Interleave Research Report

Women Who Use Drugs Facing Gender-Based Violence in Europe

July 2022

Co-funded by
the Justice Programme-Drugs policy Initiatives
of the European Union

INTERLEAVE
AN INTERVENTION TOOLKIT TO DEAL WITH WOMEN DRUG USERS VICTIMS OF GENDER BASED VIOLENCE

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This publication has been produced by Fundación Salud y Comunidad as a part of the Consortium which implemented the INTERLEAVE project, an initiative involving drug and gender-based violence services and organisations as well as a European Network.

Consortium partners:
Comunità di Venezia Società Cooperativa Sociale (Italy) (Leading organisation).
Fundación Salud y Comunidad (Spain).
Therapiesalon in Wald (Austria).
Therapieverbund Ludwigsmühle Gemeinnutzige Gesellschaft MBH (Germany).
IREFREA- Instituto Europeu para o Estudo dos Factores de Risco em Crianças e Adolescentes (Portugal).
Humanitarna Organizacija Zajednica Susret (Croatia)
ENSA-European Network of Social Authorities (European Network)
EU-Open SRL (Italy)

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The authors express gratitude to colleagues and experts for their interviews/ quotes/ information provided: Xavier Ferrer Pérez (supervision), Miriam Vázquez de Santiago (survey's validation), Aura Roig Forteza (survey's validation), Elda Molina, Èlia Buzzy, Clara Castaño, Marta Álvarez Feijoo, Gemma Maudes Rosselló, Núria Homs, Berenice Domínguez, Adriana Francisco, Alicia Salamanca, Marta Llorca, Isabel Alarcón, Alicia Clotet, Lidia Jiménez, Sandra Gasca, Mariola Segura, Virginia Iglésias, Mireia Martínez, Belén Sánchez, Mónica Chacón, Roser Vicente, Otger Amatller Gutiérrez, Ana Burgos García, Marta Cremades Gurrea, Gemma Altell Albajes, Maite Tudela Marí, Paolo Stocco, Federica Ferraro, Barbara Cibin, Irene Simone, Dirk Kratz, Rebecca Büch, Thomas Legl, Iris Reuter, Lea Verdel, Miroslava Rozankovic, Jelena Pozaic, Fernando Mendes, Rosarinho Mendes, Elena Curtopassi.

The authors express gratitude to all our dissemination partners: Espai Ariadna, Pisos Gaia, Metzineres, Dianova, ATRA, Asociació d'Ajuda al Toxicòman (AAT), Font Picant, Crisàlide, Comunitat Terapèutica Can Coll, Comunitat Terapèutica Riera Major, CIBE Valencia, Pisos Cosmos, CAS Lleida, fdr+ Fachverband Drogen- und Suchthilfe e.V., Drogenhilfe Saarbrücken gGmbH comeback gmbh Bremen, Paritätischer Landesverband Rheinland-Pfalz / Saarland e.V., Der Paritätische Gesamtverband.

And to all the women and non-binary people who have contributed through their valuable insight to a better understanding of gender-based violence among women who use drugs, and to advancing policies, protocols and strategies to address it.

Recommended citation format: Plaza Hernández, L., Hansen Rodríguez, G., and Bedoya Cardona, E. Y. (2022). INTERLEAVE – Research Report. INTERLEAVE European Project. Available online at: www.interleave.eu

This report, was funded by the European Union's JUST DRUGS Programme (2019).

The content of this report represents the views of the authors only and is their sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

INTERLEAVE

AN INTERVENTION TOOLKIT TO DEAL WITH WOMEN DRUG USERS
VICTIMS OF GENDER BASED VIOLENCE

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1. Context and objectives of the research

1. Context and objectives of the research

Women make up approximately a **quarter of all people with serious drug problems and around one-fifth of all entrants to drug treatment in Europe (EMCDDA, 2017)** [1]. Among them, a **high percentage are victims of gender-based violence (GBV) (Thérèse Benoît and Marie Jauffret Roustide, 2015)** [2] . Despite the increasing efforts and initiatives at local and international level to tackle this problem, not enough initiatives are focused on providing effective prevention and support to reduce the vulnerability of women accessing drug services.

INTERLEAVE project ("an INTERvention tooLkit to deal with women who use drugs victims of gender-based violence") is an initiative funded by the European Commission under the European JUST DRUGS Programme (call JUST-2019-AG-DRUGS) aimed at supporting initiatives in the field of drugs policy.

This project aims to assess gender-based violence experienced by women who use drugs (WWUD) in the participating countries, as well as best practices in prevention and intervention in order to produce an intervention model (a toolkit) that considers and optimises existing measures already in place. With a multi-level and interdisciplinary approach, the project is designed to support civil society organisations by strengthening their capacity to make a difference at the local level and to provide better coordinated services. More specifically, and in the context of the research presented here, the project has conducted an overall assessment of specific local initiatives carried out by participating countries through literature review, structured questionnaires, focus groups and key informant interviews to evaluate current tools for active prevention of gender-based violence in favour of the empowerment of affected women and to identify best practices in this regard. From this, the project will develop a set of intervention tools to be tested for the first time in the countries participating in the project, in order to support civil society organisations by strengthening their (i) advocacy role, (ii) capacity to make a difference at the local level, (iii) methods of sharing best practices.

To this end, a **European partnership** has been set up, composed of different organisations in the field of drug intervention, a European network and a European programme manager:

> Comunità di Venezia Società Cooperativa Sociale (Italy), leading organisation.
> Fundación Salud y Comunidad (Spain), in charge of Documentary Review and Participatory Survey (research).
> Therapiesalon in Wald (Austria), in charge of Exchange of Best Practices, Capacity Building and definition of an Interventional Toolkit.
> Therapieverbund Ludwigsmühle Gemeinnutzige Gesellschaft MBH (Germany), in charge of Exchange of Best Practices, Capacity Building and definition of an Interventional Toolkit.
> IREFREA- Instituto Europeu para o Estudo dos Factores de Risco em Crianças e Adolescentes (Portugal), in charge of Dissemination, Communication and Exploitation.
> Humanitarna Organizacija Zajednica Susret (Croatia) .
> ENSA-European Network of Social Authorities (European Network).
> EU-Open SRL (Italy).

The overall objective of this research was to carry out a comprehensive analysis of the profile of women who use drugs (WWUD) facing GBV and best practices developed so far at the international level, specifically within the participating countries in this research, from a gender and feminist perspective.

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1 https://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Women-who-use-drugs.pdf
2 https://rm.coe.int/improving-the-management-of-violence-experienced-by-women-who-use-psyc/168075bf22

level, specifically within the participating countries in this research, from a gender and feminist perspective.

The Specific Objectives of the research were the following:

> Analysing the types and characteristics of gender-based violence experienced by women who use drugs in the international level, as well as the best practices developed so far to tackle this phenomenon.

**> Mapping the types of GBV faced by women who use drugs in the participating countries,
as well as the prevention and intervention practices developed in each participant country.**

> Defining the key points regarding women who use drugs facing GBV to be addressed in order to build a practical toolkit to mainstream gender perspective and address GBV in drug treatment services (related to WP3: Exchange of best practices, capacity building and definition of interventional toolkit).

The following sections of this report will elaborate on the research methodology, the main results, discussion of findings, and conclusions.

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2. Methodology

2. Methodology

In relation to the methodology, the research tools and the research analysis approach are presented below:

2.1. Research tools

The different research tools used in the research are presented below:

2.1.1. Literature review

A review of more than 80 scientific and grey literature documents related to gender-based violence experienced by women who use drugs was carried out. Subsequently, a database of the literature consulted was created, including title and year of each publication, authorship, abstract, and a summary of the most salient ideas related to the project's research. Finally, a theoretical body of the most relevant contributions was drafted (see section 3.1. Literature review main findings, of this report as well as the bibliography included in the annexes).

2.1.2. Surveys

Based on the scientific and grey literature reviewed, two surveys were designed:

> **the first one, addressed to women who use or have used drugs and are or have been survivors of gender-based violence;**

> **the second, aimed at professionals who work with them.**

The survey aimed at women who use drugs incorporated aspects related to the sample, drug use, their experience of gender-based violence, the intersection between use of drugs and gender-based violence, and the care received in relation to drug use and gender-based violence.

The survey aimed at professional staff included information about the sample, general characteristics of the services where the professionals work, a description of the intervention and general best practices.

Both surveys were validated by two professional experts in the field of gender and drugs as well as by all partners of the consortium.

Subsequently, they were disseminated among different drug services in the 6 country partners: Austria, Croatia, Germany, Italy, Portugal and Spain. Guidelines were drawn up and distributed among the partnership with the aim of guiding the methodology for the implementation of the surveys, considering ethical and data protection aspects.

Although it was initially planned to obtain 300 responses from women who use/have used drugs and GBV survivors (50 per country partner) and 600 responses from professional staff (100 per partner countries, the distribution of the responses obtained was as follows:

	Number of valid responses Women's survey
Austria	34
Croatia	50
Germany	14
Italy	64
Portugal	30
Spain	69
	261

	Number of valid responses Staff survey
Austria and Germany	124
Croatia	91
Italy	95
Portugal	34
Spain	148
	492

Table 1. / Number of women's and staff valid responses

Austria, Germany and Portugal faced particular challenges in achieving the initially agreed responses due to the difficulties caused by the pandemic situation but also due to resistance from some services/resources to facilitate access to women who use drugs (WWUD). Furthermore, Austria and Germany jointly disseminated the staff questionnaire as it was in the same language (German).

Regardless, the sample was assessed as sufficiently large to be analysed, although the cross-country comparison was somewhat limited.

For further information on the surveys you can check Annex_3_surveys templates.

2.1.3. Focus groups

Fifteen focus groups were also conducted, in order to complete the information gathered through the surveys:

> 12 focus groups (2 per partner country with women who use or have used drugs – WWUD- surviving gender-based violence -GBV):

In total, 66 women from 11 different services participated in the project

> 7 "mixed"[3] therapeutic communities
> 1 mother-child therapeutic community for WWUD and mental health issues

3 We put "mixed" in quotation marks because these are communities for men and women where the majority of users tend to be men.

> 1 integrated service for WWUD facing GBV
> 1 integrated and harm reduction service for WWUD facing GBV
> 1 information and attention service for women surviving GBV
> 3 focus groups with professional staff (1 in Croatia, 1 in Italy, and 1 in Spain).

In total, 11 professional staff (8 women and 3 men) from 8 different drug services participated.

In the same line as the surveys, guidelines were drafted to drive the methodology for the implementation of the focus groups, considering ethical and data protection issues.

The focus groups addressed questions related to the following aspects:

> The relationship between gender-based violence and drug use
> Experiences in care services
> Improvements needed in the care services.

For further information on the focus groups you can check Annex_4_Focus Groups templates.

2.1.4. Interviews

A total of 120 key informant interviews were also conducted (20 per partner country), in order to complete the information gathered through the surveys and the focus groups.

In total, the following professional profiles were involved:

> Number of drug professionals: 67
> Number of professionals from the gender field: 31
> Number of professionals in the field of drugs and gender: 14
> Number of professionals with a political profile: 8

In the same line as the surveys and the focus groups, guidelines were drafted in order to drive the methodology for the implementation of the interviews, considering ethical and data protection issues.

The interviews addressed the same content as the focus groups:

> The relationship between gender-based violence and drug use
> Experiences in care services
> Improvements needed in the care services.

For further information on the interviews you can check Annex_5_ Interviews template.

2.2. Mixed methodology

The research has combined a mixed quantitative and qualitative methodology through open-ended questions included in the 2 surveys and through the focus groups and interviews.

For further information on the quantitative and qualitative data you can check Annex_3_ surveys template, Annex_4_Focus Groups template, and Annex_5_Interviews template.

2.3. Gender and feminist analysis

This research follows a gender approach, which constitutes the framework paradigm and perspective from which we choose to understand reality in order to transform it.

Gender analysis is a methodological framework suggested by several international organizations such as the World Health Organisation (WHO) and European Institute for Gender Equality (EIGE) based on the following:

a) Quantitative and qualitative analysis by using gender-disaggregated data
b) The consideration of gender in the interpretation of the data

To this end, it is pertinent to address what is understood by gender, gender inequality and gender-based violence (Observatorio Noctámbul@s, 2018):

Gender

The concept of gender, as a category of analysis, explains how society is structurally organised through the categories of gender (woman/man-cis or trans-/ and non-binary gender identities) and how power relations interact. There are different theoretical positions on this issue. Hegemonic discourse organises society through biological perspectives, arguing that the cause of differences and subsequent inequalities is to be found in certain genetic differences that determine individual, group and social behaviour.

Throughout history, this view has justified patriarchal power relations as inherent to human nature and, therefore, difficult to transform. According to these views, there may be fundamental regulations and legislation, but these views basically focus on explaining that the essence of the differences between women and men is genetic and intrinsic to their gender behaviour. In contrast to biological determinist positions, an alternate discourse focuses on the notion that society is based on the existence of a sex/gender/desire system within a framework of heteropatriarchal, capitalist and colonial power relations. This discourse allows us to understand that gender is a type of binary classification, which is socially constructed, and which assigns a series of categories to femininity and masculinity. These are based on gender stereotypes, which are dynamic, and socio-culturally and historically rooted. This reveals how people learn to be girls or boys from the moment they are born and during their development through forms of social control in their daily lives. Thus, we find a series of social diktats that support a certain social, economic and political model based mainly on the superiority of men over women, and on the hierarchy of values associated with masculinity over those associated with femininity:

(i) Sex, being the body, we are born with, in terms of biological and genetic explanation;
(ii) Gender, in terms of binary, opposite and complementary social construction;
(iii) Sexuality in terms of people's desire and how they interact sexually. The current model of society based on heteropatriarchal power relations promotes an essentialist worldview and the adaptation of people to this binary model (woman/man).

This refers to the cis-normativity of sex-gender-desire, where individuals and society can only be understood in terms of a natural relationship of female-femininity-heterosexuality and male-masculinity-heterosexuality. Any form of rupture of this normativity will provoke differing forms of violence and legal or social punishments, thus regulating the behaviour of individuals, their interaction with each other, and society in general.

Therefore, this study seeks to address the fact that the axis of structural gender oppression (the unequal male-female relationship) intersects with the axis of sexual discrimination and exclusion

(on grounds of gender identity and orientation that generate discrimination against lesbian, gay, bisexual, trans, intersex, queer or non-binary people or others) within the framework of the sex-gender (hetero)-patriarchal power system. This framework allows us, firstly, to sustain a well-founded proposal for analysis and critical action in response to patriarchal discourse. Secondly, it provides us with a sufficiently broad framework to incorporate the numerous feminists and LGTBIQ+ perspectives. Moreover, and finally, it helps us to approach gender inequalities through an intersectional perspective, thus incorporating other axes of oppression that operate in the society in which we live.

Gender Inequalities

A gender perspective allows us to understand how gender stereotypes are reproduced and operate in the different spheres and strata of our society, generating inequalities in physical, symbolic and resource distribution spaces. From a feminist perspective, the socio-economic epicentre of society should be based on people's needs, on reproductive work and, ultimately, on the sustainability of life as the epicentre, and not on a market economy of capitalist accumulation. Gender inequalities are also reproduced in other spheres of life: in education (formal, non-formal and informal), in state structures and legislation, in religions, in the media, and at different levels: among individuals, peer groups, family, community, etc. In short, a gender perspective helps us to understand that the root of gender-based violence are the inequalities that foster and produce it. It will be difficult to build a fairer and more equitable society free of gender-based violence if these inequalities are not combated.

Gender-based and Gender-related violence

Gender violence is all the violence that emerges from the heteropatriarchal power system which punishes those behaviours and experiences that question the sex-gender-sexuality model or that directly try to overthrow it.

Therefore, gender-based violence encompasses all violence experienced by women because they are women. Violence against women is a structural phenomenon that is based on a social, economic and symbolic schema that subjugates women and their experiences and knowledge, presenting men as the true subjects of our patriarchal societies.

Gender-related violence is violence that not only affects women, but also violence that is perpetrated against any person on the basis of stereotypical sex, gender and sexuality roles, and that has a negative impact on their identity and social, physical and/or psychological wellbeing (for example, LGBTQIA+ groups). In short, gender-based violence encompasses all forms of violence that have their origin in stereotypical views of gender and the power relations that this entails. Therefore, gender-based violence in our society mainly affects women's bodies and non-heterosexual (lesbians, bisexuals and gay people), or people of transgender and/or non-binary gender identities (trans*, queer, etc.) [4] .

4 Biglia, B., y Jiménez, E. (Coord.). (2015). Hagamos nuestra la prevención. Guía de apoyo para la prevención de profesorado. URV, Tarragona

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3.

Main Findings

3. Main findings

The main results from all sources of information consulted, so, literature review, surveys, focus groups and interviews, are described below:

3.1. Literature review main findings

Several studies point to the high prevalence of all types of gender-based violence (GBV) among women who use drugs or alcohol (UNODC, 2016; Lozano-Verduzco et al., 2016; Athena Foundation, 2016; Weaver et al., 2015; Valencia et al., 2020; Shirley-Beavan et al., 2020). According to recent research by Valencia et al. (2020), 88% of women who use drugs had experienced psychological violence, 71% had experienced at least one episode of physical violence by an intimate partner and 49% had experienced some form of sexual assault in their lifetime. Approximately 30% of women drug users (and 53.6% of injecting drug users) were involved in sex-for-drugs/money situations.

However, detection, intervention and coordination at the intersection of drug or alcohol abuse and GBV in women still appears to be very limited (Weaver et al., 2015). Therefore, there is an urgent need to develop interventions adapted to the specific needs of these women (Valencia et al., 2020) from a gender perspective (Benoît & Jauffret-Roustide, 2015; Athena Foundation, 2016; EMCDDA, 2017; UNODC, 2018; Shirley-Beavan et al., 2020). Hence the need to go deeper into the different gender-based violence that affects women who use drugs or alcohol, as well as the best practices for prevention and intervention identified to date.

Gender-Based Violence and Drug Use

Therèse Benoît and Marie Jauffret Roustide (2015) identified different types of violence experienced by women drug users after conducting focus groups with drug professionals:

Interpersonal violence

This refers to intimate partner violence and violence experienced during childhood in the context of sexual "abuse" (Benoît & Jauffret-Roustide, 2015).

Indeed, some women use drugs to cope with the post-traumatic stress disorder resulting from sexual violence experienced during childhood in abusive relationships, usually by a close relative (Benoît & Jauffret-Roustide, 2015).

Similarly, many women use drugs (mainly tranquillisers and painkillers) to cope with the violence they experience in their daily lives, such as the overburdening of women's lives (Hansen, 2020) or violence in the context of a couple's relationship (Da Silva Carvalho et al., 2019; Fox & Galvani, 2020). In the intimate partner context, perpetrators often justify violence because of women's drug use, as Fox and Galvani (2020) point out in the case of alcohol. If the partner is also a person who uses drugs, this makes women more vulnerable to violence, especially when the partner has a strong urge (craving) to use or has stopped using (withdrawal) (Valls et al., 2013; Gilchrist et al., 2018; Gadd et al., 2019) and because this often exposes women to prostitution to finance their own and their partner's use (Valls et al., 2013). If the partner does not use, the account of violence related by the woman who uses drugs is questioned. Moreover, in this case, perpetrators often justify their violence on the grounds that they are 'helping' the woman to stop using. Some partners encourage women to use and obstruct their access to treatment (Valls et al., 2013; Shirley-Beavan et al., 2020) in order to continue to perpetrate violence against them. Following intimate partner violence, some women are forced to live on the streets (Bretherton,

2017), which can initiate or exacerbate use. Often, women who use drugs on the street/shelter home are forced to find a man to "protect" them from other perpetrators, even if they are also perpetrating violence against them.

Violence related to the social environment

This refers to violence in the context of drug use - buying and selling, and drug use in party contexts. Jessell et al. (2015) report that some women who use drugs are sexually assaulted by friends or strangers after using with them or when they were under the influence of drugs without being aware of it. They note that women who use drugs are often seen as unworthy of sexual respect and as always willing to sell their bodies for drugs or money. It is also the case that women who use drugs are offered drugs for free as a means of coercion/pressure to obtain sexual favours or to sexually assault them (Boyd et al., 2018).

This violence also refers to violence related to contexts of prostitution as a means of financing their own drugs and sometimes that of the partner. Often, women who use drugs are forced to exchange sex for drugs, money or a place to stay. It is commonly assumed that women who use drugs and sex workers are willing to offer sex for money regardless of the context, which is another form of violence. In addition, rape and robbery by clients and the police are common. In this sense, some women also use drugs to cope with sex work (Benoît & Jauffret-Roustide, 2015).

Finally, this type of violence includes violence in situations of trafficking for the purpose of sexual exploitation by mafias, which particularly affects migrant women in an irregular situation, which considerably increases their exposure to violence (Benoît & Jauffret-Roustide, 2015).

Furthermore, the literature finds that undocumented migrant women, sex workers (Shirley-Beavan et al., 2020), homeless women (Bretheron, 2017; Shirley-Beavan et al., 2020), women with a mental health diagnosis (Weaver et al., 2015; Tirado-Muñoz et al., 2017) and trans women who use drugs are more exposed to situations of gender-based violence.

Institutional violence

This is the violence that occurs in different resources and services such as health and social services (Benoît & Jauffret-Roustide, 2015; Shirley-Beavan et al., 2020) when they place barriers and obstacles that difficult access and the use of such services for women who use drugs. In the judicial context there is a tendency to give little credibility to the story of women victims because they use drugs which ends up re-victimising them. Sometimes, the police (Shirley-Beavan et al., 2020) do not sufficiently protect women in prostitution because they are women who use drugs. Some authors (Valls et al., 2013; Da Silva Carvalho et al., 2019) highlight the fact that many women who use drugs blame themselves for the violence they experience. In this sense, even some women do not believe they deserve protection from the police or other authorities when they have been assaulted (Jessell et al., 2015). Benoît and Jauffret-Roustide (2015) also point out that emergency services tend to show moralising and blaming attitudes towards women who use drugs or do not respond to emergency situations because "they were actually asking for it". On the other hand, sexual and reproductive health and child protection services tend to consider women who use drugs as "bad mothers", promoting sometimes the withdrawal of custody of their children by default or as a routine, without a careful consideration of its consequences or possible alternatives.

This concept also relates to the violence that occurs within drug services and other resources aimed at people who use drugs. The lack of training and/or awareness of some professionals (Benoît & Jauffret-Roustide, 2015; Shirley-Beavan et al., 2020) leads to a failure to identify and consider and to minimising the gender-based violence that affects women who use drugs, by

normalising the context of violence. In addition, there is a tendency not to recognise women as active protagonists, able of developing their own strategies. The literature consulted points to the fact that services for people who use drugs are often highly masculinised (Boyd et al., 2018; Shirley-Beavan et al., 2020), dominated by the presence of men, often (ex-)aggressors – either traffickers who ask women for sex for drugs or clients of their sex work - so that women, feeling neither comfortable nor safe, prefer not to attend or avoid these services as Boyd et al. (2018) report that in some drug services women are expected to behave better than men, to take care of them and to clean up, and some male users even expect women to provide a sexual 'service'. In some therapeutic communities (Lozano-Verduzco et al., 2016; Boyd et al., 2018), female users are frequently stigmatised and sexually assaulted by some male users, including staff, and violence by untrained male professionals such as maintenance staff or security as has been reported in residential centres. In general, as Shirley-Beavan et al. (2020) suggest, there are many barriers to accessing harm reduction services for women who use drugs in Europe. Similarly, there are barriers to accessing gender-based violence services for women who use drugs (Athena Foundation, 2016).

Finally, some legislative frameworks that promote anti-drug policies force drug users to move into dangerous environments (illegal market), especially for women, and pose a barrier to access harm reduction services (Shirley-Beavan et al., 2020).

Socio-cultural violence

Socio-cultural violence promotes gender inequalities and stereotypes that stem from structural oppression of women in general, and particularly affect women who use drugs as transgressors of traditional gender roles. In this sense, women who use drugs are more stigmatised than male users (Benoît & Jauffret-Roustide, 2015).

Best practices for prevention and intervention

The literature suggests the following best practices in intervention with women who use drugs or alcohol users facing gender-based violence:

A gender and feminist approach is recommended. That is, starting from the context of systemic/structural socio-political and cultural oppression of men towards women and other dissident gender identities (Valls et al., 2013; Benoît & Jauffret-Roustide, 2015; Roig Forteza, 2018; Shirley-Beavan et al., 2020; UNODC, 2018; EMCDDA, 2017; Altell & Mollón, 2020; Hansen, 2020; Goldenberg, 2020). This includes systematised data collection and gender impact assessment of the service (Benoît & Jauffret-Roustide, 2015).

