theme park or a playground, going to the movie) and there is a parent talk group on a regular basis involving the residents that are parents. In Trempline visits of the children are possible, as much as spending a weekend with their children in the facility.

*“On dresse un bilan de la situation au niveau parentalité lors de la phase accueil, on peut organiser des visites et remettre des contacts en place. Des weekends où les enfants peuvent venir sont organisés. Il y a une chambre parentale pour l'organisation des weekends, où les mères peuvent loger avec leurs enfants.” (Residential service K)*

*“We take stock of the situation at the parenting level during the welcome phase, we can organise visits and restore contacts. We make sure that children can come along on weekends. There is a parent room for weekends where mothers can stay with their children.” (Residential service K)*

In Centre de Cure et de Postcure Les Hautes-Fagnes few mothers come with their child(ren).

*“On n'a pas voulu développer cet à tout prix cet axe. Pas de demande particulière.” (Residential service B)*

*“We didn't want to develop this axis. There's no particular demand.” (Residential service B)*

Trempline and De Kiem state that it is not a given for substance using parents to conciliate their parental role and their long-term residential therapy. Moreover, it is a true challenge to do so.

#### 4.5.4 *Staff competencies and training*

The teams of the gender-sensitive residential programmes are **multidisciplinary**, nearly all of which have a (mental) health treatment license, and mostly composed of educators, psychologists, social workers, and a psychiatrist. Some programmes also include animators or physiotherapists and only Clinique Notre-Dame des Anges employs nurses some of which are specialized in psychiatry. In Kairos (Hôpital Psychiatrique du Beau Vallon), educators are also nursing auxiliaries.

Trempline, De Spiegel, Katarsis and OP+ have a policy regarding **matching** clients and staff by gender, especially when clients specifically request a male or female counsellor. Other programmes cannot always meet the client's request due to a lack of staff. In all the therapeutic communities involved in this research and in OP+ (Adic vzw) about one up to six or seven of the clinical staff are in recovery themselves. Meanwhile, none of the psychiatric hospitals report a current staff member that is in recovery. In most programmes a female staff member is in charge of the women groups, this given the particularity of female substance use and the vulnerability it brings along (i.e. anxiety, trauma, violence, troubled relationship with men, ...).

*“Voor de individuele therapie beschouwen we het niet als een evidentie. Ah, het is een vrouw, dus bij de vrouwelijke therapeut. Nee. Maar we bevragen dat wel altijd. Want voor hetzelfde geld vindt een vrouw mij een heel vervelende vrouw of dat er een slechte match is. Maar naar gender toe hebben we daar wel wat oog voor. Bij de mannen eigenlijk ook hoor. Als we denken van daar is een thematiek waarbij mogelijks het geslacht van de therapeut een rol kan spelen, dan gaan we dat bij mannen ook vragen. In de mate van het mogelijke houden wij daar rekening mee. En de vrouwengroepen uiteraard, dat wordt door vrouwen gedaan.” (Residential service I)*

*“For the individual therapy, we don't consider it as self-evident. Oh it's a woman, so to the female therapist. No. We always ask. Like... Because, by the same token, a woman might find me very annoying or that it's a mismatch. But in terms of gender, we do watch out for this. With the men too, you know. If we think there is a theme where the gender of the therapist can possibly have an impact, we will ask the men too. Within the possibilities, we take this into account. And the women groups, of course, are led by women.” (Residential service I)*

Only in Kairos (Hôpital Psychiatrique du Beau Vallon), De Kiem and Psychiatrische Kliniek Alexianen there are a few staff members that work with **women only**. The staff in the other programmes work with both men and women. Centre de Cure et de Postcure Les Hautes-Fagnes and Kairos (Hôpital Psychiatrique du Beau Vallon) highlight the importance of having a mixed team regarding age and gender in order to maintain a suitable balance. However, including a female general practitioner, psychiatrist or physiotherapist is desirable and valuable too.

**Formal staff meetings**, case conferences and treatment planning meetings are held on a weekly basis and when it appears to be necessary. Next to that, there are daily, less formal deliberations on cases and treatment plannings, especially when there is a new staff member. All residential programmes stress that communication between all staff members is an essential part of their functioning.

*“On fait beaucoup de partage social, on est toujours deux quand on voit les clientes. En permanence tout se dit, notre cohérence c'est très important, la dynamique d'équipe, la cohérence entre nous, c'est notre force. Même si on n'est pas toujours d'accord et on se le dit, surtout quand c'est émotionnellement fort, les réunions informelles c'est très important, et puis parfois on passe le relais, quand c'est trop.” (Residential service D)*

*“We do a lot of social sharing; we are always two when we see the patients. Everything is constantly being said, our consistency is very important, team dynamics, coherence between us, it's our strength. Even if we don't always agree and we say so, especially when it's emotionally strong, informal meetings are very important, and sometimes we pass the baton, when it's too much.” (Residential service D)*

Generally, staff members subscribe to **continuing education or training** according to their affinity and their background. Often the coordinators of the programmes do not know the specific trainings followed by each member of the team, while in some services the staff members report on the attended training during a staff meeting.

*“Chacun choisit en fonction de ces centres d'intérêts. Les outils doivent être variés, c'est la force de conviction de l'équipe qui compte, que ce soit la gestalt, la pleine conscience ou les danses folkloriques. C'est la croyance du groupe, qui compte c'est très important. Les deux armes, la communauté de l'équipe et la communauté des résidents. Alors il y a un projet, une âme.” (Residential service B)*

*“Everyone chooses according to their areas of interest. The tools must be varied, it is the force of conviction of the team which counts, whether the gestalt, mindfulness or folk dances. It is the belief of the group that counts, it is very important. Both weapons, the team community and the community of residents. So there is a project, a soul.” (Residential service B)*

Centre de Cure et de Postcure Les Hautes-Fagnes and Clinique Notre-Dame des Anges organise a **training for new staff members**. Clinique Notre-Dame des Anges proposes a two-hour training (done twice) on addiction, depression and personal particularities. Centre de Cure et de Postcure Les Hautes-Fagnes offers a training on the policy about gender and sexism at the centre. De Kiem offers a training on the specific aspects of treatment in a therapeutic community to new staff members that do not have experience with the therapeutic community model. Next to that, all residential programmes in Flanders strongly recommend the two-year training programme on counselling in the context of alcohol and drug use of *Vlaams expertisecentrum Alcohol en andere Drugs (VAD)* to all of their staff members. In two of these services it is mandatory for new staff members to commence the training in the first year of their employment.

*“Vanuit de VAD bestaat er nu die opleiding, een tweejarige opleiding, en eigenlijk wordt iedereen die hier werkt verwacht om dat gedaan te hebben. Niet direct de start, niet vanaf de eerste dag, maar dan toch binnen het jaar dat je hier werkt, dat je daar aan begint. [...] Hier intern heb je ook nog opleidingen voor uw therapie te kunnen geven. Allé, iemand die van de schoolbanken komt, kan geen encounter leiden hè. Dat moet je ook nog leren.” (Residential service G)*

*“The VAD [Flemish expertise centre for Alcohol and other Drugs] now offers a course, a two-year course, and everyone who works here is expected to have done it. Not right at the start, not from the very first day, but at least within a year you should have started the course. [...] You also have internal training courses for therapy. Of course, someone fresh out of school can't be expected to lead an encounter, you know. That's something you still have to learn.” (Residential service G)*

The time that each clinical staff member spends on getting training related to women and their recovery is minimal. The very **limited offer of training** focusing on themes like comorbidity of mental health and substance use, parenting, human development, sexuality, trauma, sexual abuse and family violence in relation to women and/or alcohol and drug use is likely the rationale behind this. However, the programmes believe in the added value of these opportunities.

*“Dat [training] ging niet specifiek over vrouw, maar over man en vrouw. Ze maken geen opsplitsing tussen mannen en vrouwen. [...] Op zich zou dat wel interessant zijn, in die zin dat we misschien ons nog niet te bewust zijn van hoe verschillend dat kan zijn. Allé, als er al een verschil is, hè. Wij hebben ook allemaal in ons team bijvoorbeeld rond agressie en intrafamiliaal geweld een opleiding gehad binnen [naam residentieel programma], maar ja, dan gaat dat over man en vrouw zijnde, en de dynamiek die daar kan plaatsvinden. Maar zo wat er achterliggend bijvoorbeeld bij die vrouwen, specifiek bij die vrouwen, dat hebben we niet gehad in ieder geval. Dus misschien is dat wel interessant omdat ge er nu van uit gaat dat dat misschien niet bestaat of gelijk is.” (Residential service A)*

*“That wasn't specifically about women, but about men and women. They don't make a distinction between men and women. [...] That could actually be quite interesting, in the sense that we might not yet be aware of how different that can be. After all, if there is already a difference, you know.*

*For example, everyone on our team has had a training course on aggression and domestic violence at [name residential programme], but, you know, then it's about both the husband and the wife, and the dynamics that take place. But what lies behind these women, specifically these women, that is something we haven't explored yet. So, this might be interesting because at the moment you assume that it might not be real or that it is equal." (Residential service A)*

Regarding training practices related to women and substance use, the **two yearly seminar organized by the four therapeutic communities in Flanders** is almost the sole and definitely most frequently mentioned one. The only disadvantage is that it only takes one day and it is informative. A comprehensive training offering specialized theoretical frameworks and concrete practical suggestions is lacking in the field.

Trempoline has the intention to organize specific formations concerning gender, and ex-residents who work there know a lot about addictions.

#### 4.5.5 Programme challenges

Concerning the difficulties encountered, some service coordinators of residential services highlight those faced because of the **facilities**. Either the building is old or run-down, there is insufficient space (e.g. no garden or play ground where children in the parent-child programme can play) or there is very bad access to public transport. Often it is complicated to retrieve funding to improve the facilities.

Half of the gender-sensitive residential centres underscores some difficulties regarding **staff** in the programme. Some initiatives report it to be hard to find qualified and trained staff, mostly male staff, whereas keeping staff members is not really a problem. Other initiatives mention staff turnover and a lack of staff having a negative impact on the functioning in the facility.

Half of the gender-sensitive residential centres points out the **financial** challenge of managing the programme, which are all but one therapeutic community programmes. Budget cuts, increased costs and limited reimbursement being the source of the problems.

Most initiatives have no difficulty **keeping the programme at full capacity**. Some even have a waiting list. De Kiem, OP+ and Kangourou (Trempoline) however report that due to client flow it can be a challenge to get female users in the treatment programme on the one hand and to keep them enrolled for the whole programme length on the other hand. They note that this is an on-going concern, but varies strongly from time to time.

All mixed-gender residential programmes declare that **managing a mixed-gender facility** is a challenge. The most reported difficulties concern preventing sex and relationships, women's safety and keeping men and women separate. All programmes prohibit sex or relationships with fellow residents during the treatment programme and maintain some ground rules in this regard (e.g. a separate hallway for men and women, a door separating the hallways for men and women, an alarm at night, a lock on the bedroom door of women, women sleep in pairs, anti-sexism regulations, etc.). These rules and measures not only safeguard the women feeling safe and secure, but they also not distract them from the purpose of their stay in the treatment programme.

*"De vrouwen slapen alleen. We hebben een vrouwengang en een mannengang met een deur tussen en een alarm tussen. Eigenlijk noemen wij dat het seks-alarm. Onderling hè. (lacht) Ja, het is zo moeilijk voor die vrouwen om nee te zeggen hè. En omdat zij in de minderheid zijn, pak dat er een vrouw alleen ligt, de kans is zo groot dat er iemand, moesten ze bij elkaar op de gang kunnen komen, die vrouwen gaan niet nee zeggen, of die kunnen dat heel moeilijk, of die willen die aandacht soms vanuit hun patronen. Als ze met twee zijn, moeten ze altijd samen liggen. Het is niet de bedoeling dat ze alleen liggen. Ook zo'n beetje voor sociale controle. [...] Ze hebben ook een slot op de deur, ze mogen hun slaapkamerdeur ook altijd op slot doen. En het alarm gaat op 's avonds als ze gaan slapen en 's morgens vroeg zal de nacht dat afzetten. En als er iets is en dat gaat af, dan zullen ze ook gaan kijken want dat zou eigenlijk niet mogen. Ik weet dat we daar een*

*beetje alleen in zijn, in dat systeem, maar we hebben zoveel problemen gehad met die vrouwen, het was zo schrijnend dat ge zo denkt van 'Eigenlijk, die kunnen niet nee zeggen, ge moet ze beschermen tegen hun eigen'. [...] Ze voelen zich daardoor wel veiliger, dat ze zeggen van 'Eigenlijk vinden we dat niet slecht'." (Residential service I)*

*"The women sleep alone. We have a hallway for women and a hallway for men, with a door in between and an alarm. We actually call it the sex alarm. Amongst ourselves, you know. (laughs) It's really hard for these women to say no. And because they are in the minority, a woman who is lying alone, there is a very big chance that someone, should they be able to get to each other in the hallway, those women won't say no, or they find it difficult to say, or they sometimes seek that kind of attention because of their patterns. If there are two women, they always have to lie together. They are not allowed to lie separately. Also a little bit for social control. [...] They also have a lock on the door, they are always allowed to lock their bedroom door. And the alarm is switched to the evening position when they go to sleep, and is switched back to day when the nightshift leaves. And if something happens and the alarm goes off, well, then they'll take a look, because that shouldn't really be allowed to happen. I know we are kind of on our own in this, in that system, but we've had so many problems with the women, it was so heart wrenching that you think like 'Really, they can't say no, you have to protect them from themselves'. [...] It makes them feel safer, and they say 'Actually, we don't think it's a bad thing'." (Residential service I)*

Still, the services acknowledge the **added value** of a mixed-gender facility, because men and women approach certain things from different perspectives. This offers the opportunity of learning from each other and being confronted with the other sex in a safe and controlled environment. Not only can women learn from a male perspective, and vice versa, but also can female clients learn that not all men are similar to the men they possibly had bad experiences with.

*"Eigenlijk vinden we dat [mixed-gender programma] altijd heel leerrijk, dus we vinden dat boeiend, we vinden dat eigenlijk goed dat we dat hebben. Omdat zij ook elkaars verhaal horen. Inderdaad als ge hier bijvoorbeeld allemaal vrouwen bij elkaar hebt, dan is het vaak ook de man, de agressor, ik zeg maar iets, in een relatie. Terwijl we hebben ook al mannen binnen gehad, die bijvoorbeeld evengoed slachtoffer waren van agressie. Dat die vrouwen ook een andere kijk krijgen op... Dus ik vind dat eigenlijk altijd een interessante wisselwerking om de twee samen te hebben. Dat die elkaar ook op dat vlak leren kennen. Of juist leren van niet elke man is zo. Er zijn ook nog andere mannen. Dus ik ben eigenlijk wel voor een gemengde bezetting, ik zie daar wel voordelen." (Residential service A)*

*"For us that [mixed-gender programme] is always really very educational, so we find it fascinating, we think it's basically good that we have it. Because they also hear each other's story. Indeed, if you have all the women together here, then it's often the husband, the aggressor - just to give an example - in the relationship. While we have also had men in here as well, you know, who were also victims of aggression. The fact that these women also get a different perspective on... So I always find it an interesting interaction to have the two together. That they can also get to know each other on that level. Or learn that not every man is the same. There are also other men. So I'm actually in favour of mixed occupancy, I can see the benefits." (Residential service A)*

However, Kairos (Hôpital Psychiatrique du Beau Vallon) thinks that managing a **single-gender** treatment programme easier than managing a mixed-gender one.

*"C'est plus facile qu'un programme mixte, en termes gestion des relations, d'agressivité, pas de formation de couple, séduction à gérer. Pour les activités, les femmes sont toujours partantes. Les groupes de paroles seraient plus difficiles à gérer, et la facilité de parole des femmes ne serait plus*

*là, elles seraient plus superficielles, elles sauraient moins se renforcer entre elles et régler les problèmes de relation homme-femme, ce dont elles ont souvent besoin.” (Residential service D)*

*“It’s easier than a mixed-gender programme, in terms of relationship management, aggression, no couple issues, seduction to manage. For the activities, the women are always up for it. The discussion groups would be more difficult to manage, and women would not find it as easy to talk any more, they would be more superficial, they would be less capable of supporting each other and solve man-woman relationship problems, which they often need.” (Residential service D)*

A specific remark has been made by some parent-child residential programmes. They mark the absence of **fathers** with their child(ren) and their inclination to enrol more fathers in the programme.

A few centres indicate that managing a programme sensitive to **gender** is difficult. Even though it slowly starts to evolve, it is not a given that all staff members are convinced of women having specific needs other than those of men. Hence, it is not always obvious to change the mentality in a treatment service to start implementing initiatives concerning gender.

A lot of centres highlight the on-going challenge to meet the client’s **needs**. They report that lately a substantial amount of substance users in treatment programmes have more and more diverse needs. They need for example more assistance in administrative and financial matters as these areas of life are more affected by problem substance use once they enter treatment. Another programme marks that their assistance is very outlined and people sign up for that. They prefer working with a given offer rather than maintaining a supply and demand policy. Other programmes state that it is hard to find a job for female clients because of their recurrent psychopathology, and that there needs to be special attention to women due to the minority position that they are in and the difficulty they have to stand up for themselves. Also, guaranteeing safety of women is on-going challenge, and some programmes indicate that clients want to negotiate their leaving the hospital when they feel comfortable or when they want their weekends free.

#### 4.5.6 Programme costs

The principal financial **source** is the same for the four residential centres in Wallonia, i.e. Inami. The main financial source for the programmes in Flanders is *Rijksinstituut voor ziekte- en invaliditeitsverzekering (RIZIV)*. The initiatives have a budget for the global functioning of the programme in which the gender question is a cross-disciplinary theme. Hence there is no specific budget for the gender-sensitive approach. The programmes in psychiatric hospitals are financed by the hospital itself.

*“On n’a pas chiffré, on n’a pas cloisonné. On a adapté les outils qu’on avait, on n’a pas de subventionnement particulier pour la spécificité genre.” (Residential service B)*

*“We did not encrypt, we did not partition. We adapted the tools we had, we do not have specific subsidies for gender specificity.” (Residential service B)*

For almost all initiatives, the budget is adequate, but there is no room to extend the gender-sensitive approach in the programme. The budget is **tight** and excludes extra costs (e.g. renovation of the building, organizing a theme party for children of clients, broken infrastructure like a cot, etc.) other than the basic expenses.

*“Ja, ik denk dat op zich... Voor hetgeen we nu doen, volstaat het, maar ook niet meer. Ge kunt niet zomaar uitbreiden hè. Bijvoorbeeld ik vind dat er veel meer mogelijkheid zou moeten zijn om niet alleen vorming te volgen, maar ook boeken te kunnen kopen, of materiaal.” (Residential service J)*

*“Yes, I think that basically... For what we are doing now, it’s enough, but nothing more. You can’t just expand, you know. I think, for example, that there should be more possibilities not only to do training courses, but also to buy books or material, yes.” (Residential service J)*

In a service or programme, finding a **balance** between the available financial resources, the number of employees, the workload of each employee, the general policy and vision, the general objectives, and the interest in the field of gender-sensitivity and women in treatment, is an actual challenge. Most of the outpatient as well as residential organisations report having a **pioneer** in their programme staff that steps up for female clients and strives for a gender-sensitive approach and the implementation of concrete measures for female users.

*“Ik denk gewoon tout court dat er bij het MSOC dat er inderdaad nog wel meer aandacht kan voor komen, maar hier moet je dat echt hebben van een drijvende kracht. Er moet hem daar iemand achter zetten en dan gaat dat. [...] De algemene werking is al zodanig intensief dat er dan euh... Op dit moment ook zeker minder aandacht is voor zoiets hè, voor gender-specifieke dingen. [...] Dat ligt niet persé aan een echt van ‘het interesseert ons niet’. Het is dan gewoon iets dat nog niet aan de orde is geweest. [...] Er is gewoon binnen heel de organisatie een gebrek aan plaats, tijd, ook omdat het niet een doelstelling op zich is hè, het wordt niet verwacht van ge moet iets doen voor vrouwen alleen. Nee, want je moet iets doen voor heel het MSOC. Al hetgeen je hier dan doet gender-specifiek is een extraatje hè. [...] En je krijgt er ook geen extra geld voor hè. Integendeel, ze zouden misschien nog zeggen van ja, dat is niet wat er van jullie verwacht wordt.” (Outpatient service F)*

*“I just think, simply put, that indeed more can be done at the MSOC [Medical Social Reception Centre], but you really have to rely on a driving force. Someone needs to take the lead and then it will move. [...] The overall operation is so intensive that there, umm... There is currently also definitely less attention for these things, you see, for gender-specific things. [...] This isn't necessarily because of a feeling of ‘it doesn't interest us’. It is just something that hasn't been discussed yet. [...] Within the whole organisation, there is simply not enough space, or time, also because this isn't a goal in itself, you see, it isn't expected that you have to do something for just the women. No, because you have to do something for the MSOC as a whole. Everything you do here that is gender-specific is an extra, you see. [...] And you don't get any extra money for it either. Quite the opposite in fact. They might even say, well, that isn't what is expected of you.” (Outpatient service F)*

## 5 Conclusion

The mapping of gender-sensitive services in Belgium and the semi-structured interviews with key informants from these services prove that a considerable number of gender-sensitive initiatives are identified in the alcohol and drug treatment field. It is clear that single-gender as well as mixed-gender treatment services are already implemented in the treatment demand reduction field in Belgium. However, it appears that a gender-sensitive approach is being operationalised in different ways and the effectiveness of the different programmes has not been confirmed yet.

Even though a gender-sensitive approach is a genuine concern for the different programmes and professionals, a theoretical framework or clear perspective is desired. This might turn gender-sensitivity into a more concrete and accessible concept, which may stimulate and attract other services to adopt the approach in their programmes. In line with the latter, we observe from the analysis that the conceptualisation of gender in the context of alcohol and drug prevention and treatment demand reduction on the one hand and the particularity of a substance using woman in society on the other hand, is very differing from programme to programme. Some organisations report retaining a coherent perspective and understanding of this topic, whereas in some organisations generating a clear vision regarding gender and gender-sensitivity is more challenging. Also, the extent to which gender-sensitivity is translated into concrete measures in a programme and the degree to which a gender-sensitive approach is adopted in a programme varies widely and depends on several aspects. In this regard, the commitment of a pioneer in the organisation and an elaborated vision are defining factors, as well as sufficient budget, staff and facilities.

Based on their experience and daily practice, the programme directors involved in this research indicate an existing need for gender-sensitive practices. The programmes and their professionals report paying attention to the specific needs of women. However, there is a need for specific tools and methods to work with, as well as specific training on gender related issues in the field of alcohol and drug prevention and treatment demand reduction. Merely an absolute minimum of all staff members of the gender-sensitive initiatives are educated or trained in gender issues in substance use prevention and treatment. Also, restricted budget, minimal staff and unsuited facilities impede creating a safe environment and a set of specific activities for women.

Based on the findings, it appears that the persistent stigma on women and substance use in society, and the concurring feelings of shame and guilt that these women experience, put women in a vulnerable position and make it hard for them to get enrolled in treatment programmes. Next to that, the outpatient case management programmes are often not abundantly known in the alcohol and drug demand reduction field on the one hand, and the general healthcare services and the substance users themselves on the other hand. Based on the interviews, general health counsellors such as general practitioners and gynaecologists, appear to not adequately know the available programmes and services for female substance using clients which leads to few referrals by first line healthcare services. Also, one of the most crucial reasons for female users not to enter treatment, is parental responsibilities and care. Care for their child(ren) is experienced by female users as a challenge to seek for help. Next to a more difficult entry to treatment for women, the organisations report that retaining female clients in the programme is the next delicate hurdle to take. Female clients are more likely to drop out treatment programmes due to especially responsibilities regarding their child(ren), but also due to the start of a relationship in the treatment programme, family obligations or external influences (e.g. financial situation).

Based on the data retrieved through a survey and semi-structured interviews, one of the most central features in treatment of women in outpatient programmes and in residential programmes, is parenthood (motherhood) or pregnancy. In that regard it is crucial not to consider a female substance using client as an independent parent, but to also consider 'the other parent' who is possibly not the primary focus of the treatment programme, but needs to be involved in the treatment programme of the female substance using client as well. Next to that, although parenthood is an essential consideration of treatment of women, attention must be drawn to not limiting a gender-sensitive approach in programmes to the parental role of clients.

Although women have a lot of responsibilities, the most important role that is being assigned to women by women and their environment on the one hand and by health and justice services on the other hand, is the role of first care giver of their children. This declaration implies specific needs related to childcare during a mother's treatment, and urgently suggests a shift in mentality in society as regards the (stereotype) roles of women and the conceptualisation of parenthood.

Based on the mapping of gender-sensitive services and the interviews with programme staff members, the prevention field in Belgium accounts for very few gender-sensitive initiatives. There is an extensive lack of targeted and specific campaigns for women regarding for example harm reduction initiatives, sex work, pregnancy, and alcohol and/or medication. An improved understanding of women and substance use will facilitate the development and implementation of more efficient campaigns for girls and young women. However, it is important to note that most likely an underreporting of gender-sensitive preventive actions is set in the research, possibly due to ambiguity regarding the definition and interpretation of gender-sensitive prevention.

Last but not least, the gender-sensitive initiatives plead to not only include the broader context (i.e. family, friends and community) of women in working on gender-sensitivity in the field of prevention and treatment demand reduction. Moreover, the involvement of men – such as a partner, a father, (a) brother(s), (a) son(s) – in the narrative of gender-sensitivity in the alcohol and drug demand reduction field is emphasized as a crucial element in order to make sustainable changes the development of prevention campaigns for girls and young women and treatment demand reduction services for substance using women.

# EXAMPLES OF GENDER-SENSITIVE INITIATIVES IN SOME EUROPEAN COUNTRIES

*Sarah Simonis*

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## 1 Introduction

To explore what is lacking in terms of gender-sensitive services in treatment settings in Belgium, it is valuable to first establish a state of affairs on what is currently settled in Europe and how EU countries currently respond to new challenges and issues with regards to this topic. Though literature on gender-sensitive initiatives in Europe remains scarce, some common topics can be listed that regularly appear in gender-sensitive initiatives that are currently in place. To this end, this chapter provides an overview of the known responses and initiatives that are women-specific and are already implemented in some European countries. First, we specify and describe what types of initiatives are implemented in European countries through the information provided by some of the Reitox national focal points (NFP) and EMCDDA reports. Second, one example of good-practice is presented more in detail in order to highlight the importance of integrating several services. Finally, a review of current recommendations and guidelines of international organizations is provided, in order to set a global frame for our own findings and national recommendations.

## 2 Methodology

The Reitox network is the European information network on drugs and drug addiction and was created at the same time as the EMCDDA. This network includes national focal points (NFP) of each EU country and Norway and Turkey. All NFP were contacted in order to map gender-sensitive initiatives in outpatient and residential programmes throughout Europe, as well as to identify examples of good practice regarding mixed-gender and single-gender approaches in treatment.

Countries that were previously identified by the EMCDDA to have gender-specific initiatives were contacted separately from August to October 2016. In total, 29 European countries were contacted of which seven countries responded that they currently have gender-sensitive initiatives in treatment facilities: Germany, France, Croatia, Lithuania, Italy, Spain, and Hungary. Some of these countries provided also leaflets on specific initiatives and website links for complementary information.

In a next step, a literature review was performed based on the available information through the EMCDDA's reports and Best Practice portal, in addition to a review of specific guidelines and recommendations from the World Health Organization (WHO), the United Nations of interregional Crime and Justice Research Institute (UNICRI), and the United Nations office on Drugs and Crime (UNODC).

## 3 Available initiatives in Europe

Even if the topic of gender-specific approaches is clearly defined as a current need in the field of drug abuse (Arpa, 2017), the number of initiatives is still limited. Each respondent EU country has a specific approach of gender-sensitivity, with specific projects or target populations.

Countries report to collect epidemiological data that might lead to a better understanding and a global view of the phenomenon to further develop and implement evidence-based interventions and policies and best practices, which are tailored to the particular needs of women.

For the description of the reported initiatives, three categories are taken into account, based on the categorization established from chapter two on current Belgian initiatives: prevention, outpatient settings and residential programmes.

### 3.1 Prevention initiatives

Previous EMCDDA reports have mentioned that the main focuses of gender-specific prevention initiatives are sex workers as well as targeted school prevention (EMCDDA, 2006; Ferri, 2015).

In general, few countries reported gender-specific prevention initiatives. In France, a particular prevention campaign was created to target women that continue consuming alcohol during pregnancy (personal communication with French NFP). In Germany, the organization Lagaya creates specific workshops and trainings in the field of prevention. Basically, they target high schools, youth movements and youth protection services. Gender specificities are taken into account regarding several topics (illicit substances, licit substances, new psychoactive substances, eating disorders) in a similar way as there is attention for religious and cultural aspects, as well as for individuals' sexual orientation (personal communication with German NFP).

### 3.2 Outpatient initiatives

In the EMCDDA reports, most gender-specific outpatient settings target pregnant women and focus on perinatal care, although women with child(ren) and family issues are also a major preoccupation (EMCDDA 2006; EMCDDA 2012).

Several EU countries reported on specific outpatient programmes that provide counselling specifically targeted at pregnant women with child(ren) and families. One example is the "Józan Babák Klub" in Hungary, which provides medical, legal, social and psychosocial care/services for pregnant women or mothers with a child under two years old.

Next to this, psycho-social care for women in substitution treatment, needle exchange programmes and specific therapy groups are of major interest as well. As an illustration, in Hungary the "Exchange Only for Women" service is offered to female injecting drug users (IDU) and female relatives of IDUs. Moreover, the project is carried out by an exclusively female staff. Besides needle/syringe exchange, a long list of special healthcare and social services are provided such as consultations with doctors, district nurses, social workers, testing for HIV/HBV/HCV, coaching on general life skills, hygiene and dietary counselling, access to condoms and pregnancy tests, information on family planning and raising children, sexual education, counselling on legal issues and access to internet (personal communication with Hungarian NFP).

### 3.3 Residential programmes

Examples presented in the reports of the EMCDDA mostly concern residential centres that offer to women the possibility to stay in the centre together with their child(ren) (EMCDDA 2006; EMCDDA 2012).

Several countries confirmed the existence of specialized programmes for women in therapeutic communities, specific rehabilitation programmes and specific projects in prison settings. The purpose of most of these initiatives is to support drug and/or alcohol addicts to be reintegrated into the social life and labour market in order to help avoiding social exclusion by improving a better access to healthcare services.

Within the Penitentiary institution of Požega, the only prison exclusively for women in Croatia, various treatment programmes are implemented for alcohol and drug abusers. Examples of these programmes are: an initiative focussing on pregnant women, a psycho-social treatment programme, a specific treatment for minors with aggressive behaviour, and a programme called "Prisoners as parents" (personal communication with Croatian NFP).

### 3.4 A good practice example

Amongst all identified European initiatives, we underline one programme as an example of good practice to point out the importance of integrating several dimensions of the gender issue in the recovery process. But also to mention the relevance of proposing a real diversity in the treatment programmes in order to correspond to the variety of female users' situation.

"FrauSuchtZukunft" is a German association based in Berlin that offers a broad spectrum of female-specific support regarding addiction problems. The association was created in 1982 and the services offered for women with or without children are also partly open to transsexual and intersexual persons. Within these services, substance use and addictive behaviours are looked upon as an individual strategy that women develop to cope with particular pressure and difficulties in life.

The offered support by the association ranges from a combination of counselling and other healthcare, various forms of assisted living, up to the area of "occupational integration" which aims for a timely and sustainable integration into the labour market. All offered services are dedicated to strengthening the health and well-being of women and young girls. Last, but certainly worth mentioning, the association is additionally committed to enable children from addicted families to grow up in a healthy way and in a reliable environment while giving the mothers all the needed support in their treatment (personal communication with German NFP; website of the initiative<sup>3</sup>).

More specifically, the association applies a comprehensive and integrated approach through three components: an outpatient service, a residential service and a job/social rehabilitation service.

#### 3.4.1 *The outpatient service provides*

- Anonymous consultation for women, girls, transsexual and intersexual persons who are abusing illicit substance. They provide also psychosocial care/support for women and transsexuals in substitution treatment;
- Internet or phone consultation;
- Ambulatory treatment/family help;
- Self-help groups for women;
- Prevention workshops for girls and young women who consume licit/illicit substances (e.g. information, harm reduction).

#### 3.4.2 *The residential/housing service provides*

- Supported single living for drug/alcohol-free mothers and their child(ren) (under six years old) or pregnant women in apartments nearby the FrauSuchtZukunft office. Support, counselling on pregnancy, perinatal care, parenting and education are offered. Besides that, also contact and assistance with authorities or youth services, assistance for financial management, housing and job or professional orientation is provided;
- Supported group living for drug- and alcohol-free women, with the possibility to bring children;
- Supported single living for homeless women. They help with the organization and structuration of the everyday life and encourage the autonomy of the person;
- Therapeutic community for women in a house with garden;
- Supported group living for homeless women in substitution treatment;

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<sup>3</sup> <https://frausuchtzukunft.de/>

- Apartment for women with mental health issues (group living) including counselling and questions on specific mental illnesses, counselling for a better autonomous life and guidance on mental health and substance use.

These different services are complemented by a range of activities and support, depending on the specific situation and needs of the women: pedagogical and therapeutic groups; individual consultation; assistance/structuration for the everyday life, promoting an autonomous life; relapse prevention; intervention in case of crises; PTSD treatment; guidance for finances; support regarding administrative procedures and visits with authorities or doctors; therapy based on work (garden, kitchen, housing); courses (yoga, non-violent communication, ..); spare time activities (with or without instructions); ambulatory therapy/group therapy; professional orientation/creative jobs/job training (e.g. catering industry: Café Seidenfaden – kitchen or administrative jobs); care and sensitivity to trauma.

### 3.4.3 *The social rehabilitation/Job service provides*

- Job workshops with evaluation of the competencies, preparation of application documents, support during the recruitment procedure;
- Jobs in a creative manufactory;
- Training of life skills in groups, exploration of personal and professional resources, socio-pedagogical support, training in catering industry (Café Seidenfaden: kitchen, administrative tasks and cleaning), training or jobs via specific individualized programmes including an income;
- Ambulatory therapy.

## 4 Available international guidelines and recommendations

On a global scale, throughout the last years, based on the clear lack of gender-sensitive initiatives and related reliable data, several guidelines, recommendations and resolutions have already been published by European or international organizations to promote gender-based interventions (EMCDDA, 2012; UNICRI, 2011; UNODC, 2012; WHO, 2014). All of these recommendations advocate that there is an urge to integrate and understand the gender dimension in drug abuse in general, as well as stating the need for future initiatives that are able to address the different needs of women and that integrate trauma-informed services, interventions in prison, pregnancy care, childcare, or mental health services. A safer physical environment and a welcoming, non-judgmental place are essential to provide qualitative healthcare.

It is clear that a crucial first step towards a better understanding of the need of female substance users and gender-related queries remains the estimation of the prevalence of this specific target population (Arpa, 2017). Special attention should go to removing barriers to enrol into treatment, in particular the lack of childcare and the fear for legal consequences, as well as finding a balance between the protection of the child and the separation from their parents (Arpa, 2017; EMCDDA, 2006). Moreover, better support towards policy makers is required to promote gender equality and integrate women using substances in the development of treatment and prevention programmes (EMCDDA, 2012).

Therefore, the interest of this study is to acquire a better understanding of the topic and to learn how implementing gender-sensitive initiatives in Belgium, and this by means of an international framework of guidelines.

## 5 Conclusion

To contribute to a measurable reduction in the drug demand reduction field, the EU drug action plan has defined several actions regarding gender-specific issues such as, improving the availability and effectiveness of evidence-based prevention measures, the exchange of best practice in prevention, and developing and expanding the

availability, coverage and accessibility of evidence-based comprehensive and integrated treatment services. Though the plan emphasizes the importance of integrating a transversal approach of gender issues, the low number of initiatives that put focus on gender-sensitivity as identified through the different Reitox national focal points, suggests that this issue has so far not been a priority in most EU countries. In Belgium, for example, there is a concern expressed on the topic, but nevertheless a lack of a global approach and philosophy is observed.

As part of the scarce initiatives that are offered, the primary concern is pregnant women. Though certainly a topic of great importance, we might question whether these are services that truly take into account a special focus on the gender dimension? Obstacles and needs of female users are diverse, hence requiring a variety of services that correspond to the complexity and specificity of women's life, including social and cultural differences.

# SECONDARY ANALYSIS OF GENDER DIFFERENCES IN POPULATION AND TREATMENT SAMPLES

*Johan Rosiers, Sarah Simonis, Else De Donder, Tina Van Havere, Lies Gremeaux*

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## 1 Introduction

International studies reported substantial differences between male and female substance users and revealed that the gender ratio in treatment populations differs according to treatment modality and primary substance. Though the gender ratio may vary by country or substance, generally male outnumber female by four, suggesting an inequitable access for women to treatment (Montanari et al., 2011). Still, gender differences among substance abusers in and out of treatment are poorly documented in Belgium, mainly due to a lack of national data covering the prevalence of substance use in the population. The extent of this gender gap has not yet been studied between population and treatment samples. In this chapter, several available databases are analysed, some covering only Flanders, others covering the whole Belgian population: the Belgian Health Interview survey (BHIS, Belgium), the VAD school survey (Flanders), the VAD student survey (Flanders), the VAD nightlife survey (Flanders), the Belgian branch of the Global Drug Survey (GDS, Flanders), and the Treatment Demand Indicator register (TDI, Belgium).

The aims of this chapter are threefold:

As a first aim, this study investigates the gender gap in use and problem use of alcohol, illicit substances and psychoactive medication among the general population, specific populations of young people, at risk populations (i.e. recreational substance users) and persons treated for substance use problems in Belgium and in Flanders.

As a second aim, this study looks for trends in the gender gap regarding use and problem use of alcohol, illicit substances and psychoactive medication in the same study populations in Flanders and Belgium.

Finally, the third aim is to compare the extent of the gender gap between population and treatment samples in Belgium.

## 2 Data sources and methodology

### 2.1 Belgian Health Interview survey (BHIS)

First, the gender gap in substance use and problem substance use is assessed in the general population (between 15 and 64 years). Therefore, data of the Belgian Health Interview survey are analysed. The BHIS has been developed by the Scientific Institute of Public Health (WIV-ISP) to collect information on the health of the general population, their medical consumption (e.g. use of psychoactive medication), their lifestyle (eg. substance use) and some socio-economic parameters. Its aim is to measure the health status of the population and their health needs in order to develop a pro-active health policy (Charafeddine et al., 2012). The first wave of the BHIS took place in 1997 and was followed by four consecutive waves carried out in 2001, 2004, 2008 and 2013. The methodology and core questions have remained quite similar throughout the different survey waves, which allows to measure significant changes over time.

The target population of the survey covers all individuals residing in Belgium at the time of data collection, with no restrictions regarding nationality or age. The basic sample size is 10.000 interviews. This fixed number of

individuals is divided between the three regions in Belgium: 3500 in Flanders, 3500 in Wallonia (including 300 in the German-speaking Community) and 3000 in Brussels. Three types of questionnaires are used: a household form that collects information on the characteristics of the household (e.g. composition, monthly income, and health expenditures), a face-to-face form that collects information from selected members of the household on topics such as chronic illnesses, disabilities, ... and a self-administered written form that collects personal information among all respondents. The written questionnaire is used for topics that are more sensitive (e.g. alcohol and drug use). Because the questions on substance use are most comparable for the last three waves of the BHIS survey, this secondary analysis will focus on the periods 2004 – 2008 – 2013.

The BHIS is a cross-sectional household interview. As a result, people living in an institution (including psychiatric institutions) or prisons are excluded from the survey for practical reasons. Also people who do not have a national identification number, such as homeless persons or persons without legal permit, are not selected for participation in the survey (Gisle, & Demarest, 2014). Since these groups are at increased risk of substance use, this may bias the findings regarding substance use. Consequently, results of the Health Survey are likely to underestimate the actual prevalence of illicit substance use since some populations (prisoners, institutionalized persons, homeless persons, etc.) were not asked to participate.

## 2.2 VAD school survey

Since alcohol and drug use is most often initiated during adolescence and young adulthood, we analyse prevalence data among three groups of young people (15-30 years old, see also 4.2.3 and 4.2.4). VAD, the Flemish centre of expertise on alcohol and other substances, uses two monitoring instruments for measuring substance use in young people (see also 2.3).

First, the VAD school survey is a yearly survey on substance use targeted at pupils (12-18 years of age) in secondary schools in Flanders (Rosiers, 2016a). This survey started in 2000-2001 and the latest data available concern the year 2015-2016. Data from the VAD school survey are analysed over time to assess changes in gender differences over the years regarding various substances and frequency of use. Due to some changes in the questionnaire over the years, data are not comparable for the whole data collection period. For this study, we focus on comparable data for the period 2007-2008 until 2015-2016. In 2015-2016, a total of 27,146 pupils from 63 different Flemish schools participated in the survey. A representative sample of 7,349 pupils was drawn to facilitate further analyses. The survey is a self-administered questionnaire that is answered anonymously.

Besides personal information (sex, age, education level), prevalence and frequency of substance use (tobacco, alcohol, cannabis, other illicit substances, medicines, gambling and gaming), the questionnaire includes data regarding age of onset, motives for (not) using alcohol or cannabis, negative experiences after using alcohol or illicit substances, availability of substances, perception of substance use among peers, expected reactions of peers and parents regarding substance use, knowledge of drug legislation, knowledge of school regulations or consult possibilities at school, school atmosphere, ...

More information on this survey can be found at [www.vad.be/alcohol-en-andere-drugs/onderzoek/leerlingenbevraging.aspx](http://www.vad.be/alcohol-en-andere-drugs/onderzoek/leerlingenbevraging.aspx)

## 2.3 VAD student survey

The second database of young people, the student survey, started as a collaboration between the University of Antwerp and VAD (Rosiers et al., 2014). The student survey is aimed at students in higher education (universities and university colleges). It is a self-administered online questionnaire. Demographic questions as sex, age, faculty and living conditions are asked. 'Living condition' assesses the extent to which students live at home (e.g. with parents) or in a student apartment. The questionnaire further includes questions regarding prevalence and frequency of substance use (tobacco, alcohol, cannabis, other illicit substances, medicines), problem use of alcohol (AUDIT), problem use of cannabis (ProbCannabis-DT) or other substances (DAST-10), motives for using

alcohol and context of use, negative experiences after using alcohol or illicit substances, health and mental well-being (GHQ-12).

The student survey has been organized three times, in 2005, 2009 and 2013. In 2017, a fourth wave of the study took place, but these data were not available at the time of the analyses. In 2005, the survey was organized for the first time within the network of University of Antwerp and the Antwerp University Colleges, in 2009 it was extended to higher education in Ghent and in 2013 it concerned all higher education institutions in the cities of Antwerp, Ghent and Leuven. Because the student characteristics in these consecutive waves differ too much, we only analysed the data of 2013. In total, 19,822 students completed the online questionnaire. A representative sample of 2,375 students was drawn to facilitate further analyses.

More information on this survey can be found at [www.vad.be/onderzoek/studentenbevraging](http://www.vad.be/onderzoek/studentenbevraging)

## 2.4 VAD nightlife survey

Gender differences in substance use are also analysed among ‘at risk’ populations through a secondary analysis of data from the VAD-nightlife survey in Flanders and the Belgian branch of the Global Drug Survey (see 4.2.5).

In 2003, VAD started with a survey in nightlife settings in Flanders. This survey was repeated six times (2003, 2005, 2007, 2009, 2012 and 2015) (Van Havere et al., 2012, van Wel et al. 2016). In every wave, a sample of party people was selected at three clubs, two dance events and two music festivals in Flanders. These specific events and clubs were chosen because of their scale (to ensure a large enough sample size) and location (regional spread). The same locations were involved each year of the survey, with the exception of events that were not organized anymore or clubs that stopped their participation. In this case, comparable events or clubs were included with similar characteristics such as music styles, visitor profiles, number of attendees and indoor/outdoor event.

In each survey from 2003 to 2015, between 607 and 775 respondents completed an anonymous self-report questionnaire. In total, over 4,000 party people participated in the study (Rosiers, 2016b; Van Havere et al., 2012). For this survey, we cannot state that the data from any particular year are representative for the wider population of party people. Since we do not have a representative sample and since the selection of the events where respondents were recruited differed over the years, it is not possible to give trends in substance use for this survey population. Therefore, this study focuses only on the last data collection in 2015.

In 2015, 770 respondents were selected at dance events, music festivals and clubs in Flanders. Besides socio-demographic information, study participants (mean age 25.5 years) answered questions on patterns of going out, music preferences and frequency and patterns of substance use (tobacco, alcohol, cannabis and other illicit substances, psychoactive medication). Since 2012, problem alcohol use was assessed using the AUDIT-C.

More information on this survey can be found at [www.vad.be/alcohol-en-andere-drugs/onderzoek/uitgaansonderzoek.aspx](http://www.vad.be/alcohol-en-andere-drugs/onderzoek/uitgaansonderzoek.aspx)

## 2.5 The Global Drug Survey (GDS)

The Global Drug Survey (GDS) is a yearly online worldwide survey on substance use. 102 000 people from more than 50 countries participated in the survey of 2015, among which 1998 (2%) persons from Flanders in Belgium (Winstock et al., 2015). The University College of Ghent coordinates the Belgian branch of the GDS since 2013 (Van Havere, 2017). In this chapter, we will use the data of GDS 2015 because these are the latest available data. The recruitment strategy is an example of non-purposive sampling. As participants in this survey may have a greater interest in or experience with substances, they are not representative for the wider population. Still, web surveys are an efficient way of gaining in-depth understanding of stigmatised behaviours (Barratt et al., 2017). Therefore, the findings provide a useful snapshot of what substances are being used and how these have an impact on people’s lives in Belgium. Numerous variables are included in this survey (e.g. demographic

variables, substance use prevalence, prevalence of alcohol use, prevalence of problem alcohol use (AUDIT), and motives for substance use). A long list of licit and illicit substances is included in this survey: 'classic' substances like alcohol, cocaine, MDMA, speed, but also several new psychoactive substances (NPS) like 4-FA, 2-cb, DMT etc.

## 2.6 Treatment data - Treatment Demand Indicator (TDI)

Finally, we focus on treatment data based on the Treatment Demand Indicator (TDI) to describe gender differences regarding substance of abuse and the representation of women in various treatment modalities. The Treatment Demand Indicator (TDI) is an epidemiological indicator that is collected in a standardised way since 2000 in all 28 member states of the European Union, Turkey and Norway, on behalf of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (Antoine et al., 2016). Through the use of this indicator, insights are gained regarding the characteristics, risk behaviours and substance use patterns of service users at the time of their admission into treatment. As such, the register provides information on the incidence of treatment demands.

In Belgium, the extended registration started at a national level in 2011 and since that date an increasing number of treatment facilities are participating in the data collection. The Scientific Institute of Public Health (WIV-ISP) has been appointed as coordinator for the registration. This surveillance register collects information on every treatment episode started by service users for a substance use disorder. Information is collected on socio-demographic characteristics, treatment history and substance use patterns. Service users are identified as unique individuals, using their national identification number in order to identify multiple treatment episodes followed by the same person. To allow a wide coverage of the population, a large range of treatment facilities, both residential and outpatient, have the possibility to participate in this registration. Registration is done for every new treatment episode defined as the period between the start of treatment (the first face-to-face contact between a professional treatment provider and service user) and the end of activities provided in the context of this programme.

TDI includes information about demographics (age, sex, nationality, living situation, working situation, education level), treatment history and substance use (primary substance causing problems, other substances used, frequency and route of use, injecting substance use). Since 2015, all Belgian hospitals are obliged to participate in the registration. Only the data from 2015 will be included in this secondary analysis, as this is the most recent and complete collection period. In 2015, 28 453 new treatment episodes were registered in the Belgian TDI: 64% in Flanders, 26% in Wallonia and 10% in Brussels. Two third of the treatment episodes were registered in residential treatment centres, primarily hospitals (~60%). Specialized rehabilitation centres (residential and outpatient services) and mental healthcare centres represent about 30% and 7%, respectively.

We have to point out some limitations of the TDI database: 1) the lack of data from non-specialized services (e.g. general practitioners, low threshold medical centres, and private practices); 2) potential duplication among registered service users (30% are registered without national identification number); and 3) registrations only refer to new treatment demands (not to persons yet in treatment).

## 2.7 Common indicators of substance use

In the databases we studied, substance use and problem substance use are not measured in a similar way. To facilitate comparability of the analysed data, we selected ten common indicators which are relatively equally measured in all surveys. These indicators are:

- **Age of onset of alcohol use:** this indicator gives the average age when alcohol was used for the first time in the study population
- **Last year alcohol use:** this indicator identifies persons who drank alcohol recently, that means during the past 12 months. Within this group, we also look at people who drank alcohol **regularly**, that is at

least once a week. In the VAD student survey, regular alcohol use is differentiated by type of drink (beer, spirits).

- **Overconsumption of alcohol (+14/21):** this indicator categorizes weekly users of alcohol in accordance with the definition of excessive alcohol use, in particular more than 14 glasses of alcohol per week for women, and 21 or more glasses of alcohol per week for men. The GDS does not include this item.
- **Risky alcohol use (+10):** this indicator categorizes weekly users of alcohol according to a new Flemish preventive guideline on alcohol use, which was launched by VAD in 2016 (VAD, 2016a). This guideline is based on available evidence on health and mortality risks of alcohol use, guidelines from other countries, data on alcohol use in Flanders, acceptability of the guideline and clarity and communicability of the message (VAD, 2016b). There is no difference made between men and women in the new guideline. Because men have more acute risks as a result of alcohol use, their risk of alcohol-related mortality is higher. Women are more vulnerable for long-term health risks due to alcohol use. For both men and women, drinking more than 10 standard glasses a week increases health risks.
- **Binge drinking and heavy drinking:** in the VAD surveys, binge drinking is measured in a gender-specific way taking into account a specific time span. NIAAA (2004) suggested that the term 'drinking occasions' should be limited in time. They launched the definition of 4+/5+ units within a time span of two hours. Later, US studies advised to put the cut-off for binge drinking on four glasses for women and six glasses for men (Chavez et al., 2011; Olthuis et al., 2011). Therefore, a more customised definition of binge drinking was proposed by VAD, defining this as drinking at least four standard glasses of alcohol in a two-hour period (women) and drinking at least six glasses of alcohol in the same time span (men). This definition was also used by other researchers in Belgium (Amrani et al., 2013).

In BHIS and GDS, measures of hazardous drinking are based on the third question from the AUDIT (Saunders et al., 1993). BHIS uses the original question, so the results refer to the proportion of the total population drinking six or more glasses of alcohol on one occasion (without taking into account the time span).

GDS uses a gender-specific variant of the same AUDIT-question, with a threshold of six or more glasses of alcohol on one occasion as indicator for heavy drinking among women, and a threshold of eight or more glasses of alcohol on one occasion as indicator for heavy drinking among men.

- **Problem use of alcohol:** problem use of alcohol is measured with different questionnaires in various surveys. In the VAD surveys and the GDS, problem alcohol use was identified using the validated Alcohol Use Disorder Identification Test (AUDIT) (Saunders et al., 1993). "Alcohol use disorder" is an umbrella term for alcohol dependence, abuse and intoxication. It points to problems caused by alcohol consumption in relation with different life domains (health problems, personal relationships, school, work, ...). Several studies indicate that AUDIT-C, the shortened version of AUDIT, in which only the first three questions are used, is a better indicator for problem or risky drinking than the AUDIT (Bradley et al., 2007; Rumpf et al., 2012). For AUDIT-C, we use the gender-specific cut-off score of 4+ for woman and 5+ for men (Reinert & Allen, 2007).

In the BHIS, the CAGE questionnaire is used to identify problem drinking (Ewing, 1984). CAGE is an acronym for 'Cut', 'Annoyed', 'Guilty' en 'Eye-opener', the main topics of the four questions<sup>4</sup>. Item responses on the CAGE are scored 0 or 1, with a higher score as an indication of alcohol problems. A total score of two or more is considered clinically significant.

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<sup>4</sup> • Have you ever felt you should Cut down on your drinking? • Have people Annoyed you by criticizing your drinking? • Have you ever felt bad or Guilty about your drinking? • Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

- **Age of onset of cannabis use<sup>5</sup>:** this indicator gives the average age when cannabis was used for the first time in the study population.
- **Last year use of cannabis:** this indicator refers to the last year prevalence of cannabis use, i.e. the recent use of cannabis. Within this group, we also focus on persons who use cannabis **regularly**, that is at least once a week in the VAD surveys. For the BHIS, regular use of cannabis cannot be calculated.
- **Last year use of other substances than cannabis (ecstasy, amphetamines, cocaine):** this indicator refers to the last year prevalence of the use of other substances than cannabis (ecstasy, amphetamines, cocaine). For the GDS, only last year use of all illicit substances can be included.
- **Use of psychoactive medication:** this indicator differed between several surveys. In the BHIS, the use of psychoactive medication refers to the use of sleeping pills, tranquilizers and antidepressants in the past **two weeks**. In the VAD surveys, use of psychoactive medication refers to using sleeping pills/tranquilizers during the past **12 months**. The GDS did not collect this information.
- **Drunkenness and regular drunkenness** (at least once a week): is only studied in the VAD school survey.
- **Combined use of illicit substances and alcohol:** is only studied in the VAD nightlife survey.
- **Combined use of different illicit substances:** is only studied in the VAD nightlife survey.

## 2.8 Age groups

In the analyses, we distinguish between three age groups as referred to in chapter five on treatment experiences of female substance users:

- 15-30 years: VAD school survey (12-18 years); VAD student survey (18-25 years), VAD nightlife survey (15-30 years), GDS (16-30 years) and BHIS (15-30 years)
- 31-45 years: BHIS
- 45+: BHIS

## 2.9 Statistical analyses

Previous research mainly focused on the male to female gender ratio (Montanari et al., 2011) for assessing gender differences in substance use. In this study, odds ratios (OR) were used in order to estimate the association between gender (male/female) and the selected indicators of substance use. The more the OR value differs from 1, the stronger the association or, otherwise said, the higher the gender gap. The 95% confidence interval (CI) is used to estimate the precision of the OR, but is only mentioned in the tables and annexes.

Multivariate logistic regression models were used to further assess the impact of gender in risky drinking patterns. Different indicators for problem alcohol use were used as dependent variables (i.e. 'more than weekly beer drinking', 'being at-risk for problem drinking by the AUDIT-C (cut-off 4/5)', 'being at-risk for problem drinking by CAGE (cut-off 2)'). Besides gender, also living situation (living in parental house versus living independent), age of onset of drinking and mental health problems were used as dependent variables in these models. To measure the respondent's mental health state, the 12-item General Health Questionnaire (GHQ-12) was used. This is an internationally recognized, validated instrument for measuring psychological well-being.

The GHQ-12 is included in the VAD student survey and in the BHIS. The GHQ-12 is a multidimensional scale, including three sub-scales: anxiety and depression, lack of self-confidence and social (dys)functioning (Vanheule

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<sup>5</sup> In the GDS questionnaire, different categories of cannabis were included but in this report only the results for herbal cannabis will be presented, as in the VAD and BHIS surveys.

& Bogaerts, 2005; Gao et al., 2004). In this study, GHQ-12 is used as an indicator of mental well-being, with the lowest scores for each GHQ-12 question being recoded to 0 and the highest scores to 1. Then, the scores are added so that a score between 0 and 12 is obtained. A cut-off point  $\geq 4$  is used to refer to psychological problems (Biro et al., 2011; James et al., 2013; Lundin et al., 2017).

For the nightlife population, going out in bars was also selected as an independent variable in the multivariate model.

To assess the goodness-of-fit of the multivariate models, Nagelkerke  $R^2$  is used. In order to set a threshold for an acceptable model fit, the magnitude of this pseudo  $R^2$  measure should be above 0.1.

All these analyses were performed using SPSS 23 (VAD surveys and GDS) and SAS (BHIS and TDI). The significance level was set at  $\alpha = 0.05$ . Significant differences are mentioned in the tables with the symbol (\*\*\*) if  $p < 0.001$ ; (\*\*) if  $p < 0.01$ ; (\*) if  $p < 0.05$ .

### 3 Results by type of substance

In this chapter, we present the main results for gender differences in the use of alcohol, psychoactive medication and illicit substances. We mainly focus on odds ratios, because these are statistically significant indicators of potential gender differences. The odds ratio indicates if there is a gender difference and magnitude: the more the value differs from 1, the bigger the gender gap.

#### 3.1 Alcohol

##### 3.1.1 Age group 15 to 30 years

##### 3.1.1.1 Secondary school students (VAD school survey 2007-2016)

The results of the secondary school survey show a clear decline in last year use of alcohol over the last years. While two thirds of the population drank alcohol in the previous 12 months in 2007-2008, this rate dropped to just above half of the population in 2015-2016. Male and female secondary school students have equally high last year prevalence rates and we see a similar, declining tendency among both genders (see annex Table 1).

The age of onset for alcohol use does not significantly differ between male and female adolescents. The mean age of onset is around 14.5 years for both genders, when assessed among 18 year old students, indicating that a lot of secondary school students start drinking alcohol under the minimal legal drinking age<sup>6</sup>.

Gender differences are observed when we look at riskier drinking patterns, like 'regular drinking', 'binge drinking' and 'drunkenness'. Regular alcohol use, defined as drinking at least once a week, is more common among male students than among female students. In the period 2007-2008 until 2015-2016, the levels of regular alcohol use dropped significantly, but equally among both genders (see Figure 4.1). OR during that period fluctuated between 1.7 and 2.2, indicating almost twice as many risky drinkers among male respondents, but without indications that gender differences increased or decreased over that period (see annex Table 2).

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<sup>6</sup> In Belgium, it is forbidden by law to sell, serve or offer alcohol to people under 16. Spirits may not be sold, served or offered to minors under 18 years.

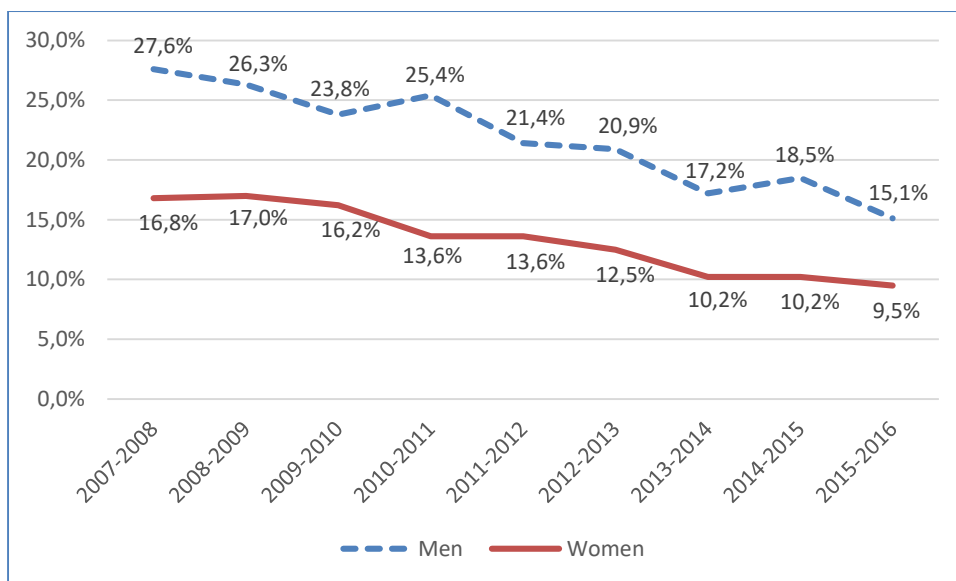


Figure 4.1 Evolution of regular alcohol use among secondary school students in Flanders (2007-2016).

Source: VAD (2017)

Notably, the prevalence of last year drunkenness does not show a similar linear decrease. Between 2010-2011 and 2014-2015, these rates increased for both male and female secondary school students. Only in 2015-2016, the rates of last year drunkenness dropped again, in a way that male rates were as high as five years earlier, whereas female students were only slightly higher than in 2010-2011. So gender differences, if any at the start, even got smaller. Odds ratios for gender differences decreased from 1.4 to 1.2, although still significant (see annex Table 3).

Regular drunkenness, defined as being drunk at least once a week, is characterized by a clear gender gap. Although regular drunkenness does not occur often (around 3% among boys, 1% among girls), the difference between both genders remained relatively solid around 3.0, with two 'extremes': OR = 4.1 in 2012-2013 and OR = 2.7 in 2015-2016 (see annex Table 4). Future research whether the latest OR are an indication for a declining gender gap, or just a chance occurrence.

A last risky pattern to be examined among secondary school students is 'binge drinking' (at least once a week). It was not yet possible to monitor evolutions over a longer period, since this indicator is only measured since 2013-2014. During the last three school years, male students show slightly higher prevalence rates of binge drinking than female students (OR = 1.7-2.2) (see annex Table 5).

### 3.1.1.2 Higher education students (VAD student survey 2013)

Surveys among higher education students show that the age of onset for alcohol use is lower for men than for women. 71.4% of the male students drank alcohol for the first time when they were younger than the legal age of 16 years. Among female students, 60.0% had their first alcoholic consumption before the age of 16.

However, this does not mean that drinking alcohol is more common among male students. Similar to the secondary school students, no gender difference was observed in last year alcohol use (see annex Table 14). Prevalence rates are very high among both genders (98.0% among males, 97.9% among females). If we look at specific categories of alcoholic beverages, some gender differences are observed. Male students have significantly higher last year prevalence rates for spirits (distillated alcohol) and beers than female students (OR = 1.6 and 3.4, respectively). Last year consumption of both alcoholic beverages is also very high among women: 81.6% for beer and 80.2% for spirits.

If we look at regular alcohol consumption, some gender-specific phenomena emerge. Regular use of beers and spirits is significantly more common among male students (OR = 4.4 and OR = 1.6), but regular use of wine is twice as common among female students (OR = 0.5). Male students demonstrate more frequently risky drinking patterns than their female counterparts. Regular binge drinking (see above) is much more common among men (OR = 4.2). Based on the gender-specific 4+/5+ cut-off score for the AUDIT-C as an indicator for increased health risks, men show more risk behaviour than women (OR = 1.9).

To assess the impact of gender in frequent and risky drinking, we constructed two multivariate logistic regression models: Model 1 with frequency of beer consumption as dependent variable, and model 2 with the AUDIT-C score, based on a cut-off score of 4+ for women and 5+ for men as dependent variable.

Model 1 (see Table 4.1) indicates that gender is a much stronger indicator for frequent beer drinking than commonly emphasized indicators like living situation and age of onset. The OR for gender is two to three times higher than for living situation and age of onset. Mental health, measured by GHQ-12 with four as cut-off point, does not affect the frequency of beer drinking in this model.

Table 4.1 *Correlates of frequency of beer consumption during academic year among secondary school students (dependent variable: occasional (0) vs. regular (1))*

	B	S.E.	Exp. (B) (OR)	95% C.I.	p
Living situation*	0.64	0.10	1.90	1.57-2.31	<0.001
Age of onset for drinking beer	-0.49	0.05	0.62	0.57-0.67	<0.001
GHQ-12 (score $\geq 4$ )	-0.14	0.11	-	-	0.190
Gender**	1.51	0.10	4.52	3.73-5.49	<0.001
(Constant)	2.44	0.23			
Nagelkerke $R^2 = 0.25$ (Sig.: $p < 0.001$ )					

\*: Living in parental house vs. living independent

\*\*: Woman=1; man=2

In model 2 (see Table 4.2), the strength of the model and the impact of gender are lower but still significant. The benefit of this model is that the assessment of the risk behaviour is already gender-tailored. In this model, gender plays an equally important role in predicting risky alcohol consumption than living situation and age of onset. As in model 1, mental health does not have an impact on risky drinking.

Although both models are not very powerful, these results emphasize the importance of gender in the occurrence of risky drinking behaviours.

Table 4.2 *Correlates of problem drinking among secondary school students (dependent variable: AUDIT-C dichotomous score cut-off 4+ (women) / 5+ (men) (no (0) vs. yes (1))*

	B	S.E.	Exp. (B) (OR)	95% C.I.	p
Living situation*	0.64	0.10	1.89	1.56-2.28	<0.001
Age of start of drinking alcohol	-0.62	0.05	0.54	0.49-0.59	<0.001
GHQ-12 (score $\geq 4$ )	-0.14	0.10	-	-	0.175
Gender**	0.57	0.10	1.76	1.46-2.13	<0.001
(Constant)	1.47	0.23			
Nagelkerke $R^2 = 0.18$ (Sig.: $p < 0.001$ )					

\*: Living in parental house vs. living independent

\*\*: Woman=1; man=2

### 3.1.1.3 Nightlife participants (VAD nightlife survey 2015)

Although this survey aims at a specific, high-risk population for alcohol and drug use, similar gender ratios are observed as in the two other VAD surveys. No gender differences are found regarding last year prevalence of alcohol use (see annex Table 15). Once again, we see a higher prevalence among male party people of regular alcohol drinking (OR = 2.9) and binge drinking (OR = 3.3). Based on a recent guideline to prevent harmful alcohol, developed by VAD, significantly more men than women drink more than 10 alcoholic beverages per week (OR = 5.4). Even if we assess overconsumption of alcohol in a gender-specific way, i.e. 14+ drinks for women and 21+ drinks for men as indicator, this gender gap persists (OR = 6.2). The gender ratio for problem drinking (based on the AUDIT-C) lies in the same range of that among higher education students (OR = 2.0) (cf. 2.3.3).