Likewise, the literature consulted suggests a harm reduction approach (Roig Forteza, 2018; Shirley-Beavan et al., 2020; Goldenberg, 2020) have more flexible rules with the aim of facilitating access and permanence of women who use drugs, including trans [5] women, to the service.

It is suggested not to compartmentalise interventions in relation to drug use and gender-based violence into separate blocks (Benoît & Jauffret-Roustide, 2015). This points to the need to offer comprehensive services that incorporate both dimensions at the same time. In this sense, interesting experiences have been described such as "Metzineres" and "Espai Ariadna" in Barcelona, Spain, for women who use drugs who are survivors of gender-based violence that also incorporate the harm reduction and gender perspectives (Roig Forteza, 2018; Shirley-Beavan et al., 2020; Altell & Mollón, 2020; Hansen, 2020). If this is not possible, it is proposed to adapt the guidelines to favour the access and permanence of women users, including trans* women,

5 Both transsexual and transgender women.

to shelter services for women survivors of violence (Benoît & Jauffret-Roustide, 2015) and/or to adapt harm reduction services (Roig Forteza, 2018; Shirley-Beavan et al., 2020), in addition to other services such as shelter homes.

In any case, it is recommended to create women-only spaces where women can feel comfortable and safe, and from where they can address specific issues that affect them, including violence experienced (EMCDDA, 2017; Benoît & Jauffret-Roustide, 2015). For example, guilt for non-compliance with gender mandates; care, partner and family as forms of self-realisation; "liking others", the importance of the body, beauty and sexuality for women; the myth of romantic love; the need to connect with and understand the other; knowing how to say no, expressing demands and needs; self-esteem: "being" beyond others (Atenea Foundation, 2016); motherhood and fatherhood; or co-responsibility (Valls et al., 2013).

Another aspect to consider is the need to train professionals working with women who use drugs facing gender-based violence from a gender and feminist perspective (Benoît & Jauffret-Roustide, 2015). In this sense, it is important for professionals to work on personal factors that may hinder the detection of gender-based violence (fears, beliefs, etc.) (Valls et al., 2013). It is also suggested that hiring women who use drugs as "peer-workers" has also proved to be a good practice to improve women's access and adherence to the service/institution, making them feel more comfortable and safe (EMCDDA, 2017; Roig Forteza, 2018; Shirley-Beavan et al., 2020).

Several authors recommend the involvement of women who use drugs in the design, development and evaluation of the service. This is essential to ensure that service regulations, the design of spaces and activities take into account the specific needs of women and their often neglected children (Benoît & Jauffret-Roustide, 2015). The participation of women who use drugs in harm reduction spaces is also recommended (Roig Forteza, 2018; Shirley-Beavan et al., 2020) even in response to the prevention of overdose situations (Goldenberg, 2020).

It is also suggested to promote women's empowerment and autonomy throughout the process (Benoît & Jauffret-Roustide, 2015; Roig Forteza, 2018; Shirley-Beavan et al., 2020). In this sense, the denomination proposed by some authors when referring to women who use drugs as "women with experience of drug use" and, for example, "violence", "homelessness", "sex work", "racialisation", or others, can contribute to recognising the agency of women consumers as political subjects (Roig Forteza, 2018; Shirley-Beavan et al., 2020).

The Atenea Foundation (2016) points out the following keys for intervention with women who use drugs in terms of gender mandates: family pressures on women who use drugs often suggest that maintaining a relationship with them is not always a priority or appropriate. If partner violence is suspected, joint interventions with the partner are not recommended and, if the partner is also a person who use drugs they should be dealt with by different professionals and services. Beyond investigating how drug use affects the couple's relationship, it is interesting to investigate how the couple's relationship affects drugs use (Valls et al., 2013). In therapeutic spaces, it is recommended not to punish or judge the use of the body and sexuality as a response of self-affirmation and recognition by women who use drugs but rather to reinforce other forms of self-affirmation. Often the misuse of the notion of "sex addiction" may imply a disguised way of judgment. Prohibiting partner relationships in therapy is not recommended either, as this often leaves out women, who are subject to the mandate to "love and connect with others". In line with the same mandate, it's key to consider the importance of body image for women's self-esteem, as well as to abandon the model of bidependence and dual dependence that essentialises women's emotional dependence, as if it were an "innate" or "natural" aspect of all women, rather than the result of a social construction.

The need to encourage mutual support among the women in the service/programme rather than the competitiveness that often exists along gender lines is also pointed out. It is crucial, as also suggested by other authors (Benoît & Jauffret-Roustide, 2015; Shirley-Beavan et al., 2020)

to address all gender-based violence experienced by women who use drugs throughout their lives (including institutional violence), in relation to drug use. Valls et al. (2013) highlight the importance of avoiding justifying violence due to drug use and abstinence as a "remedy" for violence. These authors also insist on avoiding blaming or judging women during the intervention, believing women's accounts of violence, and conveying messages of support.

The need for a comprehensive approach that, beyond addressing the psychological dimension, favours the autonomy and social reintegration of women survivors of violence by considering other aspects such as the need for economic income or housing, among others (Benoît & Jauffret-Roustide, 2015), has been pointed out. It is also suggested to address other aspects such as mental health, sexual and reproductive health or others frequently interrelated with drug use and violence (EMCDDA, 2017; Roig Forteza, 2018; Shirley-Beavan et al., 2020).

Some authors argue for the need to promote, within the service framework, belonging to a supportive community, rather than a community that women have to "cope with" (Roig Forteza, 2018; Shirley-Beavan et al., 2020).

Several authors recommend promoting coordination with local services, movements and networks and community projects that can support women who use drugs (EMCDDA, 2017; Benoît & Jauffret-Roustide, 2015; Roig Forteza, 2018; Shirley-Beavan et al., 2020). In this regard, the need to promote systematic screening for GBV through various tools has been pointed out (Valls et al., 2013; Caldentey et al., 2016). In addition, Benoît and Jauffret-Roustide (2015) suggest working to sensitise local networks to give credibility to the testimony of violence by women who use drugs, even if they are under the influence of substances or engaged in sex work.

Some authors recommend promoting networks of women who use drugs and contact with local/regional and international networks of women who use drugs as a strategy to exchange experiences to address the stigmatisation, violence and criminalisation that women who use drugs face. An example of this is the meeting organised in 2019 in Barcelona, that culminated in the "Barcelona Declaration" which recognised the need to integrate the gender dimension in drug policies (Roig Forteza, 2018; Shirley-Beavan et al., 2020).

Finally, the need to demand sustainable financing/funding from funders that allow the continuity and sustainability of services for women who use drugs who are survivors of violence has also been highlighted (Benoît & Jauffret-Roustide, 2015). States are also urged to incorporate the violence experienced by women who use drugs into national strategies and plans (Benoît & Jauffret-Roustide, 2015), and to move towards decriminalisation of illicit drug possession and sex work (Goldenberg, 2020).

Literature review conclusions

Women who use drugs are impacted by the same violence as all women worldwide in the context of a patriarchal society marked by inequality and structural oppression against them, meaning they also experience interpersonal, social, institutional and socio-cultural violence. However, the literature has revealed specific interactions in relation to drug use in each of these contexts. This highlights the need for a specific holistic approach based on harm reduction in the broad sense of the term[6] and a gender and feminist perspective, which addresses the practical and strategic needs of women who use drugs survivors of violence, as well as their children.

6 In doing so, we want to include abstinence-oriented models that do not punish consumption, as is the case in the experience of Espai Ariadna in Barcelona, Spain.

3.2. Surveys

The main results from all sources of information consulted, so, literature review, surveys, focus groups and interviews, are described below:

3.2.1. Survey aimed at women who use drugs

The results found for each of the sections of the survey targeting women who use drugs (WWUD) will be described in this section: the socio-demographic profile of the sample of women surveyed, drug use, reported gender-based violence, the intersection between drug use and gender-based violence:

a) Our sample study

The 97.7% (n = 255) of the sample self-identify as women[7], while only 0.77% (n = 2) and 1.53% (n = 4) self-identify as transsexual or transgender and non-binary, respectively. As there are very scarce number of non-binary and trans respondents, doesn't allow for any potential comparison; therefore, the data will not be systematically disaggregated by these three gender categories. However, this is an issue that should be addressed in future research separately.

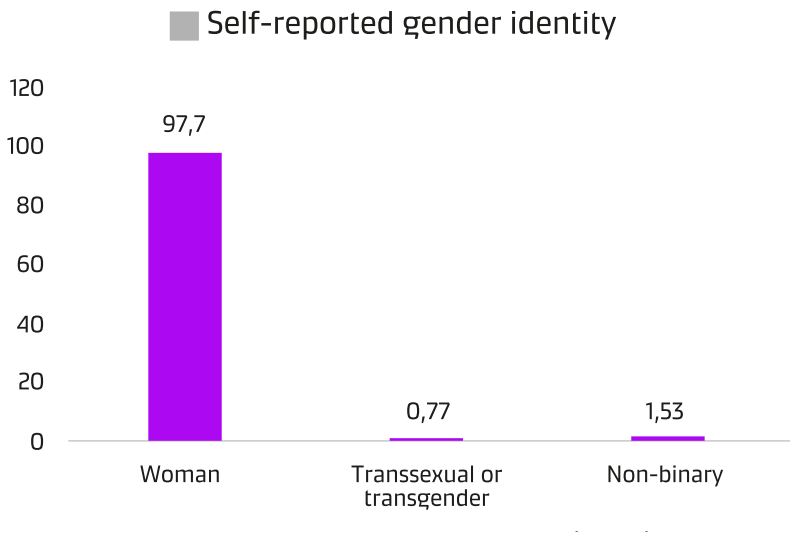

Figure 1 . / WWUD sample and country of residence (N=261)

The majority of the sample is aged between 25/34 years old (n = 81) and 35/44 years old (n = 79). This is followed by the 45/54 age group (n = 52), the 55/66 age group (n = 26), and finally the 18/24 age group (n = 19).

7 Since most of the sample self-identifies as women, the sample will be referred to as women in the following.

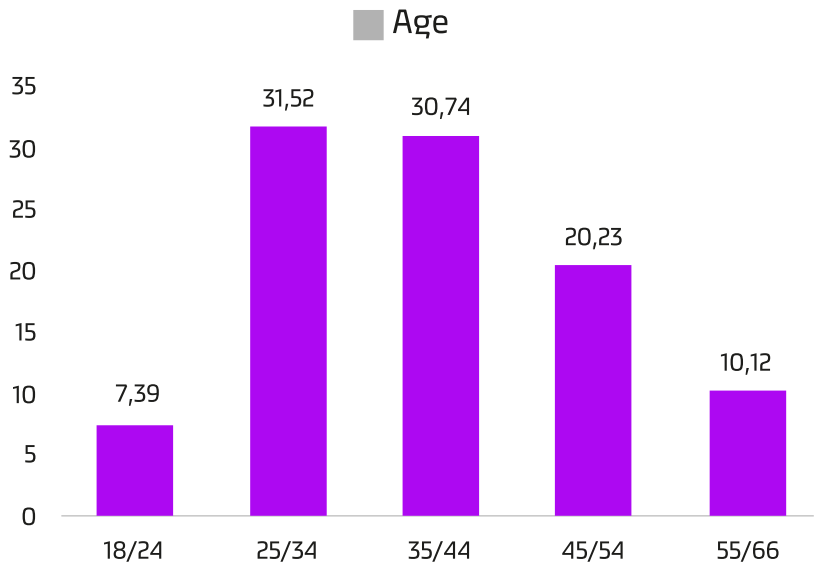

Figure 2. / WWUD by age (N=257)

In terms of sexual orientation, 74.71% (n = 195) of the sample self-identified as heterosexual. This is followed by those who self-identify as bisexual (n = 37), lesbian (n = 17) and those who describe themselves as pansexual (n = 2). 4.6% prefer either not to answer (n = 10) or would rather self-describe (n = 2).

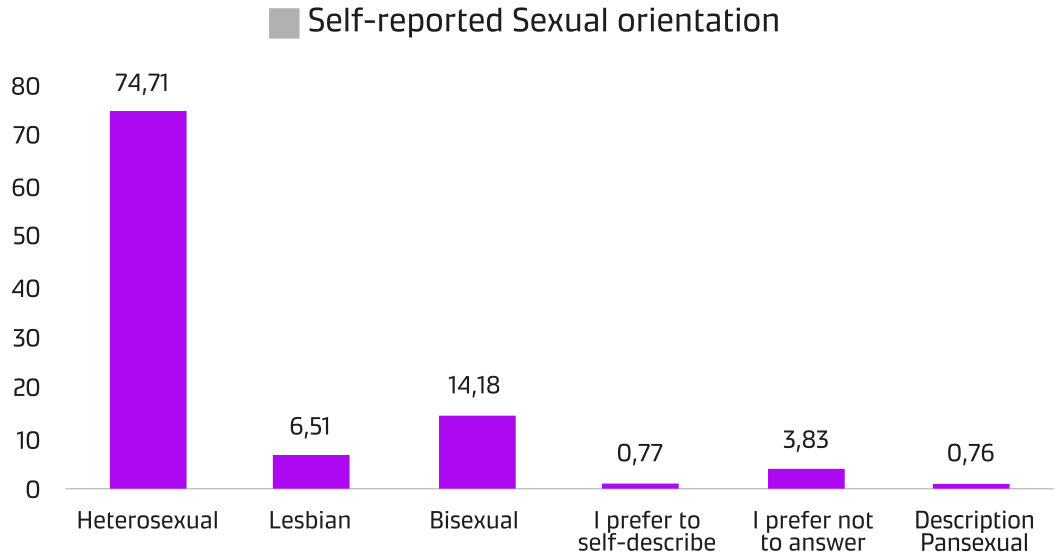

Figure 3. / WWUD sample and self-reported sexual orientation (N=261)

Women surveyed are mainly from Spain (n = 69), Italy (n = 64) and Croatia (n = 50). They are followed by Portugal (n = 30), Austria (n = 34) and Germany (n = 14).

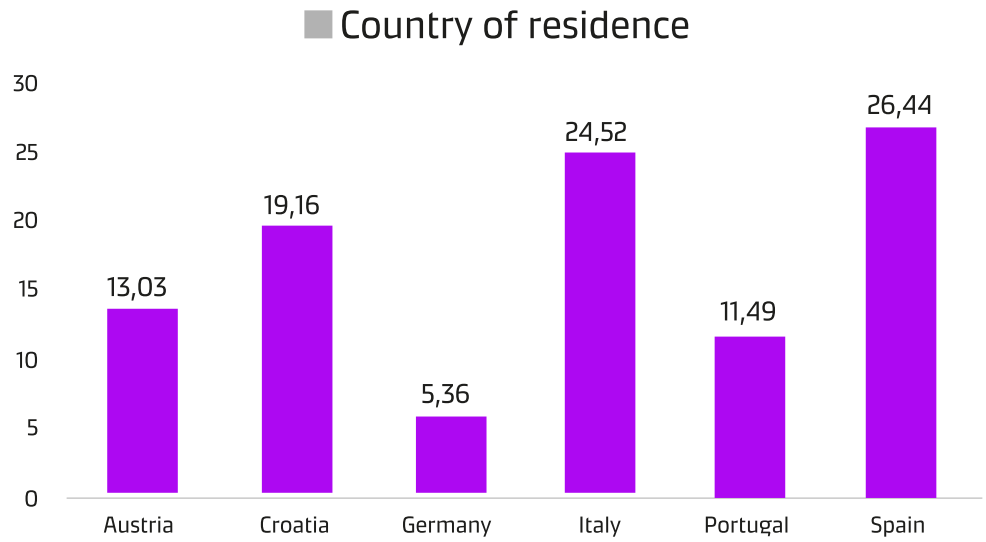

Figure 4. / WWUD sample and country of residence (N0261)

89.27% (n = 89) of the sample was born in the partner countries. 7.28% (n = 19) were born in other EU countries, and only 3.45% (n = 9) in non-EU countries.

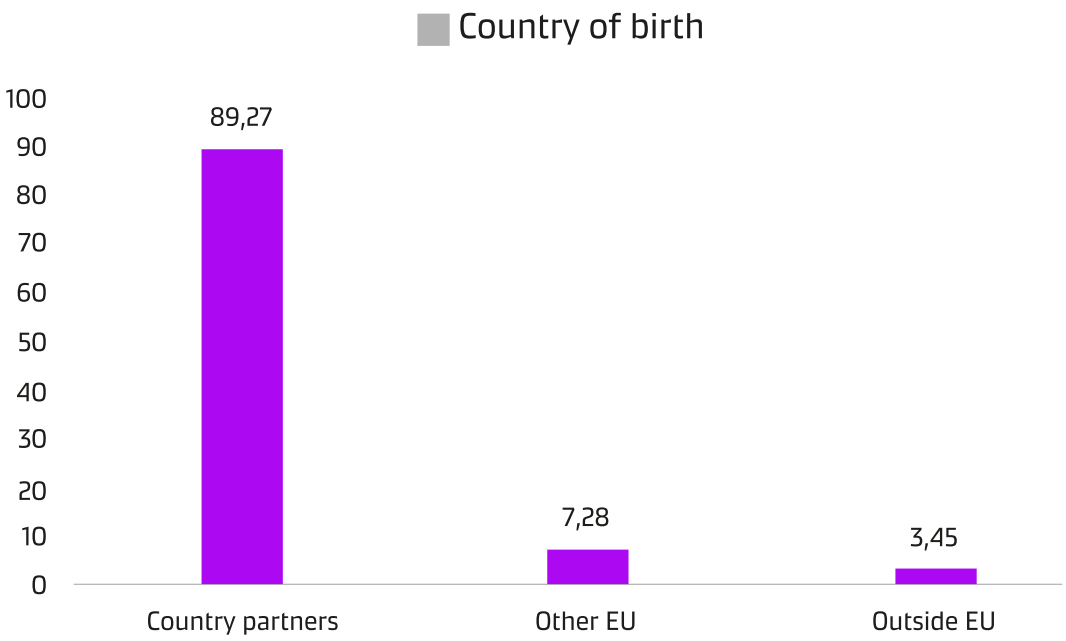

Figure 5. / WWUD sample and country of birth (N=261)

The majority of the women reported having secondary education (n = 99) or vocational training (n = 63) degrees. This is followed by those with primary education (n = 39) and university degree (n = 38), and with a considerable smaller percentage by those with a Master's degree or higher (n = 7). 5.75% (n = 15) have not completed primary education.

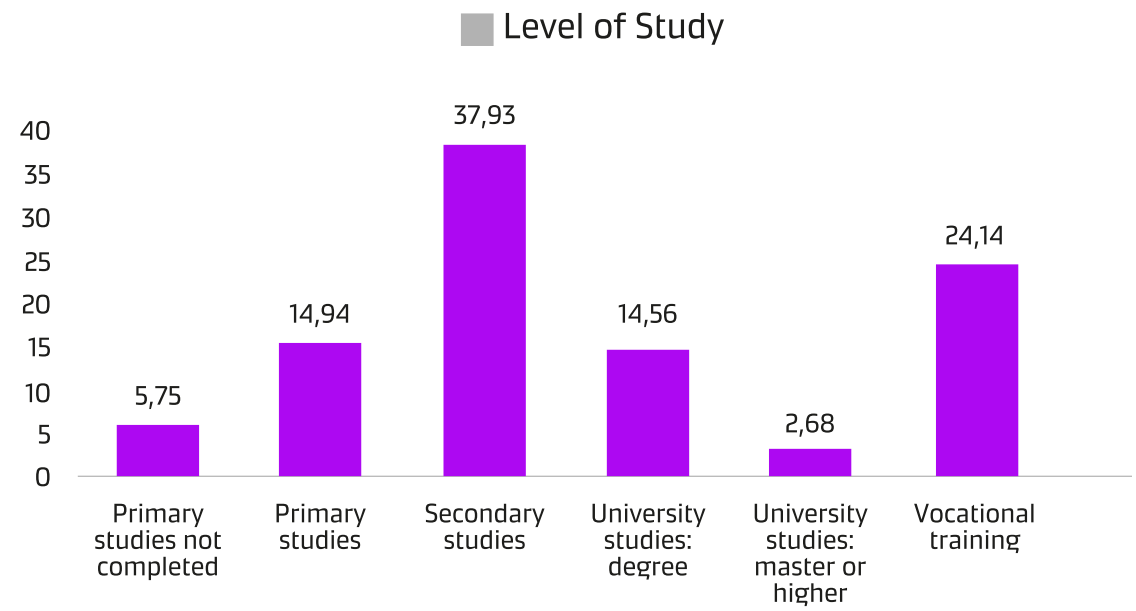

Figure 6. / WWUD sample and highest degree achieved (N=261)

The majority of women (n = 144) reported being linked to a therapeutic community or residential centre for people who use drugs. This is followed by 66 and 22 of women who reported, respectively, being linked to an outpatient care/day centre for people drug-use related problems. Finally, and to a lesser extent, women who are access a harm reduction service (n = 20), those who engage in integrated service for women who use drugs facing GBV (n = 19), those who are in an information and attention service for women victims/survivors of GBV (n = 8) and those who are in a home/shelter for women survivors of gender violence (n = 1).

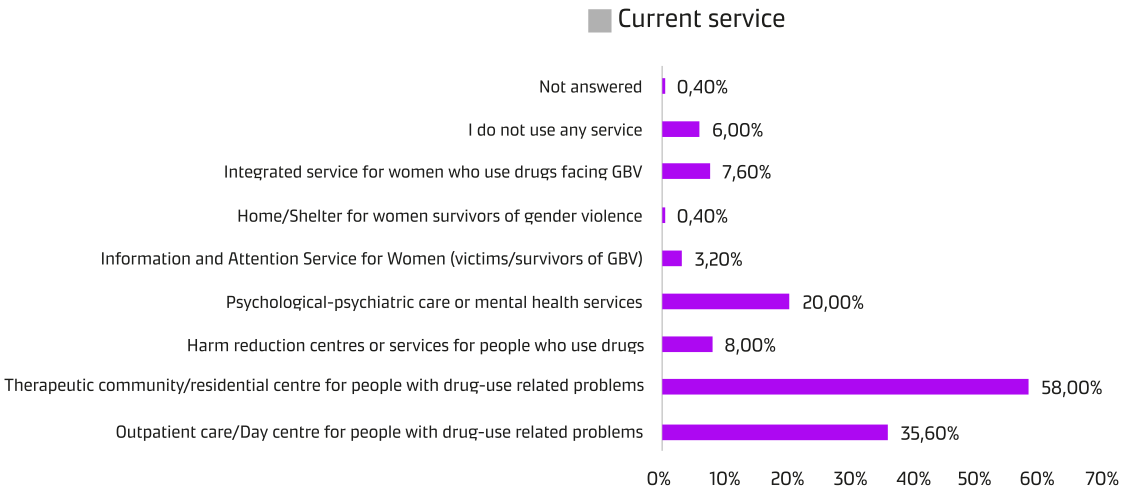

Figure 7. / WWUD sample and current services (N=250)

Regarding their source of income, 102 of the women surveyed reported receiving financial income from social benefit, which seems to correlate with the high percentage of women in therapeutic community/residential centres for people with drug use related problems.

53 are in full-time employment, 40 have family support, 22 work part-time, and 20 work in the informal economy (full or part-time).

14 of the women surveyed reported earning income from other activities such as asking for money in the street, selling drugs, sex work or others, 10 reported being dependent on their partner, while 5 reported being unemployed.

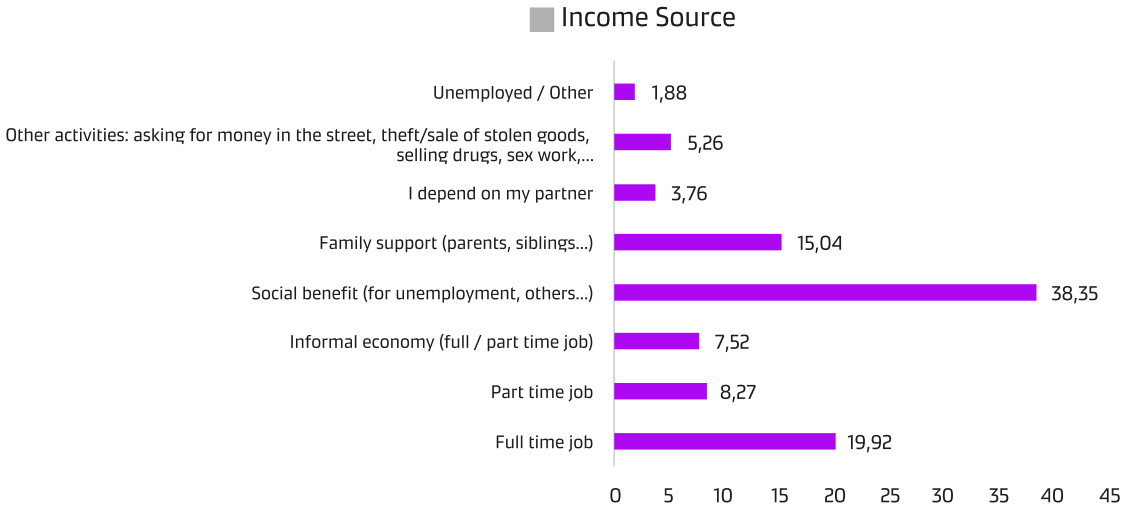

Figure 8. / WWUD sample and income source (N=261)

In terms of housing situation, unsurprisingly, 99 of the women surveyed reported living in an institution/residential centre (Shelter home/ Therapeutic Community...); 66 reported living in rental housing; 41 in their own home; 31 in someone else's house or flat; and, to a lesser extent, women reported living in a room/housing shared with other people different from family (n = 18), squat (n = 4), and living on the street (n = 2).