Similar to the higher education survey, we ran a multivariate logistic regression model to assess the impact of gender on risky drinking patterns in the nightlife survey (see Table 4.3). We used a model with frequency of alcohol consumption as dependent variable. This model also indicates that gender was the strongest predictor for regular alcohol drinking, even stronger than going out in pubs or bars. Living situation did not have an impact at all.

Table 4.3 *Correlates of frequent alcohol consumption among nightlife participants (dependent variable: frequency of alcohol consumption (occasional (0) vs. regular (1))*

	B	S.E.	Exp. (B) (OR)	95% C.I.	p
Living situation*	0.13	0.21	-	-	0.539
Going out in pubs or bars	0.44	0.06	1.55	1.38-1.74	<0.001
Gender**	1.03	0.20	2.81	1.89-4.18	<0.001
(Constant)	2.44	0.23			
Nagelkerke R <sup>2</sup> = 0.21 (Sig.: p<0.001)					

\*: Living in parental house vs. living independent

\*\*: Woman=1; man=2

### 3.1.1.4 Nightlife participants (Global Drug Survey 2015)

As opposed to most previously mentioned surveys, we observe a significant difference between the age of onset for alcohol use among female and male respondents of the GDS. However, the difference was rather small: the mean age of onset for female respondents was 14.1 years and 13.8 years for male respondents.

In the GDS population, the results demonstrate no significant differences between female and male respondents for last year use of alcohol (OR = 1.4). 96.4% of all female and 97.3% of all male respondents reported they drank alcohol in the last year.

For weekly drinking, a gender difference is observed: weekly drinking appeared more often among male (78%) than among female respondents (70.9%) (OR = 1.5). If we look at risky drinking patterns, like prevalence of heavy drinking (defined in the GDS as six or more drinks per occasion for women and eight or more drinks for men), a clear difference is observed in the group of weekly heavy drinkers: 17.1% of all women reported weekly heavy drinking in comparison with 33.0% of the male respondents (OR = 2.4). Also for risky alcohol use, defined as more than 10 drinks per week, we find a clear gender difference: 3.3% of the female drinkers drink more than 10 drinks in comparison with 10.9% of the male respondents (OR = 3.6).

Based on the AUDIT-C gender-specific 4+/5+ cut-off score, no difference is found between male and female respondents: 74% of all men and women scored above the cut-off score.

### 3.1.1.5 General population (Health Interview Survey 2013)

As in the VAD surveys, male and female adolescents show the same levels of last year drinking. The prevalence of alcohol use in the general population (80.0% among men and 76.4% among women) is lower than in the higher education and nightlife survey of VAD (see annex Table 16). As in the other databases, gender differences become manifest when risky drinking patterns are analysed. Risky drinking, measured according to the new VAD standards for risky drinking (>10 drinks per week), is more prevalent among men than among women (OR = 3.1). Also regular heavy drinking (OR = 4.1), measured in a different, non-gender-specific way compared to the VAD surveys, is significantly higher among men. For the assessment of problem alcohol use, the CAGE (with a cut-off of 2+) is used in the BHIS. Based on this threshold, the male population of 15 to 30 years old scores more than twice as high compared with the female population of that age (OR = 2.2).

### 3.1.2 Age group 31 to 45 years

Unlike the results of the surveys among the younger population, a gender difference regarding last year alcohol use is observed in this age group: 85.7% of the men aged 31 to 45 drank alcohol during the previous 12 months, compared to 76.1% of women of the same age (see annex Table 17). This is a rather small, but significant difference (OR = 1.9). Regarding risky drinking, the results of this age group do not differ from those among younger persons. Gender ratios for drinking  $\geq 10$  drinks per week (OR = 2.6), overconsumption of alcohol (OR = 2.1), weekly heavy drinking (OR = 5.6) and problem drinking based on CAGE  $\geq 2$  (OR = 2.2) are similar to those among the 15 to 30 age group.

### 3.1.3 Age group above 45 years

In this age group, a slight significant gender difference is observed in terms of last year alcohol use (OR = 2.0) (see annex Table 18). Notably, the gender gap for risky drinking patterns becomes smaller in this older population. Gender differences in risky drinking patterns as measured by the  $\geq 10$  drinks standard (OR = 2.0), overconsumption by the 14/21 standard (OR = 1.7), problem drinking by CAGE  $\geq 2$  (OR = 1.9) and harmful heavy drinking (OR = 2.7) are less pronounced in this older population.

### 3.1.4 Conclusion gender gap alcohol

The last year prevalence of alcohol use does not show clear gender differences. When the focus is shifted to more risky alcohol use patterns, we consistently find gender differences with male populations being more susceptible to problem or risky drinking. Among the youngest age group, available data from national and regional surveys (Flanders) all point at the same magnitude of odds ratios for gender differences (see Table 4.4).

Table 4.4 Summarizing table: Comparison men-women odds ratios in all analysed databases<sup>7</sup>

	VADschool (12-18 y)	VADstudent (17-25 y)	VADNightlife (15-30 y)	GDS (16-30 y)	HIS Flanders (15-30 y)	HIS Belgium (15-30 y)
<b>Regular alcohol use</b>	1.7 (1.5-2.0)	Beer: 4.4 (3.7-5.2) Wine: 0.5 (0.4-0.6) Spirits: 1.6 (1.3-2.0)	2.9 (2.0-4.1)	1.5 (1.1-2.0)	-	-
<b>Regular binge drinking or heavy drinking</b>	BD: 1.7 (1.3-2.2)	BD: 4.2 (3.0-6.0)	BD: 3.3 (2.3-4.7)	HD: 2.4 (1.8-3.2)	6.8 <sup>8</sup> (3.2-14.5)	4.1 <sup>4</sup> (2.7-6.2)
<b>&gt;10 alc. drinks/week</b>	-	-	5.4 (3.5-8.2)	-	3.0 (1.5-6.1)	3.1 (2.1-4.8)
<b>&gt;14 (F)/&gt;21 (M) alc. drinks/week</b>	-	-	6.2 (3.8-10.0)	-	3.6 (1.3-10.2)	2.6 (1.5-4.6)
<b>AUDIT-C (4+/5+)</b>	-	1.9 (1.6-2.2)	2.0 (1.3-3.0)	n.s.	-	-
<b>CAGE (2+)</b>	-	-	-		2.6 (1.3-5.6)	2.2 (1.4-3.6)

The largest gender gap in terms of odds ratios is found for indicators of regular binge or heavy drinking, risky drinking (more than 10 drinks per week) and overconsumption of alcohol (>14/>21 drinks per week) among young people (15-30 years). Odds ratios are smaller for regular alcohol use and for screenings of problem drinking. For regular alcohol use, we observe divergent ratios for different types of alcoholic beverages: regular beer drinking is four times more prevalent among men, whereas regular drinking of wine occurs twice as much among young women than among young men.

Despite a decline in regular alcohol use among men and women, as shown in the secondary school survey, the gender ratios remain intact.

Multivariate logistic regression models for the younger age group show that gender is a strong correlate of regular alcohol use, and even a better predictor than 'usual suspects' like living situation (in parental house or independent), frequency of going out in bars or pubs and mental health state.

Based on general population data (BHIS), we see that gender differences are apparent in all age groups (see Table 4.5). However, the gender ratio is lower in the 45+ age category: the oldest age group shows the lowest odds ratios for all three indicators of risky/problem alcohol use. Yet, this is not due to a decline in alcohol use prevalence in the male population, but rather to a higher prevalence of risky drinking among women > 45 years.

<sup>7</sup> If there is an empty field, the OR is non-significant.

<sup>8</sup> In contrast with the VAD surveys, BHIS used a non-gender-specific way to measure binge drinking, which may explain the higher odds ratio in BHIS populations.

Table 4.5 Summarizing table: Comparison men-women odds ratio in three age categories, based on BHIS data

Odds ratio men-women (Belgian population)	BHIS (15-30 y)	BHIS (31-45 y)	BHIS (45+ y)
<b>Regular heavy drinking</b>	4.1 (2.7-6.2)	5.6 (3.4-9.2)	2.7 (2.1-3.5)
<b>&gt;10 alc. drinks/week</b>	3.1 (2.1-4.8)	2.6 (1.8-3.7)	2.0 (1.6-2.4)
<b>&gt;14 (F) / &gt;21 (M) alcoholic drinks/week</b>	2.6 (1.5-4.6)	2.1 (1.2-3.6)	1.7 (1.4-2.2)
<b>CAGE (2+)</b>	2.2 (1.4-3.6)	2.2 (1.6-3.1)	1.9 (1.5-2.3)

Source: BHIS 2013 (WIV-ISP)

## 3.2 Cannabis and other illicit substances

### 3.2.1 Age group 15 to 30 years

#### 3.2.1.1 Secondary school students (VAD school survey 2007-2016)

The age of onset for cannabis use is at 15.7 years for both male and female students, based on assessment of 18-year-old secondary school students. Over a nine years period, the last year prevalence of cannabis use remained stationary, with twice as many male students using cannabis than female students (OR between 1.8 and 2.1) (see annex Table 6). For regular use of cannabis, defined as at least once a week, prevalence rates are also very stable over the last nine school years. In general, regular cannabis use is three to four times more prevalent among male students (OR between 2.6 and 4.4) (see annex Table 7).

Regarding the use of other illicit substances, the prevalence is very low among 12-18-year-old secondary school students. Last year use of substances like ecstasy, cocaine and amphetamines is rather rare and more common among male students (OR between 1.6 and 3.0) (see annex Table 8-11). Regular use in this population is so infrequent that no significant gender differences could be observed.

#### 3.2.1.2 Higher education students (VAD student survey 2013)

There are no significant differences between men and women regarding age of onset of cannabis use. 20.3% of all male and 19.2% all female students started using cannabis before their 16<sup>th</sup> anniversary, respectively. Around a third of all students who already used cannabis, started using it at age 18 or later. Last year use of cannabis is clearly more prevalent among male students (OR = 2.6), and regular use is – although not very common – particularly more prevalent among men (OR = 6.6) (see annex Table 14).

Male students also show higher last year consumption rates for ecstasy and amphetamines (OR = 3.2) and cocaine (OR = 3.2) (see annex Table 14), although absolute numbers in these categories were again very low.

#### 3.2.1.3 Nightlife participants (VAD nightlife survey 2015)

Not surprisingly, prevalence rates for consumption of illicit substances are substantially higher among visitors of clubs, dance events and festivals than among school populations in secondary and higher education. Looking at gender differences, the same patterns emerge as in the VAD surveys. Last year use (OR = 2.7), as well as regular use of cannabis (OR = 2.3) is more than twice as prevalent in male party people (see annex Table 15).

The gender ratio for last year use of other illicit substances than cannabis has the same magnitude (OR = 2.5).

Combined use of illicit substances and other products is also more prevalent among male party people. Both the combination of illicit substances and alcohol (OR = 3.2) and of an illicit substance with another illicit drug (OR = 3.7) are clearly more prevalent among men (see annex Table 15).

To assess the impact of gender on party drug use (i.e. last year use of ecstasy, amphetamines, cocaine and GHB), we entered a multivariate logistic regression model with living situation and frequency of going out in clubs and dancing as additional independent variables (see Table 4.6). The results show that gender was once again the strongest correlate, rather than living situation or frequency of visiting clubs and dancing. The odds ratio for gender is more than twice as strong compared to the impact of frequency of visiting clubs/dancing.

Table 4.6 *Correlates of last year use of party drugs (dependent variable, (occasional (0) vs. regular (1))*

	<i>B</i>	<i>S.E.</i>	<i>Exp. (B) (OR)</i>	<i>95% C.I.</i>	<i>p</i>
Living situation*	-0.12	0.20	-	-	0,565
Going out in clubs/dancing	0.23	0.05	1.25	1.13-1.32	<0,001
Gender**	1.08	0.21	2.96	1.95-4.46	<0,001
(Constant)	1.47	0.23			
Nagelkerke R <sup>2</sup> = 0.13 (Sig.: p<0.01)					

\*: Living in parental house vs. living independent

\*\*: Woman=1; man=2

\*\*\*: Ecstasy, amphetamines, cocaine, GHB

### 3.2.1.4 Nightlife participants (Global Drug Survey 2015)

Regarding the age of onset of herbal cannabis use, no difference is observed between male and female respondents. Last year cannabis use differs between men (80.6%) and women (71.2%) (OR = 1.7), and also weekly cannabis use is more prevalent among (59.8 vs. 45.1%) use this substance on a weekly basis; for men this is (OR = 1.8). Although the same gender differences are found as in the other databases, the extent of the odds ratios is lower in the GDS sample.

Looking at illicit substance use in general (including a long list of NPS, cannabis, cocaine, etc.), we also find a clear gender difference: last year illicit substance use is almost twice as common in the male group of GDS respondents (OR = 1.9).

A multivariate logistic regression model was run to assess the impact of gender on illicit substance use in relation to other potential mediating factors. Based on the weak Nagelkerke R<sup>2</sup>-value of the model, gender nor the other independent variables had a substantial impact on illicit substance use.

### 3.2.1.5 General population data (Health Interview Survey 2013)

Last year cannabis use is about twice as prevalent (OR = 2.2) among young men (14.8%) than among young women (7.4%) (see annex Table 16). Prevalence rates for the use of other illicit substances are very low in this general population sample between 15 and 30 years old. Last year use of other illicit substances like ecstasy, cocaine and amphetamines is very uncommon (< 2% for both genders).

### 3.2.2 Age group 31 to 45 years

Despite the declining prevalence of cannabis use for both genders compared to persons between 15 and 30 years old, last year cannabis use in this age group is even more a male business (OR = 5.0) (see annex Table 17). For other illicit substances, the high odds ratio (8.5) tends to overestimate gender differences in relation to the rather low proportions in this sample (men: 2.0%; women: 0.2%).

### 3.2.3 Age group above 45 years

With substantially lower prevalence rates than among the younger age groups no significant gender gap could be observed in this age group (see annex Table 18). Last year use of other illicit substances was almost not found among both genders.

### 3.2.4 Conclusion gender gap cannabis and other illicit substances

The prevalence of cannabis and other illicit substance use is substantially higher in the youngest age group from 15 to 30 years old. All parameters of illicit substance use are far more common among men.

When we compare the results of the five surveys among the youngest age group, we see that – despite the fact that the age of onset for cannabis use is equal for men and women – prevalence rates are significantly higher among men for all parameters. The odds ratios for last year cannabis use as well as for last year of other illicit substances vary between two and three. The biggest gender gap is found in the higher education survey where male students are up to seven times more likely to use cannabis on a regular base than female students. This gender ratio is much smaller among secondary school students (odds ratio between three and four) and among participants in nightlife settings (VAD: OR = 2.3; GDS: OR = 1.8).

The VAD nightlife survey reveals some additional interesting findings. Combined use of illicit substances and alcohol and combined use of several illicit substances have significantly higher odds (between three and four) for men. A multivariate regression model show that gender is a stronger correlate for last year use of party drugs than living situation (in parental house or independent) and frequency of going out in clubs and dancings.

In the age group between 31 and 45 years, odds ratios remain higher for last year use of cannabis, but not for last year use of other illicit substances. In the oldest age group (>45 years), the use of all illicit substances is too rare to generate clear gender differences.

## 3.3 Psychoactive medication

### 3.3.1 Age group 15 to 30 years

#### 3.3.1.1 Secondary school students (VAD school survey 2007-2016)

The survey results give diverse impressions depending on the kind of psychoactive medication. Over the last eight school years, there were no gender differences in last year use of stimulant medication (see annex Table 12). Prevalence rates were around 1 to 2% for both male and female secondary school students. For sleeping pills and tranquilizers we see a different result. The last year prevalence of this type of medication is not only more than two to four times higher than the last year prevalence of stimulant medication use, but also a significant yet low gender difference is found, indicating that the use of tranquilizers is slightly more prevalent among female students: over the last six years, the odds ratios varied slightly between 1.3 and 1.8 (see annex Table 13).

#### 3.3.1.2 Higher education students (VAD student survey 2013)

The last year prevalence for the use of sleeping pills and tranquilizers as well as for stimulant medication use is around 5% among students in higher education. When looking at gender ratios, we see that last year use of stimulants is more present among male students (OR = 2.6), while last year use of sleeping pills and tranquilizers is slightly more prevalent among female students (OR = 1.6) (see annex Table 14).

#### 3.3.1.3 Nightlife participants (VAD nightlife survey 2015)

Compared to the student populations, consumption rates of sleeping pills and tranquilizers do not differ as much as consumption rates of illicit substances among nightlife participants. Nevertheless, last year and regular use of sleeping pills and tranquilizers are more prevalent among nightlife visitors. Regarding gender differences, last year (OR = 1.7) and regular use (OR = 2.4) are more common among females in nightlife settings, although both results are not significant at the 0.01 level ( $p=0.03$  resp.  $p=0.02$ ) (see annex Table 15).

### 3.3.1.4 General Population (Health Interview Survey 2013)

The prevalence of last year use of sleeping pills and tranquilizers as well as the use of antidepressants in the past two weeks is equally low for men and women (around 2-3%) in this sample. No significant gender differences are observed (see annex Table 16).

### 3.3.2 Age group 31 to 45 years

The population between 31 and 45 years has higher last year prevalence rates for psychoactive medication use than the youngest age group. Although slightly more women (7.4%) than men (5.4%) take sleeping pills and tranquilizers, no significant gender differences are observed in odds ratios. For the use of antidepressants in the past two weeks, a significant gender difference is observed (OR = 0.5), indicating that twice as many women take these medicines than men (see annex Table 17).

### 3.3.3 Age group above 45 years

The results of the HIS clearly indicate that the use of sleeping pills and tranquilizers makes a giant leap in the oldest age group: 16.7% of all men and 24.2% of all women in this age group have taken these psychoactive medications during the previous 12 months. The gender difference is significant (OR = 0.6), indicating that almost twice the number of women take these psychoactive medications compared to men. We observe a similar gender ratio (OR = 0.6) for the use of antidepressants in the past two weeks (see annex Table 18).

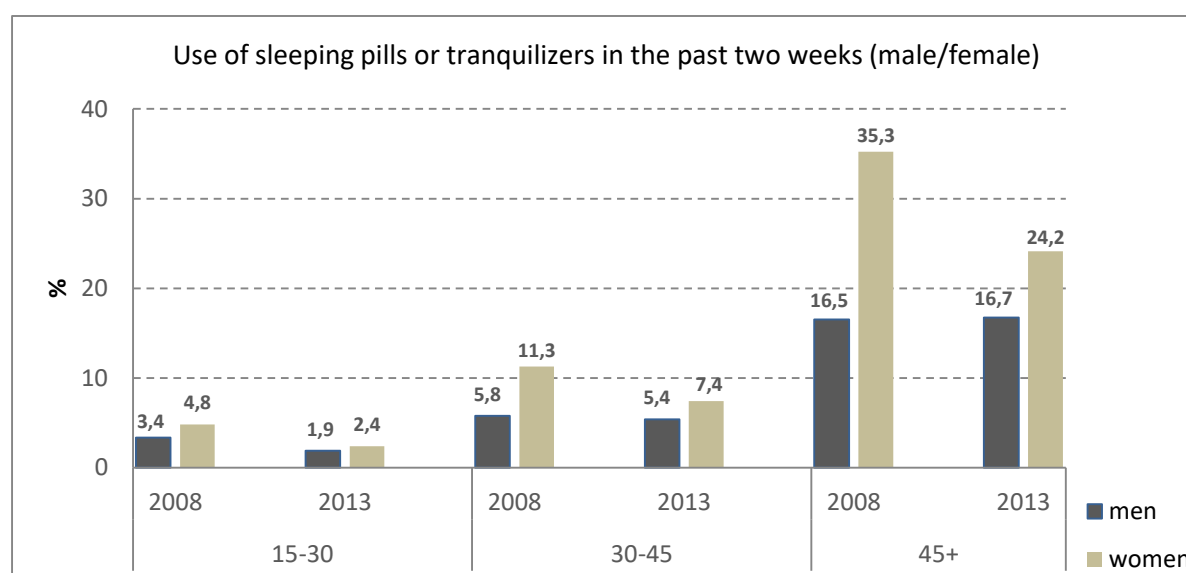


Figure 4.2 Evolution in the use of sleeping pills and tranquilizers in three age categories in the past two weeks.

Source: BHIS, 2008 and 2013 (WIV-ISP)

### 3.3.4 Conclusion gender gap psychoactive medication

The use of sleeping pills and tranquilizers is clearly more prevalent among older persons. For the youngest age group (15-30 years), the three surveys indicate a slightly higher prevalence of the use of sleeping pills and tranquilizers among female students and young adults, with odds ratios for last year use around 1.5 to 2. Female respondents recruited in nightlife settings show a more than two times higher prevalence of regular use of sleeping pills and tranquilizers.

A Belgian population survey do not demonstrate any gender difference regarding last year use of sleeping pills and tranquilizers, not in the youngest age group, nor in the age group 31 to 45 years. It is only in the oldest age category (>45 years) that women have slightly higher odds to have taken this psychoactive medication in the previous year.

Gender differences in recent use of antidepressants only occur at a later age, i.e. from the age of 30 years on. Although the prevalence of antidepressant use increases with age, gender differences remain.

To assess gender differences regarding stimulant medication use, we could only use data from two VAD student surveys. Among students in secondary education, no gender differences are observed concerning last year use, but in higher education this prevalence is almost three times as high among male than among female students. The gender gap in the use of stimulant medication among higher education students may be due to the frequent use of this psychoactive medication as a 'cognitive enhancement' pill among male students.

## 4 Results from the registration of treatment demands in Belgium

As in the first part of this report, results are still split according to three age categories: 15-30 years, 31-45 years, and > 45 years.

### 4.1 Results by type of centre

The database of the Treatment Demand Indicator (TDI) is an epidemiologic tool that provides a global view at Belgian level concerning the demand for drug and alcohol treatment. In 2015, 208 treatment programmes participated in the TDI registration: 111 in Flanders, 68 in Wallonia and 29 in Brussels (Antoine, 2016).

In the TDI registration, three types of treatment centres are distinguished (see Figure 4.3):

1. Specialized centres: medical-social care centres (MMT), day care centres, centres for specialized consultations, residential crisis centres, and therapeutic communities. They have the obligation to register each new episode of treatment.
2. Mental health services: in Flanders, services have the obligation to transmit all information, in Wallonia, only centres who provide specialist services for drug/alcoholic users are invited to participate.
3. Hospitals: general and psychiatric hospitals. The registration is mandatory since 2015.

The total proportion of women registered for a treatment episode in 2015 was 28.4% vs. 71.6% for men (see annex Table 19 and Table 24). Differences in the proportion of women are largest in specialized centres and smallest in hospitals.

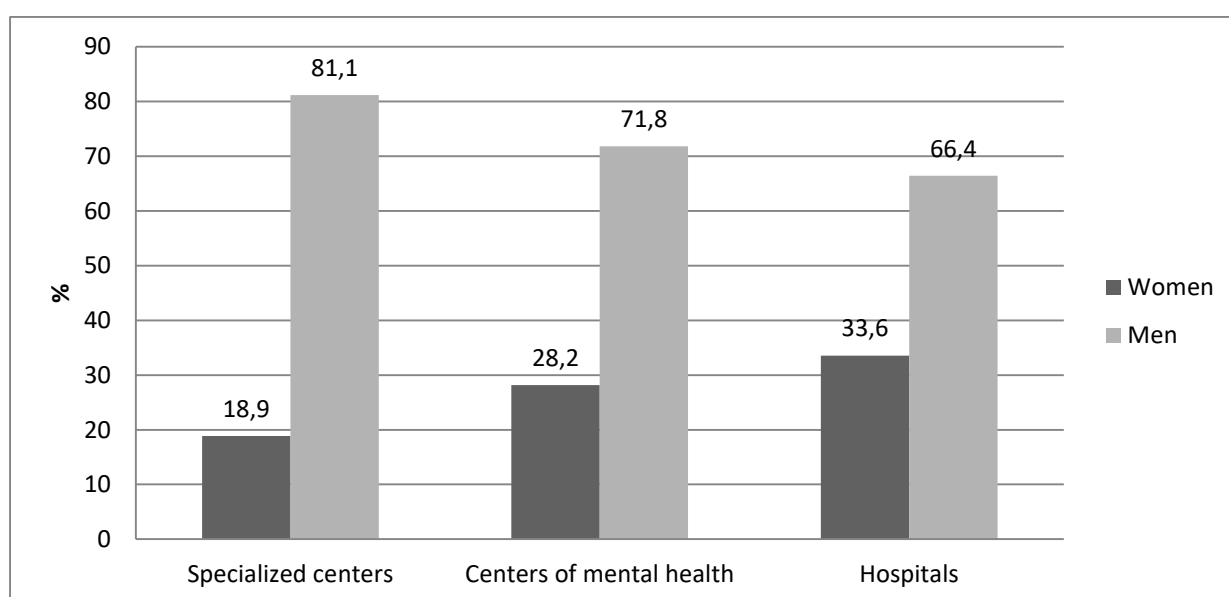


Figure 4.3 Proportion of women and men by type of centres in Belgium in 2015.

Source: Treatment Demand Indicator, 2015 (WIV-ISP)

Odds ratios were calculated following the logic for all men/women in the TDI-database; the proportion of users treated in one type of centres (e.g. hospitals) compared to the proportion of users in the other types of centres (e.g. specialized centres and centres of mental health). The purpose of this part of results is to give another perspective of the male to female ratio based on a comparison between the attendance of the different types of services.

#### 4.1.1 Centres of mental health

For the mental healthcare centres, we note no significant differences in attendance rates between women and men (see annex Table 20).

#### 4.1.2 Hospitals

If we take into account the general proportion of women in the different types of centres, hospitals are clearly the type of centre that is most contacted by women (33.6%) (see annex Table 21).

For this type of centre, the gender ratio is inversed. Women search more often treatment in a hospital than men. We observe that the gender ratio remains more or less the same in different age categories (OR = 0.64 in the 15 to 30 years age group, OR = 0.63 in the 45+ age group), with a slight increase of the proportion of women in the 31-45 age group (OR = 0.53).

#### 4.1.3 Specialized centres

Specialized centres are more often contacted by men. Gender differences range from OR = 1.5 among 15 to 30 years old; over OR = 2.0 for persons between 31 and 45 years to OR = 2.2 among the 45+ group (see annex Table 22).

#### 4.1.4 Conclusion

If we consider the repartition of women in treatment for a substance-related problem by types of centres and age category, we observe that the proportion of women in treatment increases with age. In the youngest age group, the OR is 1.5 in favor of male. In the age group between 31 and 45 years, the OR decreases to 1.3, while in the oldest age category (45+) the gender ratios switches in favor of female (OR = 0.6).

If we look at the proportion of women and men by type of centre in general, we find women more often in hospitals (OR = 0.5), while men are clearly more present in specialized centres (OR = 2.1). The proportion that starts treatment in mental healthcare centres is equally high among men and women.

## 4.2 Results by type of substance

Table 4.7 presents the proportion of women in the TDI-data by main substance category. The main substance is the substance for which the person started the treatment. The highest proportion of women is seen in the substance category hypnotics and sedatives (50.4%), followed by alcohol (32.0%) and others (30.4%). We also notice a high proportion of women for stimulant substances other than cocaine (28.0%).

Table 4.7 Proportion of women by main substance category in Belgium in 2015

Main substance	Women (n)	Women (%)
Alcohol	13,835	32.0%
Cannabis	3731	17.8%
Opiates	3224	20.1%
Cocaine	2206	19.8%
Stimulants other than cocaine	1287	28.0%
Hypnotics	1075	50.4%
Other substances	112	30.4%
Hallucinogens	36	8.3%

Volatile inhalants	7	28.6%
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Source: Treatment Demand Indicator, 2015 (WIV-ISP)

Odd ratios were calculated in relation to persons in treatment only. We are talking here about incidence, not prevalence like the other databases.

We took into account the problem consumption of a substance to calculate the OR and not only the main substance for which the person is in treatment (e.g. problem consumption of alcohol versus non-problem consumption of alcohol), in order to have a better point of comparison with the other databases. We again split up the data in three age categories: 15-30 years, 31-45 years, 45+.

#### 4.2.1 Age group 15 to 30 years

For alcohol and cocaine, we do not observe significant gender difference in treatment populations. Compared to men, women enter treatment more often because of problem use of opiates, stimulants other than cocaine and hypnotics. Men on the other hand, enter treatment more frequently for problems with cannabis use (see annex Table 25).

#### 4.2.2 Age group 31 to 45 years

Women in treatment demonstrate a higher prevalence of alcohol and hypnotics use as main substance. On the other hand, cocaine, opiates, stimulants other than cocaine and cannabis are more prevalent among men in treatment (see annex Table 26).

#### 4.2.3 Age group above 45 years

As in the previous age group, men show equally high OR for cannabis, stimulants other than cocaine, cocaine and opiates. Women enter treatment more frequently for problem use of hypnotics, but no significant difference is observed regarding problem use of alcohol.

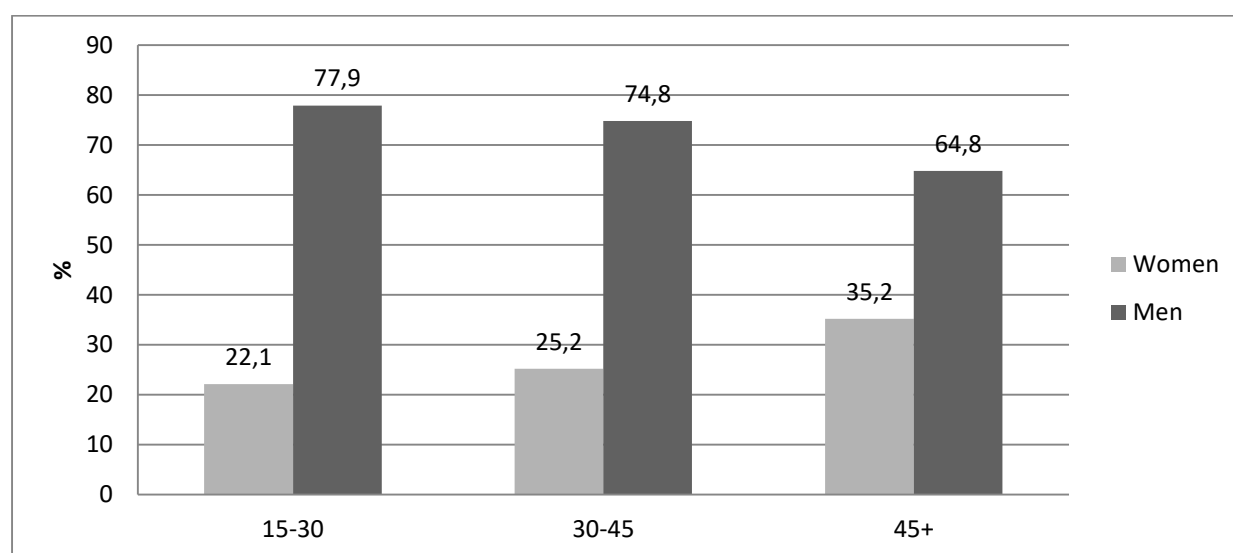


Figure 4.4 Proportion of women and men in treatment centres by age categories in Belgium in 2015.

Source: Treatment Demand Indicator, 2015 (WIV-ISP)

#### 4.2.4 Focus on alcohol

If we study problem use (not necessarily as main substance for which the person started the treatment) of alcohol in a more detailed way, using smaller age groups, we see that problem use of alcohol for both men and women increases with the age, in particular after the age of 45 years. This tendency is confirmed until 60 years

for women and until 65 for men. The proportion of women in treatment with alcohol as a substance causing problem reaches 90.5% of the population among persons 60 to 64 years. After the age of 60 years, the curve decreases a little bit for women, but for men this tendency remains, to reach 96.9% after the age of 65.

From the age of 54 years, the proportion of men in treatment for problem use of alcohol tends to be higher than the proportion of women (see Figure 4.5).

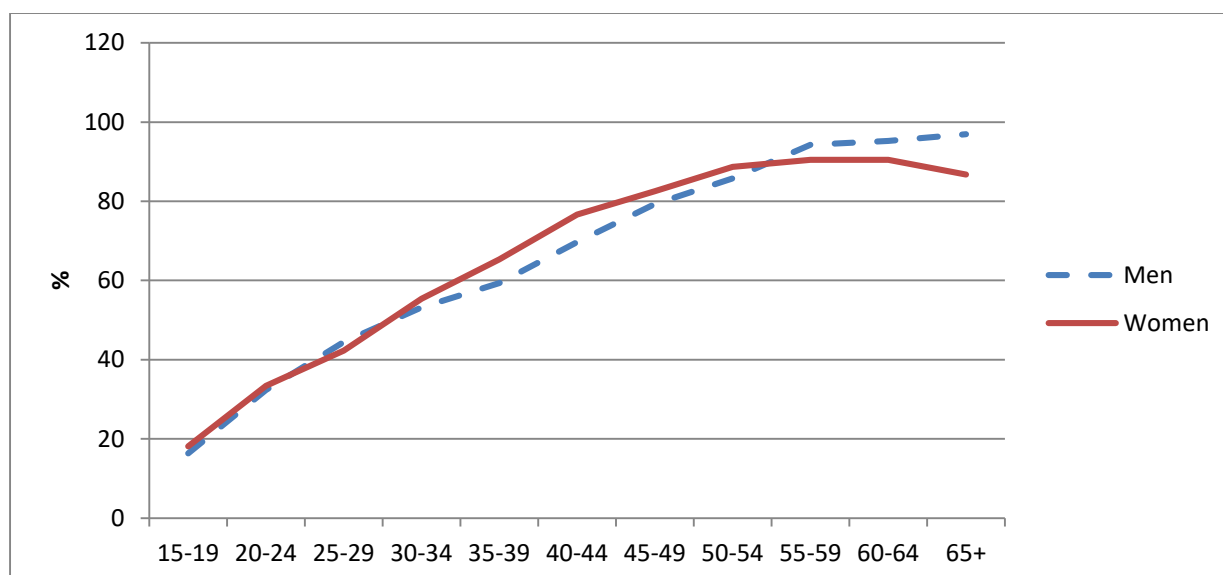


Figure 4.5 Proportion of men and women in treatment for problem use of alcohol in 2015 in Belgium.

Source: Treatment Demand Indicator, 2015 (WIV-ISP)

#### 4.2.5 Conclusion gender gap substance

Generally, men are more likely to enter treatment due to problems with the use of cannabis (OR = 2.1), cocaine (OR = 1.8) or opiates (OR = 1.6). On the other hand, women mostly seek treatment for problem use of hypnotics (OR = 0.6) and alcohol (OR = 0.7) (see annex Table 29).

We see few gender differences in the type of substance used by men and women in treatment centres, especially among the youngest age category (15-30), except for cannabis (OR = 1.9) and hypnotics (OR = 0.6). The observed differences in type of substance use increase with age: we find significantly more men than women in treatment for problem use of cocaine (OR = 3.1), opiates (OR = 2.6) and cannabis (OR = 2.1) after the age of 45 years.

## 5 General conclusion

Despite the differences in the databases analysed, we can make a careful comparison between certain tendencies and gender differences observed in the population data in the first part of this chapter and the characteristics of people seeking treatment for substance use described in the latter part. We observed different gender ratios for different substances.

For alcohol, it is clear that the prevalence of risky and problem drinking higher among men. The only divergence in that pattern is the higher prevalence of regular wine drinking among female students. When it comes to risk assessment, even with gender-specific measures (binge or heavy drinking, AUDIT-C, 14+/21+ drinks as threshold for overconsumption), the odds are clearly higher for men than for women. The gender gap narrows slightly with higher age, but this is not due to decreasing drinking levels among men. Higher prevalence rates of alcohol consumption among older women explain this shift.

Cannabis and other illicit substance use is clearly more manifest among the youngest age group and is predominantly a male behaviour. In the included surveys, regular use of cannabis was two to seven times more prevalent among male adolescents and young adults. This gender gap persists in the age group between 31 and 45 years, despite declining prevalence rates.

Combined use of illicit substances with either alcohol or other illicit substances is three to four times more prevalent among male adolescents and young adults. In the oldest age group, use of illicit substances was too rare to observe gender differences.

Results for last year use of sleeping pills and tranquilizers and recent use of antidepressants show similar ratios, but in the opposite direction. More women than men use this type of psychoactive medication. In addition, for the use alcohol and psychoactive medication, we see increasing prevalence rates with increasing age, while for illicit substances, we see the opposite: the younger, the higher the prevalence.

The use of stimulants indicates an opposite gender ratio: the proportion of male students using stimulant medicines is three times higher than the proportion of female students. The fact that more male students use these medicines (e.g. Ritaline) as a substance to enhance study performance ('learning pill') could explain this difference.

Based on treatment demand data for illicit substance use, we see higher prevalence rates and risky use patterns among men and consequently more men enter treatment for cannabis, hallucinogens, cocaine and opiates. Findings on the use of psychoactive medication like sleeping pills/tranquilizers and anti-depressants reveal an opposite gender ratio: more women use these medicines and more women are in treatment for abuse of these products in each age category.

If we take the proportion of men and women in substance use treatment in general and we look at the specific proportion of women that enter treatment for alcohol problems (which is higher than men), it seems as if women enter alcohol treatment more easily than men.

The results also show that women more often seek treatment in hospitals while men are more present in specialized centres. The assumption is that the type of substance explains the choice of treatment centre. As women enter treatment more easily for alcohol problems than men, they probably seek treatment for alcohol abuse in hospitals first.

Considering the theoretical framework for the analyses and the limitations of comparing prevalence and incidence rates, assessing correctly the gender gap is not feasible. In that regard, the strategic implications for future research are extremely important in order to implement further analyses and have a better knowledge of this gender-issue.

Despite several reliable databases available in Belgium, this chapter was a rather difficult exercise, due to the lack of common and comprehensive databases, not only for gender. In that way, if we want to have a more complete view of the Belgian situation and a decent analytical framework, we urge to create a common way of working with similar data in the whole country that include also more data on vulnerable populations, as well as data from general practitioners and private practices.

# TREATMENT EXPERIENCES OF FEMALE SUBSTANCE USERS

*Julie Schamp, Sarah Simonis*

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## 1 Introduction

In order to determine how experiences of female users are shaped by gender and the power of social structures, it is a prerequisite to first establish a theoretical framework that is used as the basis for the further approach throughout the study. In that way, the gendering process will be better understood together with the particular needs of women (Miers, 2002).

### 1.1 Gender-sensitivity in a post-modern approach

There are two theoretical approaches in the field of substance use: the classic approach and the post-modern approach. The classic rationale underlines the disease aspect of substance use and hence implies that abstinence is the only way to recovery. Also, it tends to marginalize people and perceives them as deviant. The postmodern approach rather integrates the concept of a system of social inequalities. As such, recovery is not only seen as a personal responsibility, but also as a social issue in which social differences such as ethnicity, gender and class need to be taken into account (Neale et al., 2014).

In that respect, the specific needs and demands of an individual are reflected upon. This post-modern approach wants to integrate basic human rights of users as well as their own voices by recognizing inequalities. The development of a gender-sensitive perspective tends to be more pertinent in the post-modern approach of substance use (Ettore, 2004).

### 1.2 Complexities and diversities of stories of female users

On the one hand, gender is to be seen as a process, and a part of the male-female interaction by defining the normative role of being a woman or being a man as well as by dividing the social life in a private and public space. On the other hand, gender is also an institution, a part of culture that structures society in an unequal way. In other words, society has specific expectations about men and women's behaviour by determining what is appropriate for both of them (Ettore, 2015).

Even though women use substances differently than men (Ettore, 2004), there is also a great diversity and complexity in the experiences lived by women (Im & Meleis, 2001). Women are not a heterogeneous group and gender is also not an exclusive form of inequality. Gender intersects with other inequalities such as origin, sexual orientation or socio-economic status, within and outside of the female group. Despite the fact that gender is an important structure, other multidimensional factors need to be integrated in order to correctly apprehend the other social structure as well as the context of each woman. Examples of these are racism, poverty, unemployment, health problems and caring obligations (Neale et al., 2014).

### 1.3 Recovery capital as a facilitator

Introducing the concept of recovery capital, defined as the "sum of resources that an individual can draw upon to initiate and sustain recovery processes" (Cloud & Granfield, 2008, as cited in Neale et al., 2014), allows to figure out what type of diverse resources women are able to mobilize in the recovery process, or whether they access to these resources successfully.

This concept comprises four components:

- i) the **social capital** including relationship with family, intimate partner, and friends;
- ii) the **physical capital** including income and expenditure, housing and homelessness;
- iii) the **human capital** including physical appearance, lifestyle like norms, values, attitudes, beliefs linked to social conformity and dominant social behaviour; and
- iv) the **cultural capital** including education, training and employment, informal knowledge and life skills, hopes and aspirations, and physical and mental health.

A better access to recovery capital enhances the chance to overcome substance use related problems (Cloud & Granfield, 2008; Neale et al., 2014). In addition, the personal circumstances of each individual (relationship, behaviour) that can negatively affect the recovery should be taken into account. In that regard, specific challenges and barriers have been observed and attributed to women, such as a higher rate of mental health problems compared to men, experiences with violence and abuse, emotional issues due to sex work, the care for the children, fear of losing child custody, a strong social stigma and feelings of shame (Cloud & Granfield, 2008, as cited in Neale et al., 2014).

Social norms and expectations that promote gendered roles and the definition of femininity can be more detrimental towards female users in comparison to male users. By putting higher expectations on material and psychological demands (physical appearance, caring obligations), the recovery process gets compromised (Neale et al., 2014).

## 1.4 The body as an essential ingredient of a holistic approach

A thorough insight in women's specificities and contexts is required to create a gender-sensitive approach, as well as a full understanding of the gendered experiences of sexuality and the body image (Ettorre, 2004). The body is an essential part of the social identity and self-expression. Cultural differences and similarities between men and women are present in their physical presence as well, and social injunctions are given to their body. Hence, gender is thereby embodied (Ettorre, 2015; Miers, 2002). As Bourdieu (2000, as cited in Miers, 2002) said, "the most serious social injunctions are addressed not to the intellect but to the body". The body defines who we are and who we want to be (Ettorre, 2015).

The notion of embodied deviance is defined as "the historically and culturally specific belief that the deviant social behaviour manifests itself in the materiality of the body, as a cause or an effect, or perhaps as merely a suggestive trace" (Urla & Terry, 1995, p. 2). In that way, substance users mark their bodies by having deviant social behaviours and determine thereby their lower social status and their lack of morality. In this regard, the bodies of users are looked upon as deviant and deserve to be excluded. Female users are considered to be women who failed as women (Ettorre, 2015), their bodies having difficulties to solve societal tasks and deviate from the ideals. These societal tasks, the four "R's" (Ettorre, 2004, 2015; Turner, 1996) – being: Restraint, Representation, Regulation and Reproduction - can be a source of problems.

The **representation** or self-image is the ability to present oneself in an acceptable and appropriate way to society. In the case of substance use, the body can be shaped in an identifiable way and the self-image of substance users in society can become a problem.

The **reproduction** task is a difficult one for substance users because their bodies are often not perceived as acceptable by society to start or have the responsibility over a family life, for both moral and medical reasons. Reproduction is led by normative ideologies in society and that society decides what bodies should reproduce and what bodies should not. Bodies of female users are not judged suitable for this responsibility. Pregnant women are therefore a major concern for drug policies.

The self-control of a body or **restraint** task is shaped by societal norms. A normal body is supposed to control bodily functions and desires, such as eating and sexual desire and needs. substance using bodies are perceived

as unable to control these functions. Moreover, their bodies are identified as a loss of control, meaning that they are incapable to control their desires. And, in the meantime, female bodies are also perceived as pleasure seeking and part of a substance culture resistance.

The **regulation** task concerns the external behaviour of bodies, “how do bodies regulate themselves when they confront a variety of social problems related to urban life?” (Ettorre, 2004, p. 5). Their bodies are perceived as a menace to the integrity of normal behaviour in the urban life, and concurrently bodies of female users are also an element of urban consumption.

To completely understand the stories of these women, it is a central thought to overcome “the traditional neglect of the body” (Ettorre, 2004, p. 7) by encouraging and strengthening a holistic approach with a woman oriented-perspective.

## 2 Methodology

In this chapter, we aim at a better insight in the perspectives of female substance users regarding barriers and facilitators in relation to the field of alcohol and drug demand reduction in Belgium. We focus on the intersections that they encounter as well as on trajectories and critical events they experience in using alcohol and drug treatment services.

In that way, female users’ experiences and perspectives on facilitators and barriers regarding alcohol and drug treatment were explored by means of semi-structured in-depth interviews. 60 female users were recruited, of which 30 in Flanders and 30 in Brussels and the Walloon Region (see Table 5.1). The period of the recruitment started in November 2016 and ended in March 2017. In order to recruit a diverse and heterogeneous sample of substance using women regarding age, socio-economic background, primary substance of abuse and previous treatment experiences, a targeted sampling was used. Female respondents from drug as well as from alcohol services were recruited, including early intervention, harm reduction and treatment programmes. Based on the gender-sensitive initiatives identified in an earlier stage of the research (see Chapter 3: Examples of gender-sensitive initiatives in European countries, p. 15-20), women were recruited in mixed-gender and women-only services, and in residential as well as outpatient services (e.g. methadone centres, psychiatric hospitals, mental healthcare centres). The researchers contacted directly the centres with a gender-sensitive approach identified in the first phase of the study to participate in the recruitment of female users. Also, other treatment centres in contact with female substance users were contacted. Finally, a strategy of snowball sampling was adopted after the first contacts with female users as a method to reach and find so-called hidden populations. As an incentive, a voucher of 20 euro was given of each participating women. These in-depths interviews were performed on site, were fully registered and lasted between 40 and 90 minutes.

Age stratification (20-30; 31-45; 45+) was applied in order to keep the same proportion of women in each age category. Eligible participants for the study needed to have at least a minimal treatment trajectory and/or experiences with alcohol or drug demand reduction services. Hence, the minimum age of participants was set at 20 years old. The specific age stratification of 20-30, 31-45 and 45+ was chosen in accordance with the age stratification for the quantitative secondary analysis in chapter four. Further, attention was given to an equal proportion between women in outpatient settings and residential programmes.

Table 5.1 *Characteristics of female respondents in Flanders and Wallonia, and in total (n=60)*

Number of respondents by age category			
Age category	Flanders	Wallonia	Total
20-30	11	9	20
31-45	10	11	21
45+	9	10	19
Number of respondents by type of main substance			
Substance	Flanders	Wallonia	Total
Heroin	8	8	16
Cocaine	3	8	11
Cannabis	2	2	4
Alcohol	12	7	19
Medication	0	3	3
Speed	3	1	4
Ecstasy	0	1	1
GHB	2	0	2
Number of respondents by setting			
Continuum of care	Flanders	Wallonia	Total
Outpatient	14	14	28
Residential	16	16	32
Number of respondents with (small) child(ren)* compared to number of respondents in residential programmes with child(ren)			
Children	Flanders	Wallonia	Total
Women with child(ren)	23	25	48
Women with small child(ren)*	11	5	16
Women in residential programme with small child(ren)*	4	3	7

\* Children until the age of seven, since seven is the maximum age that children can enter a residential treatment programme with their mother.

The trajectories of these women, along with obstacles and facilitators with regard to entering, staying or dropping out of treatment were explored through in-depth interviews. The thematic guideline for these interviews was constructed based on the findings of the mapping and the characteristics of gender-sensitive initiatives in Belgium, but also available literature on the topic was used (Covington, 2015; Gilchrist et al., 2015; Green, 2006; Greenfield et al., 2006; Grella, 2015; Hodgins, 1997).

After a short socio-demographic assessment, the interview guideline was conceived and especially adapted to questioning the interaction between agency of female users, the availability of resources and difficulties that women encounter in seeking treatment. The guideline was structured around four major themes:

- i. barriers and facilitators experienced by female users and critical events they experienced as (un)helpful;
- ii. availability or lack of various forms of support and resources;
- iii. gender-sensitive treatment; and
- iv. their personal needs regarding this approach, and personal future perspectives.

The data emerging from these interviews were fully transcribed and analysed with the qualitative software programme Nvivo to examine key themes and meanings that may have been manifest or latent in the

transcribed data. The analysis was performed by two researchers (one for the Flemish interviews and one for the French interviews). In order to analyse the interviews and to code these in the same way, each researcher elaborated a coding tree for the analysis based on the Flemish/Walloon data. These two coding trees were then compared and discussed in detail including similarities and dissimilarities in order to develop a final coding tree, conjoint for both parties. Several major themes and patterns emerged from the discussion and became the starting point for the thematic analysis. During the coding of the interviews, the coding tree was adapted and enlarged by new nodes and sub-nodes. Every change and addition to the coding tree was communicated and discussed with the other researcher to optimize the similarity in coding.

### 3 Results

Research has proven that substance users can encounter many barriers when they try to access substance treatment services (Bradley, 2017; Grella, 2008, Gueta, 2017; Stringer, 2018). However, existing literature is mostly quantitative and rarely considers the kind of factors that are identified by substance users themselves as elements that enable them to access and benefit from services. Responding to this knowledge gap, the present research explores female users' own suggestions for improving service engagement and their reports of factors enabling or impeding them to seek help.

#### 3.1 Diversity as core characteristic

The study sample is characterized by great diversity and heterogeneity of the respondents' stories and trajectories. This diversity uncovers specific characteristics of women attending outpatient programmes on the one hand, and women attending residential programmes on the other hand.

Future goals of female users and the role of substance use in their life differs for respondents in outpatient and residential settings. For those recruited in outpatient settings, of whom a large proportion is involved in Opioid Substitution Therapy (OST), occasional use of substances is part of their treatment objectives. However, for women enrolled in residential programmes advocate for total abstinence.

*"Nee, dat [gecontroleerd gebruik] is niet mogelijk. Ik zou echt graag voor altijd willen stoppen." (female user, 20-30, residential programme)*

*"No, that [controlled drug use] is not feasible. I would really want to stop using forever." (female user, 20-30, residential programme)*

Female users in outpatient programmes seem to desire a range of short-term and practical support, including help with social support and companionship, meaningful ways of spending time, housing-related support, assistance with domestic activities, and financial resources. Also, immediate and basic needs like eating, sleeping, exchanging needles or seeing a doctor for injuries are prerequisites for most female users in outpatient settings. In contrast, respondents in residential treatment programmes explain to have more needs on the long-term, like creating a family, having a job, going on holidays, and having - what they refer to as - "a normal life".

*"J'ai repris ma vie en main, mon corps en main, il y a plein de chose que je redécouvre, la nature, le fait de rencontrer quelqu'un, refaire une sortie au cinéma." (female user, 31-45, residential programme)*

*"I got my life back together, my body, there are a lot of things that I discover again, the nature, meet someone, go to the movie." (female user, 31-45, residential programme)*

As the needs and goals clearly differ, the type of help sought by these women might differ substantially. Actually, the services offered by treatment centres are often adapted to that demand. In outpatient services, the help provided is linked to the organisation of the everyday life of female users and interventions are intended to support them to work towards a healthier lifestyle and to promote access to primary healthcare. Assistance is

offered with regards to doctor's consultations, parental challenges, administrative procedures or job/education applications. Although psychological support and counselling is also offered in outpatient settings, this is not the main priority of female users. In contrast to this, female users involved in residential programmes aim at a total change in lifestyle and existence, including a fresh start that does no longer involve substance use. These residential clients differ from most clients in outpatient programmes in the fact that they are committed to a different process of understanding the role of substance use in their life and how to learn to live without drugs or alcohol.

In addition, the social network surrounding female users seems different: the urge of cutting all ties with the former social network and the 'old' environment in order to avoid any temptation to start using again is highly present among women enrolled in residential programmes. This awareness and desire is hardly observable or not present at all amid women visiting outpatient services. For the latter sample, there is an expressed intention of cutting ties with 'wrong' or 'old' friends to refrain from substance use, but this breakdown is mostly not yet accomplished.

*"De mensen uit het druggebruik, daar wil ik geen contact meer mee. En die heb ik al opzij gelegd."*  
(female user, 20-30, residential programme)

*"The people from the scene, I don't want any contact with them anymore. And I have already blocked them."* (female user, 20-30, residential programme)

*"Ja hoor [ik heb nog veel contact met mensen die nog in het milieu zitten]. Ze zijn allemaal welkom, maar ja. Zolang ze het me niet aanbieden, is het goed. En als ze het niet bij mij doen, is het goed. Als ze het durven aanbieden, zou ik nog durven ze."* (female user, 20-30, outpatient programme)

*"Yes, definitely [I still have intense contact with people who are still part of the scene]. They are all welcome, but of course... As long as they don't offer me anything, it's fine. And as long as they don't use in front of me, it's fine. If they would offer me something, I would still dare [to use], you know."* (female user, 20-30, outpatient programme)

Consequently, it should not surprise that women in outpatient programmes generally seek treatment in a centre nearby their living place. On the other hand, when seeking residential treatment, these programmes are often located (far) away from their (former) place of residence. However, this distance permits and facilitates women to cut ties more easily with their former social network.

Finally, the history of treatment trajectories and experiences that these women have had is often different. Women entering outpatient treatment services who had past experiences with residential programmes, describe the latter as too restraining and depriving their freedom. Remarkably, the exact opposite is said by female users in residential programmes who previously attended outpatient services. According to them, these services are not restrictive enough and lack appropriate support.

### 3.2 Barriers and facilitators for seeking treatment and service utilization

Based on the in-depth interviews with female users, different barriers to treatment can be distinguished (see Figure 5.1). Barriers are defined as 'events or characteristics of the individual or system that restrain or serve as obstacles to the person receiving healthcare or drug treatment' (Xu, 2007, p. 321). In addition, the main reasons for dropping out of treatment for women are described (see Figure 5.2), as well as factors that facilitate treatment participation for women (see Figure 5.3). As not all barriers and facilitators account for all study participants, mediating factors are reported in general in order of importance and according to the extent to which they have been mentioned.

### 3.2.1 Barriers for seeking treatment and service utilization

Several barriers for seeking treatment and service utilization are described by female users covering personal, external, societal, family, health and parental dimensions (see Figure 5.1).

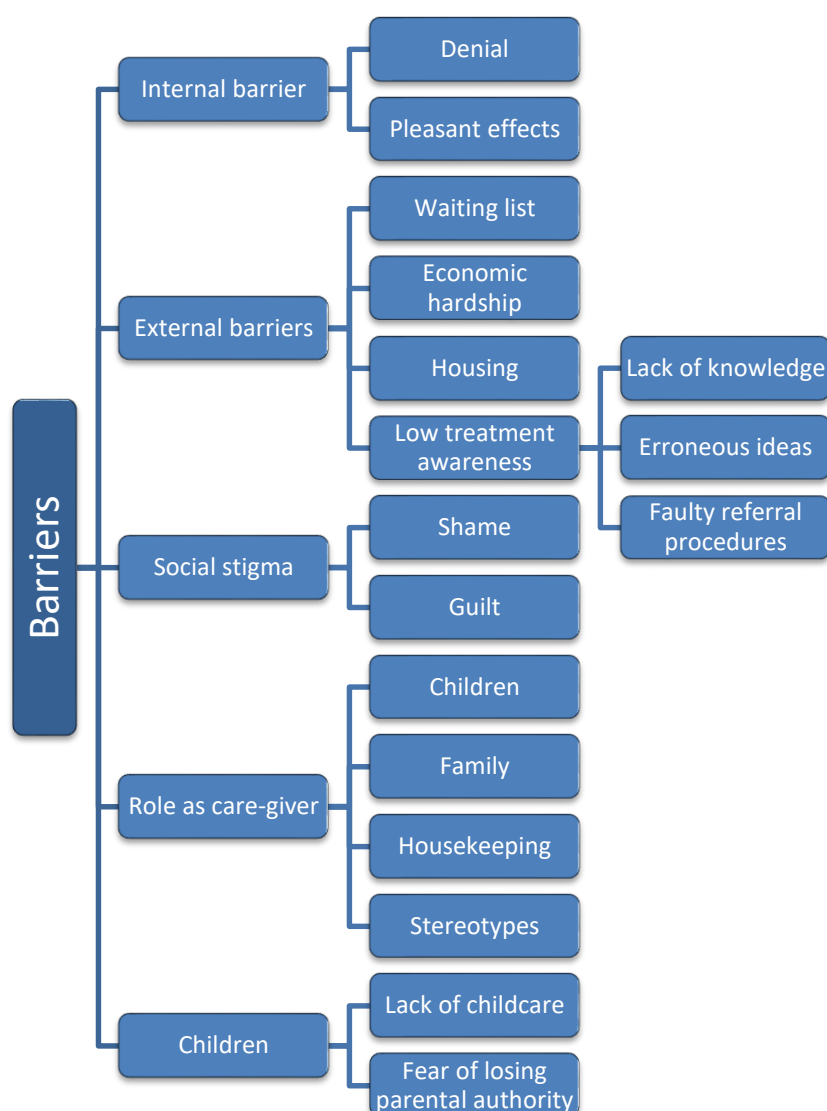


Figure 5.1 Barriers for seeking treatment and service utilization among female users.

A prominent barrier to help-seeking behaviour is the **denial or minimization of the extent of substance use** by the women themselves. Specifically, reasons for not seeking treatment are: the belief that they have their substance use under control, that they can solve their substance use and related problems themselves, or that their substance use is not problematic. Also, some women indicate that the experience of the pleasant effects of substances is more attractive and more important than a drug-free life, hinders their help-seeking behaviour. In addition, the minimization or denial of the substance use by a member of one's family, by a friend or by a general practitioner is another influence that impedes women's help-seeking behaviour is.

*"C'est vraiment mon déni et j'avais pas trop envie je me plaisais bien dans ce que je vivais, jusque ce que ça devienne vraiment trop, de trop. J'étais trop ancrée dans les, dans les problèmes, je ne payais plus de loyer non plus, j'étais vraiment dans une grosse misère, la cocaïne passait vraiment au-dessus de tout, c'était devenu une priorité, mais vraiment la priorité par rapport à ma vie, à ma santé, ma situation sociale, réseau social aussi, je m'en foutais que mes copines qui ne boivent pas,*

*qui ne consomment pas, elles ne me parlent plus. Je m'en foutais de ça, tant que j'avais euh les autres qui consommaient avec moi." (female user, 45+, outpatient programme)*

*"I was actually in denial and I didn't really want to do anything about it, I liked my life the way it was, until it really got out of hand, really out of hand. I was too bogged down by the, by the problems, and I stopped paying my rent, I was in a really bad place, the cocaine really did come before everything else, it became a priority, actually the priority over my life, my health, my social situation, social network too, I didn't care that my girlfriends who didn't drink, who didn't do drugs, didn't speak to me anymore. I didn't care about that, as long as I had the others who were doing the drugs with me." (female user, 45+, outpatient programme)*

The women interviewed also speak about several external barriers, such as being **homeless** and **unable to afford medical services**. Some respondents mentioned episodes of homelessness that aggravated their mental health, substance use and hygiene.

*"J'étais à la rue, donc difficulté supplémentaire en termes de déplacements pour se rendre dans un centre, il y a beaucoup de démarches à entreprendre, qui sont d'autant plus compliquées si on doit refaire des papiers et qu'on a même pas d'argent pour payer. Surtout si on ne bénéficie d'aucun soutien pour les faire comme des parents." (female user, 45+, outpatient programme)*

*"I was homeless, so an extra difficulty in terms of travel to a centre, there are many steps to undertake, which are more complicated if we have to do your administrative papers and no money to pay. Especially, if you don't receive any support to help making them, like your parents." (female user, 45+, outpatient programme)*

**Economic hardship** in combination with a **chaotic lifestyle** due to substance use also leads some of the women to neglect their physical condition. This in turn aggravates their situation of substance use and financial problems, and has an impact on their help-seeking behaviour.

*"Je l'ai déjà fait deux fois, mais il faudrait que je reprenne un peu de force, normalement je dois prendre des protéines, mais c'est très cher, et des vitamines. J'ai déjà été hospitalisée une semaine, et à l'hôpital ils m'en ont donné, mais autrement c'est cher. J'avais perdu 13kg, j'ai toujours été très mince, toute ma vie j'essaye de grossir." (female user, 20-30, outpatient programme)*

*"I've already done it twice, but I'd have to regain some strength, I should actually be taking protein supplements, but it's very expensive, and vitamins. I've already been hospitalised for a week, and at the hospital they gave me some, but otherwise it's expensive. I'd lost 13 kilos, I was always very thin, all my life I've tried to put on weight." (female user, 20-30, outpatient programme)*

For some of the research participants lack of information on available treatment services hinders their treatment entry. Some women report a **lack of formal knowledge** about treatment options. They do not know where to go to when seeking help and what the different options are they can apply for. Also, some women report the **absence of referrals** or late referrals to specialised addiction services by general practitioners.

*"Onwetendheid [hield me tegen om hulp te zoeken]. Ik zou het niet geweten hebben waar ik moest gaan. Ik wist van het bestaan van [naam ambulante programma] niet af. Totaal niet. En ik begrijp nog altijd de dag van vandaag niet waarom dat mijn huisarts zo lang gewacht heeft om mij daar naartoe te sturen. Dat is pas achter herhaaldelijk hervallen gebeurd." (female user, 45+, outpatient programme)*

*"Ignorance [stopped me from seeking help]. I wouldn't have known where to turn to. I had no idea that [name outpatient programme] even existed. Not at all. And, until this very day, I still don't*

*understand why my GP waited so long before sending me there. He only did so after repeated relapses.” (female user, 45+, outpatient programme)*

Other women recount **erroneous and inaccurate ideas** about residential treatment services, nourished by their social network. Their image of residential treatment programmes is often distorted, considering the latter as a ‘place for insane people’ or as extremely restrictive.

*“Het [niet in behandeling gaan] heeft eigenlijk weinig te maken met de hulpverlening. Het heeft te maken met dat ze schrik hebben om in behandeling te gaan omdat ze niet weten wat hen te wachten staat. Dat de meeste mensen denken van ‘je wordt daar vastgebonden’. En ik heb dat al veel gehoord hè. Mensen horen daar allemaal horrorverhalen van, terwijl dat eigenlijk helemaal niet waar is hè.” (female user, 20-30, residential programme)*

*“It [not seeking treatment] really has very little to do with the treatment. It has to do with the fact that they are scared to go into treatment because they don't know what to expect. That most people think that ‘they tie you up there’. And I've heard that a lot, you know. People hear all kinds of horror stories about it, while none of it is actually true, you know.” (female user, 20-30, residential programme)*

Occasionally, **waiting lists** for treatment services inhibit treatment entry. When seeking help for substance use and related problems, women most often want immediate help as at that point in time, as they have already struggled through a long process. Being confronted with a waiting list hence influences their motivation and engendered hope.

*“Je moet ook soms wachten hè. Als je belt voor een afspraak ofzo, dan ben je ook niet altijd ... ‘Ahja, kom dan maar morgen langs, of kom volgende week’. Dan is het moment al gepasseerd. Je hebt die hulp nodig als je zegt ‘nu is het moment’.” (female user, 20-30, residential programme)*

*“And you sometimes have to wait too, you know. If you call to make an appointment or something, then you're not always... ‘Oh well, come by tomorrow, or come next week’. Then the moment has already passed. You need that help when you say ‘now is the moment’.” (female user, 20-30, residential programme)*

Another barrier in the research participants’ descriptions stems from the **social stigma** on women and substance use. The persistent social stigma on female users is accompanied by feelings of shame and guilt. Women fear the judgment of others in their environment when opening up about their substance use or disclosing their treatment seeking and service utilization. This concern of judgement of one’s entourage and the coexisting shame for their substance use prompts some women to hide their substance use and avoid seeking treatment. Related to this, some women feel guilty towards significant others in their environment such as their parents, children, partner or friends. To avoid feeling guilty or feeling like they have disappointed their parents, partner or children, they attempt to ignore and hide their substance use and pursue few to no help for substance use related problems.

*“De andere mensen, wat gaan ze zeggen? Schaamtegevoel. Ja... Schuld en schaamte. [...] De maatschappij kijkt daar anders tegenaan. Van mannen wordt dat beter en meer aanvaard. Als je als vrouw verslaafd bent, word je al echt veroordeeld. Ze aanvaarden dat niet zo gemakkelijk dat een vrouw alcohol drinkt en verslaafd is.” (female user, 45+, outpatient programme)*

*“The other people, what will they say? A feeling of shame. Yes... Guilt and shame. [...] Society looks at it differently. For men it's more accepted. If you are a woman who's addicted, you are immediately judged. They won't easily accept that a woman drinks alcohol and has an addiction.” (female user, 45+, outpatient programme)*

*“On a peur de la critique, on a peur d’être jugée, donc ce n’est pas facile quoi, même dans un groupe AA c’est difficile de parler de soi-même, de son vécu, tout ça, ça ravive beaucoup de choses et ça donne envie d’aller boire. Donc je n’ai plus été.” (female user, 45+, outpatient programme)*

*“We’re afraid of criticism, we’re afraid of being judged, so it’s not easy, even in an AA group it’s difficult to talk about yourself, about your experience, all that, it stirs up a lot things and it makes you want to go drinking. So I stopped going.” (female user, 45+, outpatient programme)*

Further, the stories of the research participants reveal that women have an extensive feeling of being responsible for family and children. They consider it as their duty to nurture and care for their children, to take care of a sick or disabled family member, and to take up housekeeping tasks such as doing the laundry and cooking for their partner and family. Furthermore, women report that these responsibilities appear to a larger extent among women than among men, and that they are assigned by either women themselves or their partners, or by society in a stereotypical way. These women describe their on-going **role as care-givers**, despite their substance use, as a barrier. Seeking and engaging in treatment challenges this role, since it may jeopardise these responsibilities.