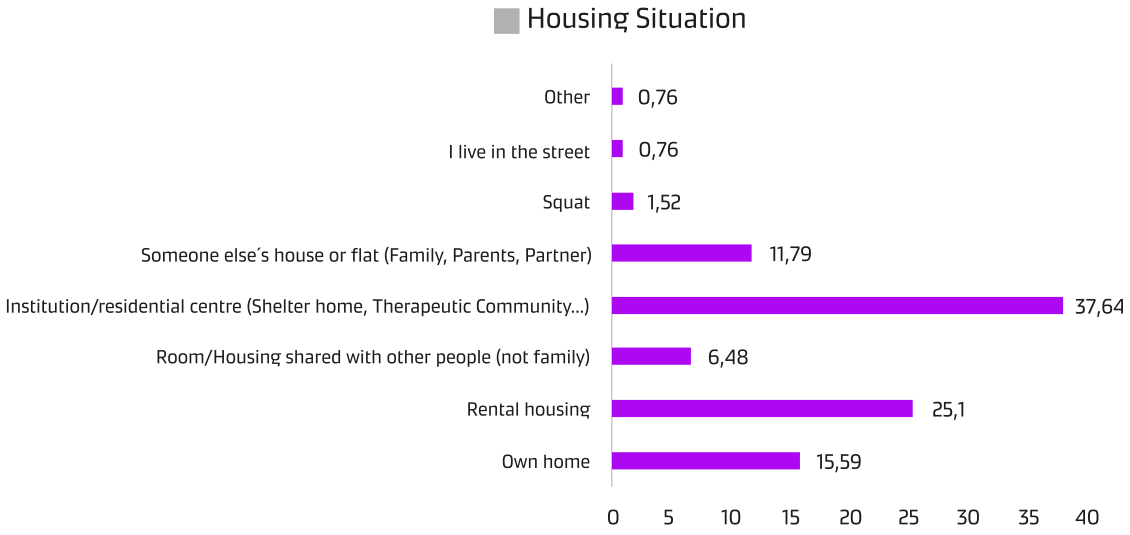

Figure 9. / WWUD sample and housing situation (N=261)

Furthermore, 90 of the women surveyed reported living in residential centres; 74 reported living with a partner; 72 with their children; 32 with other adult relatives; 23 reported living with friends/mates; 19 reported living alone; and 16 reported living with their parents.

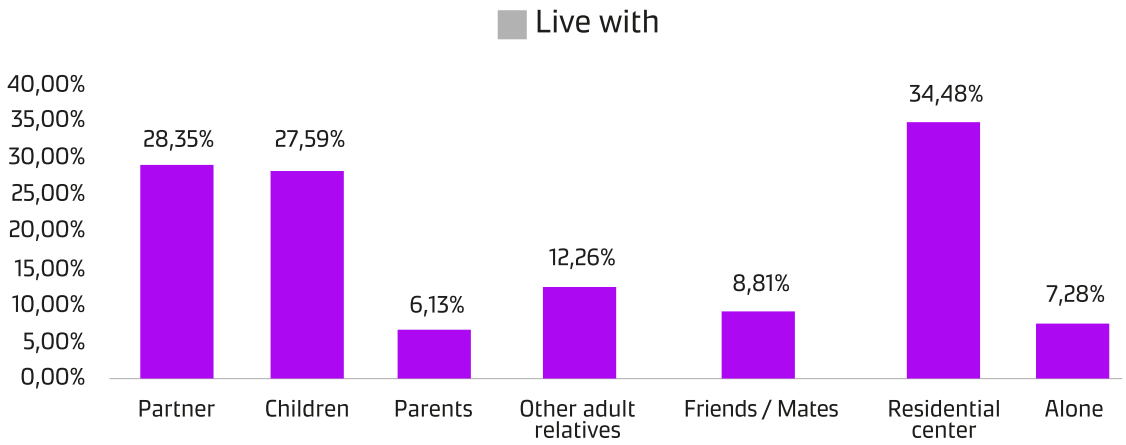

Figure 10. / WWUD sample and who they live with (N=261)

In relation to children, 157 of the women surveyed reported not having children, while 104 reported having children.

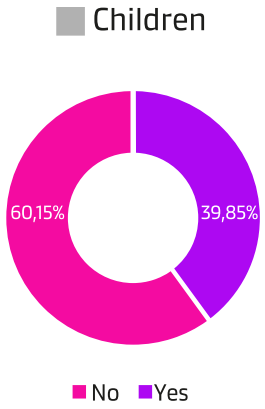

Figure 11. / WWUD sample and motherhood (N=261)

The majority of women (n = 92) reported having 1 child, while less than half (n = 43) reported having 2 children. Women who have more than 3 children account for only 8.43% (n = 22) of the sample.

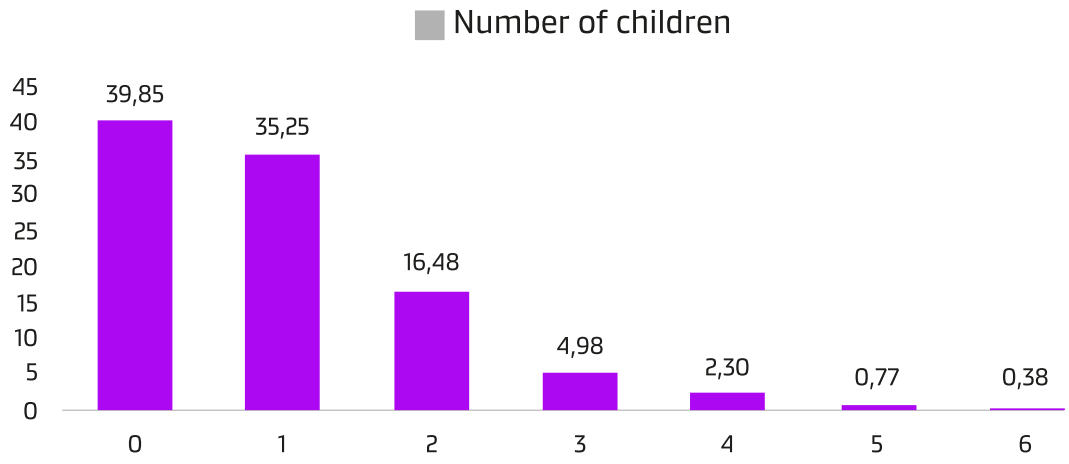

Figure 12. / WWUD sample and number of children (N=261)

104 of the women surveyed reported having had an abortion in the past, 67 reported never having had an abortion. However, 90 did not answer this question.

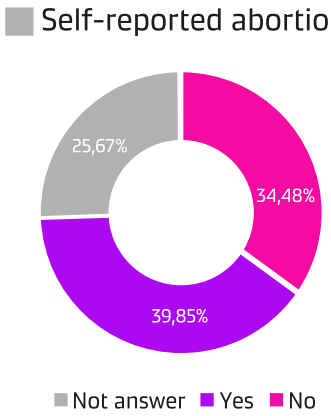

Figure 13. / WWUD sample and self-reported abortion (N=261)

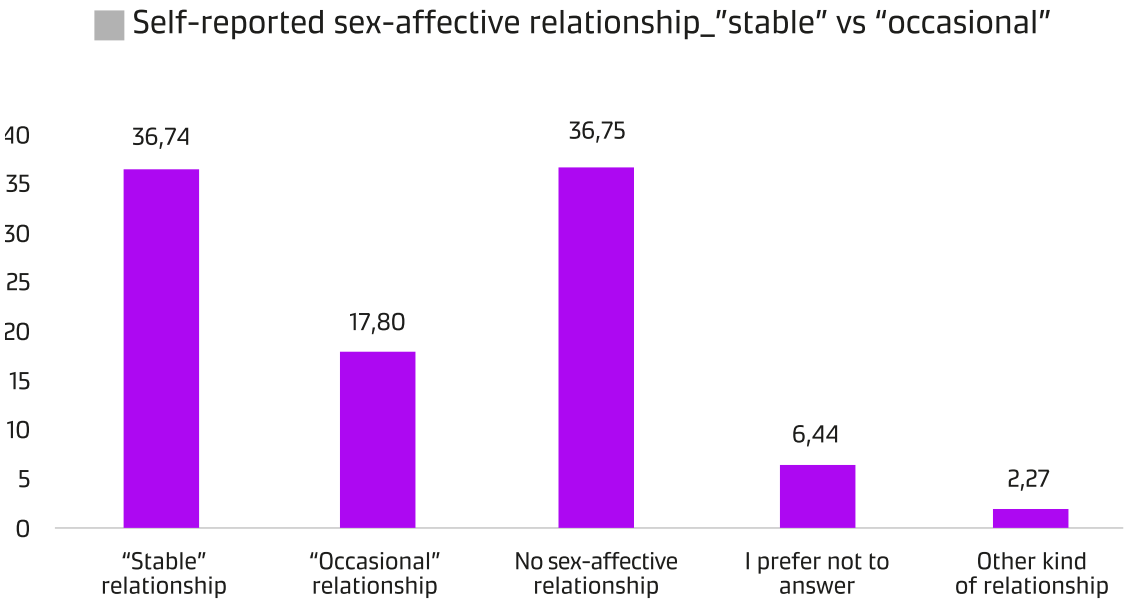

Figure 14. / WWUD sample and sex-affective relationship "stable" vs "occasional" (N=261)

The majority of the women surveyed (n = 130) reported being in a monogamous relationship, while 26 indicated being in a polyamorous relationship; 13 indicated being alone/not in a relationship, and 5 other options. However, 80 preferred not to answer this question.

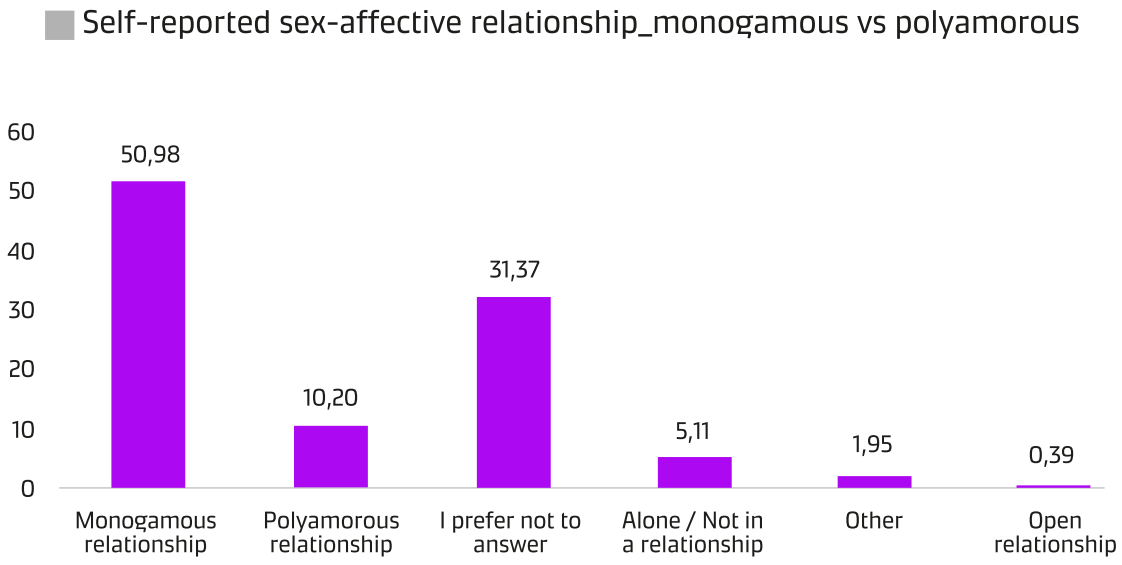

Figure 15. / WWUD sample and sex-affective relationship monogamous vs polyamorous (N=261)

148 of the women surveyed reported having relationships with one or more men; 17 with different people regardless of their gender; 16 with one or more women. However, 66 of women chose not to answer this question.

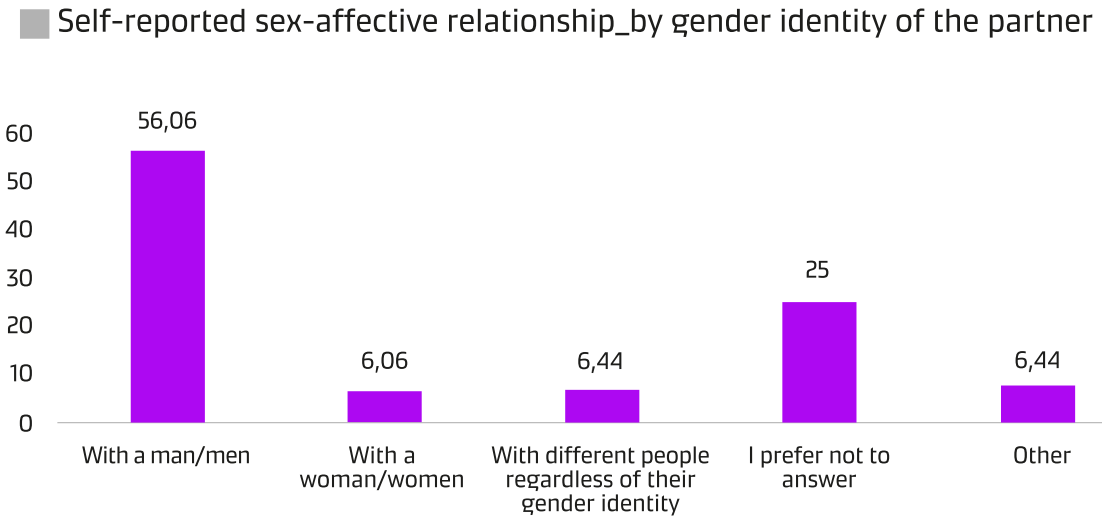

Figure 16. / WWUD sample and gender partner (N=261)

89 of the women surveyed reported being in sex-affective relationships with partners who use drugs or alcohol, while 73 reported having relationships with partners who do not. Again, a high 31.09% (n = 83) preferred not to answer, maybe because not having a relationship. 22 indicated other options.

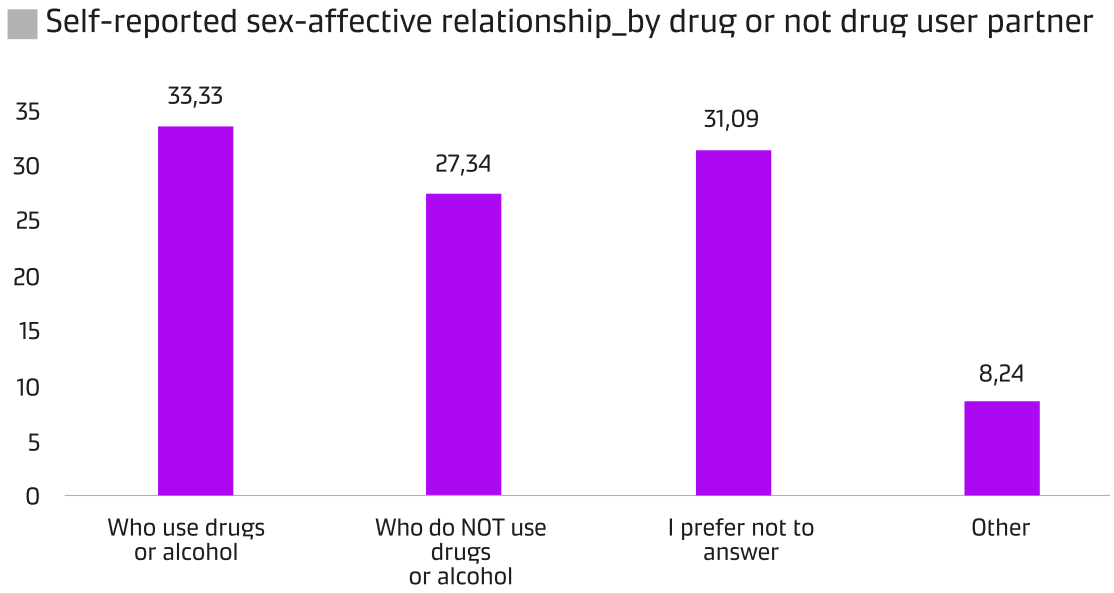

Figure 17. / WWUD sample and sex-affective relationship and partner drug use (N=261)

Likewise, 118 of the women surveyed self-reported having some mental disorder, while almost the same proportion (n = 124) self-reported not having any mental disorder. 19 preferred not to answer.

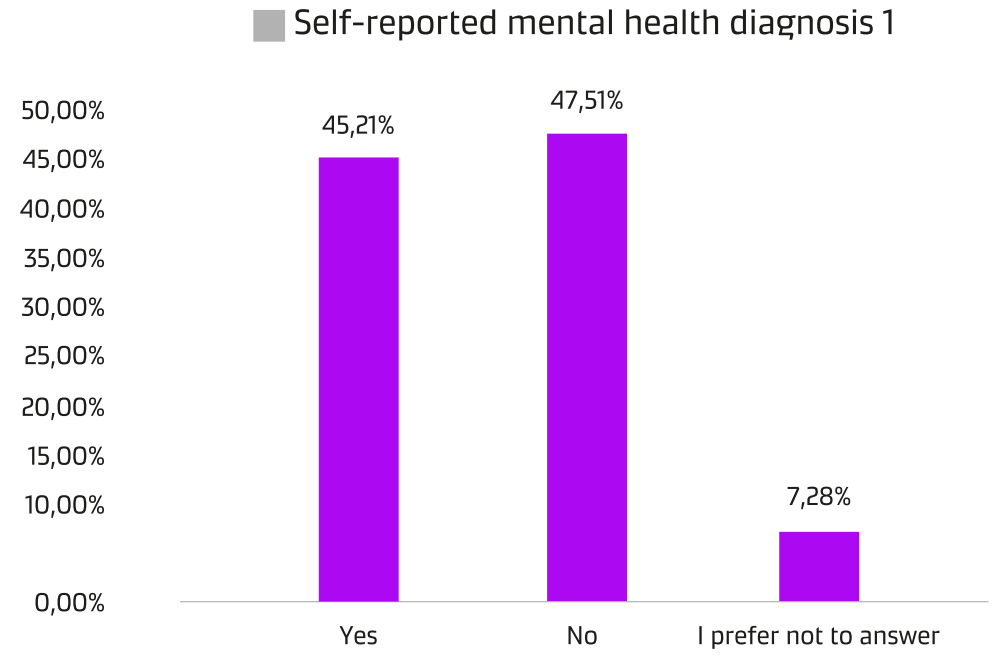

Figure 18. / WWUD sample and mental healh diagnosis (N=261)

Among the mental disorders self-reported by women, depression (n = 16), borderline personality disorder (n = 14), and other mixed diagnosis (more than 3) stand out with 13. The combination of depression and borderline personality disorder also stands out with 7, as well as personality disorder (n = 5), bipolar disorder (n = 5), and other 2-mixed diagnosis (n = 5).

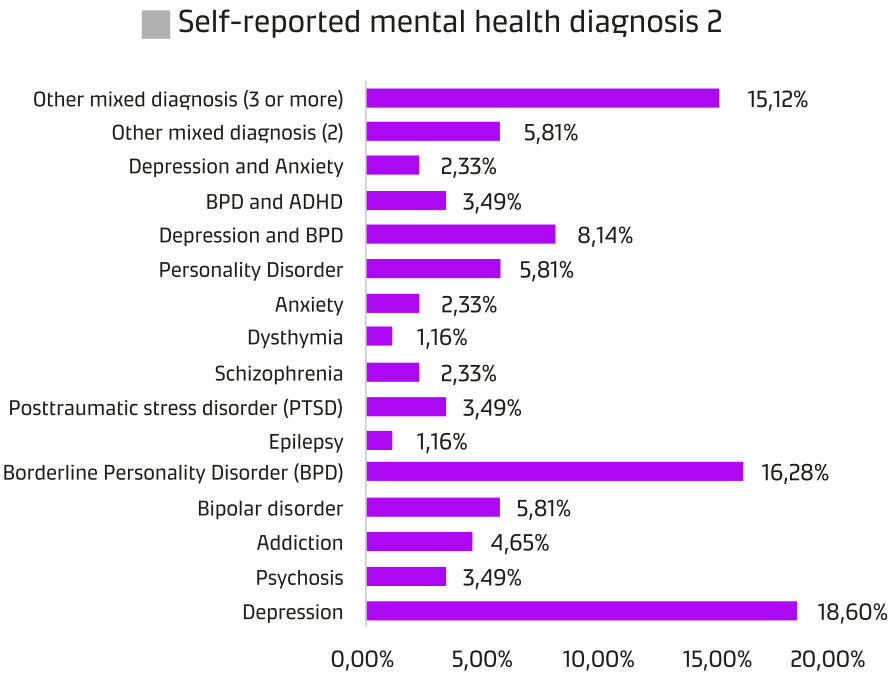

Figure 19. / WWUD sample and self-reported mental health diagnosis 2 (N=86)

Regarding physical health issues, 81 of the women surveyed self-reported an illness, compared to 53 who said they did not suffer from any illness. However, 95 preferred not to answer this question.

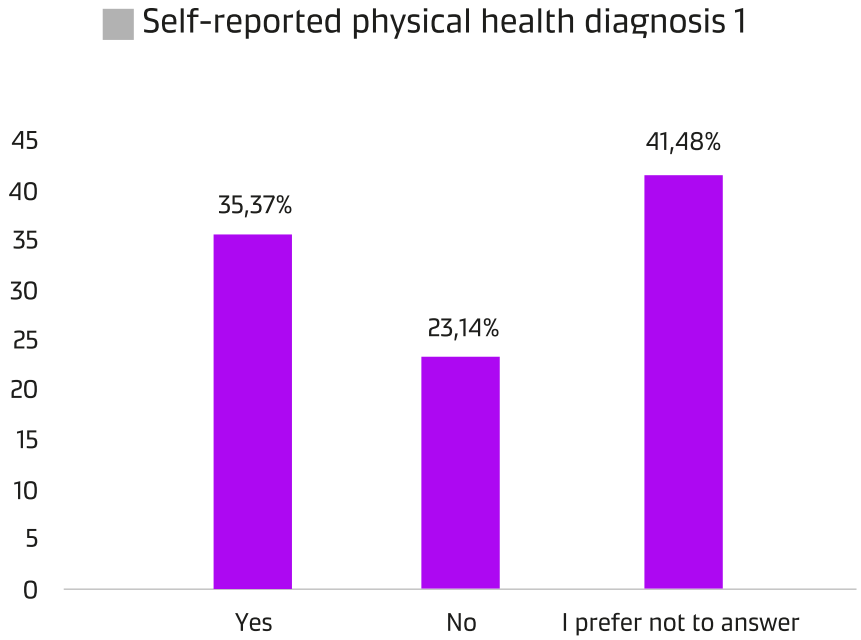

Figure 20. / WWUD sample and self reported physical health diagnosis 1 (N=229)

Self-reported diseases include mostly hepatitis C (n = 37), other STD (Sexually Transmitted Infections) (n = 18), HIV/Aids (n = 8), and Cancer (n = 4).