*“Moi, la seule difficulté que j’avais c’était que ma fille était encore à la maison. Et elle finalement, et donc, je la laissais seule, et elle finalement préférait me savoir en sécurité au centre, enfin à l’hôpital que, qu’à la maison, voilà. Maintenant qu’elle est partie, je suis libre, de faire la durée de la cure que je veux. Ça c’est une difficulté, surtout quand on est seule. Parce que là, il n’y a pas de papa, donc.” (female user, 20-30, residential programme)*

*“The only difficulty I had was that my daughter was still at home. And she finally, well in fact, I left her alone, and she finally preferred to know that I was safe in the centre, I mean in the hospital, rather than at home, that’s how it was. Now that she’s gone, I’m free to go into rehab for as long as I want. That’s a problem, especially when you’re on your own. Because in my case, there was no dad, so.” (female user, 20-30, residential programme)*

*“Ben, les hommes ils ont moins de soucis que les femmes, parce qu’en général entre guillemets, un homme, bon, il va pas, il va faire moins attention à l’enfant, enfin, je ne sais pas si vous comprenez ce que je veux dire, mais si il a envie de se détacher de l’enfant, ben c’est plus facile pour eux que pour la femme, il a moins de responsabilités. Donc la femme, elle a plus de problèmes, elle doit régler plus de choses.” (female user, 20-30, residential programme)*

*“Well, men have fewer worries than women, because usually you might say that men, they’re not going to, let’s just say they’re going to pay less attention to the child, right? I don’t know if you get what I mean, but if they want to get away from the child, well it’s easier for them than for the woman, they don’t have as many responsibilities. So the woman, she has more problems, she has to take care of more things.” (female user, 20-30, residential programme)*

Very similar and related to a woman’s role as primary care-giver, female users report the **lack of availability of outpatient and residential facilities that provide childcare services** as an important barrier to substance treatment. Most treatment programmes do not allow for parents to bring their children with them, do not provide child services, nor do they help to arrange for temporary guardianship while the parent is in treatment.

*“Ik vind dat er te weinig is voor vrouwen met een alcoholprobleem, allé, gewoon een drugprobleem, die kinderen hebben. Ik vind dat daar te weinig opvang voor is. Omdat ik met mijn kinderen zit, heb ik eigenlijk ook heel lang moeten zoeken voor een voorziening met een aanbod voor mama’s met kinderen. En dan ben ik hier [residentieel ouder-kind programma] terecht gekomen.” (female user, 20-30, residential programme)*

*"I think there are not enough options for women with an alcohol problem, or a drug problem, who have children. I think there isn't enough shelter available for them. Because I have two children, I had to spend a really long time looking for a facility that could help mothers with children. And that's when I came here [residential parent-child programme]." (female user, 20-30, residential programme)*

Another barrier related to children, and at the same time the main barrier to either outpatient or residential treatment for female users with young children, is the **fear of losing parental authority**. Women who still have custody of their child(ren) fear that opening up about their substance use to social services and/or seeking help for an addiction problem, will lead to the threat of losing child custody. Thus, at the junction of being a substance using woman and the fear of losing child custody, many are reluctant to contact social services for help, even when they recognize their need for it.

*"Weet je wat moeilijk is, die kinderen. Dat is bij mij ook heel lang een angst geweest van, als ik daarover ga praten, dat ze die afpakken. En dat is iets dat ge niet wilt natuurlijk. Ook omdat ik daar wel goed voor zorg. Maar ge denkt, ja, dat [druggebruik] gaan die nooit aanvaarden." (female user, 31-45, outpatient programme)*

*"Do you know what's hard? The children. That has been a fear of mine for a very long time, you know, if I talk about it they'll take them away from me. And that's something you don't want, of course. Also because I take good care of them. But you think, well, they'll never go along with that [substance use]." (female user, 31-45, outpatient programme)*

Similarly, a few women who are already enrolled in treatment sometimes deliberately **avoid being honest** about their situation to counsellors. They occasionally omit reporting a relapse or certain events that might negatively influence their parental rights, such as selling drugs or hosting an acquainted substance user.

*"Niemand wist het. Dan konden ze mij haar niet afpakken ook. Want ik moest in een potje gaan plassen en dan stopte ik even met speed om te tonen van kijk, ik ben clean. Maar dan, ja, deed ik dat daarachter weer wel hè." (female user, 20-30, outpatient programme)*

*"Nobody knew. Then they couldn't take her away from me either. Because I had to pee in a jar and so I would stop using speed for a while to show them: look, I'm clean. But then, yes, I went straight back to using again, you know." (female user, 20-30, outpatient programme)*

In addition, some respondents who already lost child custody, **gave up hope** and did not see the point of ceasing substance use or seeking treatment anymore. Meanwhile, their substance use was further exacerbating and prevented help-seeking behaviour even more.

*"Dat ze werden afgenomen van mij hè [heeft me tegen gehouden om hulp te zoeken]. Toen had ik zoiets van 'Ik heb toch niets meer, dus het kan mij ook niet meer schelen dat ik verder doe of niet'." (female user, 20-30, residential programme)*

*"That they were taken from me, you know [stopped me from seeking help]. Then I simply thought 'I have nothing left anyway, so I really don't care any more what I do or don't do'." (female user, 20-30, residential programme)*

### 3.2.2 Factors causing treatment drop-out

Participating female users describe several reasons for dropping out of treatment covering personal, external, structural, romantic and parental dimensions (see Figure 5.2).

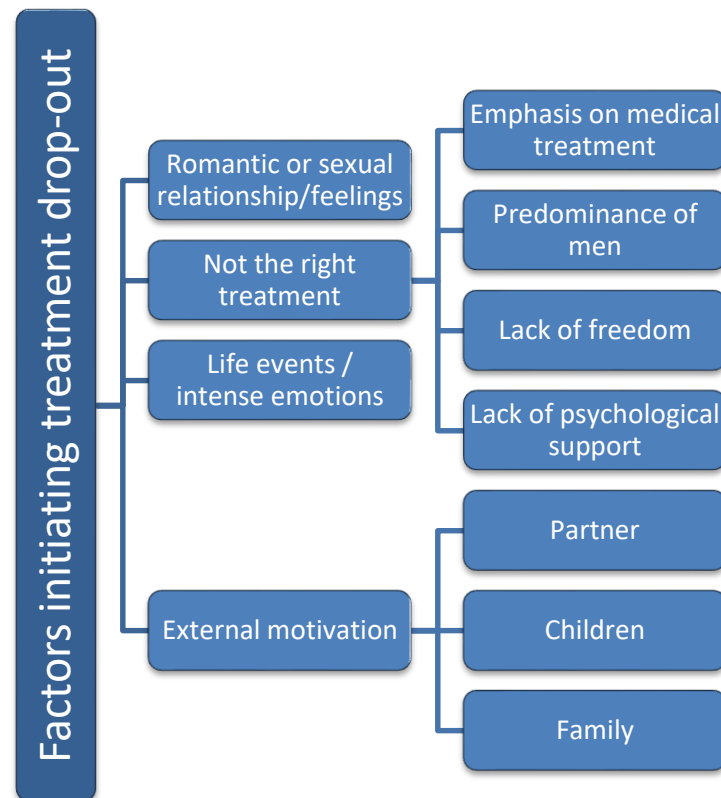


Figure 5.2 Factors causing treatment drop-out among female users.

A prominent reason for drop-out in mixed-gender residential services in the research participants' descriptions stems from initiating a **romantic or sexual relationship** with a fellow client during the treatment programme. Female users report that abstaining from intimacy and affection in a mixed-gender long-term residential programme is hard at times. However, one of the basic rules in residential treatment programmes is the prohibition of relationships with a co-resident in the programme. After all, it deducts the attention from the programme towards these new feelings. In the case of romantic or sexual feelings between two co-residents, the topic is being addressed by the counsellors not only towards the residents involved, but also in the whole group. Consequently, the residents have the choice to either terminate the relationship, overcome their feelings and remain in the programme, or to leave the treatment programme in case of continuation of the relationship.

*"Ik heb daar toen iemand leren kennen. En ik heb mij een beetje laten doen en ik ben daar mee meegegaan naar buiten en ben direct terug beginnen drinken. Ik was nog niet de hoek om. Ik had zoiets van 'ja, die gaat mij misschien kunnen helpen'. Maar toen wist ik nog niet dat hij zo erg in het gebruik zat." (female user, 20-30, residential programme)*

*"I met someone while I was there. And I let myself be persuaded and I went along with that person outside and basically straight away I started drinking again. I hadn't even turned the corner yet. I was like 'yeah, he might be able to help me'. But I didn't know yet that he was such a big substance abuser." (female user, 20-30, residential programme)*

*"Dans mes cures, je rencontrais quelqu'un, on sortait, puis on consommait et puis chaque fois la fragilité l'emportait parce que deux personnes qui sont fragiles, même si ils n'ont pas la même dépendance, ils rechutent quand même. On se dit, on va faire une fois et puis c'est tout le temps, tout le temps, et puis le couple s'est dégradé parce que ça ressemblait à rien et alors, en fait je crois que c'est parce qu'on est en manque d'affection, on est en manque de tout et en on fait pas bien*

*son travail quand on est en mixité, parce qu'on veut plaire à la personne et on ne pense plus à son problème quoi.” (female user, 31-45, residential programme)*

*“When I was in rehab I met someone, we went out, then we fell off the wagon and then each time the fragility won over because two people who are fragile, even if they don't have the same dependence, they relapse anyway. We'd say, we'll do it once and then it was all the time, all the time, and then the relationship started to suffer because it was just a mess and then, in fact I think it's because we suffer from a lack of affection, we're craving everything and we don't work as well when we're a mixed group, because we want to please the person and we no longer think about our problem, right.” (female user, 31-45, residential programme)*

A considerable number of women report that they ceased a treatment programme because it was **not the right treatment** for them. In this regard, different reasons are mentioned. A considerable number of female users report that the emphasis of some treatment programmes, especially the ones in psychiatric hospitals, primarily lays on **medical treatment** which makes them feel like a zombie and numb. Further, these respondents report a lack of focus on the specificities of addiction and recovery. Other female users mention difficulties concerning their integration in a mixed-gender programme because of the predominant **presence of men** and a male perspective. Due to the absence or underrepresentation of women in certain outpatient or residential programmes these women do not feel understood or part of the group.

*“Ik ben een paar keer naar AA geweest in [naam van stad]. En dat viel mij daar tegen. Die mannen waren over sport aan het praten en we waren daar maar met twee dames aanwezig. En ik heb gezegd als dat zo zit, voor mij hoeft dat niet. Ik ben niet meer geweest.” (female user, 45+, residential programme)*

*“I've been to AA a few times in [name of city]. And that was disappointing. Those men were talking about sports and we were there with just two ladies. And I said if it's like this, I don't want it. I never went again.” (female user, 45+, residential programme)*

Women who dropped out of residential addiction programmes in psychiatric hospitals often mention a strong emphasis on physical detox in combination with a **lack of attention for mental healing and psychological counselling** as the main reason. The few individual and group therapy sessions lead to plenty of freedom and spare time, generating feelings of being lost and useless among women and creating opportunities to start using again.

*“Ik vond dat niet zinvol, allé, ik werd daar eigenlijk niet echt geholpen. Dat was totale tijdverspilling, u bezighouden gedurende de dag. Als je naar de psychiater mocht, was dat twee minuten binnen en buiten. Kijken of dat mijn pillen nog goed waren en ik was al weer buiten. Ze luisterden daar niet naar u.” (female user, 45+, outpatient programme)*

*“I didn't see the use, you know, they weren't really helping me. That was a total waste of time, keeping you occupied during the day. If you were allowed to see the psychiatrist, you were in and out in two minutes. A quick check if my pills were still okay and I was right back outside. They didn't listen to you there.” (female user, 45+, outpatient programme)*

On the other hand, some female users report that the intense structure and many rules in residential treatment programmes cause a **lack of freedom** and can be the reason to prematurely drop out of the treatment programme.

*“Ik heb het [residentieel programma] drie keer gedaan en drie keer vroegtijdig naar huis gegaan. Omdat dat ambetant is. Echt waar. Je hebt niets van vrijheid. Geen tv. Allé ja, niet dat dat erg is, maar na een tijdje begint dat echt op je te werken. Zeker als je dan aan het afbouwen bent, loop je al ambetanter.” (female user, 31-45, outpatient programme)*

*"I did it [residential programme] three times and went home early three times. Because it isn't pleasant there. Honestly. You don't have any freedom. No TV. Not that that's such a bad thing, but after a while it really starts to get to you. Especially when you're trying to stop using, you get more annoyed." (female user, 31-45, outpatient programme)*

Another reason for dropping out of treatment that women account for is the occurrence of incidents accompanied by **intense emotions** such as fear, sadness and anger, but in a single case also happy feelings that 'demanded celebration'.

*"Ik ben eerst mijn papa en dan mijn mama verloren. Ik ben dan beginnen roken, marihuana, om rustig te blijven. En als er iemand sterft, is het van 'kom, whiskey'tje of wodka'tje erbij dat het echt weg is'. Om het te vergeten. En dan de breuk met de vriendjes ook hè." (female user, 20-30, outpatient programme)*

*"I lost my dad first, and then my mum. That's when I started smoking, marijuana, to calm me down. And if someone dies, it's like 'come on, have a whisky or a vodka to get rid of it. To forget it. And then breaking up with boyfriends too, you know." (female user, 20-30, outpatient programme)*

Another influence that may impede treatment retention is when they enter treatment primarily at the request of family or friends. At the outset, this **external motivation** appears to be effective. However, in the long run or when the programme demands efforts or awakens certain emotions or traumas, this external motivation does not contribute treatment retention.

*"Au départ oui, on le fait pour la famille, mais on se rend vite compte par la suite que ce n'est pas suffisant. Il faut que soi-même on soit vraiment décidé, ça n'arrive pas tout de suite, ça n'arrive pas du jour au lendemain. Moi il m'a fallu vraiment du temps. Je ne sais expliquer que pour mon cas ici. Je dis que c'est vrai qu'entre le moment où on décide de se faire soigner, non entre le moment où l'on accepte qu'on est alcoolique et le moment où on décide de se faire soigner, oui on a besoin d'aide, oui on a besoin d'explications, oui on a besoin d'être soutenu, mais la motivation personnelle est quand même 90% de la réussite." (female user, 31-45, residential programme)*

*"At first yes, we do it for the family, but we soon realise that it isn't enough. You yourself have to be really determined, it doesn't happen right away, it doesn't happen overnight. It took me a lot of time. I can only speak for myself here. I think that it's true that between the moment you decide to get treatment, not between the moment you accept that you're an alcoholic and the moment when you decide to be treated, yes we need help, yes we need explanations, yes we need to be supported, but personal motivation is still 90% of success."*

### 3.2.3 Facilitators for seeking treatment and service utilization

Female users in the research account for various factors that facilitate treatment participation covering personal, family, health, societal and parental dimensions (see Figure 5.3).

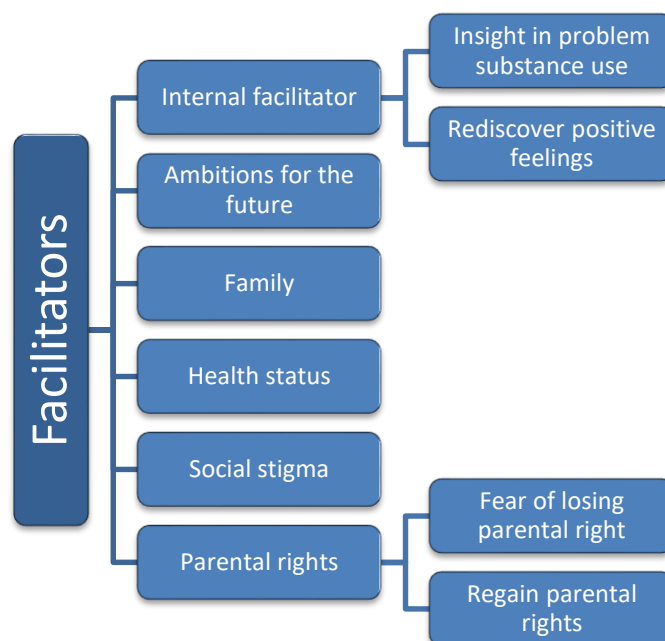


Figure 5.3 Facilitators for seeking treatment and service utilization among female users.

One facilitating factor that is frequently cited is the **insight in one's problematic pattern of substance use**. Women note that, once they reach better comprehension and awareness of their problem use as well as its detrimental effects and consequences, it encourages them to seek help and enrol in a treatment programme. In this regard, the notion of their problem is mentioned next to not knowing how to get out of that vicious circle and recover their self-respect and dignity.

*“Mais parce que je tombais toujours de plus en plus bas, et je me disais, j'ai vraiment pris conscience que la prochaine étape c'était la mort, parce que, quand tu te réveilles dans ton vomi, que tu fais n'importe quoi, tu ne te souviens même plus, et tu as vraiment presque envie de crever. Je me suis dit ici, c'est cette fameuse fois, où je me suis retrouvée inconsciente par terre, à moitié à poil, je me suis dit, je me serais cognée, je serai mal tombée, en plus tu t'isoles de tout le monde, donc j'ai une sœur que je ne vois plus parce que je me suis disputée avec elle, tu ne vois plus tes amis parce que tu t'isoles complètement, et donc je me suis dit ici, si j'étais morte, je serais peut-être restée cinq jours sans que personne s'en aperçoivent. Et je me suis dit que c'était pas une vie, et puis on se rend compte du potentiel qu'on a, ça a vraiment été le déclic.” (female user, 20-30, outpatient programme)*

*“But because I was always falling lower and lower, I said to myself, I really realised that the next step was death, because, when you wake up in your own vomit, when you do really stupid things that you don't even remember, and you really want to just curl up and die. I told myself at one point, it was that touch-bottom moment when I found myself unconscious on the floor, half naked, I told myself, I must have hit my head, I must have fell awkwardly, besides you're cutting yourself off from everyone, for example, I have a sister that I don't see any more because I had a fight with her, you don't see your friends anymore because you're completely isolated, and so I said to myself here, if I'd died, five days could have gone by without anyone noticing. And I told myself that it wasn't a life, and then we realise the potential we have, it really was the trigger.” (female user, 20-30, outpatient programme)*

Many research participants express the desire to have a **'normal life'** in the future, instead of their current life characterized by chaos, disappointment and concerns, as an influence that supports seeking and entering treatment. This normal life is defined as a balanced life in which they own a house or an apartment, maintain a

stable relationship, have (a) child(ren), build up a social network with clean friends and family, get a job or go back to school, and/or have the possibility to go travelling.

*“De gedachte dat ik eindelijk misschien een keer ga kunnen een normaal leven opbouwen. Met al mijn zwakten, maar dat ik leer grenzen trekken en mij niet meer afhankelijk maak van een partner. Dat ik nu eindelijk een keer in het leven ga staan. Een normale job met goede mensen rondom mij. Een goede ‘fond’. Dat is het belangrijkste. En de rest zal daar wel uit voortvloeien, ook mijn kinderen.” (female user, 31-45, residential programme)*

*“The idea that maybe finally I might be able to start building a normal life again. With all my weaknesses, but that I learn to set boundaries and no longer make myself dependent on a partner. That now I can finally be a part of life. A normal job with good people around me. A good ‘foundation’. That is most important. And we'll take the rest from there, my kids too.” (female user, 31-45, residential programme)*

Participants' narratives demonstrate that the **family** is an important facilitator for help-seeking behaviour. As mentioned before, the despair of family members concerning the female user and the desire for her admission in treatment, serves for some women as an external motivation and in many cases a factor initiating premature drop-out. However, having a family itself and the ambition to become sober and be there for them is for some women a motivation to seek treatment. The family in this regard may include parents, children, grand-parents, siblings or godparents. Many women declare that their children do not deserve a mother who is addicted and who is barely or not at all present in their lives. Moreover, there is also the aspect of regaining respect from their parents as well as making them proud by seeking help and entering treatment.

*“Als kind heb ik hetzelfde meegemaakt, mijn mama die verslaafd was. Dus ik wil mijn dochter niet hetzelfde leven geven. Ze verdient een cleane mama. En dat wil ik haar ook wel geven.” (female user, 20-30, residential programme)*

*“I went through the same thing as a child, my mum who was an addict. So I don't want to give my daughter that same life. She deserves a clean mum. And that's what I want to give her.” (female user, 20-30, residential programme)*

Many participants describe their **health status** as an impetus for initiating treatment. The confrontation with an unexpected mental or physical health problem or incident, or a sudden deterioration of a dragging health problem is often encountered as a rock bottom experience and a trigger to gain insight in the extent of their problem.

*“Et puis j'ai 26 ans, j'ai pas envie d'avoir une cirrhose du foie à 26 ans non plus. Le frère de mon beau-père, il l'a à un stade vraiment avancé, on ne peut vraiment plus rien y faire, voilà quoi, on ne se rend pas compte mais ça peut aller très très vite, très très vite. Surtout que moi je ne me nourrissais pas et je pouvais boire du gin comme ça à la bouteille, une bouteille par jour minimum, que ce soit de la vodka aussi, n'importe quoi.” (female user, 20-30, residential programme)*

*“After all, I'm 26, I don't really want to have liver cirrhosis at the age of 26 either. My step father's brother is at a really advanced stage, there's nothing much left to be done, that's how it is, that's what we don't realise but it can go very very quickly, very very quickly. Especially since I didn't feed myself and I could drink gin like that from the bottle, a bottle a day minimum, that or vodka too, anything.” (female user, 20-30, residential programme)*

Although for some women their health problems act as an eye-opener, others report that therapy and counselling after emergency admission as well as the role of close friends and family in response to the incident, is the decisive factor.

*“Ik ben een keer gevallen en dan ben ik opgenomen geweest in het ziekenhuis. Daar hadden ze gezien dat ik zwaar gedronken had. En dan hebben ze daar met mij gepraat en ben ik tot het beseft gekomen dat ik wel hulp nodig had. Dat is eigenlijk mijn redding geweest, dat ik gevallen ben thuis en gekwetst was. En dat ze mij naar het ziekenhuis gebracht hebben.” (female user, 45+, outpatient programme)*

*“I fell once and ended up in hospital. There they saw that I had been drinking heavily. And then they talked and talked to me and I came to the realisation that I really needed help. That was actually my saviour, that I fell at home and that I was hurt. And that they took me to hospital.” (female user, 45+, outpatient programme)*

Another facilitator, for a few women associated with having children, but mostly embedded in the social and family context, is the fear of **rejection and stigma**. Women report that feeling ashamed as well as humiliated can facilitate help-seeking behaviour. In addition, **feeling guilty** towards children, family and friends also motivates some women to look for help.

*“Franchement quand je suis arrivée ici, je me suis sentie, et je l'ai dit, je me suis sentie humiliée, diminuée, c'est pas croyable. J'avais l'impression que je n'étais plus personne, voilà, que je n'existais plus. Et c'est peut-être ça aussi qui a fait en sorte que j'ai rebondi. Parce que je me suis dit, si je ne rebondi pas ben je vais passer ma vie ici!” (female user, 31-45, residential programme)*

*“To be honest, when I came here, I felt, and I said so, I felt humiliated, as if I was nothing, it's unbelievable. I had the impression that I was no longer anyone, that's it, that I no longer existed. And maybe that's what made me bounce back. Because I thought, if I don't bounce back, well, I'm going to spend my life here!”*

*“Ik voel mezelf heel vaak schuldig. Tegenover mijn dochter, omdat ik er niet voor haar ben geweest zoals het moet. Tegenover mijn moeder, omdat ik haar heel veel pijn deed. Tegenover veel mensen hoor. Vriendinnen die ik liet vallen. En sommige jongens die ik soms echt heb gebruikt. En me vaak slecht voelen, of schamen. Of dat zelfs volledig ontkennen, bijvoorbeeld dat gebruik in mijn zwangerschap. Dat heeft allemaal meegespeeld [om hulp te zoeken]. Het meeste zelfs.” (female user, 20-30, residential programme)*

*“Many times I feel guilty. Towards my daughter, because I wasn't there for her like I should have been. Towards my mother, because I hurt her so much. Towards so many people, you know. Friends that I let down. And some boys that I sometimes really used. And often feeling bad about myself, or ashamed. Or that I am in complete denial, for instance that I used during my pregnancy. All of that played a role [in seeking help]. The biggest role even.” (female user, 20-30, residential programme)*

Still, not all emotions that induce treatment initiation are negative; the discontinuation of numb feelings makes room for **rediscovering positive feelings** and sensations as soon as participants remain sober during a few days. Experiencing emotions of all kind (e.g. positive, negative and sexual feelings), ambition or pride can support treatment utilization.

*“Je ziet gewoon alles weer helder. Je voelt alles. Je hebt terug zicht op zaken. Je hebt terug gevoelt gewoon. Je hebt terug emoties. Je bent niet meer verdoofd.” (female user, 31-45, residential programme)*

*“You just see everything a lot clearer. You feel everything. You can see things straight again. You just have your feelings back. You have your emotions back. You aren't numb any more.” (female user, 31-45, residential programme)*

*“Je suis bien avec lui, parce que je redécouvre plein de trucs quoi, c'est vraiment comme si c'était la première fois, on va dire. Que ce soit sexuel, mais même les goûts, les senteurs, les sens, tout simplement. Les sens, le goût, l'odorat, tout ça, ça revient.” (female user, 31-45, outpatient programme)*

*“I'm happy with him, because I'm rediscovering a lot of stuff, it's really like it's the first time, we'll say. Not just sexual, but even the tastes, the scents, the senses, just everything. The senses, the sense of taste and smell, all that is coming back.” (female user, 31-45, outpatient programme)*

Although a number of narratives of female users with small children illustrate the fear of losing parental authority as a treatment barrier, some mothers indicate that the **fear of losing child custody** and recognizing the damaging consequences of parental substance use motivates them to seek treatment. Receiving a **final warning** from social services regarding their parental rights, serves for these mothers as a wakeup call, and motivates them to change their problem substance use and its related problems. These mothers want to do everything in their power to make things better, to change their situation, and hence avoid losing child custody.

*“Et j'avais mon petit bout de deux ans et je me disais que, pour mon petit bout je ne peux pas rester toxicomane et que je sorte de là, faire quelque chose, et je suis toujours entrain de me battre pour essayer d'avoir mon fils, que je n'ai qu'une fois tous les dimanche trois heures.” (female user, 20-30, outpatient programme)*

*“And I had my little two year-old and I thought that, for the sake of my child, I can't stay addicted and I had to get out of that situation, do something, and I'm always fighting to try to have my son, because I only have him once every Sunday for three hours.” (female user, 20-30, outpatient programme)*

Some research participants who have already lost parental rights, are encouraged to seek help or enter treatment hoping to **regain custody** once they have completed the treatment programme.

*“Ja, maar nu de laatste keer was het eigenlijk al... Ze [dochter] was al weg hè. Ze hadden [dochter] al weggenomen en [zoon] was al alleen gaan wonen. Dus ik was ze eigenlijk al kwijt hè. Dus het was eigenlijk om ze terug te krijgen, moest ik iets doen hè, zo kon het niet verder.” (female user, 45+, outpatient programme)*

*“Yes, but it was already like that the last time... She [daughter] was already gone, you know. They had already taken [daughter] away from me and [son] had also left home. So I had already lost them both, you know. So it was basically to get them back, I had to do something, you know, it couldn't go on like this.” (female user, 45+, outpatient programme)*

### 3.3 Key concerns of female users in treatment

Besides barriers and facilitators for treatment seeking and service utilization, the trajectories of female users are characterised by several specific needs and concerns of women regarding treatment, clustered around six themes (see Figure 5.4). These concerns are not embedded in any single dimension, but rather influenced by multiple intersecting dimensions. The analysis revealed that the themes interact with one another, indicating their dynamic and interactive nature.

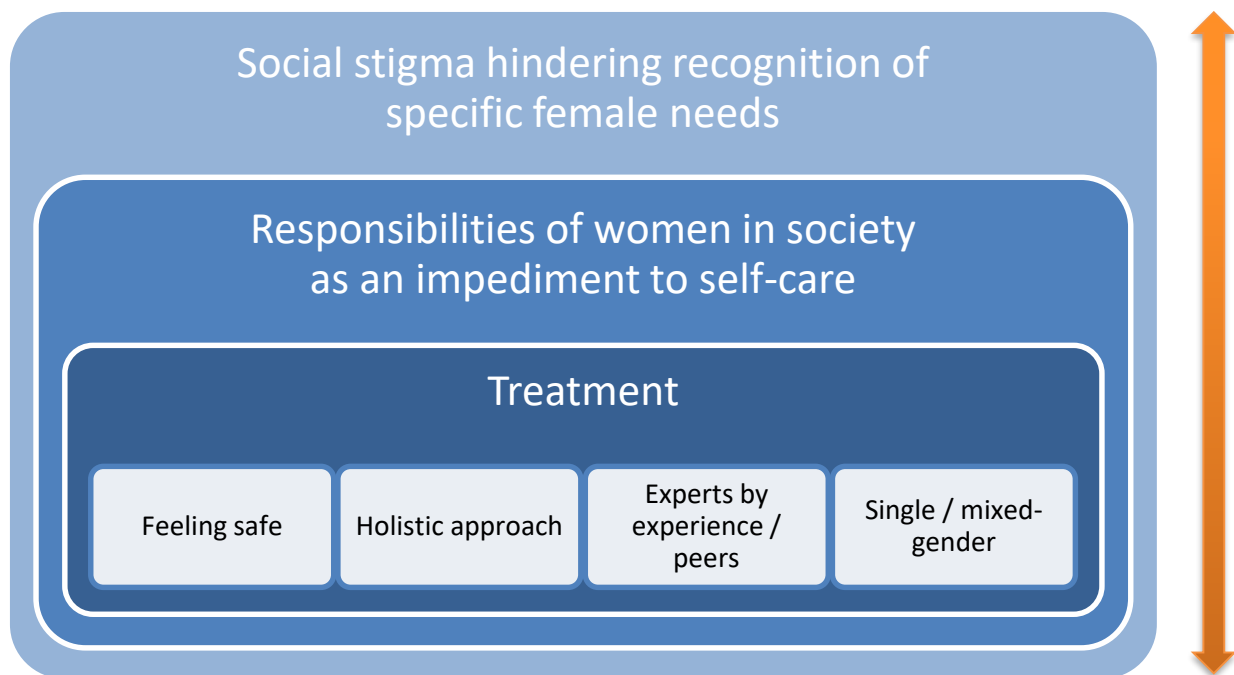


Figure 5.4 Interrelating key concerns of female users in treatment.

The themes regarding social stigma in relation to the recognition of specific female needs and responsibilities of women conflicting with self-care involve more global and societal concerns. In addition, four matters are revealed that relate to treatment features, such as the importance and meaning of feeling safe in treatment and the need for a holistic approach. Also, the role of experts by experience and peers in drug demand reduction services is elaborated on, as well as the characteristics of single and mixed-gender services.

### 3.3.1 Social stigma hindering recognition of specific female needs

The narratives demonstrate an area of conflict regarding social stigma around women and substance use on the one hand, and a demand for recognition of being a woman that has specific needs on the other hand, in outpatient as well as in residential treatment programmes. Many research participants are aware of this social stigma and experience it in their daily environment and life.

*“Je reviens avec le fait qu'on soit une femme, oui, mais un mec qui boit, consomme, ça passe quand même mieux, quoi, qu'une nana, il y a tous les préjugés qui vont avec, fille facile, fille qui n'est pas responsable, on la veut bien dans son pieu, mais pas comme mère de famille, enfin je vais dire, il y a vraiment tous ces stéréotypes qui tournent autour et qui se rattache d'autant plus à la sexualité.”*  
(female user, 20-30, outpatient programme)

*“I want to come back to the fact of being a woman, yes, but a guy who drinks, takes drugs, they're still better regarded, right, than a chick, there are all the prejudices that go with it, she's easy, she's a girl who's not responsible, we want her in her bed, but she's not cut out to be a mother, I mean there are really all these stereotypes that revolve around it, especially ones related to sexuality.”*  
(female user, 20-30, outpatient programme)

This stigma brings along a certain fragility in their being and puts them in a more **vulnerable position**. This position impacts their patterns of substance use, its recognition and their help-seeking behaviour. Consequently, some women state explicitly that being a woman should not be a core determinant in treatment.