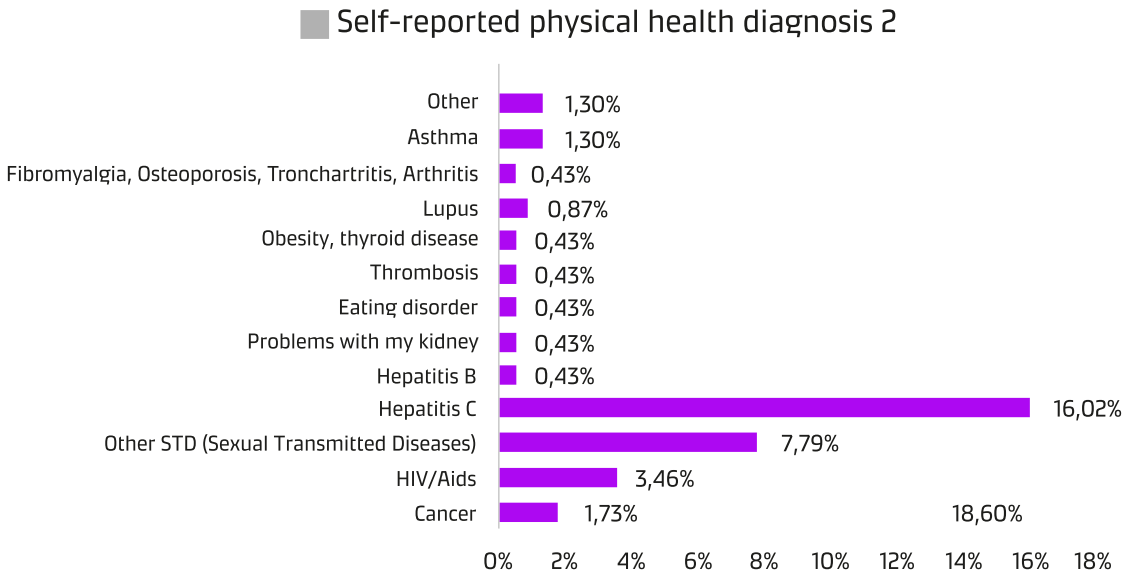

Figure 21. / WWUD sample and self-reported physical health diagnosis 2 (N=229)

b) Drug Use

In terms of drug use in lifetime, the majority of female respondents reported the use of alcohol and tobacco (n = 218; and n = 211, respectively), followed by cannabis (n = 165) and cocaine (n = 155), and benzodiazepines (n = 134) with slightly lower prevalence. Amphetamines (n = 94), MDMA (n = 94), opioid drugs (n = 86), heroin (n = 84) and non-prescription benzodiazepines (n = 88) have similar percentages around 30%. Non-prescription opioid drugs (n = 53), ketamine (n = 50), methamphetamine (n = 46) and GHB (n = 28) are reported by 10-20% of the women surveyed. Finally, with percentages below 10%, the use of New Psychoactive Substances (n = 22), mephedrone (n = 17), and other drugs (n = 21) were reported; 3.07% (n = 8) of the women surveyed declared themselves abstinent at the time they responded to the survey.

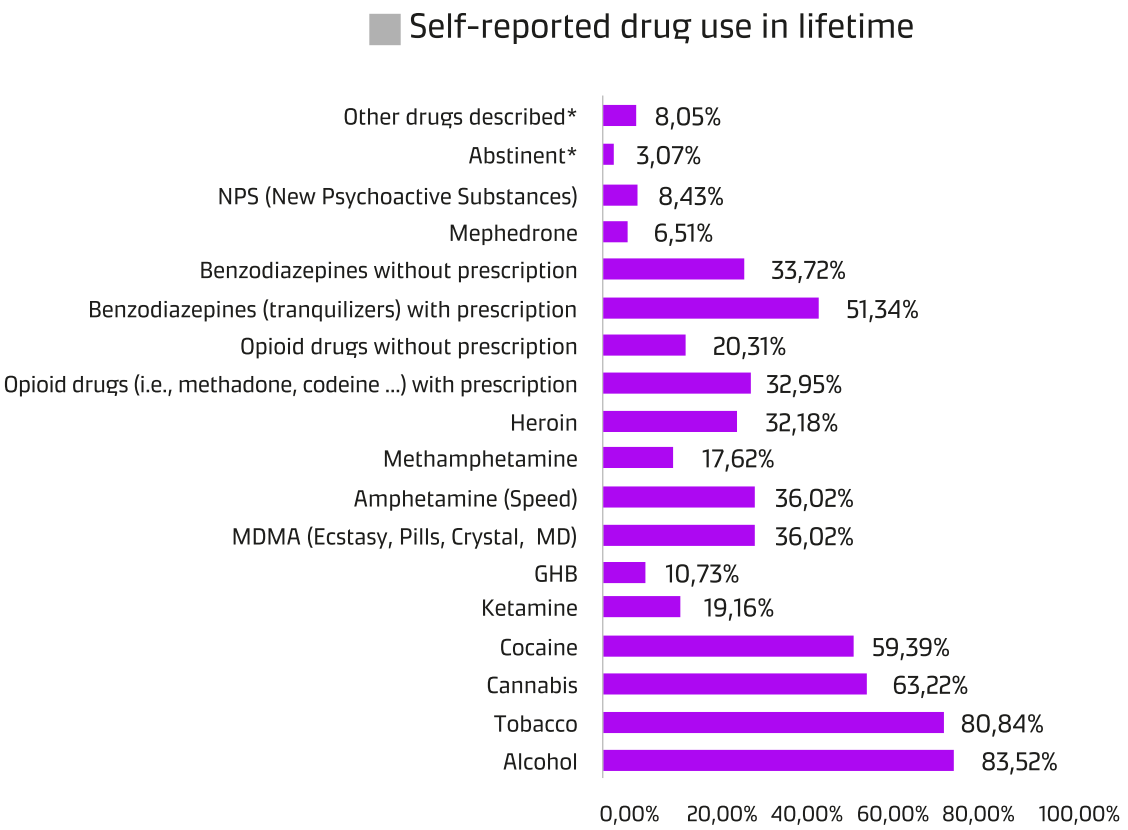

Figure 22. / WWUD sample and self-reported drug use in lifetime (N=261)

By frequency of consumption, the most reported drugs used "daily" and "often" continue to be tobacco (daily: 61.3%, n = 160; often: 11.11%, n = 29), alcohol (daily: 28.35%; often: 28.35%, n = 74 respectively), and cannabis (daily: 23.37%, n = 61; often: 13.79%, n = 36). This is followed by prescription benzodiazepines (daily: 24.09%, n = 65; often: 11.11%, n = 29), cocaine (daily: 18.01%, n = 47; often: 15.71%, n = 41), prescription opioid drugs (daily: 21.46%, n = 56; often: 6.51%, n = 17), and heroin (daily: 15.33%, n = 40; often: 8.43%, n = 22). Amphetamine is reported by female respondents at somewhat lower percentages (daily: 5.75%, n = 15; often: 8.05%, n = 21). Benzodiazepines (daily: 9.58%, n = 25; often: 9.96%, n = 26) and opioid drugs (daily: 6.9%, n = 18; often: 4.98%, n = 13) without prescription are reported with somewhat lower prevalence. Other drugs such as GHB (daily: 0.77%, n = 2; often: 1.15%, n = 3), mephedrone (daily: 1.53%; often: 1.53%, n = 4 respectively), new psychoactive substances (daily: 1.53%, n = 4; often: 3.07%, n = 8), methamphetamine (daily: 3.07%, n = 8; often: 4.06%, n = 12) or ketamine (daily: 4.21%; often: 4.21%, n = 11 respectively) are reported in considerably lower percentages.

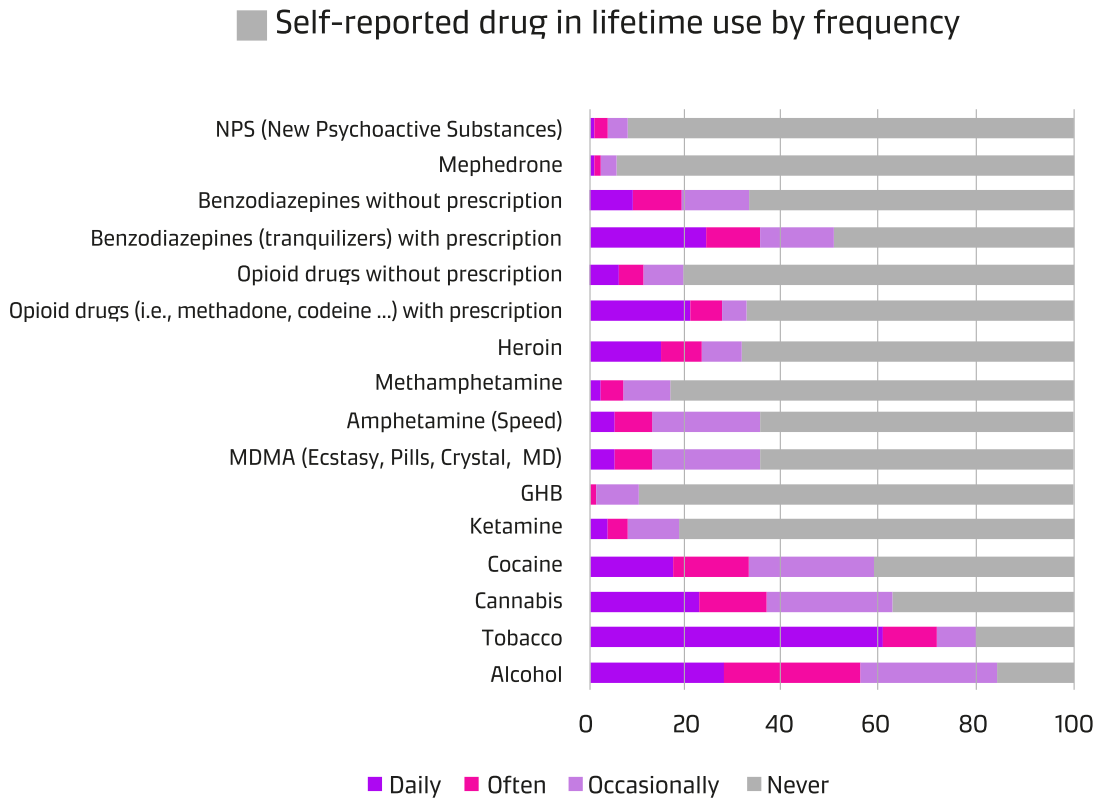

Figure 23. / WWUD sample and self-reported drug use in lifetime by frequency of use (N=261)

By frequency and drugs legal status used, the majority of the women surveyed reported using legal drugs in the highest frequencies (daily: 25.42%, n = 66; and often: 12.01%, n = 31), and similar proportions between legal (13.03%, n = 33), and non-legal (14.03%, n = 37) for occasional drug use. 71.09% (n = 185) of the women surveyed reported never having used non-legal drugs compared to 49.55% (n = 129) who reported never having used legal drugs.

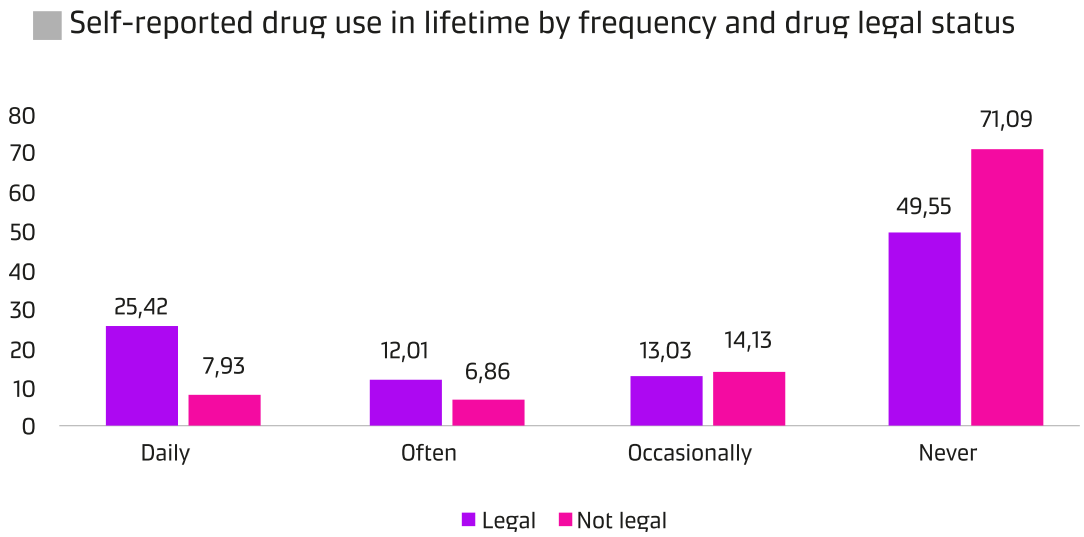

Figure 24. / WWUD sample and self-reported drug use in lifetime by frequency and drug legal status (N=261)

Regarding the ways of consumption, 100% (n = 261) of the women surveyed reported using sniffed drugs, while oral (n = 159), injected (n = 151), and smoked/inhaled (n = 127) ways of consumption reported lower frequencies.

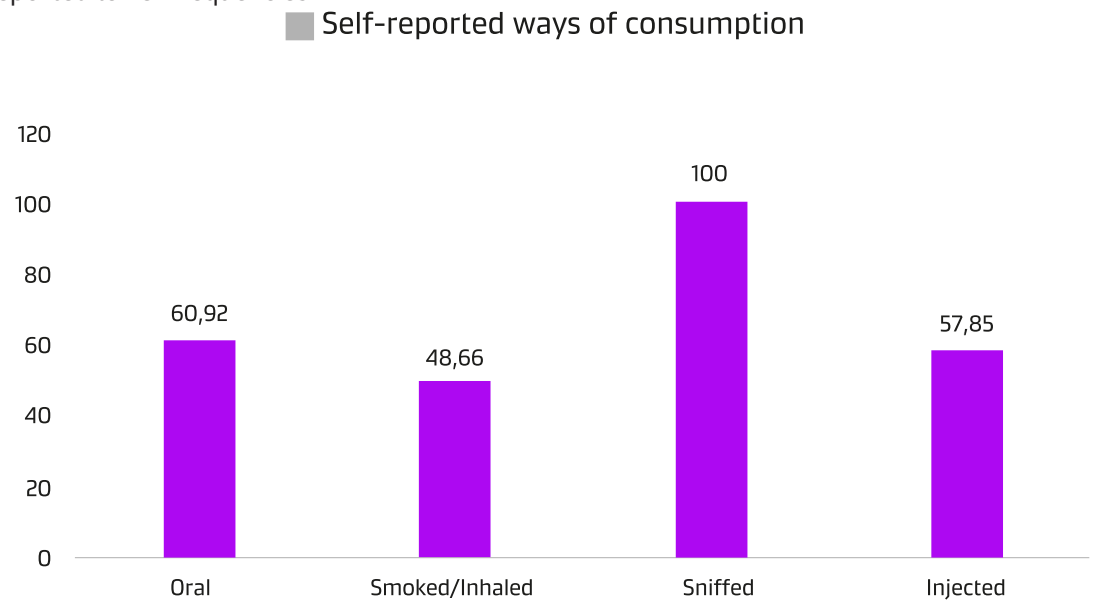

Figure 25. / WWUD sample and self-reported ways of consumption (N=261)

By drug type, cocaine and amphetamines, the most prevalent way of consumption reported by the women surveyed is sniffed (49.04%, n = 128; and 31.03%, n = 81, respectively); for methamphetamine, the most prevalent way of consumption is oral (9.59%, n = 25) followed by sniffed (9.2%, n = 24); regarding heroin, the most prevalent way of consumption is injected (24.52%, n = 64) followed by smoked/inhaled (19.16%, n = 53); finally, for opioid drugs, the most prevalent way of consumption is oral (26.82%, n = 70).

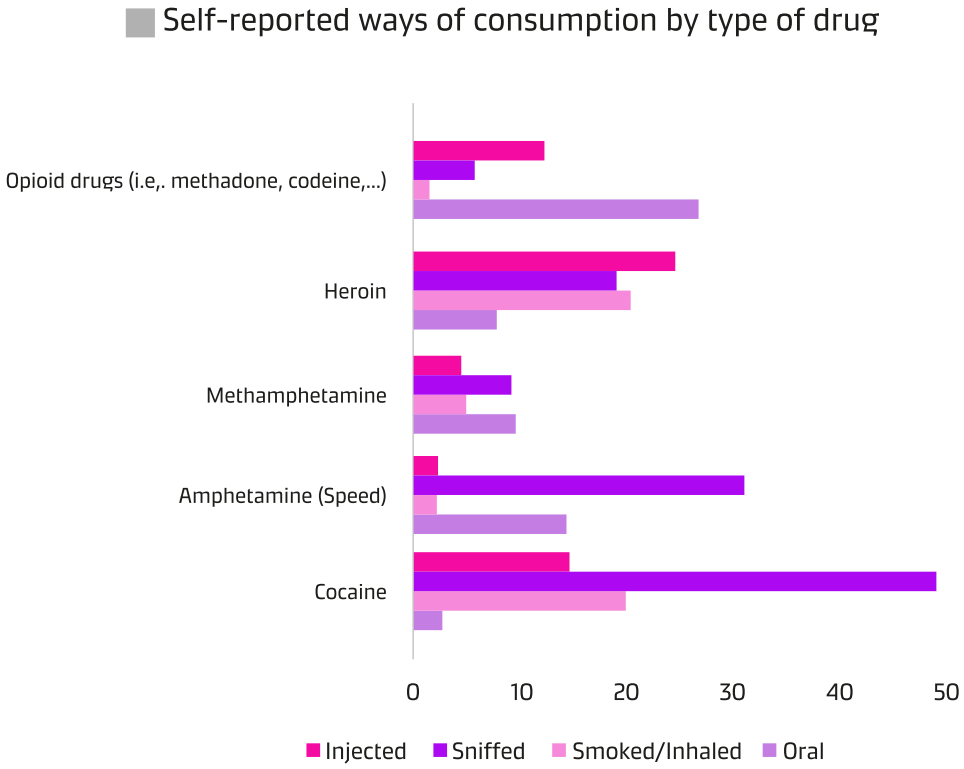

Figure 26. / WWUD sample and self-reported ways of consumption by drug type (N=261)

c) Gender-Based Violence

The majority of women interviewed reported having suffered psychological violence (n = 225) and physical violence (n = 193) at least once in their lives; 116 reported sexual violence during adulthood, 91 reported economic violence, and 62 reported sexual violence during childhood. Social violence was reported by 14.

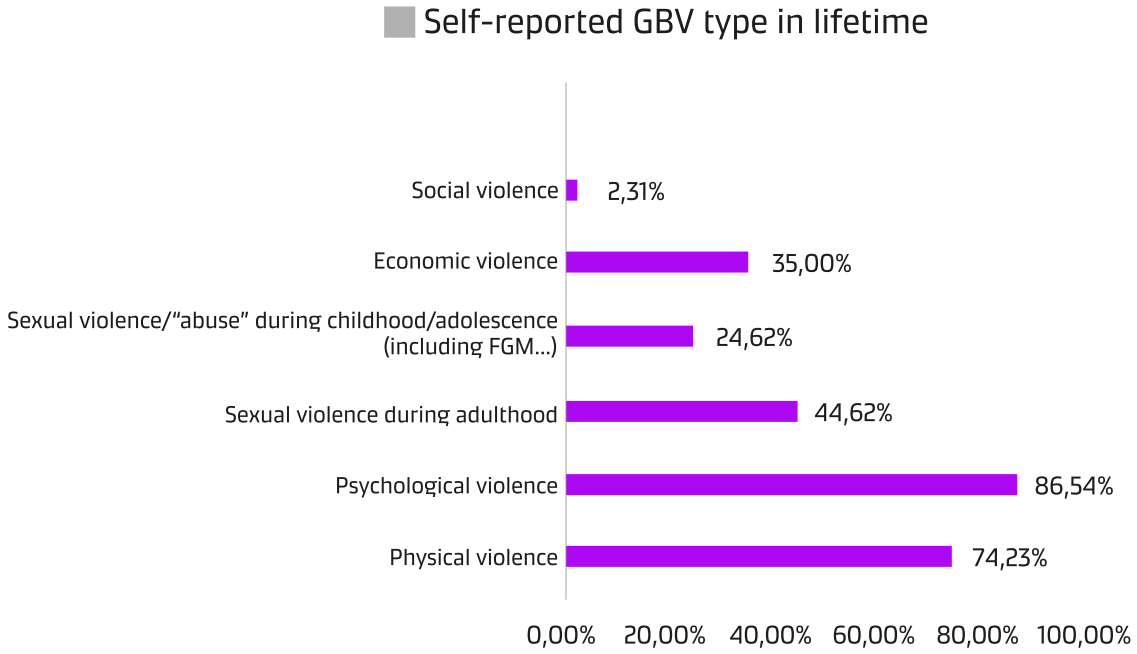

Figure 27. / WWUD sample and self-reported gender based violence in lifetime (N=260)

By contexts, the women interviewed mainly reported violence in the context of sex-affective relationships (n = 383), institutional violence (n = 341), and violence in the context of drug use (n = 313), followed by violence in the context of the family of origin (n = 262). Violence by an unknown aggressor (n = 159), in party settings (n = 153), drug trafficking (n = 125), and work contexts (n = 11) were reported less frequently. Finally, women respondents reported low prevalence of violence in the context of sex work (n = 84), homeless context (n = 80), early/forced marriages (n = 25), armed conflicts (n = 18), and female genital mutilation (n = 5).

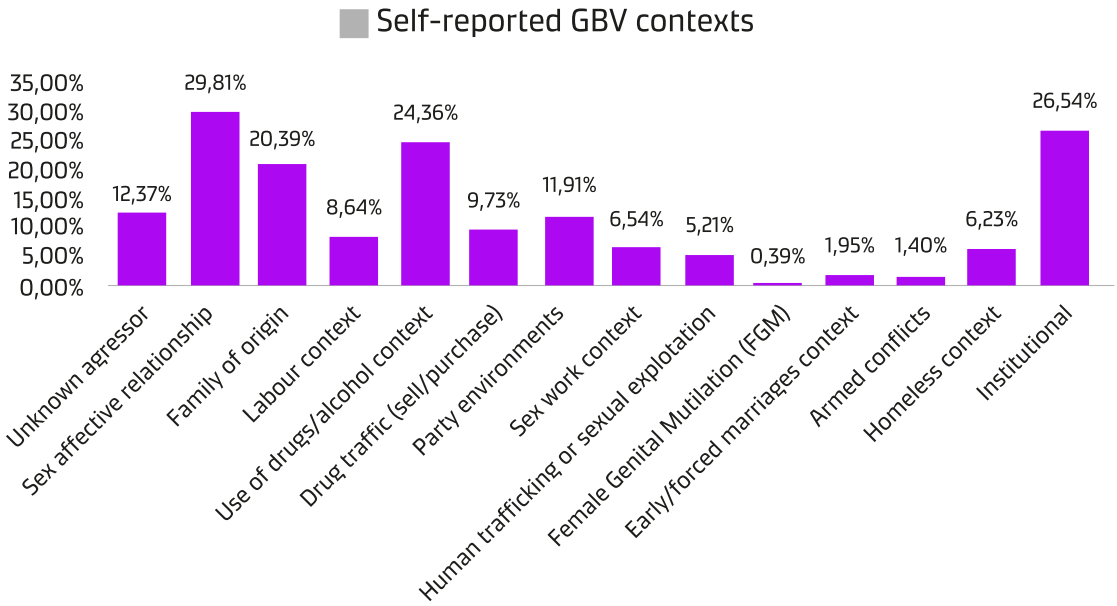

Figure 28. / WWUD sample and self-reported gender based violence contexts (N=257 by types of violence: physical, psychological, sexual, economic, other. Total answers: 1375)

Regarding the types of violence for each type of context, the women interviewed mainly reported psychological and physical violence in the case of institutional violence (psychological: 83.67%, n = 215; physical: 17.91%, n = 47); in the context of sexual-affective relationships (psychological: 54.86%, n = 141; physical: 19.46%, n = 112); family of origin (psychological: 42.02%, n = 108; physical: 32.3%, n = 83); drug/alcohol use (psychological: 39.3%, n = 101; physical: 36.58%, n = 94); work context (psychological: 20.23%, n = 52; physical: 6.23%, n = 16); party environments (psychological: 16.73%, n = 44; physical: 17.12%, n = 43); drug traffic (psychological: 16.34%, n = 42; physical: 13.62%, n = 35); sex work (psychological: 8.56%, n = 22; physical: 6.23%, n = 16); trafficking or sexual exploitation (psychological: 6.23%, n = 16; physical: 5.84%, n = 15); early/forced marriages (psychological: 2.72%, n = 7; physical: 1.95%, n = 5); and armed conflicts (psychological: 2.72%, n = 7; physical: 1.56%, n = 4).

In contrast, this trend is reversed in the case of violence in the context of an unknown aggressor (psychological: 14.01%, n = 36; physical: 19.46%, n = 50), and violence in homeless contexts (psychological: 7.39%, n = 19; physical: 8.95%, n = 23).

Sexual violence was especially reported in the context of drug use (29.57%, n = 76), sex-affective relationship (26.07%, n = 67), unknown aggressor (22.57%, n = 58), party environments (18.29%, n = 47), and family of origin (12.84%, n = 33).

Economic violence was mainly reported in the context of sex-affective relationships (22.18%, n = 57), drug/alcohol use (14.01%, n = 36), family of origin (13.23%, n = 34), and work (8.56%, n = 22). Finally, 13.64% (n = 35) of "other violence" in the institutional context stands out.

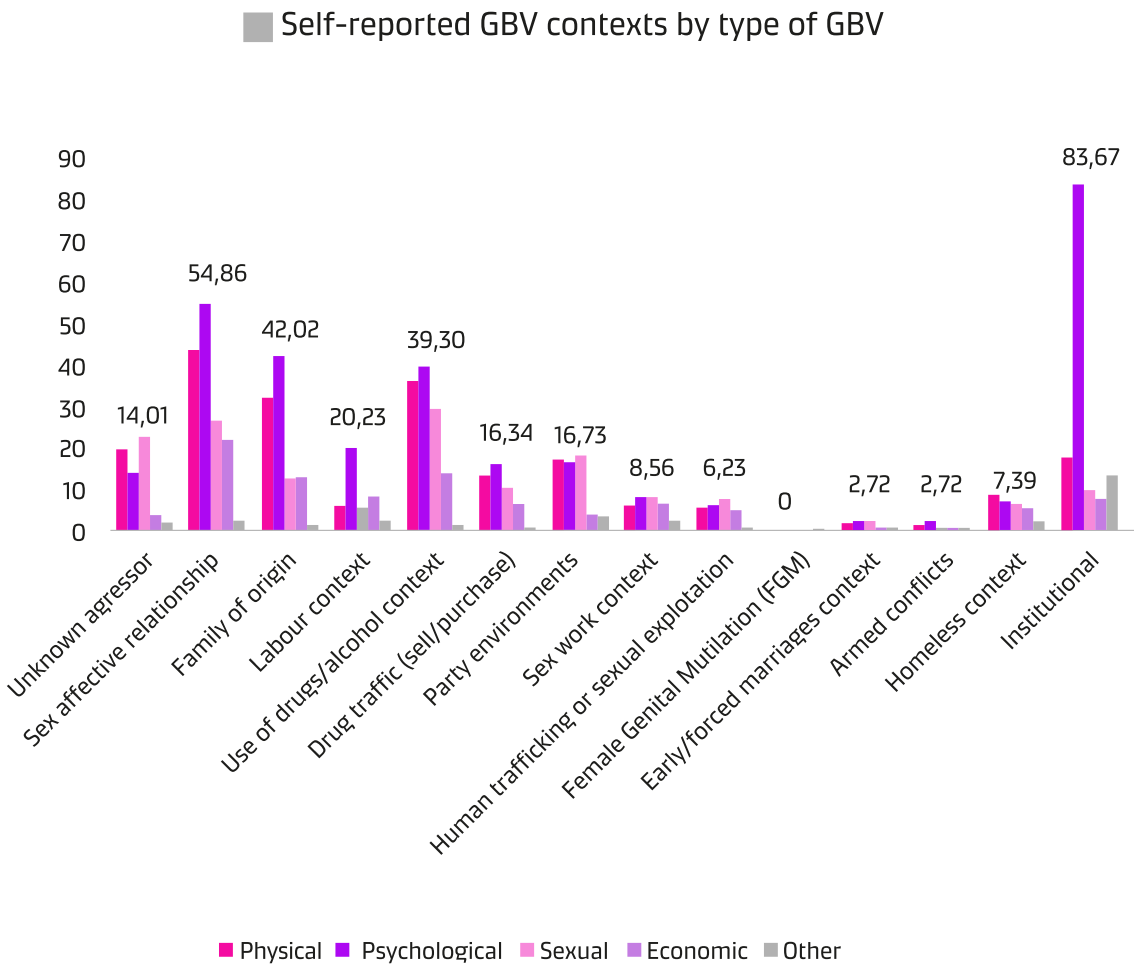

Figure 29. / WWUD sample and self-reported gender based violence and type of context (N=257)

With regard to institutional violence reported by the women interviewed, psychological violence by the police (14.4%, n = 37), legal services (12.45%, n = 32), social services (12.45%, n = 32), health centres (11.67%, n = 30), and child protection centres (10.51%, n = 27) stands out. Physical violence is also noteworthy in the case of the police, reported by 9.73% (n = 25) of women.

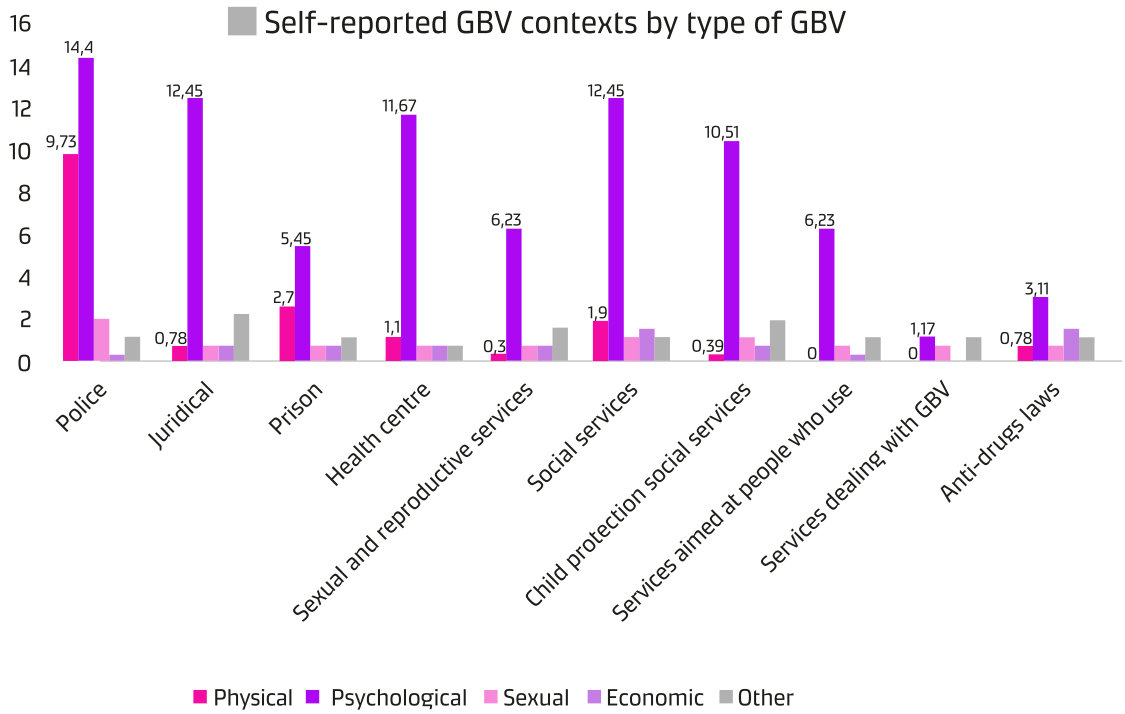

Figure 30. / WWUD sample and self-reported institutional violence by type of service (N=257)

In relation to the gender of the aggressor, the majority of the women surveyed pointed at men who use drugs or alcohol (frequently: 50.39%, n = 128; often: 35.83%, n = 91), and Men who do NOT use drugs nor alcohol (frequently: 15.75%, n = 40; often: 36.22%, n = 92) as the main perpetrators; in contrast, women have been reported as perpetrators in much lower percentages, both in the case of women who use drugs or alcohol (frequently: 5.12%, n = 13; often: 28.35%, n = 72), and women who do NOT use drugs or alcohol (frequently: 4.3%, n = 11; often: 17.32%, n = 44), especially in the case of the highest percentage.

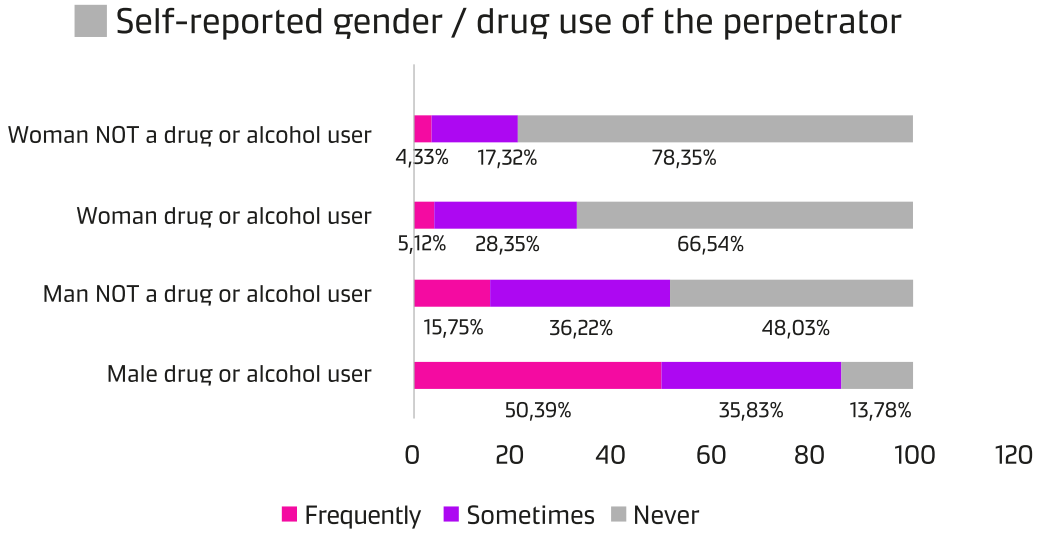

Figure 31. / WWUD sample and self-reported gender / drug use of the perpetrator (N=254)

From an intersectional point of view, the women surveyed identified poverty (n = 82) as one of the clearest axes of discrimination beyond gender and drug use. This is followed by disability (n = 48), age (n = 41), and sexual orientation (n = 36). Ethnicity (n = 22) or migration (n = 20) as axes of

discrimination have been reported less prevalently. Finally, 2.3% (n = 9) of women have pointed out other axes, while 38 have indicated that they do not feel they are impacted by other axes of discrimination besides gender and drug use.

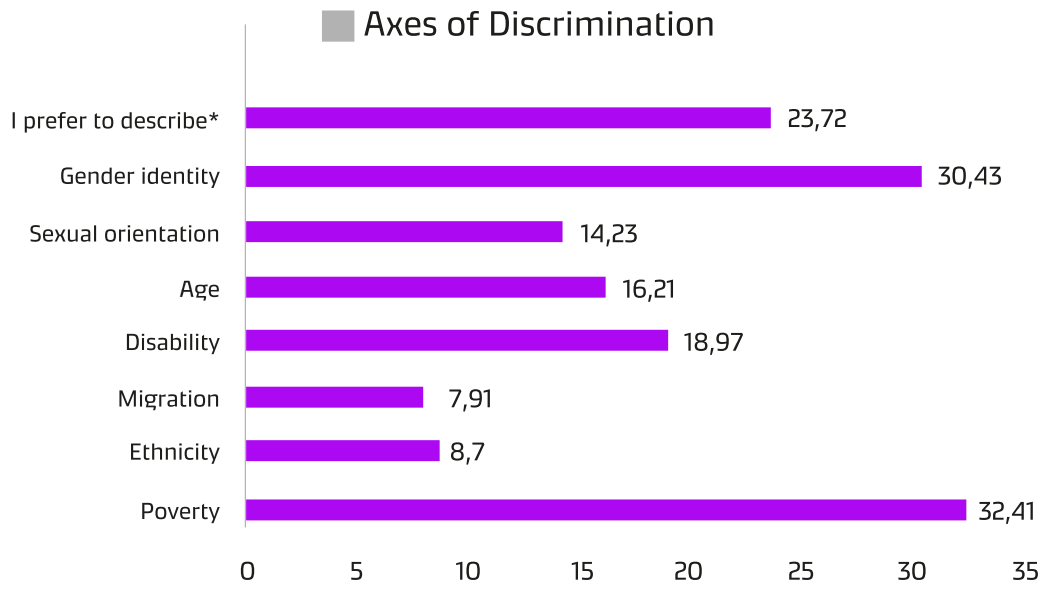

Figure 31. / WWUD sample and self-reported axes of discrimination (N=253)

d) Intersection between drug use and gender-based violence

The intersection between drug use and gender-based violence experienced by women has also been explored.

Regarding violence experienced in the context of drug use itself, 66.67% (n = 152) of the women surveyed stated that "often the person who assaulted me was under the influence of alcohol or other drugs"; 57.14% (n = 132) stated that "often when I was assaulted I was under the influence of alcohol or other drugs"; and 56.64% (n = 128) stated that "my drug/alcohol use worsened after experiencing gender-based violence":

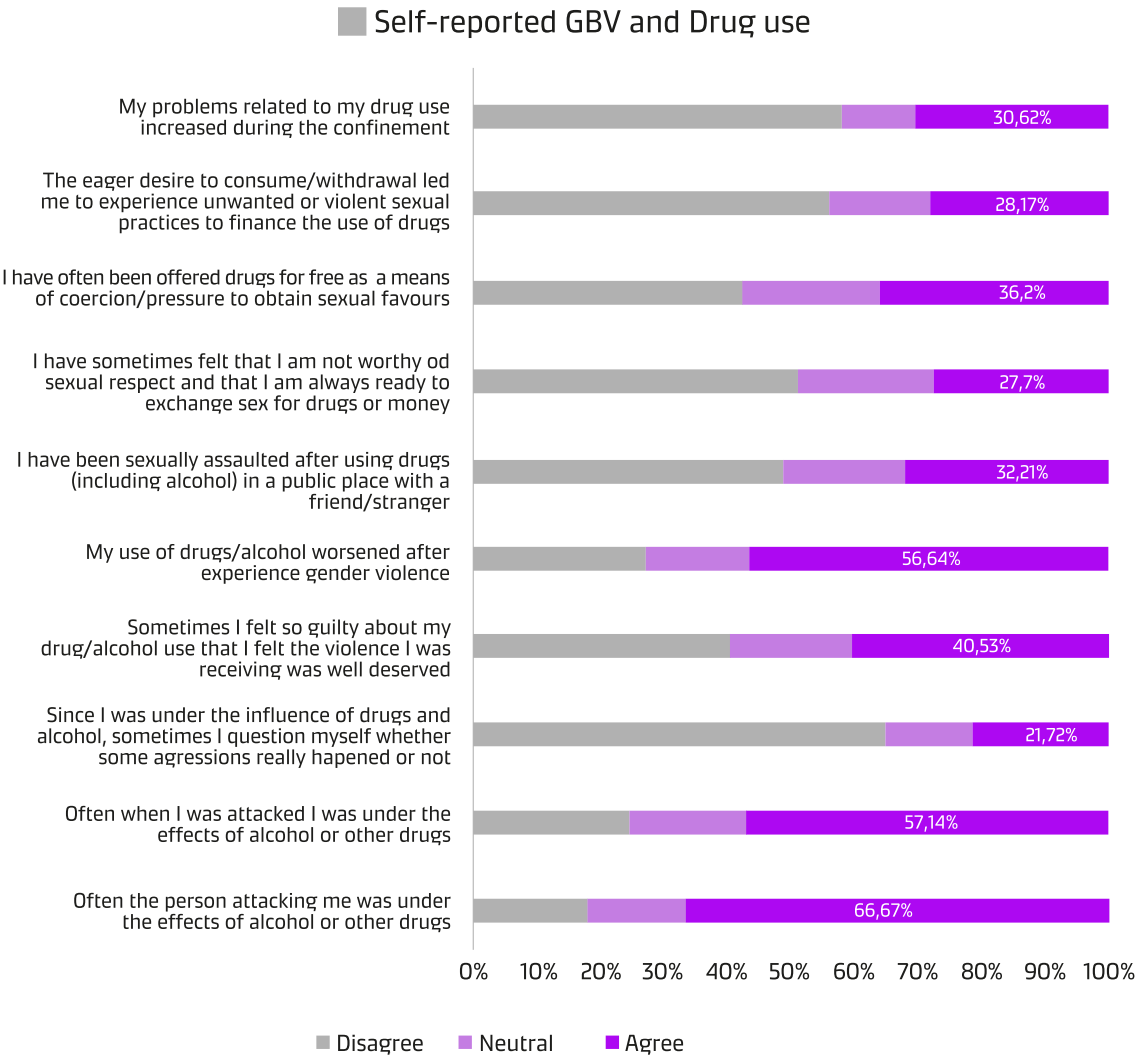

Figure 33. / WWUD sample and self-reported GBV and drug use (N=261)

Regarding violence by a partner or ex-partner, 59.91% (n = 127) of the women surveyed stated that "I felt so sad because the violence experienced from my partner that I used alcohol or other drugs (including tranquillizers/painkillers) to get some relief for these feelings"; 53.99% (n = 115) reported that "having a partner who also used drugs made me more vulnerable to violence"; and 45,59% (n = 93) of women stated "often my partner was telling that his violence against me was because my use of drugs":

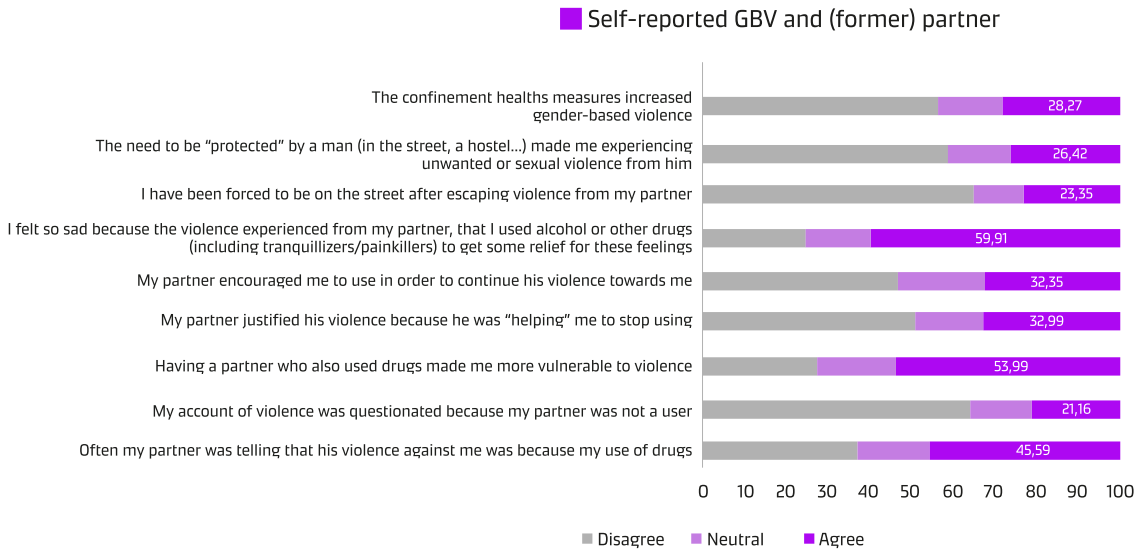

Figure 34. / WWUD sample and self-reported GBV and (former) partner (N=261)

Regarding violence reported in the context of sex work, it is worth noting that 44.32% (n = 78) of the women surveyed reported that "people believe that sex workers are willing to exchange sex for money/drugs in any context of drug use context:

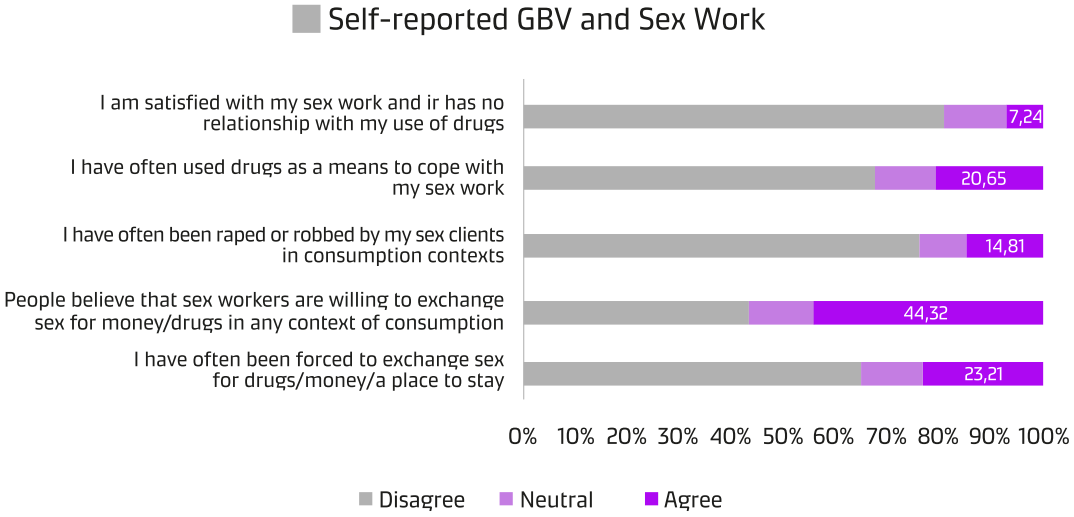

Figure 35. / WWUD sample and self-reported GBV and sex work (N=261)

Note that around 30% of respondents report sex work or related practices, either linked to their drug use (23,21%) or not related at all (7,24%). They also inform us about the violence experienced in such context, and about their use of drugs to cope with their sex work (see figure below).

In terms of other axes of discrimination, 39.69% (n = 77) of the women surveyed reported that "my personal condition (ethnic background, sexual orientation, mental health, homelessness, migration...) made me more vulnerable to violence":

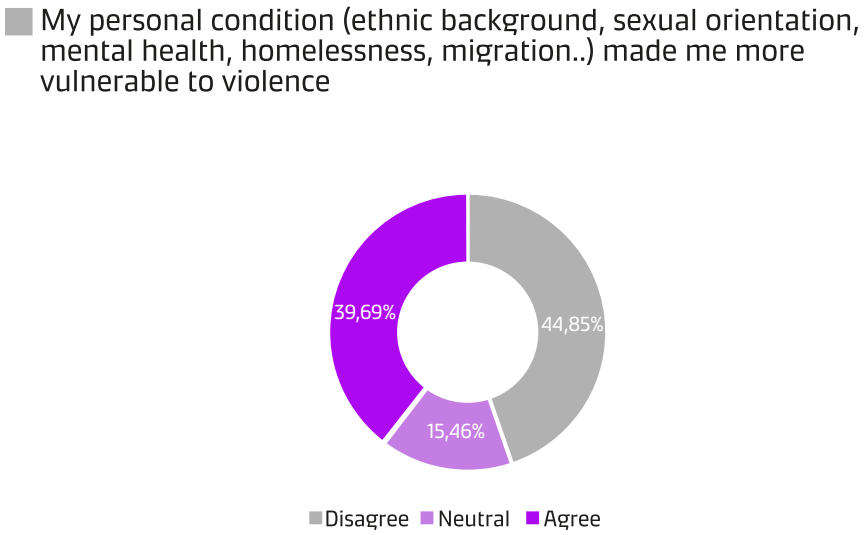

Figure 36. / WWUD sample and self-repoted perception about personal condition and vulnerability to violence (N=194)

As far as institutional violence or perceived barriers to receiving help are concerned, 43.64% (n = 72) of women reported that "I have been afraid of being considered a bad mother by child protection services and having my children taken away from me"; 39% (n = 78) reported that "I have been afraid to go to health and social services for using drugs"; and 36,17% (n = 68) reported that "I did not explain the violence I was suffering to the social/medical staff because I was afraid of not being believed, especially because my use of drugs" :

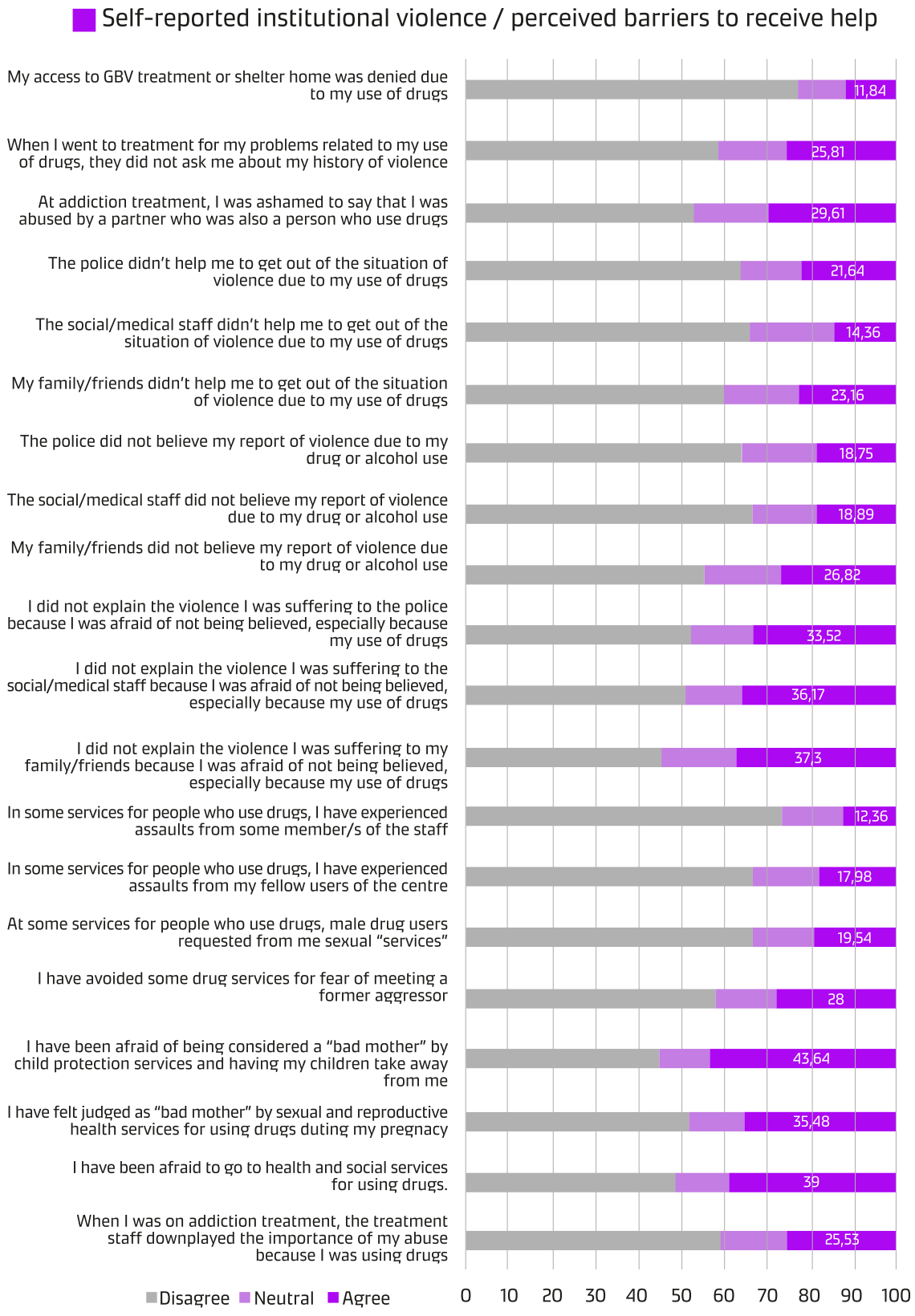

Figure 37. / WWUD sample and self-reported perception about barriers to receive help (N=261)

e) Care provided in relation to drug use and gender-based violence

On the other hand, the women surveyed reported being dissatisfied with the care received in different mainstream services, mainly the police (n = 62), legal services (n = 52), and child protection services (n = 38). Other general services have obtained higher satisfaction values, such as health services (n = 102), social services (n = 76) or sexual and reproductive services (n = 46).