*“Moet daar [mannen en vrouwen in behandeling] een verschil in gesteld worden? Dat denk ik niet. Ik denk niet dat daar een verschil in moet. Een persoon is een persoon hè. Een probleem is een*

*probleem. Of je nu een man of een vrouw bent, maakt niet uit.” (female user, 20-30, residential programme)*

*“Should a difference be made [men and women in treatment] in that area? I don't think so. I don't think there should be a difference. A person is a person, right? A problem is a problem. Whether you're a man or a woman, it doesn't matter.” (female user, 20-30, residential programme)*

However, other research participants in outpatient and residential settings report the need to talk about **topics specifically related to being a woman** such as sexuality, trauma, violence, abuse, children and partners. They prefer discussing these issues with women rather than with men in therapy sessions and during informal moments, because they feel more recognized and understood among women.

*“Les groupes de parole femmes, ou hommes, où on aborde certains thèmes comme la sexualité, c'est vraiment bien, parce que bonjour l'intimité si tu dois parler, moi la question ne se pose même pas, si il y avait eu des groupes avec hommes femmes mélangés pour parler de la sexualité, pfff, ça aurait pas été, c'est sûr, ou alors ça aurait tourné à la rigolade, le besoin de plaire aussi.” (female user, 45+, outpatient programme)*

*“Women-only discussion groups, or men-only, where we discuss certain topics like sexuality, it's really good, because you have to be a bit uninhibited if you get up and talk, there's no way I would say anything if there had been mixed groups of men and women together talking about sex, pff, it just wouldn't work, no way, or it wouldn't have been taken seriously, then you have the need to seduce too.” (female user, 45+, outpatient programme)*

Particularly in residential treatment programmes, women seem to value **female hygiene** in a very practical way. For example, they prefer taking a bath once in a while instead of having a shower, because of the relaxing effects of the former. Also, these women wish to replace the regular neutral care products such as shampoo and shower gel by cosmetics of their own choice. The former causes all residents to smell the same, while women often prefer using more specialized products with a specific scent or texture. Further, research participants describe the need for products for female intimate hygiene in bathrooms, as well as the availability of female magazines and other literature in leisure rooms. Hence, in that regard, in an implicit way in their narratives, research participants report the need to recognize their being a woman and the specific needs it brings along, other than those of men, in treatment programmes.

*“Overall zijn dat altijd douches. Ik mis een bad omdat dat iets meer een huiselijker gevoel geeft. [...] En ook, dat ontspant af en toe een keer. Soms heb je dat weleens nodig om even tot rust te komen. Zo languit in een bad gaan liggen.” (female user, 20-30, residential programme)*

*“Everywhere they always have showers. I miss a bath because it gives a slightly more homely feeling. [...] And also, it lets you relax every once in a while. Sometimes you just need to wind down and get some rest. Stretched out in a nice warm bath.” (female user, 20-30, residential programme)*

In this regard, women express the requirement to get **automatic and easy access to certain female needs** such as an appointment with a gynaecologist or products for female intimate hygiene. They want this to be integrated in residential treatment programmes and outpatient services in a natural, easy and discrete manner.

*“Donc, certaines petites choses devraient être plus accessibles, mais tout en étant sécurisé. Prendre soin de soi et pour les femmes voir un gynéco, un accès plus facile sans devoir se sentir frustrée de devoir demander à quelqu'un, à un éducateur; je peux voir le gynéco?” (female user, 45+, residential programme)*

*“So, some small things should be more accessible, but still in a safe way. Taking care of yourself, and for women, seeing a gynaecologist, easier access without having to feel frustrated at having*

*to ask someone, an educator; can I see the gynaecologist?" (female user, 45+, residential programme)*

### 3.3.2 Responsibilities of women in society as an impediment to self-care

One major conflict that the narratives show is the **roles and responsibilities** a woman is assigned to by society and by herself on the one hand, and the need to **take care of herself** on the other hand. In this regard, women are being stigmatized when they do not appear in accordance with stereotyped roles, which is compromised when substance using women are enrolled in a treatment programme.

*"Une femme c'est pas comme ça, une femme ça doit être droit, ça ne peut pas boire, ça ne peut pas fumer. Une femme ça doit être droit pour s'occuper des enfants, pour tenir la maison, pour, enfin, pour être capable de faire à manger, pour faire les courses pour faire plein de choses. Ça doit être plus fort, au regard des autres femmes en tous cas." (female user, 20-30, residential programme)*

*"A woman is not like that, a woman must be solid, she can't drink, she can't smoke. A woman must be solid to take care of the children, to keep the house clean, to, I don't know, be able to prepare dinner, to shop, to do lots of things. She must be stronger, with regard to other women in any case." (female user, 20-30, residential programme)*

Women take up different roles and related responsibilities like being a mother, being a partner, housekeeping, nursing a sick family member, having a job and a social life, etc. Some women indicate that taking a step back from these duties is complicated and that it is hard to combine with the need to take care of themselves. Women in outpatient programmes experience this **dilemma** as well as women in residential programmes.

*"Ik had ook zoiets rusteloos. Ik wilde wel opgenomen worden, maar dat moest zo snel gedaan zijn, want ik wilde terug naar huis en ik wilde weer werken en ik wilde weer voor mijn gezin kunnen zorgen. En dat moest in drie weken geklaard zijn. Maar ja, ondertussen weet ik nu we dat dat zo niet werkt natuurlijk hè. Dat dat veel langere tijd vraagt. Maar dat was voortdurend in en uit. De ene PAAZ-kliniek, de andere PAAZ-kliniek." (female user, 45+, outpatient programme)*

*"I also had a kind of restlessness. I wanted to be admitted, but I had to be finished with it quickly, because I wanted to go back home and I wanted to go back to work and I wanted to be able to take care of my family again. And it had to be done in three weeks. But I now know, of course, that that's not how it works, you know. That it takes a lot more time. But it was constantly in and out. From one psychiatric clinic to the next." (female user, 45+, outpatient programme)*

Some women who are responsible for the care of small children are offered a customised solution. Women enrolled in an outpatient programme can benefit from childcare during counselling sessions, while women wanting to enrol in a residential treatment programme have the opportunity to enter the programme together with their child(ren). However, women remark the scarcity of opportunities in Belgium to enter treatment with their child(ren).

*"Eerst ga ik nog zes maand in TG ergens slapen. Maar niet in [residentieel ouder-kind programma] met mijn dochter. Dat is maar vanaf de zomervakantie. Ik kijk er enorm naar uit, maar ik weet ook dat ik eerst mijn tijd ga nodig hebben om aan mezelf te werken. Want ik weet dat ik nog veel ga botsen." (female user, 20-30, residential programme)*

*"First I'm going to spend another six months in a therapeutic community. But not in [residential parent-child programme] with my daughter. We'll start that from the summer holidays. I'm really looking forward to it. But I also know that I'm first going to need my time to work on myself. Because I know I'm going to be hitting a lot of walls." (female user, 20-30, residential programme)*

### 3.3.3 'Feeling safe' as a crucial factor in treatment

One of the most prominent themes that research participants talk about in their narratives is the importance of feeling of safe, which accounts for different meanings and perspectives.

A substantial number of women report that the **absence of men** in the treatment programme provides a safer feeling. In outpatient women groups as well as in residential single-gender programmes, the absence of men is experienced as an assurance of a safe climate to discuss **sensitive, typically female topics** without fearing rude or insensitive reactions of men.

*"Ik vind de vrouwengroep zeer intiem in die zin, de vrouwen zijn discreet. Voor mij is dat zeer goed. Gelijkgeminden. We zitten allemaal op één dezelfde lijn. Voor mij is dat een soort uitlaatklep." (female user, 45+, outpatient programme)*

*"I find the women group very intimate in that sense, the women are discreet. This is very good for me. Like-minded people. We're all on the same wavelength. For me it's kind of a way to vent my emotions." (female user, 45+, outpatient programme)*

In terms of residential settings, women value the absence of men because it rules out the **risk of sexual or physical violence** related to men. Some substance using women have a history of negative experiences with men, such as prostitution and sexual, physical or psychological violence or abuse. For these women, entering treatment alongside men can be experienced as threatening and possibly impedes the recovery process.

*"J'ai subi beaucoup de violence de la part d'hommes. J'ai un grand dégoût des hommes, avec pas mal de difficulté dans des groupes d'hommes en centre de traitement. On devrait mettre en place des suivis plus spécifique pour ce genre de traumatismes dans les centres." (female user, 45+, outpatient programme)*

*"I've suffered a lot of violence from men. Men really disgust me and I find it hard to be with groups of men in the treatment centre. We should put in place more specific follow-ups for this type of trauma in the centres." (female user, 45+, outpatient programme)*

Furthermore, eliminating the possibility of developing **romantic or sexual feelings** for men reassures women in residential single-gender programmes. Research participants highly value the focus on their recovery in treatment and perceive developing feelings for a co-resident as a distraction of their initial and principal goals. Moreover, it is a risk of prematurely dropping out of treatment and/or start using again, as reported previously in the part on factors initiating treatment drop-out.

*"Ik mis zo soms affectie wel. Maar ik vind dat normaal dat dat hier niet mag. Want, moest je hier een relatie beginnen, stiekem of... Dan ben je niet meer met je programma bezig, maar met dat. En dat is eigenlijk ook niet goed om hier door te komen." (female user, 20-30, residential programme)*

*"I sometimes miss the affection. But I think it's quite normal that it isn't allowed here. Because, if you started a relationship here, secretly or... Then you aren't focusing on the programme any more, but on the other thing. And that really doesn't help you get through this." (female user, 20-30, residential programme)*

In addition, some research participants describe the **fixed daily structure** in residential drug demand reduction programmes such as therapeutic communities as offering a safe context. These programmes are filled with obligatory activities and therapy sessions and do not allow moments of freedom, hence avoiding boredom which may provoke feelings of craving and an urge to start using again. Moreover, women report implementing a structure and activities in their daily lives as one of the main goals after treatment completion.

*“Omdat daar [residentieel programma] heel veel structuur is. Dat is iets wat ik heel hard nodig heb. Want ja, als je in het gebruik zit, dan valt die structuur weg. Die structuur daar geeft mij rust. En geen verveling. Want als je je verveelt... [begin je weer te gebruiken].” (female user, 20-30, residential programme)*

*“Because it [residential programme] is very structured there. That is something I really need. Because if you are a user, all that structure falls away. The structure gives me peace. And no boredom. Because if you get bored... [you will start using again].” (female user, 20-30, residential programme)*

*“Moi je trouve que c'est super bien, oui le cadre, on a des activités manuelles, on a des activités physiques, on a de la marche une fois par semaine, de la gym, on a assez bien de groupe parole, ça c'est important aussi. On n'a pas le temps de s'ennuyer, et de penser.” (female user, 45+, outpatient programme)*

*“I think it's great, yes the setting, we have manual activities, we have physical activities, we go out for a walk once a week, we do gym, we have enough group discussions, that's important too. We don't have time to be bored, and to think.” (female user, 45+, outpatient programme)*

Moreover, research participants in residential treatment programmes feel safe because of the **prohibition of substance use** and the **absence of their old environment**. As mentioned before, cutting all ties with their former environment keeps them from getting tempted by old, ‘wrong’ friends or old habits to start using again.

*“Hier heb ik veiligheid. Een veilige omgeving. Want er kan geen alcohol en drugs hier binnen komen. Alles wordt hier goed gecontroleerd. Van niet te weten dat er iemand bier op zijn kamer heeft ofzo. Want dan weet ik ook van ‘jah’. Dan heeft het voor mij ook geen zin.” (female user, 20-30, residential programme)*

*“I have safety here. A safe environment. Because drugs and alcohol can't get inside. Everything is checked really well. Like knowing that someone has stashed beer in his room or something. Because then I know what's next. Then it's pointless for me, too.” (female user, 20-30, residential programme)*

*“Ce qui m'aide? C'est de ne pas être dans le milieu où j'étais avant, de ne pas être dans les mêmes habitudes, dans le même contexte, je pense que ça fait beaucoup, clairement. L'idée d'être ici, me rassure.” (female user, 45+, outpatient programme)*

*“What helps me? It's not being in the environment where I was before, not being stuck in the same habits, in the same context, I think that helps a lot, no doubt about it. The idea of being here reassures me.” (female user, 45+, outpatient programme)*

### 3.3.4 A plea for a holistic approach

Based on the interviews and fully in line with the post-modern approach of substance use, residential alcohol and drug treatment programmes should ideally integrate a holistic approach, focusing on healing both body and mind. In treatment, women ask attention for different aspects of their life; in particular, the physical part as well as the psychological part. Interviewees indicate that a substance using **body** is often not well taken care of and suffering from neglect on the one hand and the negative effects of substance use on the other hand. Choosing a drug-free life, women need to learn once again to get to know their body, to appreciate their body and to take care of their body.

*“De tout vraiment pour, et à la fois du soulagement physique quoi. Autant le psychologique que le corps, le bien-être en général.” (female user, 20-30, outpatient programme)*

*"Everything really, and at the same time, physical relief. It's the mind and body, the well-being in general." (female user, 20-30, outpatient programme)*

On the other hand, research participants note that residential alcohol and drug treatment programmes require not only physical detoxification and abstinence, but also **psychological support and counselling**. Also, identifying the cause(s) of substance use is an important objective, as well as identifying facilitating and maintaining factors for substance use. In this regard, individual counselling and group therapy can be appropriate.

*"Ik vond dat ik daar [residentieel programma] niet geholpen werd. Er was praktisch geen therapie. Er was alleen een psycholoog met wie we één of twee keer in de week een sessie hadden in groep. En voor de rest was dat allemaal zeer luchtig. De rest was bijna allemaal ergo eigenlijk. Dat was allemaal wel leuk, maar ja, in feite waren dat geen therapieën." (female user, 45+, outpatient programme)*

*"I felt that I wasn't getting any help there [residential programme]. There was hardly any therapy. There was just a psychologist who would lead a group session with us once or twice a week. And besides that, it was all very amicable. The rest was almost all ergo, really. It was fun and all that, but basically these weren't therapies." (female user, 45+, outpatient programme)*

### 3.3.5 Experts by experience and peers as facilitators

A substantial number of respondents report that integrating an **expert by experience** in the programme, more specifically a female expert by experience, would be of added value for their recovery process. In outpatient settings, an expert by experience can take up individual counselling sessions or lead a women group on a regular basis, while in residential programmes the expert by experience can function as a counsellor or educator.

*"Ik was hier soms ook kei-pissig op [hulpverlener], ik heb hen dat toen ook gezegd, omdat die altijd wel zoiets hebben van 'Ja, het is heel moeilijk en ge zijt keigoed bezig en...'. En dan dacht ik 'Ja, en straks gaat gij naar huis en drinkt gij een wijntje'. Dan had ik zoiets van 'Ge snapt er just niets van'. Hoe moeilijk en hoe euh, hè, dat dat kan zijn. En daarmee miste ik echt een ervaringsdeskundige die weet wat dat is om dat gevecht te leveren." (female user, 20-30, residential programme)*

*"I was sometimes really pissed off with [counsellor], and I also told them so at the time, because they're always like 'Yeah, it's really difficult and you're doing so well...'. And then I thought 'Sure, whatever, and later you'll go home and have a nice glass of wine'. I felt like 'You just don't get it, do you?!'. How hard and how, umm, you know, it can be. And that's when I really missed having a expert by experience who knows what it is to fight that fight." (female user, 20-30, residential programme)*

*"Die begeleiders, die hebben dat gestudeerd, ja, maar die zullen nooit weten wat dat dat is. Ik vind niet dat die ook verslaafd moeten worden eerst, maar... Ge hebt er goeie bij, maar dat is echt zo... Ja, niet plezant." (female user, 20-30, outpatient programme)*

*"Those coaches, they studied it, sure, but they'll never know what it's really like. I don't think they need to get addicted themselves, you know, but... You have some good ones, but that's really... well, not pleasant." (female user, 20-30, outpatient programme)*

Further, the advice and support by peers, is an important recommendation formulated by respondents in outpatient and residential programmes. In a setting with like-minded and equal peers, women feel more recognized, understood and supported. Research participants who prefer a single-gender group indicate that the connection with female companions makes them feel like they are not alone with their problem or an exception in society. Others value the dynamic of a group itself and state that the attendance of men and/or women in the group is of secondary importance.

*“De contacten met de medepatiënten hebben mij gesteund. Ja. Dat je er open kunt over babbelen, van... Buiten in de buitenwereld, die mensen weten dat niet, ge moet daar niet naartoe gaan voor daarover te babbelen of te doen. Gelijk hier weten ze dat en ge kunt daar vrij over babbelen.” (female user, 31-45, outpatient programme)*

*“The contact I had with the other patients gave me support. Yes. The fact that you can chat about it freely, like... Outside in the real world, those people don't know, that's not where you go to talk about it or do something about it. They know that here and you are free to talk about it.” (female user, 31-45, outpatient programme)*

Moreover, some research participants even express the desire to use their experience and life path as a way to **help others** in a similar position. They explicitly mention the aspiration to work as an expert by experience.

*“Et faire profiter de mon expérience aux autres, aller chez les AA pour aider l'autre, pour que mon expérience puisse maintenant servir à quelqu'un d'autre.” (female user, 31-45, residential programme)*

*“And being able to share my experience with others, go to AA to help others, so that my experience can now serve someone else.” (female user, 31-45, residential programme)*

### 3.3.6 Single and mixed-gender services

The narratives show women who prefer single-gender programmes as well as women who are in favour of mixed-gender programmes, in outpatient as well as residential settings. Generally, women who only have experiences with mixed-gender or single-gender services, opt for mixed-gender and single-gender services respectively, whereas women who have experience with both sort of programmes prefer single-gender programmes.

From the narratives of the female users, both programmes appear to be characterized by beneficial and disadvantageous factors. **Single-gender programmes** are judged to be low threshold when compared to mixed-gender programmes, thus providing an easier entry for women. Also, the female users in this research tend to stay longer in treatment and drop out less easily in single-gender programmes. Feelings of safety regarding men serve as an essential and decisive factor in single-gender programmes.

In **mixed-gender programmes** the risk of feeling threatened, unsure or insecure by the presence of men is higher among according to some of the research participants. Some women feel less comfortable around men and are hindered to talk freely about certain sensitive topics, such as trauma, sexuality, stigma, abuse and relationships. Also, some female users declare feeling looked at as an object of pleasure by men in the programme or receiving harsh and disrespectful commentaries. Furthermore, the risk of developing feelings for a male co-resident is mentioned repeatedly. The latter involves a shift in focus, more specifically from their recovery to preoccupation with the other person and romantic feelings. The chance of dropping out of the programme prematurely and of relapse is legitimate. In this regard, it is fundamental that residential programmes create a place in the service where women can feel safe.

*“Met mannen erbij, ik vond dat niet goed, want ik heb daar een relatie gehad hè. Het is niet echt goed omdat je dan niet meer aan jezelf werkt. Als je stopt met gebruiken, komen je gevoelens terug, en 24 op 24 zit je echt met elkaar, dus ik denk dat dat meer gebeurt.” (female user, 20-30, residential programme)*

*“With men around, I didn't think that was good, because I had had a relationship there, you see. It's not really good because then you're not working on yourself. When you stop using, your feelings come back to you, and you are literally with each other 24/7, so I think that it happens more often.” (female user, 20-30, residential programme)*

However, some women favouring mixed-gender programmes believe that the latter are a reflection of society and are closer to reality than single-gender programmes. Also, perspectives of both men and women on sensitive topics are different, but are considered to be equally valuable and can be combined in one programme to promote the recovery process of men and women.

*“Er bestaan typische vrouwengroepen en mannengroepen, maar ik heb gekozen voor een gemengde groep. Ik vind dat het meest natuurlijke. Want in het echte leven lopen wij ook niet apart he.” (female user, 45+, outpatient programme)*

*“There are typical women groups and men groups, but I chose to go to a mixed group. I think that's the most natural. Because we don't live separately in real life either, do we.” (female user, 45+, outpatient programme)*

*“Mannen zien soms andere aspecten. Of punten die je aanbrengt zien ze anders dan een vrouw en kunnen ze dat meer... Ik weet het niet, rationeel aanpakken. Of minder emotioneel. Het is altijd wel goed om de twee visies of verschillende visies samen te hebben. Dat is zeker.” (female user, 31-45, residential programme)*

*“Men sometimes see other aspects. Or they see some points that you put forward differently than a woman would and they can... I don't know, approach it more rationally. Or less emotionally. It's always good to have the two perspectives or different perspectives together. That's for sure.” (female user, 31-45, residential programme)*

Finally, women acknowledge that a mixed-gender programme can be an opportunity and chance to adjust their often distorted image of men in the context of a safe and assuring programme, therapy and counsellors.

*“Ik vind het ook wel fijn om te zien hoe dat een man zijn eigen toch ook wel kwetsbaar kan opstellen en toch ook wel heel lief kan zijn. Wij komen uit een macho-wereld eigenlijk zo. Waarin een man zichzelf moet bewijzen en heel, heel macho is opgesteld en zijn imago heel hard vooropzet. Ik vind dat wel fijn om het omgekeerde daarvan te zien. Ook de gevoelige mannen te zien, of ook eerlijke mannen te zien. Om toch ook dat beeld te laten veranderen van: ‘Oké, niet alle mannen zijn slecht’.” (female user, 20-30, residential programme)*

*“I also like seeing when a man is able to show his vulnerable side and can actually also be really sweet. We come from a macho world, that's what I mean. Where men feel like they have to prove themselves and act very, very macho and put their image first. I think it's nice to see the other side of the coin. Also to see the sensitive men, or also see honest men. To also allow for that image to change, like: ‘Okay, not all men are bad’.” (female user, 20-30, residential programme)*

## 4 Conclusion

The aim of this chapter was to obtain a deeper understanding of the barriers and facilitators towards substance abuse treatment as experienced by a diverse sample of female substance users. The analysis revealed several barriers to treatment entry, factors initiating treatment drop-out, facilitators for treatment entry and key concerns in the treatment of female users. These aspects are dynamic, interrelated and co-constructed, rather than dichotomous, and are shaped in a very particular way for each woman.

The current findings support previous results regarding various barriers to treatment for female substance users as identified in international research, such as parenthood and stigma (Brady & Ashley, 2005; Greenfield et al., 2007; Taylor, 2010), the latter being an even larger barrier to treatment for women than for men (Stringer & Baker, 2018). Consistent with research that has found that the substance use treatment gap among women is due to internal barriers to treatment, such as shame and denial of their substance use that are associated with

gender violation (Grella, 2008), the present results show internal-personal barriers such as enjoying the pleasant effects of substance use, shame and denial of problem substance use. In addition, external barriers to treatment, which are shaped by structural inequalities, such as poverty and gender-related characteristics of treatment programmes (e.g., lack of childcare), have been identified in the literature (Grella, 2008; SAMASHA, 2012). Similarly, participants' experiences show external-systemic barriers that keep women from seeking treatment, such as facing waiting lists and characteristics of treatment programmes. Female users and parents experience a number of additional barriers to treatment (Stringer & Baker, 2018), including strong maternal and family responsibilities, lack of childcare while in treatment, scarce economic resources, lack of support from a social network or partner, and possibly greater social stigma. In addition, the social stigma on substance using mothers in a two-parent household or a single parent household is even greater than the social stigma of female users and hinders help-seeking behaviour (Stringer & Baker, 2018). Moreover, the intersection of single parenthood stigma and substance use stigma may further decrease the likelihood to seek treatment services.

The normative role of being a woman or a mother and the impact of these role models on treatment are reflected in women's trajectories and the way they perceive themselves. Gendered roles and higher expectations about women and mothers regarding caring obligations can be detrimental to women (Neale et al., 2014). Human capital is determined by a strong presence of the dominant 'normal' social behaviour and its negative effects are observed among female users. Furthermore, their hopes and aspirations for the future are directly linked to a 'normal life' and 'being normal'.

Evidence shows that the approach of deterrence by means of threats is counterproductive in stimulating help-seeking. In fact, it creates 'flight from care' (Jessup, 2003, p. 296). The current research confirms this and shows that the fear of loss of parental authority inhibits treatment participation. The obvious threats of becoming stigmatized and losing custody keep women who use alcohol or illicit substances from seeking help. On the other hand, some studies indicate that the fear of losing child custody may motivate women to seek treatment (Neale & Tompkins, 2007; Virokannas, 2011). From some of the participants' point of view, this fear served as support for treatment entry.

Although effective treatment programmes for substance-related disorders are widely available, adults with a clear need for these services underutilize them (Cohen et al., 2007). Moreover, it seems that especially women are hindered in seeking treatment (Greenfield et al., 2007, 2010). Understanding barriers to treatment utilization is necessary for developing accessible treatment opportunities. The interview data show a clear desire for gender-sensitive recovery-oriented outpatient and residential treatment services, tailored to individuals' treatment demand. Such programmes should include a holistic approach to recovery focusing on body and mind, and the opportunity for women to receive treatment while maintaining their role as mothers. Further, the introduction of (female) experts by experience and women-only chat groups, as well as incorporating attention for feelings of safety need to be considered. Still, women with substance use problems are a largely heterogeneous group, with diverse goals, aspirations and hopes, thus requiring a variety of gender-sensitive services to answer their particular needs.

In developing appropriate services, specific themes need to be addressed, several conditions should be taken into account and structural challenges should be met. A gender-sensitive approach requires attention for specific themes in the treatment of female substance users including attachment, stigma and taboo, guilt and shame, trauma, sexuality and violence. Also, a holistic treatment perspective focusing on body and mind should be adopted. Furthermore, women describe the absence of men, the integration of experts by experience, the support by a peer group and the beneficial effects of single-gender programmes as prerequisites for creating a safe climate for women in treatment programmes. In mixed-gender treatment programmes, a space especially reserved for women such as a living room in residential services or a leisure room or kitchen in outpatient settings can offer a similar, safe climate. Finally, some structural challenges need to be dealt with, or at least acknowledged. There is a need for more residential services for parents and child(ren) as well as child-friendly settings in mixed-gender outpatient and residential programmes. In addition, a shift in mentality regarding parental and societal responsibilities must be pursued, as well as destigmatisation of female substance use

whether or not associated with parenthood in society as well as among treatment programme staff. Also, female users should be better informed on what specialist addiction services are available and what types of support can be accessed in particular agencies.

# EXPERTS' VIEWS ON CHALLENGES AND PREREQUISITES FOR A GENDER-SENSITIVE APPROACH IN ALCOHOL AND DRUG DEMAND REDUCTION

*Julie Schamp, Sarah Simonis*

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## 1 Introduction

This chapter aims at exploring experts' opinions regarding necessary services and programmes for female users along the continuum of care, as well as obstacles and challenges that female users experience when contacting alcohol and drug services. The input and opinions of both service users, experts by experience and professional experts will give insight on gender-issues in relation to treatment entry and treatment trajectories of female users. Additionally, the prerequisites for implementing gender-sensitive services are explored.

## 2 Methodology

Based on the results of the in-depth interviews with female users (see Chapter 5: Treatment experiences of female substance users), prerequisites for implementing gender-sensitive services were explored by means of a discussion group strategy. In total, four discussion groups were organized: two in Flanders (Ghent and Leuven), one in Wallonia (Namur), and one in Brussels. The sessions were organized between October and December 2017 and each session took approximately two hours.

Various stakeholders were involved that are familiar with challenges and obstacles encountered by women in relation to treatment entry. The organisations that had participated in an earlier phase of the GEN-STAR project (see Chapter 2: Gender-sensitive initiatives for female substance users in Belgium) were contacted once more and invited to participate in this next phase of the study. Stakeholders working in the field of drug demand reduction or who are frequently in contact with female users were invited as well. The continuum of care was taken into account and reflected in the variety of participants, being social workers, general practitioners, psychologists, nurses, midwives, and treatment programme coordinators. The different backgrounds of the participants are detailed in table 6.1. Additional attention was given to the diversity of profiles by involving men as well as women, younger and more experienced persons, and professional experts as well as former users working as experts by experience and some service users.

Table 6.1 *Participants of the four discussion groups in Belgium (n=42)*

<b>Participants discussion session in Ghent (n=14)</b>
4 counsellors from residential treatment programmes
1 coordinator from residential treatment programme
3 counsellors from outpatient low threshold programmes
1 counsellor from an outpatient aftercare programme
1 prevention coordinator
1 street corner work coordinator
1 expert by experience in a residential treatment programme
2 female clients from residential treatment programmes
<b>Participants discussion session in Leuven (n=11)</b>
3 counsellors from residential treatment programmes
1 counsellor from an outpatient aftercare programme
2 counsellors from an outpatient low threshold programme
1 prevention / harm reduction worker
2 volunteers
2 policy makers
<b>Participants discussion session in Brussels (n=9)</b>
4 social workers from outpatient low threshold/harm reduction programmes
1 nurse from outpatient low threshold programme
1 counsellor from prevention programme
1 coordinator from outpatient programme
1 midwife from outpatient low threshold programme
1 counsellor residential and outpatient programme
1 health promotion and prevention worker
<b>Participants discussion session in Wallonia (n=8)</b>
2 counsellors from residential aftercare programmes
3 social workers from outpatient low threshold programmes
1 midwife from outpatient low-threshold programme
1 psychologist from residential and outpatient programme
1 doctor from low threshold outpatient programme

The GPS Brainstorm toolkit<sup>9</sup>, was used as a structuring method to organize the discussion session and to formulate concrete recommendations for the development and implementation of a more gender-sensitive approach in treatment settings for substance users.

This GPS Brainstorm technology was developed by Flanders DC, the Flemish organization for entrepreneurial creativity, and can be used to brainstorm in a group of 8 to 14 persons. Each session started by stating: “How can we make alcohol and drug demand reduction services more gender-sensitive?”. To come to this end, five topics were put forward for discussion, in addition to one empty field. These five specific issues were repeatedly mentioned by female substance users throughout the interviews and were discussed in the chapter on treatment experiences (see Chapter 5: Treatment experiences of female substance users, p. 98-106):

<sup>9</sup> <https://www.flandersdc.be/en>

- Social stigma hindering recognition of specific female needs
- Responsibilities of women in society as an impediment to self-care
- 'Feeling safe' as a crucial factor in treatment
- A plea for a holistic approach
- Experts by experience and peers to comfort support in treatment

A discussion group based on the GPS Brainstorm toolkit consists of three steps:

1) *Generating and classifying ideas.* Participants sit in pairs to explore each specific topic. A board is installed on a table and divided in six parts, each part for one topic. Participants stay around this board. During the session, the GPS board turns and all participants have the opportunity to write ideas on post-its for each theme (see Figure 6.1).

2) *Selecting ideas.* After this first step, participants explore the different ideas on the post-its and vote for ideas that they would like to be realized or that they find particularly pertinent to develop a gender-sensitive approach in the alcohol and drug demand reduction field (see Figure 6.1).

3) *Elaborating ideas in specific project cards.* After having established a ranking of the most relevant ideas, participants briefly develop a project card for the three selected top ideas, including the following elements: title of the idea, definition of the idea, advantages, disadvantages, solutions, impact, and required parties.

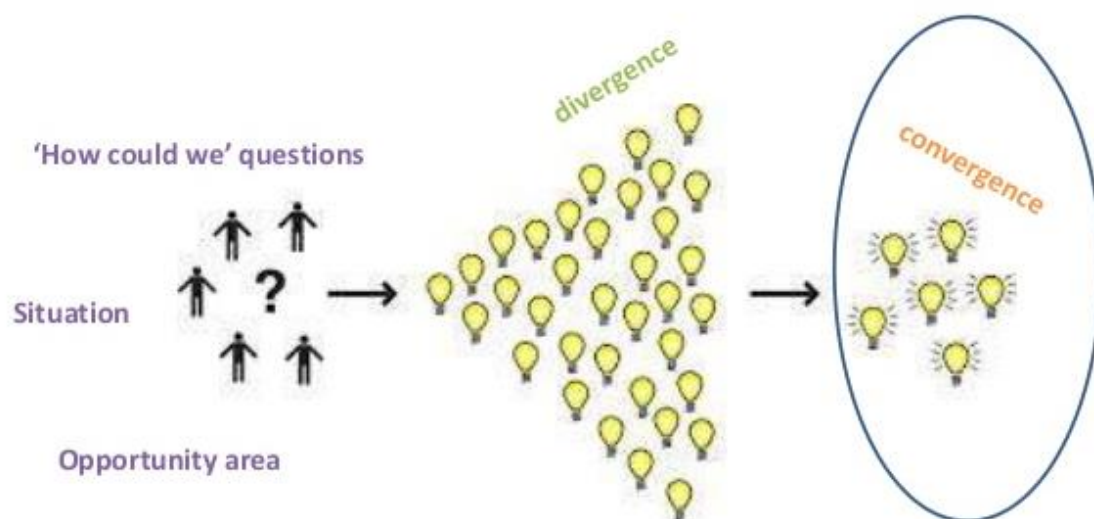


Figure 6.1 The brainstorm process in the four discussion groups.