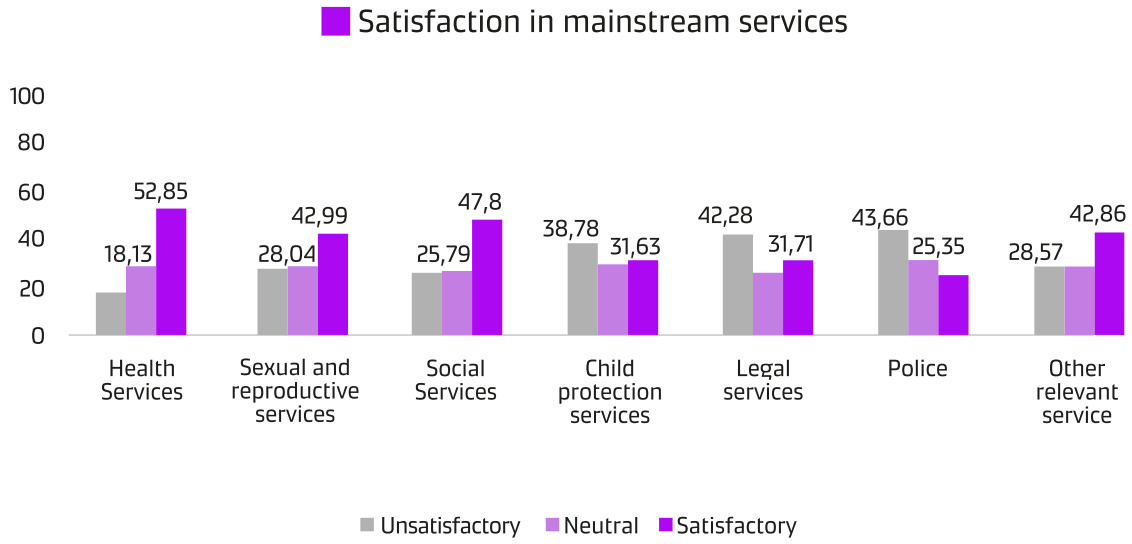

Figure 38. / WWUD sample and self-reported satisfaction in mainstream services (N=261)

On the other hand, specific services[8] seem to have higher frequencies of satisfaction than general services. Therapeutic communities/residential centres stand out (n = 129), although this may be due to the bias of the sample which, as we have seen, is made up of 58% (n = 144) women who are currently in this type of service. This is followed by satisfaction rates of around 50%, as in the case of outpatient care for people with drug-use related problems (n = 89), day centre for people with drug-use related problems (n = 58) or harm reduction centres or services for people who use drugs (n = 51). In general, low percentages of dissatisfaction have been reported, below 20%, except in the case of home/shelters for victims of GBV, around 22,92% (n = 11).

8 By specific services we mean those services aimed at serving people who use drugs, women victims/survivors of GBV or both.

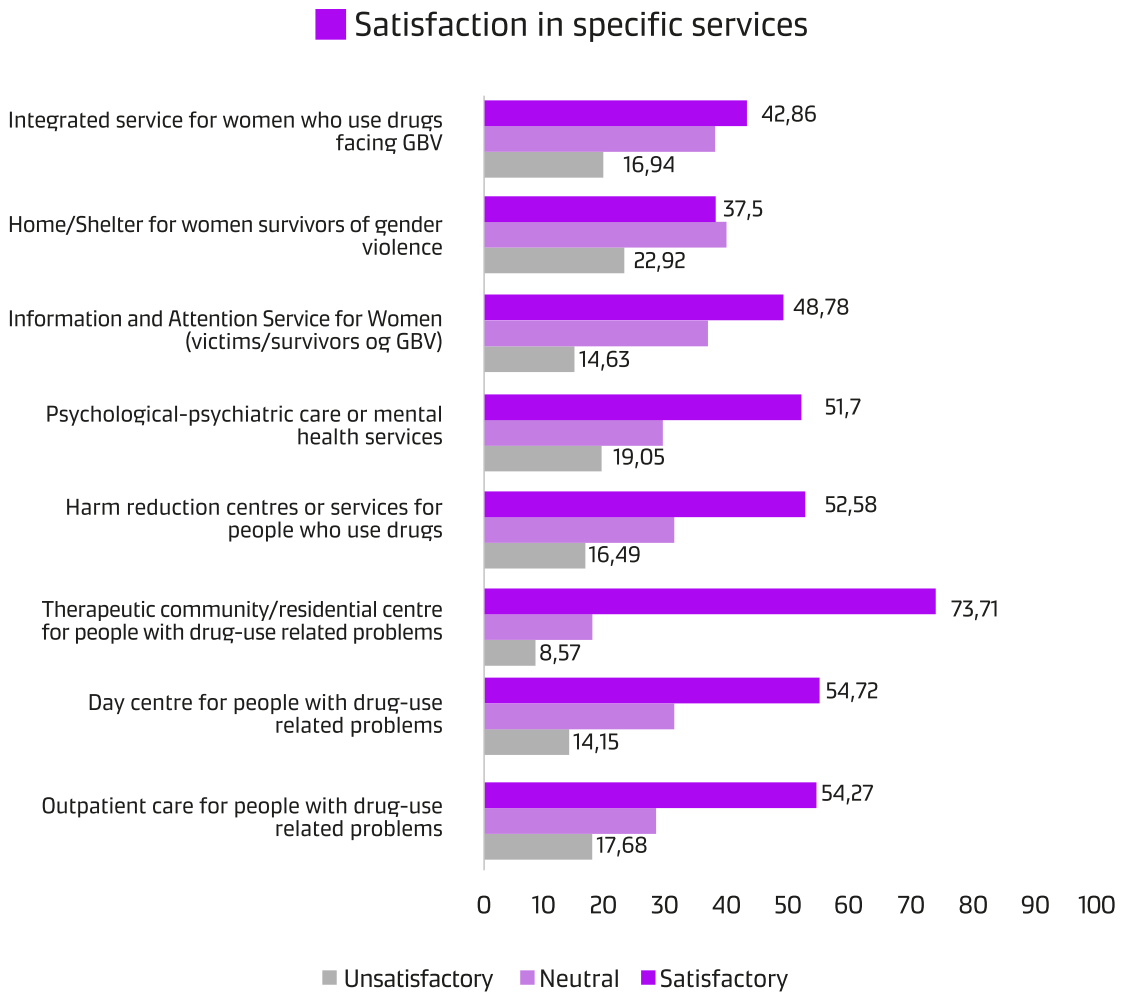

Figure 39. / WWUD sample and self-reported satisfaction in specific services (N=261)

Similarly, the women surveyed reported feeling more judged in mainstream services than in specific services. Thus, in mainstream services, although the majority of women reported not feeling judged, they reported being judged in 30-40% for different services (health services: 40.96%, n =102; police: 39.52%, n = 98; legal services: 29.15%, n = 72; child protection services: 28.11%, n = 70).

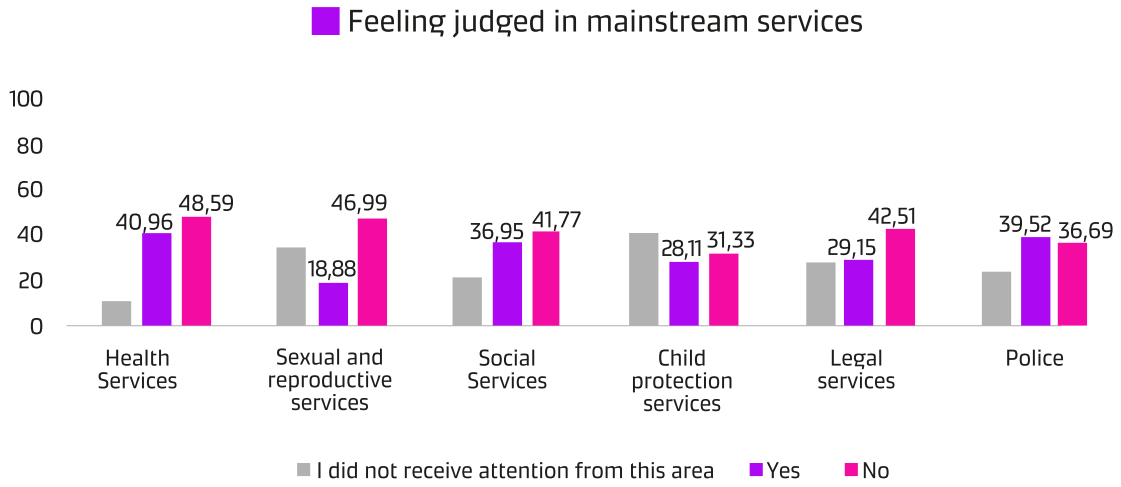

Figure 40. / WWUD sample and self-reported perception about feeling judged in mainstream services (N=261)

On the other hand, in the case of specific services, women felt that they were judged to a lesser extent with percentages generally below 10%, except in the case of psychological-psychiatric care or mental health services (20.88%, n = 52), outpatient care for people with drug-use related problems (17.67%, n = 44), and therapeutic communities/residential centre for people with drug-use related problems (15.66%, n = 39). The latter would contrast with the satisfaction levels reported for these types of services. Of note is the lower prevalence of feeling judged by integrated services (5.22%, n = 13).

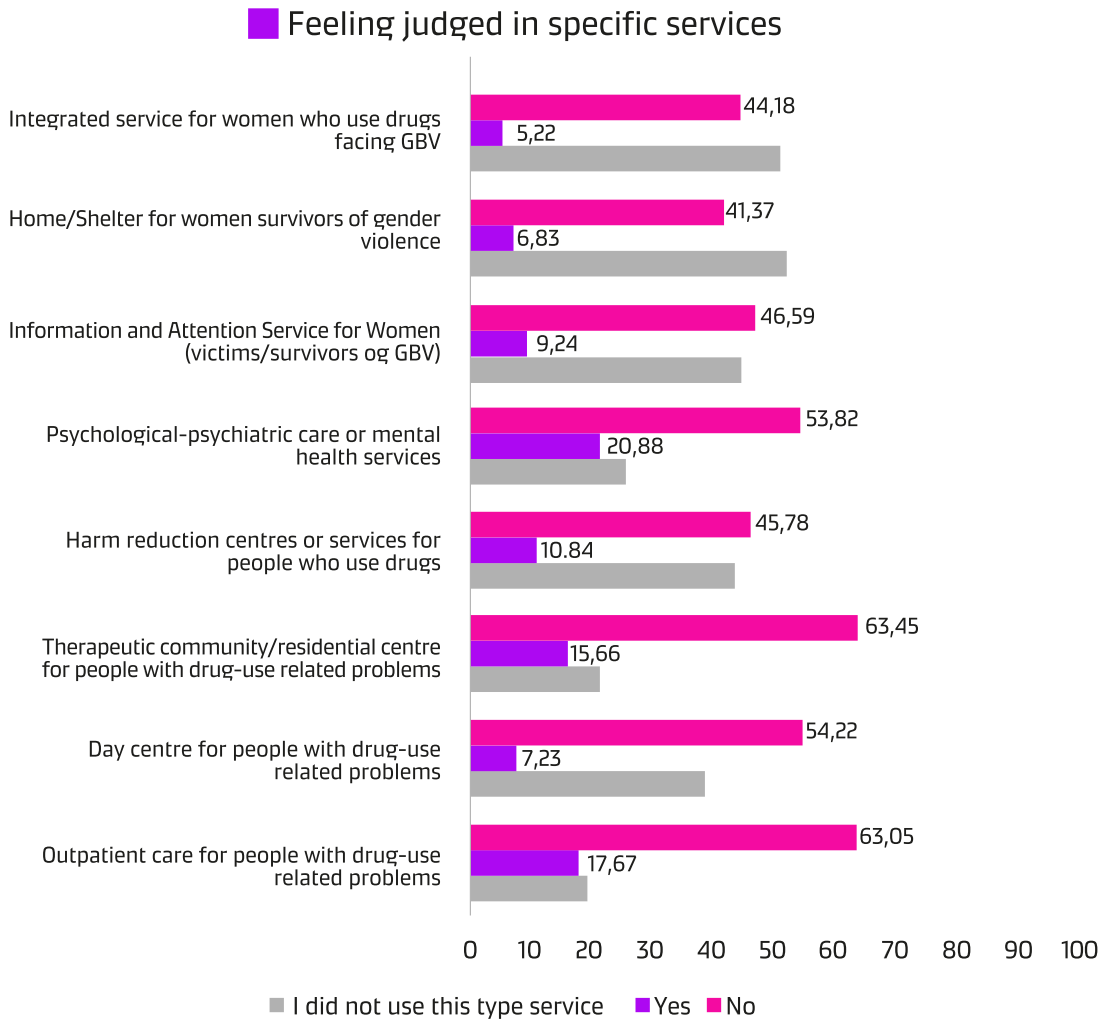

Figure 41. / WWUD sample and self-reported perception about feeling judged in specific services (N=249)

Finally, in relation to the positive aspects that define the current service, the women surveyed have pointed out that the empathy of professionals towards women participants/users of the service (n = 169); knowledge of professionals about drug use (n = 141); mental health is considered (n = 123); the autonomy/empowerment of women (n = 103), and social "reintegration" is actively promoted (n = 96). In general, aspects that have traditionally been considered in specialised care services and that do not necessarily imply the implementation of a gender perspective. However, aspects such as socio-political activism is actively promoted (n = 26) or early detection systems and protocols for GBV (n = 46), or the design of spaces/facilities considers the specific needs of women and their children (n = 50) are much less reported by women.

Figure 42. / WWUD sample and self-reported perception about positive aspects that define treatment services (N=261)

3.2.2. Survey aimed at professional staff

The main results for each of the sections of the survey aimed at professional staff are presented below: the profile of the sample, the general characteristics of the services where the professionals work, description of the intervention and best practices carried out:

a) Sample

In terms of gender, the professionals surveyed self-identified themselves mainly as women (n = 385), men (n = 95) and, to a minimal extent, as transgender and non-binary gender identities (TNB) (n = 4). 1.63% (n = 8) of the sample preferred not to answer this question.

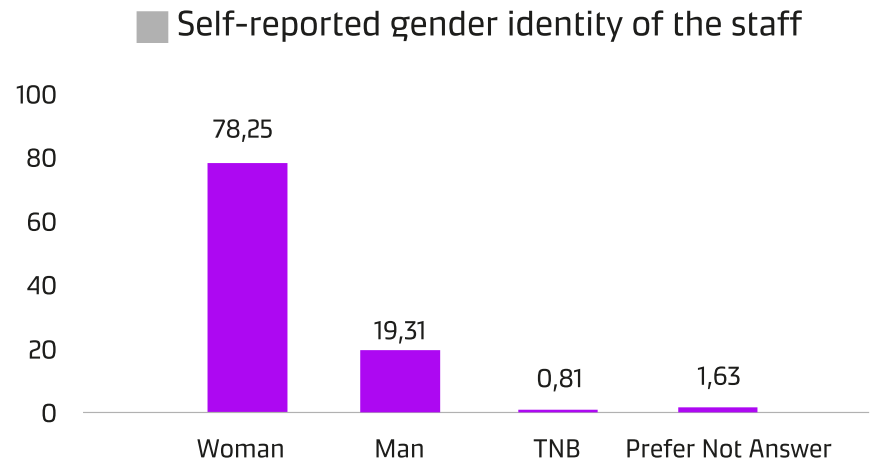

Figure 43. / Staff sample and self-reported gender identity (N=492)

In terms of country of residence, the professionals surveyed reported belonging to the partner countries in the following proportion: Spain (n = 146), Austria and Germany (n = 124), Italy (n = 95), Croatia (n = 91), and Portugal (n = 34).

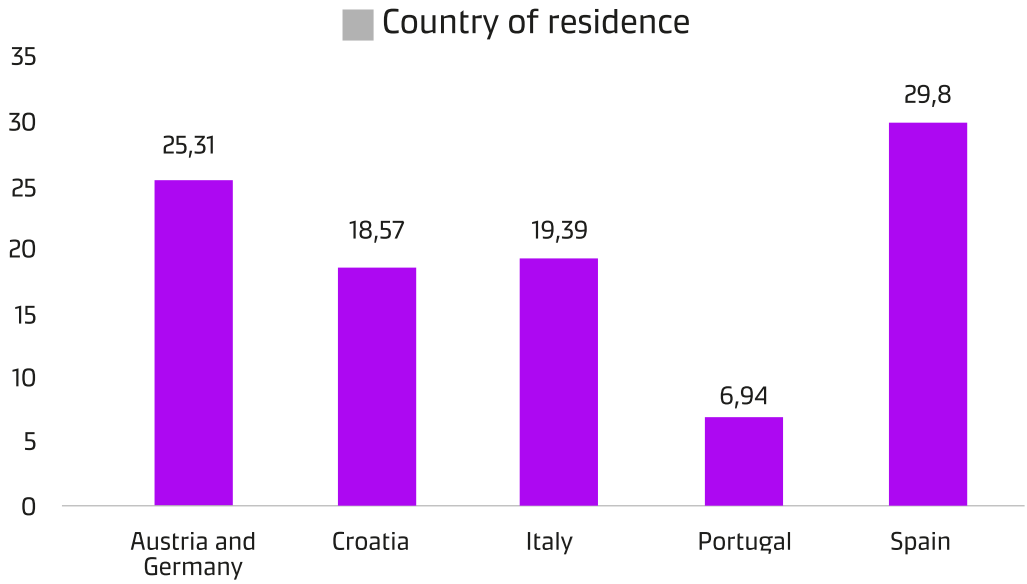

Figure 44. / Staff sample and country of residence (N=490)

b) Description and characteristics of services and workplaces of professionals

In terms of types of services, the professionals surveyed reported that they were mainly working in therapeutic communities/residential care for people with drug-use related problems (n = 177) and outpatient care + day centre for people with drug-related problems (n = 100). It is closely followed by harm reduction services (n = 44); psychological-psychiatric care or mental health services (n = 41); home/shelter for women survivors of GBV (n = 35); information and attention service for women (victims/survivors of GBV) (n = 21); integrated service for women drug users facing GBV (n = 19); services aimed at homeless people (n = 4); and finally, prevention services (n = 2).

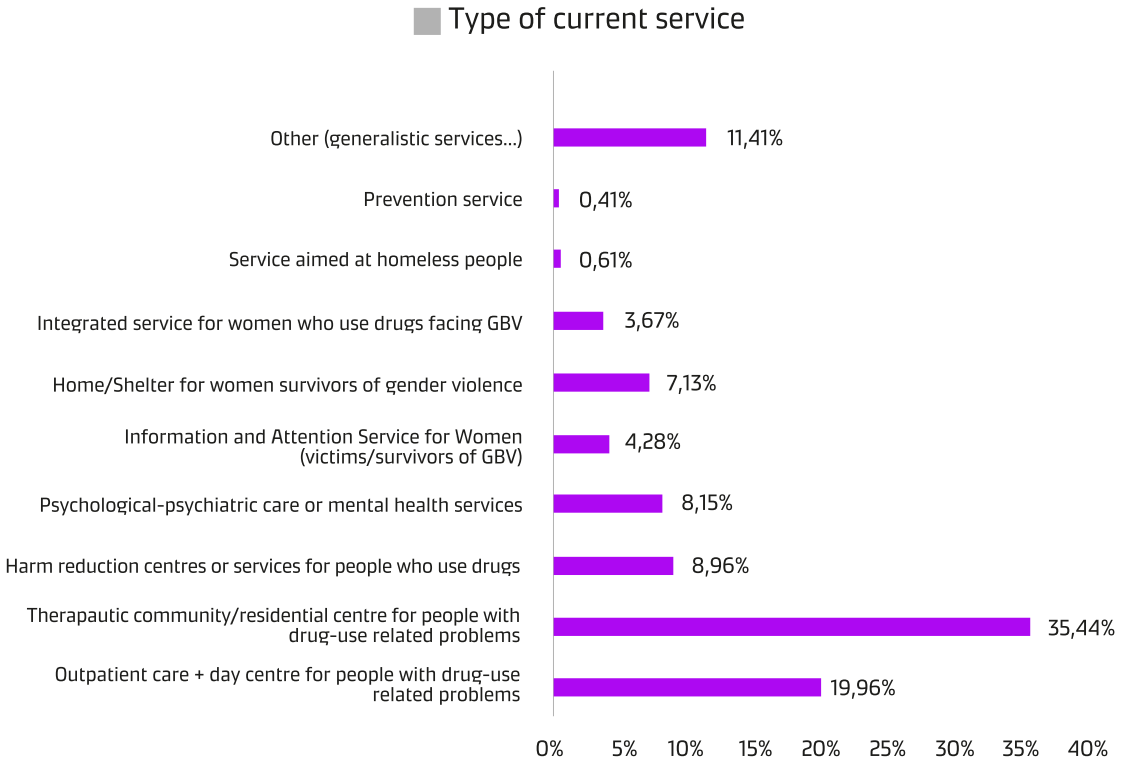

Figure 45. / Staff sample and type of current service (N=491)

By gender, significantly more men reported working in therapeutic communities/residential care for people with drug-use related problems (56.84%, n = 54) compared to 29.17% (n = 112) of women ($p < .001$)[9], which would indicate the professional masculinisation of these services. The same pattern is reproduced for psychological-psychiatric care or mental health services, where 10.53% (n = 10) are men compared to 7.29% (n = 24) women. However, the rest of the services have more women than men, especially in the case of outpatient care + day centre for people with drug-related problems (women: 22.4%, n = 64; and men: 12.63%, n = 6) ($p < .05$).

9 The percentages we compare have been obtained by dividing the values for men and women by the total sample of men and women, respectively; not by dividing by the total sample.

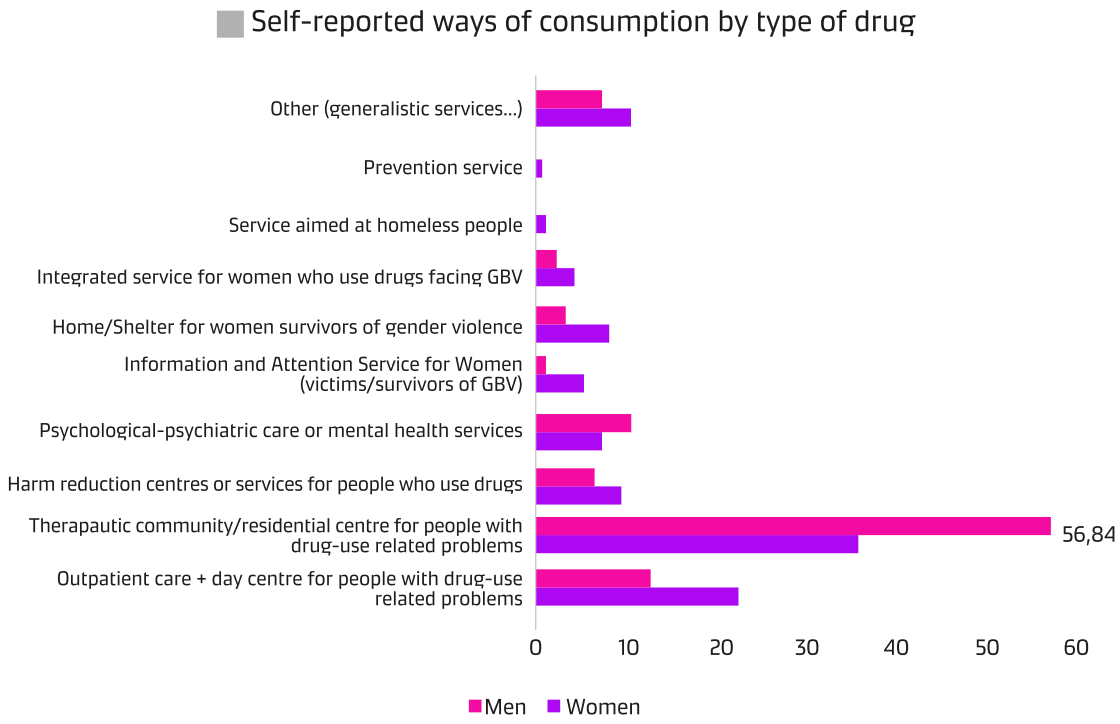

Figure 46. / Staff sample and type of current service by gender (N=479)

Most of the professionals report to be working in centres whose beneficiaries are both "Women and men who use drugs" (n=307), therefore centres nor specific for women neither focusing specifically on GBV. This is followed by "women who use drugs facing GBV" (n = 151); socially excluded people in general (n = 142); families (n = 134); women facing GBV (n = 113); and women who use drugs (n = 100).

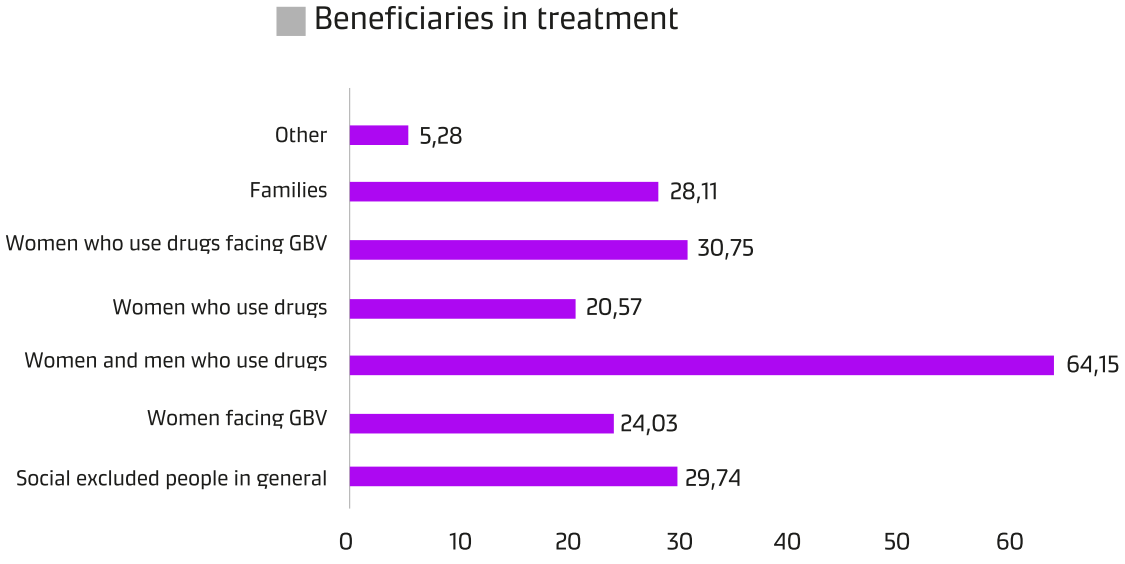

Figure 47. / Staff sample and beneficiaries in treatmen (N=491)

On the other hand, the majority of professionals reported that in the services in which they work there are exclusion criteria (n = 259) compared to 228 who said there were no exclusion criteria.

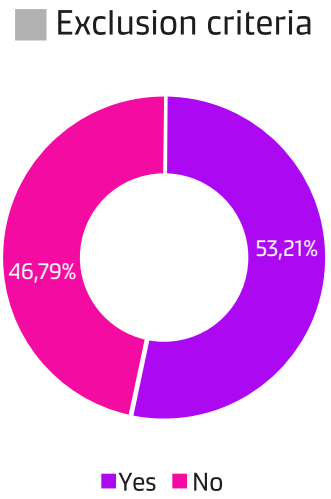

Figure 48. / Staff sample and exclusion criteria (N=487)

Exclusion criteria included severe mental disorders (n = 121) and drug/alcohol use (n = 74). This was followed by sex work (n = 31) and not being able to pay established fees (n = 29). The remaining exclusion criteria reported in frequencies below 8,49%.

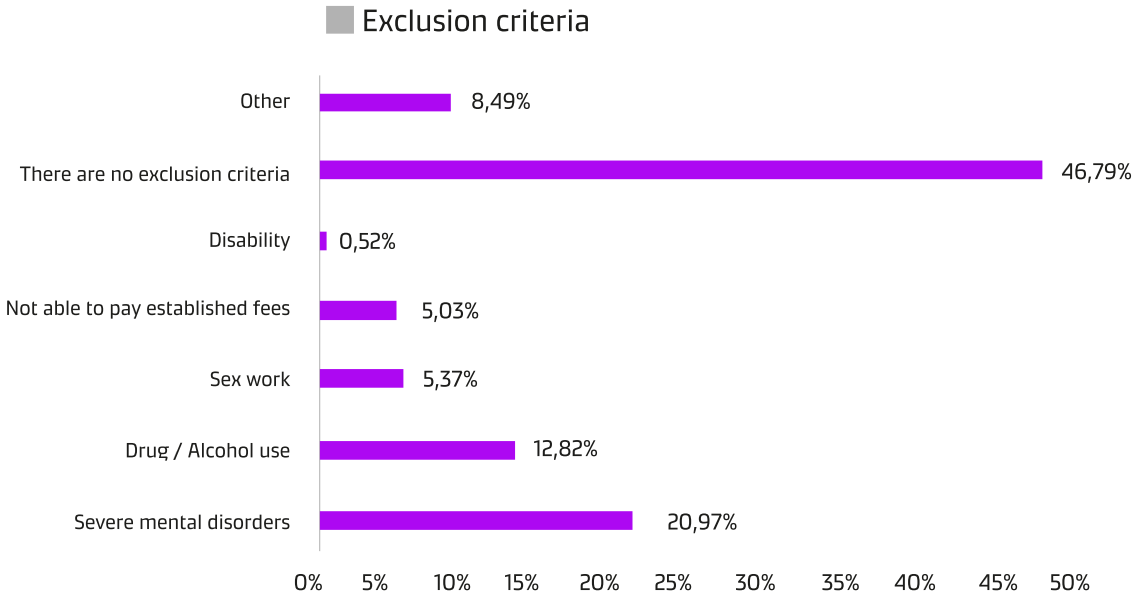

Figure 49. / Staff sample and exclusion criteria types (N=259)

Regarding the staff professional profile, a majority of psychologists (n = 419), social workers (n = 368), and educators (n = 310) were reported as working in these services. To a lesser extent, they are followed by nurses (n = 281), support staff (n = 270), psychiatrists (n = 263), volunteers (n = 246), and physicians (n = 233). Finally, peer workers (n = 157) and lawyers (n = 144).

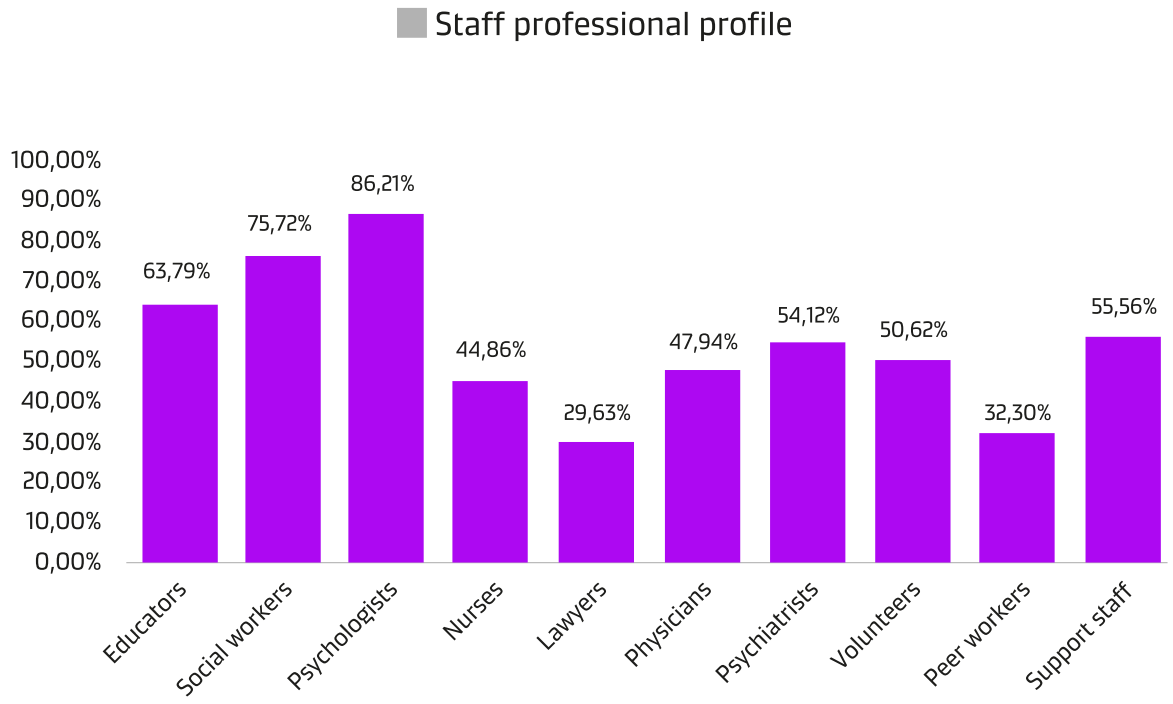

Figure 50. / Staff sample and their professional profile (N=486)

Professionals also reported that the services in which they work are mainly financed by public funds (n = 401), as opposed to private funds (n = 61) or other sources of funding (n = 24).

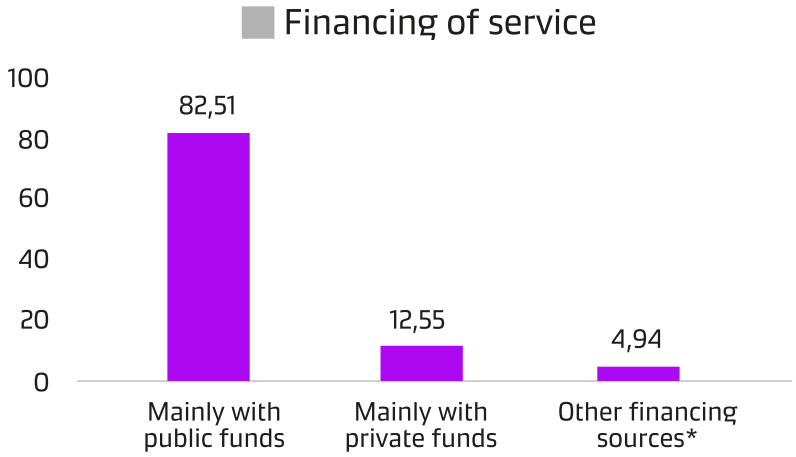

Figure 51. / Staff sample and services main financial source (N=486)

c) Description of the intervention

Regarding the type of service approach, the professionals surveyed mainly indicated the biopsychosocial approach (n = 265) followed by the reintegration into society approach (n = 221), the abstinence-oriented approach (n = 209), and the harm reduction approach (n = 195). It is followed by the rights-information and support approach (n = 153), and the integrated social care approach (n = 176). The trauma-oriented approach and the gender-based/feminist approach, the most linked to the gender perspective, are only reported in 26.13% (n = 127) and 24.49% (n = 119) of the cases, respectively. And the biomedical (n = 50) and legal (n = 44) approaches have the lowest prevalences.

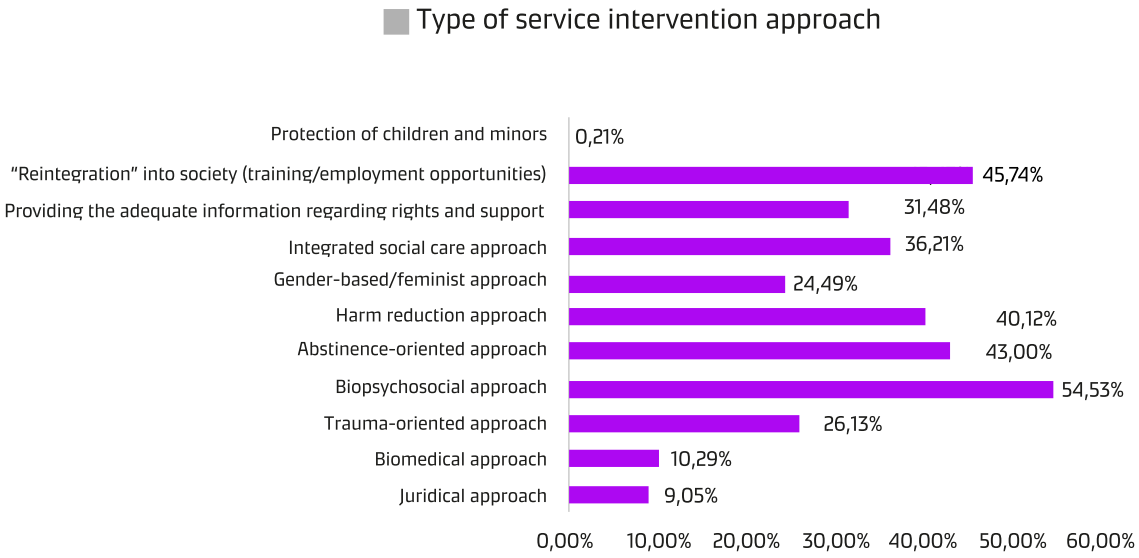

Figure 52. / Staff sample and type of service intervention approach (N=486)

By gender, it should be highlighted that more female professionals have reported that their services are working from the gender-based/feminist approach (27.63%, n = 105) compared to 11.7% (n = 11) of men ($p < .01$)[10]. In contrast, the opposite occurs in the case of the trauma-oriented approach, reported by more male professionals (31.91%, n = 30) than female professionals (23.68%, n = 90) ($p < .05$).

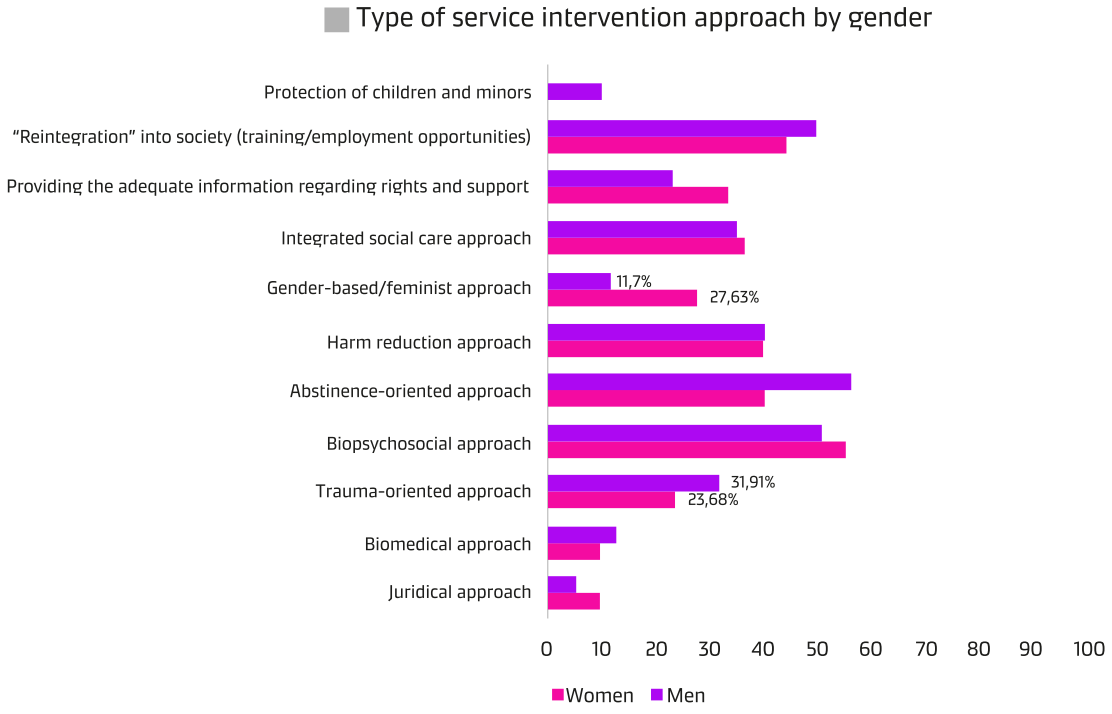

Figure 53. / Staff sample and type of service intervention approach by gender (N=486)

10 The percentages we compare have been obtained by dividing the values for men and women by the total sample of men and women, respectively; not by dividing by the total sample.

On the other hand, the majority of surveyed professionals have reported a sufficient (n = 201) or a lot (n = 219) adaptation of services to Covid-19 pandemic.

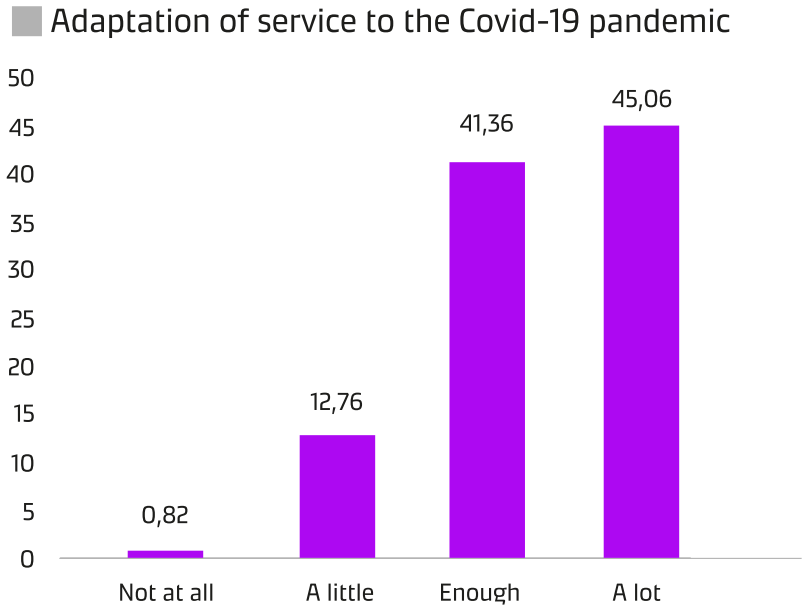

Figure 54. / Staff sample and service adaptation to COVID-19 pandemic (N=492)

Likewise, regarding general aspects defining the staff's current service, the professionals surveyed reported the highest frequencies for specificity (n = 239), innovation (n = 191), sustainability (n = 286), transferability (n = 214), networking (n = 284), and evaluation of the effectiveness and efficiency (n = 260) of the services in which they work.

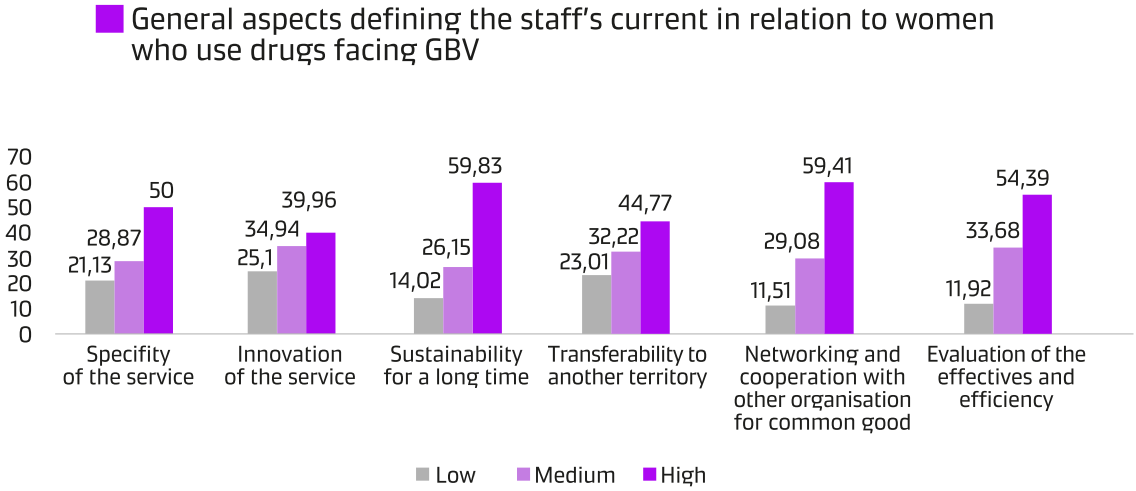

Figure 55. / Staff sample and generals aspects defining staff current service in relation to women who use drugs facing GBV (N=478)

As specific aspects defining the self-perception of the staff about the service they are currently working in, the empathy of the professionals towards women who use drugs facing GBV (n = 423) stands out; followed by mental health is taken into account (n = 411); the knowledge of professionals about drug use (n = 391); the autonomy/ empowerment of women is promoted (n = 376); social "reintegration" is actively promoted (n = 373); and the idea of belonging to a support network is taken into account (n = 349). That is, aspects that have traditionally defined most services and do not necessarily indicate that a gender perspective is being implemented.

Figure 56. / Staff sample and specific aspects defining staff current service in relation to women who use drugs facing GBV (N=482)

d) Best practices

As aspects to be improved, professionals have highlighted the knowledge of professionals about the interaction between drug use and gender violence (n = 260); knowledge of professionals about gender violence (n = 191); the empathy of professionals towards participants/users of the service (n = 165); low thresholds/flexibility for service access (n = 152); addressing issues that specifically affect women who use drugs and have experienced gender violence (n = 151); and the existence of spaces only for women (n = 151). These aspects are therefore very representative of the implementation of a gender perspective in care services.

Figure 57. / Satff sample and aspects to be improved in services aimed at women who use drugs facing GBV (N=478)

Finally, the professionals surveyed have mainly pointed to "integrated services for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective should be promoted" (n = 245) as the most desirable option for women who use drugs. This is followed by the option: "existing centres for people who use drugs need to better integrate a gender perspective, as specifically the GBV issue" (n = 161); and, eventually, the option "existing centres for women survivors of violence should be adapted to include women who use drugs" (n = 72).

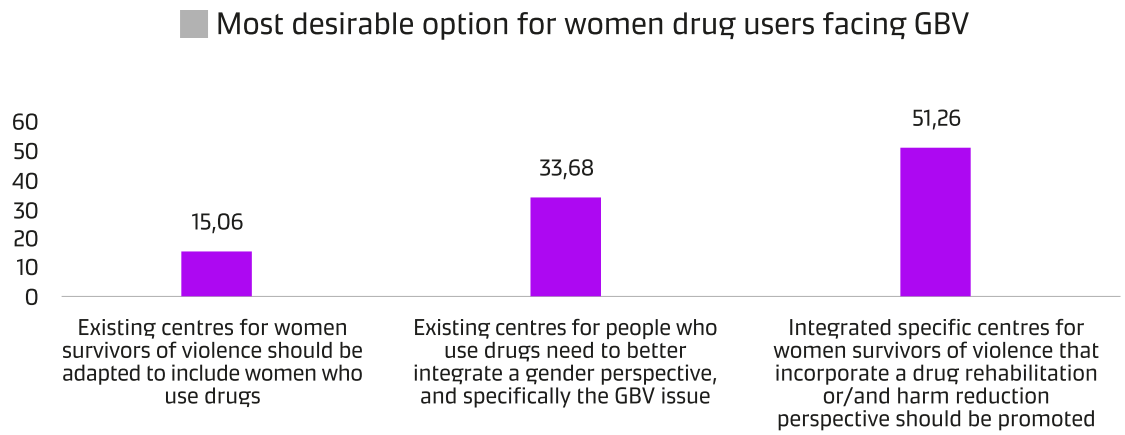

Figure 58. / Staff sample and most desirable option for women who use drugs facing GBV (N=478)

By gender, it stands out that significantly (p < .001) more women point to the option "integrated services for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective should be promoted" (n = 209) compared to men (n = 32)[11].