In the two discussion groups in Flanders, the last phase of the brainstorm was not completed due to time restrictions. However, the main ideas were ranked according to relevance, as well as elaborated orally rather than in writing on the provided project cards.

All the written ideas were kept and organized afterwards. Similarities and differences between the different sessions were discussed among the researchers, as well as the most frequently selected ideas. In the results part, only the main topics chosen by the participants are described. The results exclusively reflect the thoughts and ideas of the experts presented in the discussion groups, in order to improve and implement more gender-sensitive initiatives in Belgium. Their ideas are based on their own experiences with female users. Some of these ideas are more elaborated than others.

### 3 Results

The discussion groups in both Flanders and Wallonia demonstrate different measures and opportunities regarding gender-sensitivity in the alcohol and drug demand reduction field. Given the diversity, the findings are clustered around five broad dimensions. First, the more structural findings requiring adjustments or developments in infrastructure or on a more global level are discussed. Second, ideas regarding cooperation and networking in the professional field as well as concerning female users are described. Next, thoughts on essential themes and elements in the treatment of women are elaborated regarding outpatient as well as residential treatment. Furthermore, we focus on extensive campaigns in order to sensitize and raise awareness on different topics not only among female substance users and in the drug demand reduction field, but also among men and in the society at large. In the last part, attention is drawn to the role of men in the narratives of gender-sensitivity in prevention and treatment.

#### 3.1 Policy-based implications

In pursuit of an optimal integration of gender-sensitive measures, there is a need for implementing a comprehensive **policy regarding gender-sensitivity** by alcohol and drug prevention and treatment services. This vision should be noted in a document that is available for all staff members and should focus on answering the question ‘How can we better reach and help female users?’. Ideally, this document is managed in a dynamic, evolving and interactive way rather than as a passive document. A general philosophy and framework should be included as well as specific guidelines, procedures and practices grafted on the particularities of the service. Hence, this document could serve as a starting point for concrete methods to work with female users in the programme(s) and service(s). In this way, a better understanding of the concept gender-sensitivity could be created, consequently allowing an easier translation to methods and practices.

Of utmost importance, the attitude of staff members working with female users clearly needs to be open-minded and non-judgmental. Further, it is preferable that gynaecologists, psychologists or doctors for female users in treatment centres are women. As mentioned before, women tend to talk easier about sensitive topics with other women than with men. A **policy in which a “person of reference” is appointed in treatment centres** allows female users to at least have the choice whether their counsellor is a man or a woman.

In all discussion groups, the current lack of and hence need for **exchanging good practices** between professionals is mentioned. Learning from methods and procedures in other programmes is extremely valuable and may offer opportunities for implementation in one’s own programme or for collaboration with other services. A digital platform could meet these needs.

It is essential that all gender-sensitive initiatives, measures and programmes are embedded in a **global gender-sensitive way of thinking**, respecting some key features such as a safe and welcoming environment, accessibility and affordability, and guaranteed anonymity. Further, to ensure continuity and a maximum chance on a relationship of trust with female users, initiatives should strive for long-term goals rather than applying short-term projects.

In addition, the experts express the need for more **training opportunities regarding gender issues**. Specific training could be helpful for professionals in order to be more aware of the specificities of women and female users, as well as the representations and stigmatizations present regarding women and substance use.

#### 3.2 Structural measures

The experts define some challenges regarding **treatment options for substance using mothers and their child(ren)**. There are currently eight outpatient services in Belgium for parents/mothers and their child(ren) which are addressed by a great number of female users. However, the demand is higher than the capacity of these programmes, confronting some women with a waiting list and no proper care immediately available. Moreover, the scope of these services is particularly local, leading to counsellors not being able to meet the

needs of women living further away from this service. Regarding residential services for parents/mothers and their child(ren), experts acknowledge a similar challenge. The demand for these services is high, whereas the available places are limited, often resulting in a waiting list for mothers in need. Hence, there is a clear demand for more outpatient and residential services for mothers and their child(ren). There are a number of inspiring good practices for outpatient and residential programmes as described in chapter two (Gender-sensitive initiatives for female substance users in Belgium). Related to the focus on families in recovery, maintaining the “kangaroo room” within hospitals is reported to be an issue as well. These specific rooms allow to develop and strengthen the mother-child bond after birth.

One of the most important challenges defined in outpatient services is the lack of a **child-friendly setting**. This includes practical and infrastructural measures specifically targeting children. Examples are the creation of a kids corner or a room with toys for children, as well as assigning a staff member time to take care of children whilst their mother can have a consultation with a counsellor or doctor. But even beyond that, it concerns efforts made towards women to ensure a welcoming place and a service that is well adapted to their realities. The service should allow more flexibility regarding opening hours and consultations for female users, taking into account their responsibilities as a mother which often hamper help-seeking behaviour and treatment retention.

In Flanders, the experts underline the importance of acknowledging specific female needs from the start of the treatment programme. Sensitive topics for women such as trauma, violence, sexual abuse, should be explored from the start. Consequently, during the intake process, counsellors should question the **situation and safety of the child(ren)** by trying to portray from the beginning who is taking care of the child(ren), in what way, where and when, etc. This will allow for a better and more customised support and assistance not only for women, but also for their environment.

In Wallonia, not only the safety of the child(ren) was discussed but that of the entire family as well. As such, assuring the security of the relatives of female users during the treatment or aftercare can be helpful to keep female users into treatment, and provide adequate support whenever necessary. It is only when this condition is fulfilled that women will be able to consider their own recovery and rehabilitation as a priority.

In both Flanders and in Wallonia, experts call for a **combination of single-gender and mixed-gender elements in treatment**. From their experiences, women tend to talk easier and more freely in a women-only group. Also, it seems that the absence of men enhances their feelings of safety. On the other hand, the experts acknowledge that women need to learn again to be confronted with men and live together in a healthy way. Treatment including counselling and a safe environment is an ideal way to start this process. The concept of specific support groups for women only in outpatient settings and in residential programmes already exists, but deserves more attention, especially in mixed-gender programmes. These groups allow women to get out of seclusion by creating and maintaining ties, and therefore reinforce their female identity and empowerment. A non-judgmental place where women can be heard about specific women-related themes such as sexuality, sex work, parenthood and violence, and where they can freely share their own reality in a safe environment, can also offer a good opportunity to learn more about what exists in specialized addiction services. These groups can be a safe place to exchange and share knowledge and experiences, besides the added value of talking about sensitive topics. As mentioned before, the professionals get the impressions that the social dynamic differs when the space is shared with both men and women. In that respect, a space dedicated to women only offering support and counselling, such as a separate bathroom or a specific living room is highly recommended in both outpatient and residential mixed-gender services. The dependency on men, and more precisely a man from the close network of a female user, was regularly commented upon by the participants. Hence, the importance of preserving women-only residential programmes is underlined by the stakeholders. These centres allow a safe and welcoming space for women, in which they can focus on themselves, without the pressure of a partner or member of a close network. Nevertheless, in order to maintain a good balance in the diversity of approach and treatment, it is essential to keep the overall composition of staff mixed-gender. Every person is different, in that order, keeping diversity regarding age, sex, ethnicity or professional background is crucial. The multidisciplinary of the team is highly recommended.

Another idea put forward by the experts is the opportunity of a **detox department in a treatment centre reserved for mothers and their child(ren) only**. In that regard, placement of the child(ren) by child protection services can be avoided as well as a breakdown of the mother-child bond, as this seems to be a major source of motivation for drop-out/continuation of the treatment programme. However, the stakeholders call attention to the fact that this kind of service is promising, but might not be suitable for every woman. Above all, enrolling into treatment as well as agreeing to the conditions related to the treatment setting, will always remain the mother's own choice. The personal situation, the age of the child(ren), the motivation as well as the support of the rest of the family are all decisive aspects in this context.

Concerning adapted services for mother and child(ren) in Wallonia and to lesser degree in Flanders, the creation of **services that are mainly dedicated to the daily responsibility of a mother towards her child(ren) outside the drug demand reduction field** are suggested by the brainstorm participants. Suggestions for adapted services within this domain of well-being for both mother and child(ren) are nurseries, medical care for mothers and child(ren), and parenthood counselling. The idea is to create a structure outside the alcohol and drug demand reduction field, thereby attempting to remove the potential label of "addict", perceived as an obstacle by female users and society. Including and involving other vulnerable women in different situations of insecurity, such as homeless women or female victims of domestic violence, could be a possibility as well. In a second phase, female users would then be able to enrol into a treatment programme that is implemented in a specific setting that still approves the child(ren) to remain in close vicinity of the mother while detoxing.

During all discussion groups, the experts mark an important lack of easy access for specific services for women, like gynaecologist consultations or contraception. Often, financial restraints hinder female users to see a doctor or gynaecologist, let alone use an appropriate method of contraception. They plea for a **minimum price for contraception and health practitioners visits**, or even make it costless for vulnerable populations.

To optimize accessibility of treatment services, other options to reach female users should be considered which are less conservative and more innovative. The participating experts propose the development of **online self-help groups** and a **helpline** with flexible hours. Women might appeal to these initiatives at the most convenient time for them and from wherever they are. Hence, having children or a lack of transportation would then be less of a barrier to seek treatment. Also, by safeguarding their anonymity, these opportunities reduce the risk of being stigmatized along with feelings of fear and shame. Female users in outpatient settings tend to have more immediate and basic needs (e.g. eating, getting some rest, paraphernalia for injecting drugs and taking a shower). These highlight the importance of outreach and street work, like a mobile bus with medical services. The "**médibus**" in Brussels run by Dune and Doctors of the World is a good practice mentioned in this regard. The staff provides paramedical care, syringe exchange and tries to implement a harm reduction philosophy. Being available and present at the time that women formulate their need for help, is a gain of time and can be a great help.

### 3.3 Important themes in treatment

In the discussion groups in both Flanders and Wallonia, a global policy of **awareness-raising on stereotype gender roles, attitudes, behaviours and inequalities** within the centres and more globally in society was deemed an important focus. This type of initiative requires to include men imperatively and should focus on various themes such as domestic violence, parenthood, familial responsibilities and contraception. For the stakeholders, these themes are directly linked to the multiple roles and responsibilities that women face every day and that put a permanent social pressure on them. Taking care of women and providing services for them is consequently complicated. It is essential to create separate chat groups for both men and women, besides mixed-gender therapy groups, as well as elaborated psycho-educational seminars within the centres. The different roles that women take up in society need to be made negotiable among both men and women. Doing so in treatment, allows women to be better prepared for a life after treatment on the one hand, and open up the possibility to break through stereotyped thinking.

An essential ingredient of treatment are **psycho-educational seminars**. Most treatment programmes provide an offer of psycho-educational seminars and nominate this as crucial in treatment of female users. However, the experts point at some additional topics that are greatly valuable to focus on in treatment such as **self-awareness**, **self-confidence** and **self-knowledge**. In addition, treatment programmes should offer **assertiveness** training to female users, giving them the strengths to come up for themselves and the courage to say no to certain situations, or even to men.

Further, the idea of a **holistic approach** of care and services is tackled. In order to consider body and mind in a gender-sensitive approach, it is important that female users can first be seen as women, before being seen as addicts. However, in a holistic perspective not only education or psychotherapy regarding body image is an added value for treatment of female users. Additionally, attention must be drawn to spiritual health. Recovering in a holistic way is healing one's relationships and environment, respecting one's body, setting new perspectives and goals, and finding one's soul purpose. Finding more time and space to learn the pleasures of life again is an integral part of the process. In this regard, experts propose to integrate yoga classes, relaxation sessions and mindfulness sessions in treatment programmes for female users.

Another way to reduce stigmatization and stereotype gender attitudes can be by implementing **gender-challenging activities** in treatment centres. These activities contain inversed or neutral roles, for example a mechanic class for women and a knitting course for men. Residents in the treatment programme can choose the activity of their preference.

### 3.4 Cooperation and networking

Experts suggest the need to create and develop **networks around female users, consisting of both professionals and private persons**. In regards to the establishment of a professional network, every specificity needs to be included. Issues like mental health, childcare, social support, sexuality, trauma, and housing are to be considered. All these specific demands require special attention at the time of admission. Assuming that different services are regrouped in the same area or at proximity, integrated services can be valuable to female users for reducing travel efforts. Also, it can help to avoid losing women between services, often located in different areas which might discourage them to continue treatment. Creating a solid network in the field of alcohol and drug demand reduction is important but not sufficient. Other services need to be integrated as well, for instance child protection services, sex worker services or general healthcare services like a dentist, oculist and gynaecologist. A better exchange of information between services are key to a better understanding of each specific situation and ensures better outcomes. To this end, a collaboration structure is required. A global medical file could be helpful for the creation of integrated services and serve as a tool to share information with the different stakeholders. However, special attention must be paid to the informed consent of the client: this is essential as the client can be the only one who decides which type of information can be shared between professionals.

Linked to the issue of outreach work for women and creating safe places for female users, the topic of female sex workers was discussed. By conceiving a secure place for sex workers with a medical office, police station, talking groups and harm reductions initiatives, the safety and quality of life of women can be improved. Also, it can help stakeholders to reach these women more easily. Due to their job, these women tend to come less to a treatment service during opening hours. Services that are available directly on one location can be advantageous for them. The project of the Eros centre in Liège is named as a good practice in this regard. A challenge mentioned regarding partnerships and collaboration is that professional partners working in the field of drug demand reduction or with vulnerable women are quite limited. Hence, partnerships in this sector are often complicated and changing mentalities regarding substance using women is a long process. Additionally, the private network of women needs to be expanded. Women are often isolated and captured in their small networks. Their world is built around their partner and child(ren), while a network of friends is often lacking. Counsellors can help female users to expand their network with 'healthy' contacts that can provide them emotional or practical support.

The experts in the discussion groups in both Flanders and Wallonia indicate the importance of the **active role of former users in the process of recovery among female users**. Such active role could be established in many ways, going from a former female user telling her story a single time to former female users working as qualified counsellors in the treatment programme. Female users report to feel understood in a better way by experts by experience than by counsellors for the reason that the former have experienced a comparable battle, emotions and wheel of life. Further, the experts describe some former users' request to give significance to their past of substance use and to use their experiences in helping other female users in their process of recovery. They also express the value of motivating female users to use and share their experiences in the future. The volunteering of former users in a treatment programme is already a point of attention for some centres. However, the lack of time or sufficient staff is problematic to appropriately support former users. Additionally, experts note the concern of anonymity. Female users refuse to talk about sensitive topics and their emotions with someone they formerly know from their drug network. Hence, when working with experts by experience the programme needs to be sure that former users and female users in the programme do not know each other. Also, former users working as experts by experience need to be recognized in their mandate by clients on the one hand and by fellow staff members on the other hand. They pursue equivalence among all staff members. Considering these remarks, the stakeholders state that integrating former female users as experts by experience in treatment programmes can be constructive, on the condition that attention is given to establishing a clear vision and monitoring its implementation. A good programme structure to manage former users is necessary, as well as recognition with regard to mandate and remuneration. Special attention must be given to not replace the work of experts by former users only and integrating former users from outside the regional area. Also, experts propose to develop a network of experts by experience in Flanders and in Wallonia. By doing so, a service from one region could consult an expert by experience from another region.

### 3.5 Prevention campaigns and raising awareness

The discussion groups in Flanders and Wallonia stress the importance of **campaigns for prevention and awareness raising concerning women and substance use**. Targeted at female users themselves, but also at societal level. The social stigma on female users is particularly high and several misconceptions are persistently present in society. Also, the experts report an undeniable negative stigma regarding female users in various communities, resulting in feelings of shame and guilt reported by female users.

First, interventions aimed at reducing the stigma on mental illness and substance use, especially regarding female clients, are desirable. The Flemish mental health prevention campaign "Te Gek" is mentioned as an example of good practice and a starting point to develop new prevention campaigns. Such a campaign could raise awareness about gender stereotypes, inequalities and attitudes among a broad audience and could result in a more gender-sensitive attitude towards vulnerable groups. In general, public education and information campaigns are not sufficient for reducing alcohol-related problems. Media advocacy approaches, however, can be helpful to gain public support for policy changes (Anderson & Baumberg, 2006).

Second, prevention should target professionals supporting female users (such as general practitioners, gynaecologists, dentists, counsellors) to make them aware of the specific needs of this population and to decrease the judgements that female users might be exposed too. Such judgements could again induce feelings of shame and guilt, which is counterproductive for seeking help. To increase efficient referrals, adequate information on helping resources for female users and their families is necessary for general health and mental health professionals.

Third, prevention campaigns regarding the use of contraception and other aspects of female hygiene should be targeted specifically to female users. Harm reduction messages concerning, for example, infectious diseases and the use of legal and illegal substances could prevent harm on various health domains. Based on the epidemiological findings, it is clear that gender-specific information should include information on alcohol and medication, since these are the main substances for female users.

Whether to focus in these information campaigns on women only or including men and women, should be well considered. Interventions should be gender-specific in their design and message. Finally, prevention needs to be innovative in the methods that are used, for example, by looking for opportunities in new technologies, like smartphone apps.

### 3.6 What about men?

An overall remark and topic that is recurrently discussed is the role of men in the narratives of female users. The experts indicate that men have a responsibility towards women and many related issues such as gender stereotypes and responsibilities in society, as well as the social stigma on female users. In many of the above mentioned ideas and attention points, men need to be involved and addressed as much as women. Prevention and awareness raising campaigns not only have to address and inform women, but also need to make men aware of certain historically grown societal norms and tendencies influencing women and the way they are looked upon. Also, men need to be involved in the use of contraception and the accessibility of a general practitioner and a gynaecologist in order to encourage and manage birth control and sexual health among women. Further, when developing and implementing psycho-educational seminars in treatment programmes around topics such as assertiveness, body image and responsibilities, men need to be involved in a certain way and at a certain time in the process. Though in doing so, counsellors need to be cautious to still allow women to feel safe.

## 4 Conclusion

Using the innovative GPS Brainstorm toolkit method, the experts in the discussion groups managed to describe different vulnerabilities of women that seek treatment and ideas for implementing the concept of gender-sensitivity in alcohol and drug demand reduction. They report areas of attention on a policy-related level and a more (infra)structural, philosophical, as well as on a very practical level concerning treatment of female users. Further, a need is raised regarding collaboration and building networks in the field, as well as for exchanging good practices. Also, prevention is mentioned as an important field to further develop, and men are named as a crucial factor in the recovery of women.

A general remark that is observed in all discussion groups is clearly linked to the demands and needs of female users. For all participants, care should be provided according to the demands of female users and their actual needs. In that respect, more personalized support along with a clear and well-defined follow-up is crucial for the recovery of female users. Additionally, professionals in the field must be aware of their own personal representation of women and substance use. It is essential that they are free of judgment and stereotypes when working with female users, and it serves as an important step in the construction of a counsellor-client relationship based on confidence.

These results clearly reflect a need for a gender-sensitive approaches in the field of alcohol and drug demand reduction. The recommendations mentioned above will be elaborated in the next chapter in order to implement specific measures addressing women's needs.

# GENERAL CONCLUSION AND RECOMMENDATIONS

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## 1 General conclusion

### 1.1 Gender-sensitive initiatives in Belgium

International research shows substantial progress in recent years in our understanding of the influence of gender on, for example, the epidemiology of substance use, diverse pathways into treatment, clinical and service need profiles of treatment participants, and factors related to treatment retention and outcomes (Grella, 2008; Tang et al., 2012). Furthermore, previous research on health services generated a range of findings on the organizational characteristics of the programmes in which women receive substance abuse treatment, and the type of services that are provided in these programmes (Grella & Greenwell, 2004; Sacks et al., 2004).

In Belgium, few studies have focused on gender issues in drug demand reduction, except some studies among specific treatment populations (e.g. De Corte et al., 2012; De Wilde, 2006). The current research aimed at enriching these findings and exploring the concept of gender-sensitivity throughout a broad array of services and settings. Our findings show that the gender dimension is an actual concern among prevention and treatment services in Belgium, specifically those services dedicated to female users and/or users with children until the age of twelve years old. Different types of gender-sensitive outpatient initiatives are identified such as case management for pregnant women and parents with child(ren), harm reduction and low threshold groups for women, and aftercare groups for women. Also, residential gender-sensitive initiatives are available in some psychiatric hospitals and specialized treatment services. In addition, the treatment model of therapeutic communities has been modified to incorporate empowering gender-sensitive approaches for women/parents. Still, service users as well as treatment providers report a lack of gender-sensitive initiatives in outpatient and residential settings, especially in specific regions (e.g. in the provinces West-Flanders and Luxembourg, in rural areas and small cities).

### 1.2 The extent of the gender gap in Belgium

While the use of illicit substances is more prevalent among a younger and male population, the use of sleeping pills and tranquilizers is more common among women. The use of the latter substances tends to increase with age for both men and women. Moreover, proportionally more women than men tend to seek treatment for these type of drugs. Even though women are less likely than men to seek treatment, also for alcohol problems (Greenfield et al., 2007; Greenfield et al., 2010), Belgian treatment demand data show that women primarily seek treatment in hospitals and enter treatment for alcohol problems more easily than men (proportionally).

Specialized (drug) treatment centres are apparently not the first treatment option chosen by women in Belgium, which is also seen internationally (Green, 2006). Actually, women face multiple gender-specific barriers to accessing treatment. Specific barriers like motherhood, stigma and shame may explain the difficulties for women to enter treatment in specialized drug treatment centres in Belgium. Erroneous ideas about treatment, lack of informal knowledge, as well as the almost exclusively presence of men in treatment could explain this gender gap.

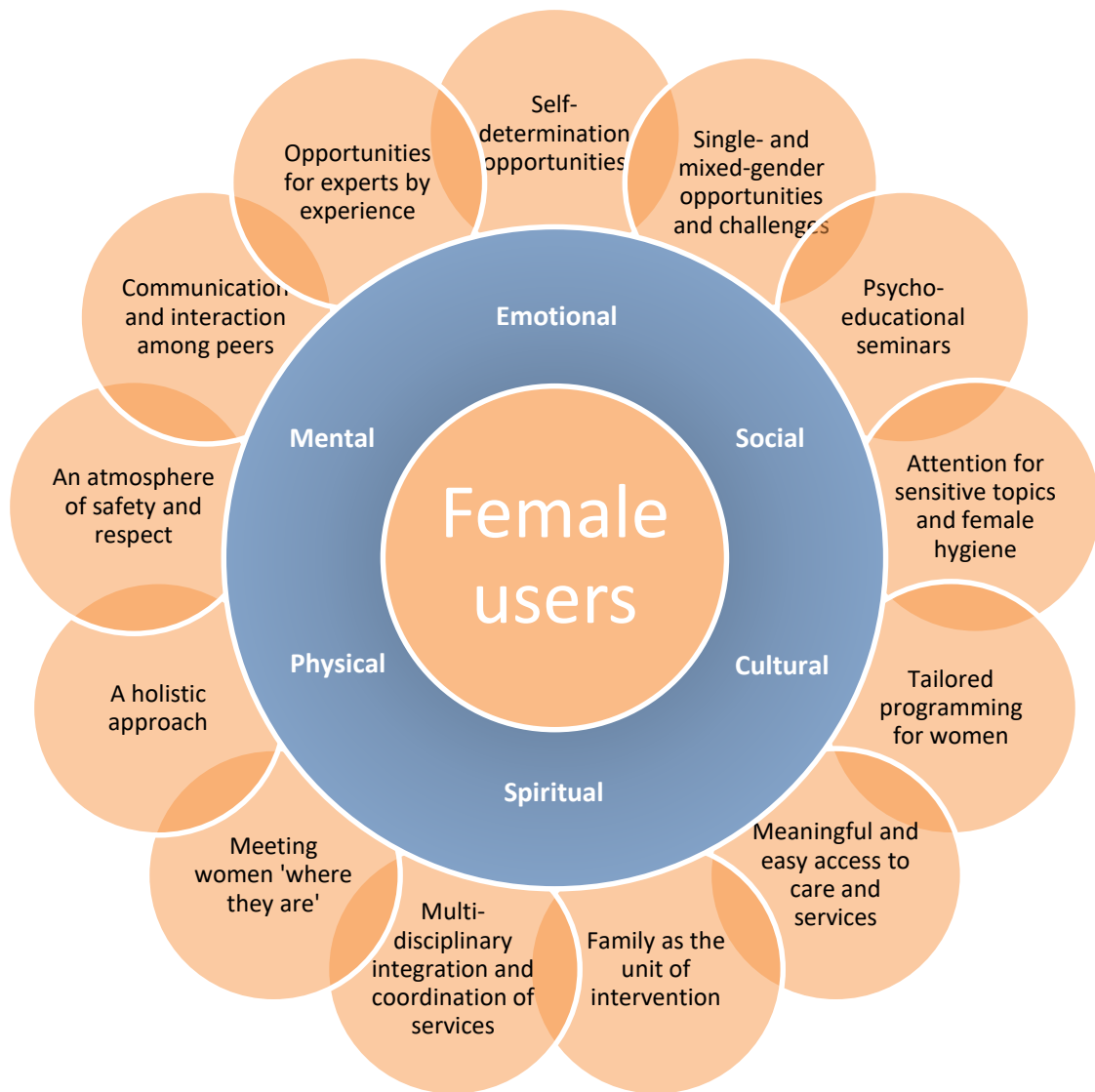
### 1.3 A conceptual framework for gender-sensitive approaches in treatment settings

Service providers reported the need for an integrated and comprehensive approach toward gender and gender-sensitivity in treatment. Moreover, service providers ask for specific tools and methods to create gender-

sensitive prevention campaigns and to develop gender-sensitive approaches in treatment programmes. As in previous research (Poehlmann, 2004), programme directors and counsellors describe training focusing on gender-sensitivity and continuing education on women-specific issues regarding health and social support as methods to enhance women-specific and gender-sensitive approaches in treatment. Still, opportunities for this type of training are exceptional.

In defining what type of gender-sensitive services are needed to address female users' needs appropriately, the research started from describing women-specific services as those offered to women only or those in which there is a higher concentration of female clients (Grella, 2008). It may also include a range of gender-neutral services, offered in a women-only environment. An example of the latter may be an outpatient or residential parent-child programme that is attended by mostly women. However, also mixed-gender services can appropriately meet female users' needs. The results of this study confirm that the concept of gender-sensitive treatment services is a complex and multidimensional one, shaped by various theoretical perspectives (e.g. Choo et al., 2016; Grella, 2008; Niccols et al., 2010). The research results suggest that there are at least 13 components to gender-sensitive substance treatment programmes that are essential for a holistic approach of addressing women's needs (see Figure 7.1). Drawing on the work of the Vancouver/Richmond Health Board (2001) and Carter and colleagues (2013), we distilled these elements into three categories. First, eight pillars are described regarding strategies to successfully engage female users in treatment. Second, three elements that account for women's unique treatment trajectories are portrayed. And third, two philosophies for delivering gender-sensitive services are specified. We acknowledge that the degree to which these items are achieved in practice may vary depending on the purpose, context and number and characteristics of female users involved. Also, many of the principles overlap and are interrelated to each other. Gender-sensitive services for women involve an integration of some or all of these components, that have – in combination – an impact on female users' total experience of entering care on the one hand, and of staying in treatment on the other hand.

As a result of this study, **eight pillars** are defined **regarding strategies to successfully engage female users in treatment**. First, both service users and service providers report the need for considering body, mind and soul in treatment. Service programmes that apply a holistic approach are more appreciated by participants and rather meet the diversity of female users' needs. Second, some female users report underutilizing treatment services because of the social stigma and past experiences with negative judgments by service providers. Thus, engaging female users in treatment begins with safety and respect (Judd et al., 2009), including the creation of a welcoming and non-judgmental women-only space where women feel comfortable to share potentially sensitive issues (Ashley, 2003). Moreover, similar to previous research (Bride, 2001), most female users emphasize that employing female counsellors is a crucial component of treatment, as they may serve as female role models. Third, participants report that building connections with peers is an important source of support during treatment (Wisdom, 2008). Therefore, facilitating the development of a network of peers is an integral part of gender-sensitive treatment programmes for women. Fourth, despite a lack of female experts by experience, service providers and service users acknowledge their added value in treatment programmes for female users. Fifth, improving access to information, skills and services are essential when attempting to empower women (Gupta, 2000). By doing so, women are encouraged to be vocal advocates of their rights and their care trajectories. Further, participants indicate that single- as well as mixed-gender services provide opportunities as well as challenges (Grella & Greenwell, 2004). Therefore, in a sixth pillar, treatment programmes need to recognize these structures and implement them consciously in the most appropriate way. Seventh, female users and service providers identify psycho-educational seminars on topics such as assertiveness and self-knowledge as valuable in the process of recovery. In the eighth and final pillar, participants report the need for treatment programmes to address potentially sensitive and painful issues such as trauma, attachment, sexuality, stigma, guilt and shame, and violence. Also, attention needs to be given to the female hygiene in treatment on a practical level (e.g. feminine care products and cosmetics, products for the female intimate hygiene, magazines for women).



*Figure 7.1* Conceptual framework of ‘gender-sensitive treatment’, based on female users’ experiences. Female users are at the centre of the framework and are encircled, first, by six dimensions of women’s health, and, second, by 13 interrelated components of gender-specific treatment (adapted from the Vancouver/Richmond Health Board, 2001).

Second, we identify **three elements that account for women’s unique treatment trajectories**. First, a gender-sensitive approach in treatment often includes services that are more relevant to women than those provided for men (Mason, 2007). The overall style of such programmes is more supportive, nurturing and cooperative, focusing on specific issues such as the multiple roles and responsibilities of women, self-worth, emotional safety and life skills training (Grella, 1999). Other examples typically associated with women’s needs are childcare, transportation assistance and the full spectrum of women’s sexual and reproductive health services (Campbell, 2009). Second, it is essential that gender-sensitive services provide social and supportive services. For example, for female users with competing responsibilities, this involves allowing them to be accompanied by their child(ren) when coming to the treatment programme, offering on-site childcare. For other female users, providing transportation support or flexible opening hours serves as a facilitator to treatment. Third, due to a tremendous diversity in the background of female users (i.e. family situation, living and housing conditions), a gender-sensitive approach in treatment should be flexible and take into consideration the diverse family contexts in women’s lives.

Finally, **two philosophies or approaches for delivering gender-sensitive services** should be considered. First, the multidisciplinary integration and coordination of an array of services has been promoted as a means for managing the multiple and complex problems of female users (Ashley, 2003; Claus, 2007; Niccols, 2010). One potential way to attain this goal, is by establishing an integrated network of services that work in partnership to connect and refer women to appropriate service providers (Wisdom, 2008). Similarly, case management models have been set up to deal with this issue (Jansson et al., 2005). Another way to achieve this goal is known as a “one-stop shopping”, in which several service providers are located together at one site (Yano, 2006). Both models require collaboration in delivering adequate responses to the needs of female users by an interdisciplinary network of providers. Also, besides linking female users to appropriate services, it is essential that support is experienced as connected and coherent by female users themselves and is characterized by continuity of care (Haggerty, 2003). The second approach stipulates that, as female users are at various stages in their lives and in their substance use, gender-sensitive service for women should involve support for all women by adequately meeting their individual health and social needs, without moral judgment. This implies flexibility in the provision of services regarding various needs and life stages (Jarrett, 2007), and may even include the delivery of services directly at home. Hence, outreach services are to be implemented in a more sustainable and tailored way and offer opportunities for female users who cannot participate in residential treatment programmes. Also, it underscores the importance of aftercare for women who have completed treatment, since continuing care and support services are key factors in maintaining behavioural changes and for recovery in general.

#### 1.4 Toward gender-transformative health promotion

The GEN-STAR study showed a lack of gender-sensitive approaches in substance abuse prevention in Belgium and a need for integrated gender-sensitive prevention campaigns, focusing on awareness raising and sensitization. Such initiatives should not only target girls and young women, but society at large. Also, prevention initiatives should be embedded in a broader long-term approach of substance abuse prevention and treatment, rather than as a stand-alone campaign. Further, the subject of gender-sensitive prevention should not only focus on female substance use, but also on gender inequity, gendered roles and responsibilities in society, and social stigma. From that perspective, the framework for Gender-transformative Health Promotion (Pederson et al., 2014) might serve as a guide to shape gender-sensitive prevention in Belgium. Specifically, gender-transformative approaches “actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives” (Rottach et al., 2009, p. 8). To achieve improvements in the lives of both women and men, and hence creating more equal chances and opportunities in substance abuse treatment, gender-transformative health promotion needs to be further explored, criticized and established in future research in Belgium.

## 2 Recommendations for substance abuse prevention, treatment and policy

Based on the findings of the current research, we formulate recommendations for the drug demand reduction field in Belgium, clustered around five major themes including specific measures to develop a structural framework for more gender-sensitive approaches in this field. A crucial element to successfully implement these recommendations in the drug demand reduction is the involvement of all actors in the implementation process, irrespective whether it concerns the policy or practice level. Political authorities at the federal, regional and local level should be aware of the necessity to work in close collaboration with various actors in the field and specialized centres for achieving sustainable and effective changes.

### 2.1 Towards a comprehensive and integrated approach

When focusing on the concept of ‘integrated treatment approaches’, two different levels need to be distinguished.

### 2.1.1 *A continuum of interventions and treatment approaches*

A strictly medical approach or solely psychological support will often not be sufficient to promote change and recovery among persons with substance use problems. An integrated approach, including attention for **each dimension of the person** - being emotional, social, cultural, spiritual, physical and mental life –, is highly recommended. These dimensions can be taken into account through combination and integration of medical care, social support, psychological counselling, personal empowerment as well as philosophical and cultural approaches.

Within a gender-sensitive framework, promotion of **holistic treatment approaches** seems essential and promising, as it allows women to discover (once again) their bodies and to be fully aware of themselves in their totality and complexity. This way of thinking and empowerment can also help women to build a new identity as a person and as a woman by providing relief to the body and mental pain.

### 2.1.2 *A tailored approach as part of a network services*

Beyond the notion of gender, each female user brings in her specific and individual context. Given the diversity and complexity of social realities and their clear impact on the outcomes of substance abuse treatment (Neale et al., 2014), establishing tailored gender-sensitive services can be regarded a prerequisite through a diverse and **interdisciplinary network of specialized and non-specialized agencies**. There is a real need for integrated treatment, including childcare services, housing support, job training, low threshold and harm reduction services, trauma and other types of specific therapy. Ideally, the approach and support should be tailored to the needs of each female user with a treatment demand. Each person's situation should be evaluated during the intake process to identify specific needs and desired support. A key factor of such an integrated approach concerns the importance of a wide range of treatment services that are offered (e.g. outpatient and residential settings; outreach work; single and mixed-gender initiatives), in order to respond to the multiplicity of female users' situations.

Also, integrated approaches should include an aftercare component to ensure continuity of care, which is regarded to be a crucial element of a recovery-oriented approach. Healthcare and treatment services should be experienced as comprehensive and integrated by service users. Moreover, services provided by various professionals should be connected and coherent with individuals' personal situation and needs. In that regard, knowledge on service users and their context are as important as their medical/psychological condition to ensure appropriate responses to their needs (Haggerty et al., 2003).

### 2.1.3 *Some examples of including gender aspects in comprehensive treatment programmes*

Besides integrated treatment approaches and integrated services, some concrete measures are recommended. To develop gender-sensitive practices in the field of treatment and prevention, we give some specific examples of such activities.

- I. In residential mixed-gender programmes, the implementation of specific women-only activities can help women to reinforce their own identity as a woman and create a sense of belonging to the group. Moreover, the difficulty of being in a large group of men can be overcome by specific women-only talking groups on topics related to sexuality, parenthood, violence or particular subjects that are identified as needs. Indeed, a safe and closed environment can be helpful to reduce the fear of judgment and to allow freedom of speech on intimate topics as well as topics regarding sex work. Importantly, when addressing the topic of 'gender', it is recommended to include and involve both men and women. Hence, the same type of groups can be developed for men as well. This approach could be a starting point to construct a shift in mentality in both groups, regarding the defined normative gendered roles and the gendered stereotype behaviours.
- II. In outpatient mixed-gender programmes, install a specific physical space for women only is recommended, as well as single-gender chat groups. These measures allow bonding with staff

members, based on a relationship of trust and encourages women to talk about more sensitive subjects. Such a separate, safe environment is a core element to get beyond the fear of judgment.

- III. Installing a specific space for women-only in residential programmes, as well as providing separate bedrooms and bathrooms are recommended. Also, attention needs to be given to the female hygiene in treatment on a practical level (e.g. feminine care products and cosmetics, products for the female intimate hygiene, magazines for women).
- IV. Provision of easy access to contraception and gynaecologist consultations in residential programmes, as well as outpatient services at a minimal cost are advised. Given the omnipresence of trauma in female users' life stories, a female gynaecologist trained in gender issues may help to diminish barriers regarding stigma and to create a safe environment to build up a relationship based on mutual trust.
- V. Given the stigmatization of female users and feelings of shame experienced by them, treatment and prevention services are advised to involve female experts by experience in the programme.

As women are usually the principal childcare provider and family responsibilities are often an obstacle when seeking treatment, their family situation should be taken into account in their treatment trajectory. Some specific recommendations that incorporate the family context are listed below:

- I. It is an urge to provide childcare services for female substance users with small children in outpatient single and mixed-gender programmes. A concrete and well-elaborated opportunity for childcare in an outpatient setting that allows female users to take their child(ren) along to these settings is considered to be of additional value.
- II. Adapted services are required to create or support the mother-child bond. Such services might be provided in the format of pro-children settings or parental support. Also, maintaining specific rooms in a hospital for female users in substitution treatment and their newborn after childbirth (e.g. kangaroo rooms) can be appropriate to reach this goal.
- III. By creating a helpline for female users that is also available outside office hours, women are provided with alternatives to seek help in an anonymous way, independent of others and while their child(ren) are at home.
- IV. A combination of outreach and outpatient services should be considered. Reaching more female users at home and including their relatives in family-focused interventions is recommended. Focusing on the home environment of female users and involving their family and network may facilitate access to treatment and other helping resources.

## 2.2 Training in gender issues and exchange of good practices

Taking into account these above-mentioned recommendations, several solutions might include specific adaptations to the treatment structure and setting. Therefore, it is essential to provide (new) training opportunities for staff members, as well as to promote the exchange of good practices between professionals from different services.

- I. Training and formation on gender-related topics must be provided for counsellors, psychotherapists, psychologists, psychiatrists and other people involved in the treatment of female users.
- II. A clear vision of what a gender-sensitive approach entails needs to be integrated in residential and outpatient programmes, based on experiences of counsellors, female users, the literature and available good practices. Such a (written) vision may facilitate the translation of abstract ideas into concrete plans and measures.

## 2.3 Attention for gender stereotypes and women's responsibilities

While it is central to address treatment of female substance users from a public health perspective, it is also meaningful to examine it from a sociological point of view. As a consequence, a broader view of the gender dimension needs to be integrated and topics related to gendered stereotypes such as domestic violence, parenthood and familial responsibilities should be addressed.

To promote gender equity and to reduce the burden of women's responsibilities, integrating psycho-education programmes which include both men and women must be elaborated. The diverse roles and responsibilities that women (can) take up in their daily lives need to be addressed in psycho-educational seminars or during therapy sessions. Adaptation to these new roles before they complete treatment is necessary to learn how to deal with these responsibilities. Such programmes can be linked to global or national campaigns of awareness-raising regarding this issue.

## 2.4 Targeted and gender-sensitive prevention campaigns

In order to develop gender-sensitive approaches along the continuum of care, gender-sensitive prevention approaches need to be further developed. In this respect, four aspects are highlighted: social stigma and the role of substances in women's life, specific talking groups, harm reduction strategies and type of substance.

- I. In order to improve female user's orientation to appropriate services and to reduce the persistent social stigma on female users, developing a recurring national prevention campaign for (mental) healthcare professionals is recommended. Various disciplines such as general practitioners, gynaecologists, social workers, psychologists and other stakeholders in contact with female substance users or vulnerable populations should be targeted, and themes like women, substance use, and shame can be tackled. Specific leaflets and referral guides can be developed with references to specialized centres, thereby attempting to reduce the gap between men and women in treatment seeking and service utilization. Such leaflets can be spread through general practitioners, primary healthcare services, anti-poverty associations, etc.
- II. Implementing specific single-gender talking groups for female users or thematic talking groups is advisable. Such groups encourage female users to freely share experiences on certain subjects in a safe, non-judgmental environment.
- III. In order to improve the knowledge of women on gender issues in relation to substance use, targeted prevention/harm reduction campaigns are necessary (e.g. regarding sexual health and transmission of infectious diseases).
- IV. As women > 45 years are more involved in the use/abuse of prescription drugs, targeted prevention and communication campaigns towards this population are recommended regarding the abuse of prescription drugs and alcohol.

## 2.5 Evaluation and monitoring

Successful application of new approaches and measures, irrespective whether it concerns gender-sensitivity or other features, will require sufficient financial resources as well as adapted facilities which should be based on structural funding rather than project subsidies. In Belgium, it will be crucial to implement more gender-sensitive approaches on all levels, as the competences regarding substance abuse treatment and prevention are split into federal and regional authorities. Also, monitoring of the progress and development of gender-sensitive policies is required in order to enable evaluation of its evolution over the years. This may include, for example, the development of a national, representative database on the prevalence of substance use and service utilisation among the Belgian population, also including vulnerable and institutionalised populations, in order to better understand the extent and evolution of the treatment gap between men and women.

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## ANNEX – TABLES

### AGE GROUP 15 TO 30 YEARS

#### Secondary school students, VAD school survey 2007-2016 (Flemish Community)

Table 1. *Last year alcohol use, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	69.0%	65.7%	**	0.04	1.16 (1.05-1.30)
2008-2009	65.1%	63.6%	n.s. (p=0.21)		
2009-2010	63.3%	61.1%	n.s. (p=0.06)		
2010-2011	64.2%	62.4%	n.s. (p=0.11)		
2011-2012	59.5%	58.0%	n.s. (p=0.25)		
2012-2013	57.3%	53.8%	**	0.04	1.15 (1.04-1.28)
2013-2014	59.4%	57.2%	n.s. (p=0.06)		
2014-2015	61.2%	57.2%	**	0.04	1.18 (1.06-1.31)
2015-2016	54.4%	53.1%	n.s. (p=0.29)		

Table 2. *Regular alcohol use (at least weakly during last year), students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	27.6%	16.8%	***	0.13	1.89 (1.67-2.13)
2008-2009	26.3%	17.0%	***	0.12	1.75 (1.54-1.97)
2009-2010	23.8%	16.2%	***	0.10	1.62 (1.43-1.84)
2010-2011	25.4%	13.6%	***	0.15	2.16 (1.91-2.44)
2011-2012	21.4%	13.6%	***	0.11	1.74 (1.51-1.99)
2012-2013	20.9%	12.5%	***	0.11	1.84 (1.59-2.13)
2013-2014	17.2%	10.2%	***	0.10	1.83 (1.59-2.10)
2014-2015	18.5%	10.2%	***	0.12	2.00 (1.72-2.33)
2015-2016	15.1%	9.5%	***	0.09	1.70 (1.47-1.96)

Table 3. Last year drunkenness, students secondary schools (12-18y), VADschool, Flanders

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2010-2011	26.0%	19.2%	***	0.08	1.47 (1.29-1.69)
2011-2012	28.9%	21.6%	***	0.08	1.48 (1.31-1.66)
2012-2013	28.4%	21.9%	***	0.08	1.42 (1.26-1.60)
2013-2014	29.8%	24.8%	***	0.06	1.29 (1.16-1.43)
2014-2015	31.4%	24.2%	***	0.08	1.43 (1.28-1.61)
2015-2016	26.1%	21.8%	***	0.05	1.26 (1.13-1.41)

Table 4. Regular drunkenness (at least weakly during last year), students secondary schools (12-18y), VADschool, Flanders

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2010-2011	3.1%	1.0%	***	0.10	3.18 (2.00-5.04)
2011-2012	2.9%	1.1%	***	0.10	2.81 (1.86-4.25)
2012-2013	3.2%	0.8%	***	0.10	4.11 (2.57-6.57)
2013-2014	3.2%	1.0%	***	0.09	3.20 (2.19-4.66)
2014-2015	2.9%	1.0%	***	0.09	2.80 (1.84-4.26)
2015-2016	2.7%	1.0%	***	0.07	2.66 (1.82-3.88)

Table 5. Binge drinking ( $\geq 4/6$  drinks woman/man in two hours)  $\geq 1x/month$ , students secondary schools (12-18y), VADschool, Flanders

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2013-2014	16.8%	13.1%	***	0.06	1.34 (1.18-1.53)
2014-2015	18.3%	13.8%	***	0.07	1.39 (1.21-1.60)
2015-2016	14.3%	12.1%	**	0.03	1.25 (1.09-1.39)

Table 6. Last year use of cannabis, students secondary schools (12-18y), VADschool, Flanders

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	14.4%	7.5%	***	0.11	2.08 (1.76-2.46)
2008-2009	14.9%	7.9%	***	0.11	2.03 (1.72-2.38)
2009-2010	15.9%	9.1%	***	0.10	1.88 (1.61-2.19)
2010-2011	14.2%	8.3%	***	0.09	1.83 (1.57-2.13)
2011-2012	13.4%	7.3%	**	0.10	1.98 (1.66-2.35)
2012-2013	13.9%	7.1%	***	0.11	2.10 (1.76-2.51)
2013-2014	17.3%	10.0%	**	0.11	1.89 (1.64-2.17)
2014-2015	14.5%	7.9%	***	0.11	1.98 (1.67-2.35)
2015-2016	13.8%	7.7%	***	0.10	1.91 (1.63-2.23)

Table 7. *Regular use of cannabis (at least weekly during last year), students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	4.2%	1.1%	**	0.12	4.08 (2.78-6.01)
2008-2009	3.7%	1.3%	***	0.11	2.92 (2.05-4.17)
2009-2010	3.3%	1.3%	***	0.11	2.59 (1.80-3.72)
2010-2011	3.8%	1.2%	***	0.10	3.19 (2.26-4.51)
2011-2012	3.9%	1.2%	***	0.11	3.33 (2.28-4.84)
2012-2013	3.8%	0.9%	***	0.12	4.42 (2.85-6.84)
2013-2014	4.5%	1.3%	***	0.12	3.55 (2.55-4.94)
2014-2015	3.1%	1.0%	***	0.11	3.24 (2.12-4.97)
2015-2016	4.1%	1.1%	***	0.11	3.77 (2.64-5.38)

Table 8. *Last year use of other illicit substances than cannabis, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	3.9%	1.3%	***	0.08	3.02 (2.12-4.30)
2008-2009	4.0%	2.2%	***	0.05	1.88 (1.40-2.53)
2009-2010	3.3%	1.5%	***	0.06	2.24 (1.58-3.17)
2010-2011	2.4%	1.2%	***	0.05	2.03 (1.40-2.92)
2011-2012	2.1%	0.9%	**	0.05	2.53 (1.59-4.02)
2012-2013	2.5%	1.0%	***	0.06	2.62 (1.68-4.09)
2013-2014	2.7%	1.4%	**	0.05	1.99 (1.40-2.83)
2014-2015	2.2%	1.3%	**	0.04	1.71 (1.15-2.56)
2015-2016	2.7%	1.7%	**	0.03	1.59 (1.15-2.20)

Table 9. *Last year use of XTC, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	2.6%	0.9%	***	0.07	3.08 (1.98-4.78)
2008-2009	1.9%	1.2%	*	0.03	1.62 (1.08-2.42)
2009-2010	1.6%	0.5%	***	0.05	3.41 (1.73-6.61)
2010-2011	0.9%	0.5%	*	0.02	1.75 (1.00-3.08)
2011-2012	1.3%	0.4%	***	0.05	3.44 (1.76-6.73)
2012-2013	1.8%	0.7%	***	0.05	2.59 (1.54-4.34)
2013-2014	1.5%	0.7%	**	0.04	2.11(1.29-3.43)
2014-2015	1.3%	0.4%	**	0.05	2.87 (1.53-5.41)
2015-2016	1.2%	1.0%	n.s. (p=0.33)		

Table 10. *Last year use of amphetamines, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	1.6%	0.8%	**	0.04	2.06 (1.27-3.34)
2008-2009	1.7%	0.8%	**	0.04	2.07 (1.30-3.30)
2009-2010	1.5%	0.8%	**	0.04	1.91 (1.18-3.23)
2010-2011	1.1%	0.6%	*	0.03	1.92 (1.13-3.26)
2011-2012	0.9%	0.4%	*	0.03	2.17 (1.10-4.30)
2012-2013	1.1%	0.5%	**	0.04	2.40 (1.26-4.58)
2013-2014	0.7%	0.4%	n.s. (p=0.16)		
2014-2015	0.6%	0.4%	n.s. (p=0.32)		
2015-2016	0.9%	0.4%	**	0.03	2.41 (1.27-4.59)

Table 11. *Last year use of cocaine, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	1.5%	0.5%	***	0.05	3.09 (1.72-5.56)
2008-2009	1.7%	1.0%	*	0.03	1.63 (1.05-2.53)
2009-2010	1.5%	0.6%	***	0.05	2.57 (1.27-4.82)
2010-2011	1.0%	0.7%	n.s. (p=0.18)		
2011-2012	0.8%	0.4%	*	0.03	2.01 (1.01-4.01)
2012-2013	0.8%	0.3%	**	0.03	2.79 (1.25-6.26)
2013-2014	0.9%	0.5%	n.s. (p=0.05)		
2014-2015	0.8%	0.4%	n.s. (p=0.08)		
2015-2016	1.3%	0.8%	*	0.02	1.63 (1.02-2.60)

Table 12. *Last year use of stimulant medication, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2007-2008	2.1%	1.5%	*	0.03	1.48 (1.00-2.18)
2008-2009	1.9%	1.8%	n.s. (p=0.99)		
2009-2010	2.0%	2.0%	n.s. (p=0.94)		
2010-2011	1.8%	1.4%	n.s. (p=0.16)		
2011-2012	1.2%	1.2%	n.s. (p=0.76)		
2012-2013	0.9%	1.4%	n.s. (p=0.14)		
2013-2014	1.7%	1.8%	n.s. (p=0.80)		
2014-2015	1.3%	1.9%	n.s. (p=0.10)		
2015-2016	2.0%	2.0%	n.s. (p=0.91)		

Table 13. *Last year use of sleeping pills and tranquilizers, students secondary schools (12-18y), VADschool, Flanders*

	<b>Men</b>	<b>Women</b>	<b>Sig.</b>	<b>Phi</b>	<b>OR M/W (95% CI)</b>
2010-2011	4.4%	6.8%	**	-0.05	0.63 (0.49-0.83)
2011-2012	4.0%	5.3%	*	-0.03	0.76 (0.59-0.96)
2012-2013	3.3%	5.8%	***	-0.06	0.54 (0.42-0.70)
2013-2014	4.9%	7.4%	***	-0.05	0.65 (0.53-0.79)
2014-2015	4.4%	7.6%	***	-0.07	0.56 (0.44-0.69)
2015-2016	4.6%	8.4%	***	-0.08	0.52 (0.43-0.64)

## Higher education students 2013, VAD student survey 2013 (Flemish Community)

Table 14. Alcohol use, higher education students (17-25y)\*, VADstudent 2013, Flanders

	Men	Women	Sig.	Phi	OR M/W (95% CI)
Last year use alcohol	98.0%	97.9%	n.s. (p=0.88)		
Age of first use alcohol					
<16 years old	71.4%	60.0%	***	0.12	Geen Odds ratio; Mann-Whitney: p<0.001
16-17 years old	26.1%	36.0%			
≥18 years old	2.5%	3.9%			
Last year use beer	93.9%	81.6%	***	0.18	3.44 (2.56-4.63)
Regular use beer (during academic year)	70.3%	35.1%	***	0.35	4.38 (3.66-5.24)
Last year use wine	90.4%	93.0%	n.s. (p=0.02)		
Regular use wine (during academic year)	15.0%	26.1%	***	-0.14	0.50 (0.40-0.62)
Last year use spirits	86.7%	80.2%	***	0.09	1.62 (1.28-2.03)
Regular use spirits (during academic year)	21.2%	14.4%	***	0.09	1.61 (1.26-2.04)
Regular binge drinking**	13.7%	3.6%	***	0.24	4.20 (2.96-5.95)
AUDIT-C (4+/5+)	64.0%	48.7%	***	0.15	1.87 (1.57-2.23)
Last year use cannabis	31.6%	15.0%	***	0.20	2.62 (2.13-3.21)
Age of first use cannabis					
<16 years old	20.3%	19.2%	n.s. (p=0.49)		
16-17 years old	46.3%	43.5%			
≥18 years old	33.4%	37.3%			
Regular use cannabis (during academic year)	8.4%	1.4%	***	0.17	6.63 (3.91-11.26)
Ever use other illicit substances than cannabis	9.4%	4.7%	***	0.09	2.13 (1.52-2.99)
Ever use amfetamines	5.8%	2.6%	***	0.08	2.35 (1.52-3.65)
Ever use xtc	7.8%	2.9%	***	0.11	2.86 (1.91-4.29)
Last year use xtc and amfetamines	5.7%	1.8%	***	0.10	3.23 (1.97-5.28)
Ever use cocaïne	5.2%	2.4%	***	0.08	2.24 (1.42-3.54)
Last year use cocaïne	2.8%	0.9%	**	0.08	3.26 (1.61-6.58)
Last year use sleeping pills and tranquillizers	5.0%	7.8%	**	-0.06	0.63 (0.44-0.89)
Last year use stimulant medication	6.9%	2.8%	***	0.10	2.58 (1.70-3.91)

\*: 94,9% of the students is 17-25 years old

\*\* : binge drinking: ≥ 4/6 drinks woman/man in two hours

## Nightlife population, VAD nightlife survey 2015 (Flemish Community)

Table 15. Substance use, nightlife population (15-30y), VADnightlife 2015, Flanders

	Men	Women	Sig.	Phi	OR M/W (95% CI)
Last year use alcohol	96.8%	94.3%	n.s. (p=0.10)	-	-
Regular use alcohol	77.3%	58.9%	***	0.20	2.37 (1.73-3.24)
Regular binge drinking*	42.8%	21.1%	***	0.23	2.79 (2.02-3.86)
>14 glasses alcohol (♀) / >21 glasses alcohol (♂)	35.5%	10.6%	***	0.29	4.66 (3.07-7.06)
>10 glasses alcohol (♀ & ♂)	42.3%	14.1%	***	0.31	4.46 (3.06-6.49)
AUDIT (4+/5+)	82.6%	74.5%	**	0.10	1.63 (1.14-2.32)
AUDIT (8+)	44.3%	11.9%	***	0.35	5.86 (4.00-8.65)
Last year use cannabis	42.1%	21.5%	***	0.22	2.65 (1.92-3.66)
Regular use cannabis	22.7%	11.3%	***	0.15	2.29 (1.53-3.44)
Last year use other illicit substances than cannabis	33.3%	16.8%	***	0.19	2.46 (1.74-3.50)
Last year use sleeping pills and tranquillizers	5.9%	9.9%	*	-0.07	0.58 (0.33-0.99)
Regular use sleeping pills and tranquillizers	2.6%	6.0%	*	-0.08	0.42 (0.20-0.89)
Combi use alcohol - illicit substances (last year)	30.3%	11.8%	***	0.22	3.24 (2.18-4.83)
Combi gebruik different illicit substances (last year)	19.0%	6.0%	***	0.19	3.71 (2.19-6.27)

\*: Binge drinking:  $\geq 4/6$  drinks woman/man in two hours

## General population, BHIS-survey 2015 (WIV-ISP; Belgium)

Table 16. Substance use, general population (15-30y), BHIS-survey 2013 (WIV-ISP; Belgium)

	Men	Women	Sig.	Phi	OR M/W (95% CI)
Last year alcohol use	80.0%	76.4%	n.s. (p=0.17)		
Overconsumption of alcohol (14/21)	7.7%	3.1%	**	0.10	2.59 (1.46-4.59)
Overconsumption of alcohol (+10)	46.1%	22.5%	***	0.26	3.13 (2.05-4.79)
Binge drinking at least weekly (+6 per occasion)	20.2%	5.8%	***	0.22	4.13 (2.74-6.22)
Cage 2+	13.1%	6.3%	***	0.12	2.23 (1.40-3.57)
Last year cannabis use	14.8%	7.4%	***	0.12	2.17 (1.49-3.17)
Last year other substances than cannabis <sup>10</sup>					
Use in the past two weeks of sleeping pills/tranquilizers	1.9%	2.4%	n.s. (p=0.54)		
Use of antidepressants in the past two weeks	1.5%	2.3%	n.s. (p=0.2401)	-0.03	0.64 (0.32-1.24)

## AGE GROUP 31 to 45 YEARS

## General population, BHIS-survey 2015 (WIV-ISP; Belgium)

Table 17. Substance use, general population (31-45y), BHIS-survey 2013 (WIV-ISP; Belgium)

	Men	Women	Sig.	Phi	OR M/W (95% CI)
Last year alcohol use	85.7%	76.1%	***	0.12	1.88 (1.45-2.44)
Overconsumption of alcohol (14/21)	5.0%	2.5%	*	0.07	2.07 (1.19-3.60)
Overconsumption of alcohol (+10)	37.2%	18.5%	***	0.20	2.61 (1.84-3.69)
Binge drinking at least weekly (+6 per occasion)	12.0%	2.4%	***	0.19	5.57 (3.36-9.23)
Cage 2+	17.8%	9.0%	***	0.13	2.19 (1.57-3.06)
Last year cannabis use	8.9%	1.9%	***	0.16	4.99 (2.88-8.67)
last year use of other substances than cannabis <sup>11</sup>					
Use in the past two weeks of sleeping pills/tranquilizers	5.4%	7.4%	n.s. (p=0.06)		
Use of antidepressants in the past two weeks	4.2%	8.4%	***	-0.08	0.48 (0.34-0.69)

<sup>10</sup> We do not include results because n<30 and the 95%-CI is too large.

<sup>11</sup> We do not include results because n<30 and the 95%-CI is too large.



## AGE GROUP ABOVE 45 YEARS

### General population, BHIS-survey 2015 (WIV-ISP; Belgium)

Table 18. Substance use, general population (45+), BHIS-survey 2015 (WIV-ISP; Belgium)

	Men	Women	Sig.	Phi	OR M/W (95% CI)
Last year alcohol use	86.5%	76.4%	***	0.13	1.99 (1.66-2.38)
Overconsumption of alcohol (14/21)	11.4%	7.0%	***	0.08	1.71 (1.35-2.17)
Overconsumption of alcohol (+10)	48.6%	32.6%	***	0.16	1.95 (1.61-2.37)
Binge drinking at least weekly (+6 per occasion)	12.3%	4.9%	***	0.13	2.71 (2.08-3.52)
Cage 2+	14.9%	8.7%	***	0.10	1.85 (1.47-2.34)
Last year cannabis use	1.5%	0.7%	n.s. (p=0.16)		
last year other substances than cannabis <sup>12</sup>					
Use in the past two weeks of sleeping pills/tranquilizers	16.7%	24.2%	***	-0.09	0.63 (0.55-0.77)
Use of antidepressants in the past two weeks	8.3%	13.6%	***	-0.08	0.57 (0.47-0.69)

### TDI, 2015 (WIV-ISP; Belgium)

Table 19. Proportion of women by type of centre in Belgium in 2015, TDI 2015 (WIV-ISP; Belgium)

Type of centre	Men		Women		Total (n)
	n	%	n	%	
Specialized centres	6046	81.1%	1406	18.9%	7452
Centres of mental health	1416	71.8%	556	28.2%	1972
Hospitals	9149	66.4%	4624	33.6%	13773
Total	16611	71.6%	6586	28.4%	23197

Table 20. Proportion of men/women in treatment by age group: centre of mental health in Belgium in 2015, TDI 2015 (WIV-ISP; Belgium)

Centre of mental health	Age group	Men	Women	Sig.	Phi	OR M/W (95% CI)
	15-30	11.9%	11.6%	n.s. (p=0.777)	0.00	
	31-45	7.9%	8.0%	n.s. (p=0.920)	0.00	
	+45	6.7%	7.5%	n.s. (p=0.156)	-0.03	

<sup>12</sup> We do not include results because n<30 and the 95%-CI is too large.

Table 21. *Proportion of men/women in treatment by age group: hospital in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

Hospital	Age group	Men	Women	Sig.	Phi	OR M/W (95% CI)
	15-30	30.6%	40.7%	***	-0.09	0.64 (0.56-0.73)
	31-45	52.0%	67.3%	***	-0.13	0.53 (0.48-0.58)
	+45	77.5%	84.5%	***	-0.08	0.63 (0.56-0.71)

Table 22. *Proportion of men/women in treatment by age group: specialized centre in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

Specialized centre	Age group	Men	Women	Sig.	Phi	OR M/W (95% CI)
	15-30	57.5%	47.7%	***	0.08	1.47 (1.30-1.67)
	31-45	40.0%	24.7%	***	0.14	2.03 (1.86-2.26)
	+45	15.8%	8.1%	***	0.11	2.15 (1.85-2.50)

Table 23. *Proportion of men/women in treatment by age group in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

All types	Age group	Men	Women	Phi	Sig.	Odds ratio + CI
	15-30	77.5%	22.5%	0.07	***	1.5 (1.40-1.61)
	31-45	74.5%	25.5%	0.05	***	1.27 (1.19-1.35)
	+45	64.8%	35.2%	-0.12	***	0.59 (0.56-0.63)

Table 24. *Proportion of men/women in treatment by type of centre in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

Type of centre	Men	Women	Sig.	Phi	OR M/W (95% CI)
Centre of mental health	9.0%	8.4%	n.s. (p= 0.84)		
Hospital	55.0%	70.2%	***	-0.14	0.52 (0.49-0.55)
Specialized centre	36.0%	21.3%	***	0.15	2.11 (1.98-2.25)

Table 25. *Proportion of men/women (15-30) in treatment by type of substance in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

15-30 (77,9% Men – 22,1% Women)					
Type of substance	Men	Women	Sig.	Phi	OR M/W (95% CI)
Alcohol	34.1%	35.4%	n.s. (p=0.368)		
Opiates	14.3%	17.3%	**	-0.03	0.80 (0.68-0.94)
Cocaine	27.4%	29.2%	n.s. (p=0.199)		
Stimulants other than cocaine	19.0%	23.4%	***	-0.05	0.77 (0.66-0.89)
Hypnotics	8.8%	14.1%	***	-0.07	0.59 (0.49-0.71)
Cannabis	66.1%	50.9%	***	0.13	1.88 (1.66-2.13)

Table 26. *Proportion of men/women (31-45) in treatment by type of substance in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

31-45 (74,8% Men – 25,2% Women)					
Type of substance	Men	Women	Sig.	Phi	OR M/W (95% CI)
Alcohol	60.7%	65.5%	***	-0.04	0.81 (0.74-0.90)
Opiates	23.7%	16.4%	***	0.08	1.58 (1.40-1.78)
Cocaine	27.1%	16.7%	***	0.10	1.85 (1.64-2.08)
Stimulants other than cocaine	13.3%	11.3%	**	0.03	1.21 (1.05-1.39)
Hypnotics	13.4%	18.9%	***	-0.07	0.67 (0.59-0.75)
Cannabis	31.3%	20.7%	***	0.10	1.75 (1.57-1.95)

Table 27. *Proportion of men/women (45+) in treatment by type of substance in Belgium in 2015, TDI 2015 (WIV-ISP;Belgium)*

45+ (64,8% Men – 35,2% Women)					
Type of substance	Men	Women	Sig.	Phi	OR M/W (95% CI)
Alcohol	87.2%	87.3%	n.s. (p=0.92)		
Opiates	10.3%	4.2%	***	0.11	2.63 (2.16-3.19)
Cocaine	6.7%	2.3%	***	0.09	3.05 (2.37-3.94)
Stimulants other than cocaine	2.5%	1.6%	**	0.03	1.59 (1.15-2.20)
Hypnotics	7.8%	17.0%	***	-0.14	0.42 (0.36-0.48)
Cannabis	7.7%	3.9%	***	0.07	2.05 (1.67-2.51)

Table 28. *Proportion of men/women in treatment with a problem use of alcohol by age categories in Belgium in 2015, TDI 2015 (WIV-ISP; Belgium)*

Age cat.	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
<b>Men</b>	14.3%	16.4%	32.4%	44.5%	53.2%	59.3%	69.7%	79.3%	85.8%	94.2%	95.2%	96.9%
<b>Women</b>	36.8%	18.1%	33.4%	42.3%	55.4%	65.4%	76.6%	82.6%	88.7%	90.5%	90.5%	86.8%

Table 29. *Proportion of men/women in treatment by type of substance in Belgium in 2015, TDI 2015 (WIV-ISP; Belgium)*

men-women in treatment					
Type of substance	Men	Women	Sig.	Phi	OR M/W (95% CI)
Alcohol	62.2%	69.5%	***	-0.07	0.72 (0.68-0.76)
Opiates	16.9%	11.0%	***	0.07	1.63 (1.50-1.78)
Cocaine	20.4%	12.6%	***	0.09	1.78 (1.64-1.93)
Stimulants other than cocaine	11.2%	9.2%	***	0.03	1.24 (1.13-1.37)
Hypnotics	10.4%	17.0%	***	-0.09	0.56 (0.52-0.61)
Cannabis	31.6%	19.0%	***	0.14	2.09 (1.95-1.23)