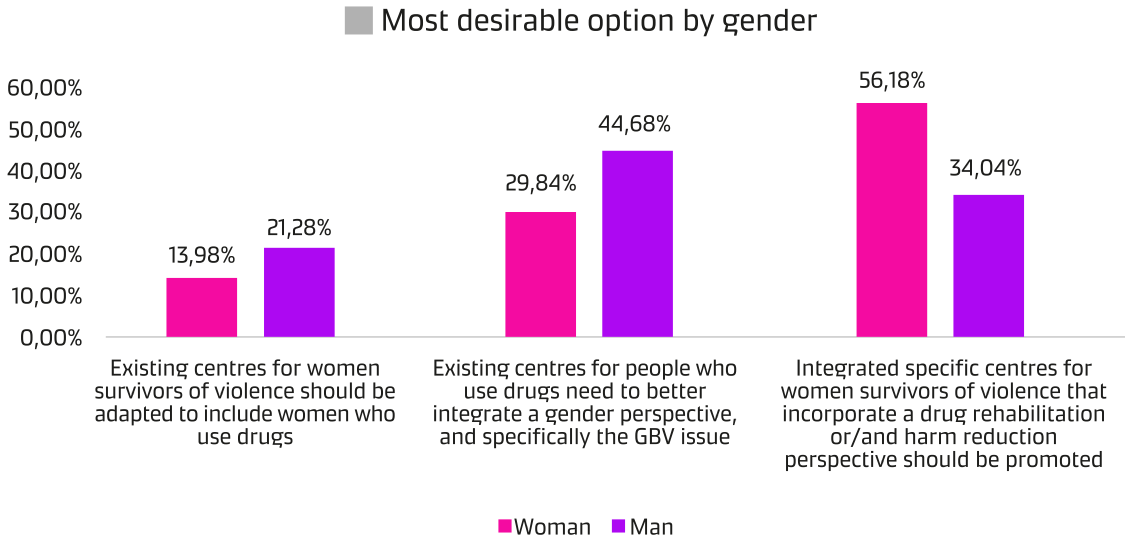

Figure 59. / Staff sample and most desirable option for women who use drugs facing GBV by gender (N=478)

11 The percentages we compare have been obtained by dividing the values for men and women by the total sample of men and women, respectively; not by dividing by the total sample.

3.2.3. Cross-overs

With regard to the cross-referencing between the variables of the two surveys, we observe the following:

1. Positive aspects that best define the service by type of service by staff

When we look at the aspects that define the services, both those that are "traditional"[12] and those that are considered to be mainstreaming gender perspective, we observe that integrated services aimed at women who use drugs facing GBV obtain higher percentages for all aspects, followed by harm reduction services, information and attention service for women (victim/survivor GBV) and then home/shelter for women.

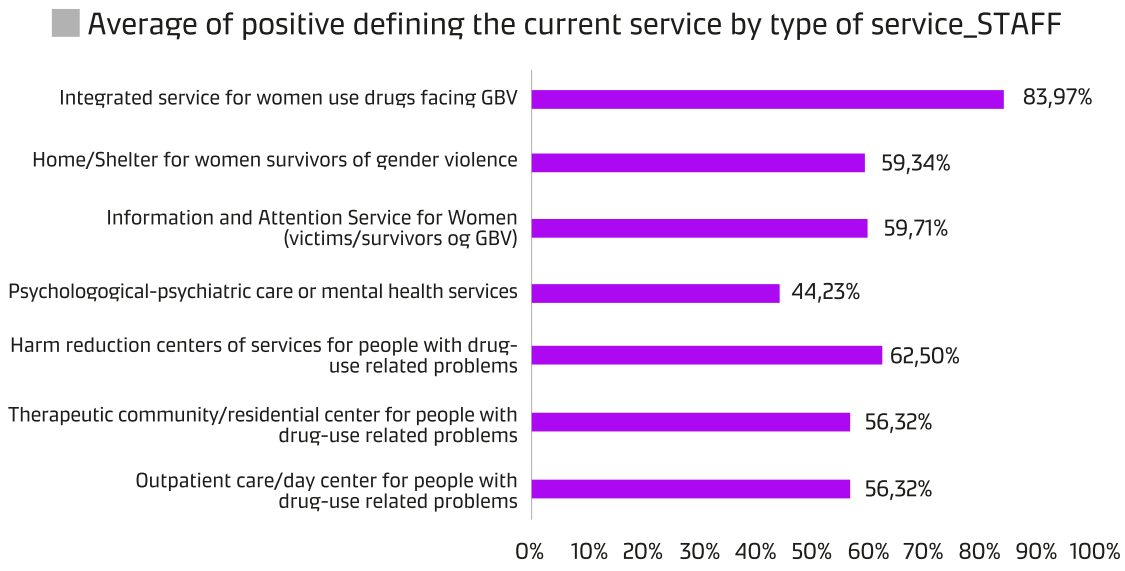

Figure 60. / Average of positive aspects defining the current service by type of service according to professional staff (N=482)

12 We considered "traditional aspects" "knowledge of drug use", "mental health", "belonging to a network" and "social reintegration". Instead we considered gender perspective-related aspects "knowledge of the interaction between drug use and violence", "the existence of spaces only for women, "addressing gender violence", among others.

The table with all values is shown below:

	Outpatient care/day center for people with drug-use related problems	Therapeutic community/ residential center for people with drug-use related problems	Psychological psychiatric care or mental health services	Harm reduction centers or services for people who use drugs	Information and Attention Service for Women (victims/ survivors of GBV)	Home/Shelter for women survivors of gender violence	Integrated service for women who use drugs facing GBV
Low thresholds/flexibility for service access	62%	48%	80%	38%	57%	37%	83%
The empathy of professionals towards women participants/users of the service	90%	87%	86%	88%	90%	89%	100%
The presence of peer-workers	19%	23%	66%	18%	5%	23%	39%
Knowledge of professionals about drug use	95%	93%	84%	75%	38%	29%	89%
Knowledge of professionals about gender violence	61%	58%	73%	55%	90%	89%	100%
Knowledge of professionals about the interaction between drug use and gender violence	68%	58%	73%	50%	48%	46%	89%
The existence of spaces only for women	40%	40%	27%	23%	57%	71%	100%
Addressing issues that specifically affect women who use drugs and have experienced gender violence	50%	42%	61%	25%	38%	11%	100%
Early detection systems and protocols for GBV are in place	22%	24%	25%	8%	48%	49%	61%
Addressing gender violence experienced throughtout the life of women, including relationship w/drug use	62%	56%	61%	45%	81%	54%	89%
Service regulations take into account the specific needs of women and their children	38%	51%	32%	25%	67%	80%	89%
The activity program takes into account the specific needs of women and their children	37%	49%	34%	23%	62%	71%	83%
The design of the spaces/facilities takes into account the specific needs of women and their children	22%	29%	23%	18%	52%	63%	72%
Mental health is taken into account	94%	88%	86%	83%	76%	86%	100%
Sexual and reproductive health and rights are taken into account	64%	57%	84%	53%	71%	80%	83%
Diversity is taken into account (sex orientation, ethnicity...)	73%	71%	86%	73%	81%	71%	83%
Women actively participate in the design, development and evaluation of the service	35%	50%	43%	38%	43%	34%	89%
Women support among women in the service is promoted	47%	76%	57%	55%	52%	71%	83%
The autonomy / empowerment of women is promoted	71%	83%	84%	68%	86%	86%	100%
Social "reintegration" is actively promoted	82%	84%	75%	58%	67%	89%	83%
The idea of belonging to a support network is promoted	74%	78%	80%	63%	62%	66%	83%
There is coordination with local networks, social movements and services to support women and other community services / organisations	69%	49%	68%	53%	76%	80%	83%
The coordination with peer networks for women who use drugs is promoted	43%	47%	61%	13%	33%	14%	78%
Socio-political activism is actively promoted	17%	14%	25%	18%	38%	20%	50%
Gender perspective approach is adopted	54%	45%	64%	28%	90%	77%	94%
Harm reduction approach is taken into account	72%	65%	86%	65%	43%	57%	78%
Average	56%	56%	63%	44%	60%	59%	84%

Table 2. Positive aspects defining the current service by type of service according to professional staff (N=491)

If we select only the traditional aspects associated with the description of services such as "knowledge of drug use", "mental health is taken into account", "belonging to a network" and "social reintegration", again the services with the highest percentages are the integrated services, followed by therapeutic communities and outpatient services.

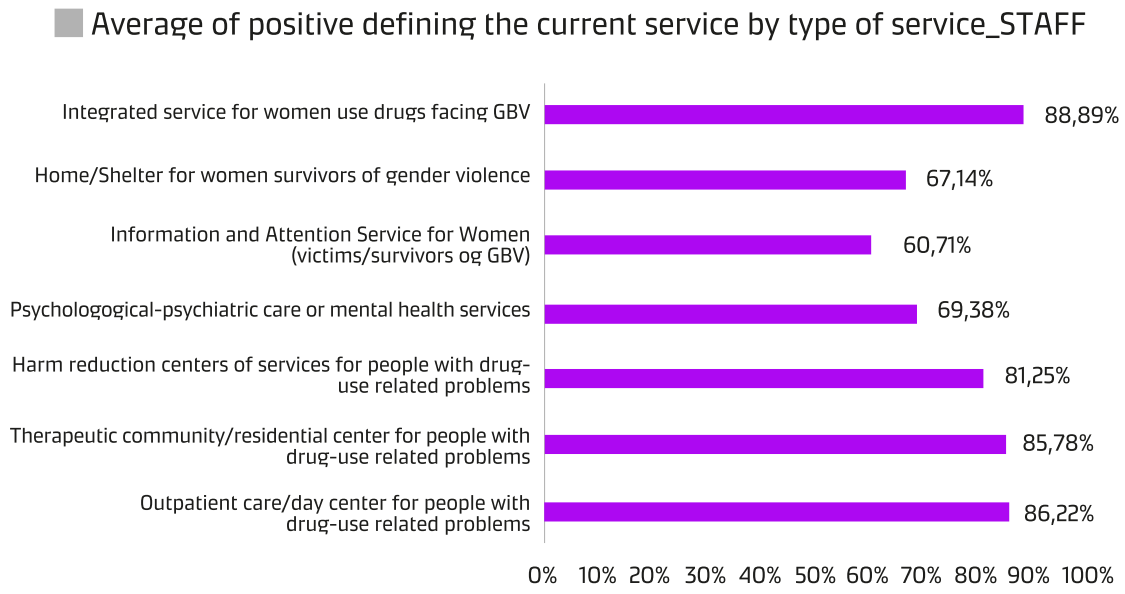

Figure 61. / Average of "traditional" aspects defining the current service by type of service according to professional staff (N=491)

When we look only at the most gender perspective-related aspects such as "knowledge of the interaction between drug use and violence", "the existence of spaces only for women", or "addressing gender violence", we find that integrated services (n = 19) are the ones that obtain higher percentages by far compared to the other services, followed by the information and attention services for women (n = 21), and harm reduction services (n = 44). What we observe from the table of results is that the integrated services incorporate aspects of the definition of more traditional addiction treatment programmes such as "knowledge of drug use", "mental health is taken into account", "belonging to a network" and "social reintegration" and also introduce fundamental indicators to work in a gender perspective such as the mentioned above. We believe that we need going beyond the traditional aspects of service definition to provide truly comprehensive services.

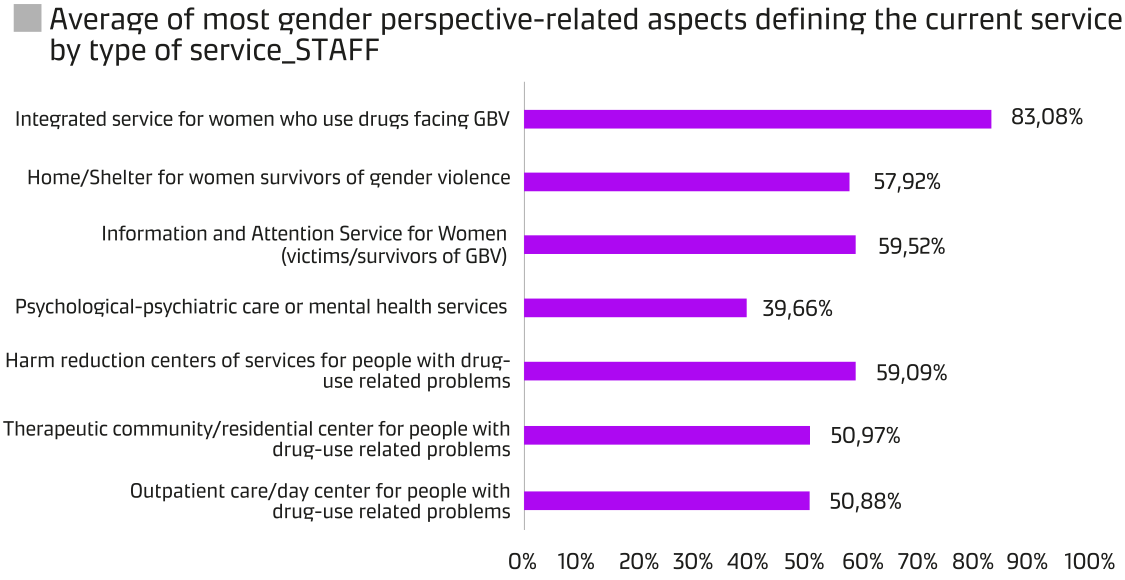

Figure 62. Average of most gender perspective-related aspects defining the current service by type of service according to professional staff (N=491)

2. Positive aspects that best define the service by type of service by WWUD

With regard to the surveyed women, the same pattern of response is observed in relation to the aspects that best define each of the services; therefore, again, integrated services aimed at women who use drugs facing GBV are the ones with the highest percentages in "traditional" and gender-related aspects, only "traditional" and only gender-related aspects:

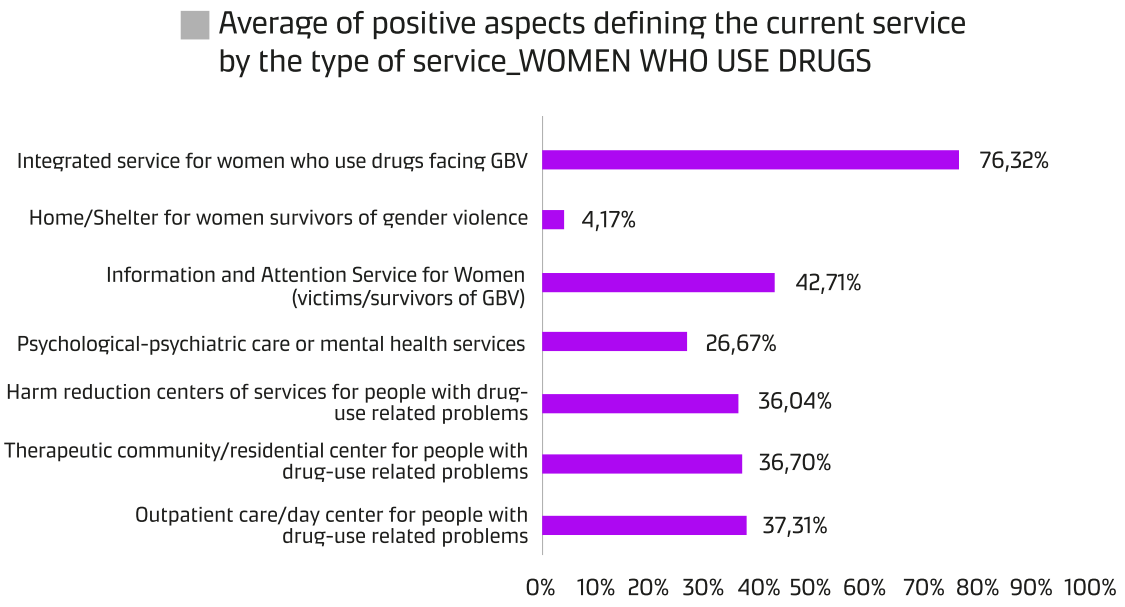

Figure 63. Average of positive aspects defining the current service by type of service according to women who use drugs (WWUD) (N=250)

The table with all values is shown below:

	Outpatient care/day center for people with drug-use related problems	Therapeutic community/ residential center for people with drug-use related problems	Psychological psychiatric care or mental health services	Harm reduction centers or services for people who use drugs	Information and Attention Service for Women (victims/ survivors of GBV)	Integrated service for women who use drugs facing GBV
Low thresholds/flexibility for service access	36%	14%	60%	32%	63%	63%
The empathy of professionals towards women participants/users of the service	52%	68%	70%	54%	63%	100%
The presence of peer-workers	42%	34%	40%	20%	25%	53%
Knowledge of professionals about drug use	44%	60%	65%	54%	75%	79%
Knowledge of professionals about gender violence	39%	40%	40%	36%	63%	74%
Knowledge of professionals about the interaction between drug use and gender violence	35%	46%	30%	28%	63%	79%
The existence of spaces only for women	38%	37%	45%	32%	63%	89%
Addressing issues that specifically affect women who use drugs and have experienced gender violence	35%	40%	30%	30%	50%	89%
Early detection systems and protocols for GBV are in place	35%	18%	25%	14%	13%	68%
Addressing gender violence experienced throughtout the life of women, including relationship w/drug use	36%	42%	15%	26%	50%	79%
Service regulations take into account the specific needs of women and their children	31%	37%	15%	18%	38%	74%
The activity program takes into account the specific needs of women and their children	37%	33%	25%	20%	38%	74%
The design of the spaces/facilities takes into account the specific needs of women and their children	33%	22%	15%	12%	38%	74%
Mental health is taken into account	36%	56%	95%	38%	38%	79%
Sexual and reproductive health and rights are taken into account	36%	28%	35%	18%	38%	79%
Diversity is taken into account (sex orientation, ethnicity...)	39%	39%	20%	26%	38%	79%
Women actively participate in the design, development and evaluation of the service	39%	39%	20%	26%	38%	79%
Mutual support among women in the service is promoted	34%	38%	20%	32%	25%	79%
The autonomy / empowerment of women is promoted	39%	48%	25%	38%	63%	84%
The idea of belonging to a support network is promoted	38%	78%	35%	14%	38%	79%
There is coordination with local networks, social movements and services to support women and other community services / organisations	38%	31%	35%	24%	50%	79%
The coordination with peer networks for women who use drugs is promoted	35%	21%	25%	16%	13%	63%
Social "reintegration" is actively promoted	38%	45%	35%	24%	25%	79%
Socio-political activism is actively promoted	30%	6%	45%	8%	25%	58%
Other that I prefer to describe	30%	1%	0%	0%	0%	0%
Average	37%	37%	36%	27%	43%	76%

Table 3. Positive aspects defining the current service by type of service according to women (N=250)

In line with the above, the graph for the "traditional aspects" defining the services is presented here:

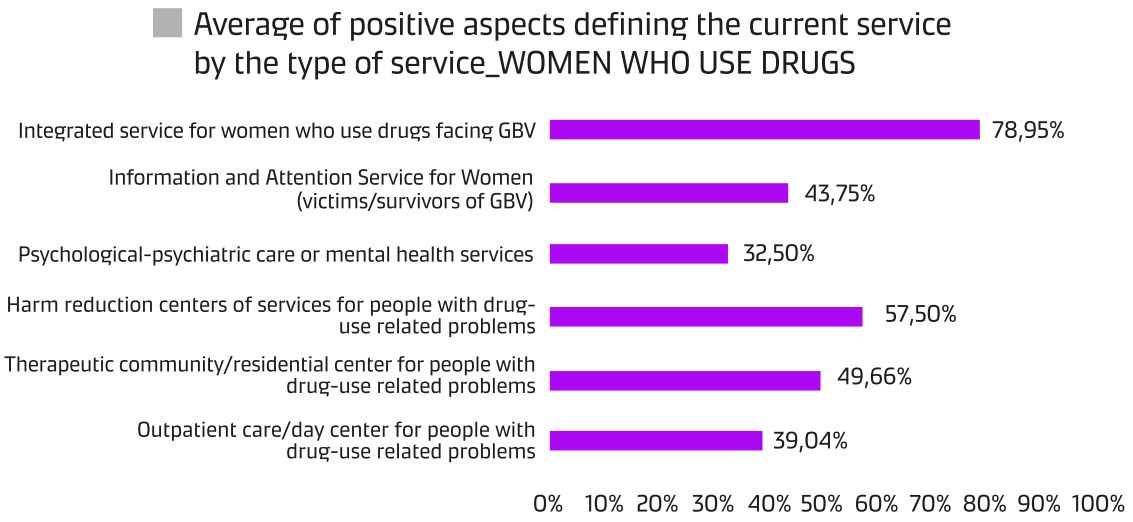

Figure 64. / Average of "traditional" aspects defining the current service by type of service according to women who use drugs (WWUD) (N=250)

And finally, the graph for the aspects only related to the implementation of gender mainstreaming in services:

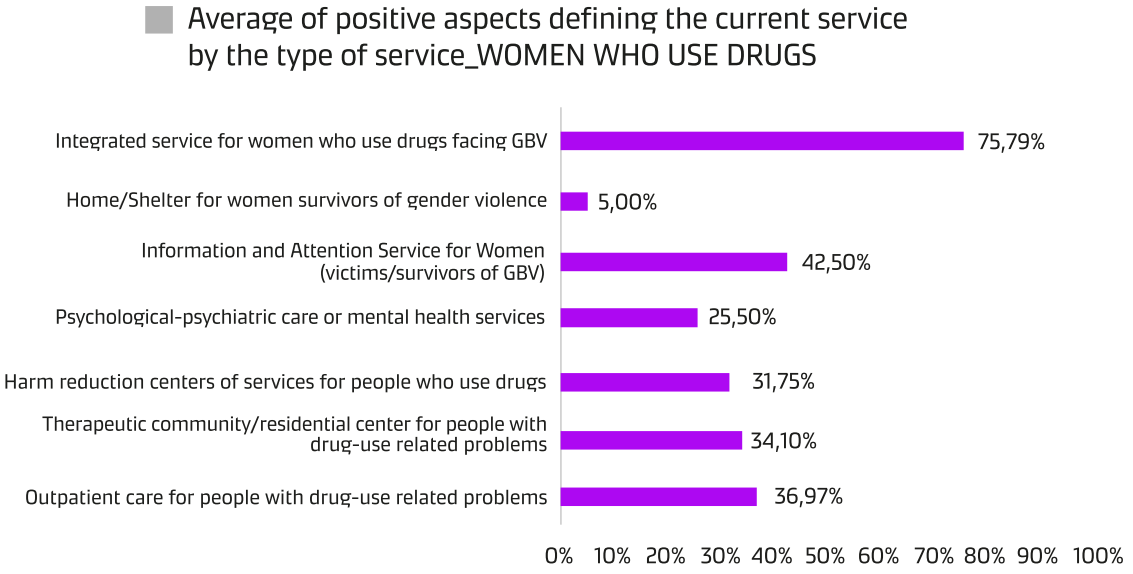

Figure 65. / Average of most gender perspective-related aspects defining the current service by type of service according to women who use drugs (WWUD) (N=250)

3.3. Focus groups

3.3.1. Focus groups with women who use drugs

The focus groups were structured in 3 parts:

1-The relationship between gender-based violence and drug use
2-Experiences in care services
3-Improvements needed in the care services.

1.- Relationship between gender-based violence and drug use

The first part of the focus groups focused on exploring the relationship between drug use and violence experienced by women throughout their lives:

> Connection between drug use and GBV:

Women who participated in the focus groups pointed to the relationship between the violence they had experienced throughout their lives and drug use, either as a cause or as a consequence of the violence they had experienced (or both):

*Yes, here I have learnt, apart from violence from the partner, there was violence the parents... **it is a violence that comes from the past**, so I think that drug use and violence is all influenced by how you have lived... (Woman/ Integrated service/Spain).*

***As long as you use drugs you obviously have to accept violence**. First of all, you must quit addiction (woman/Therapeutic community /Austria).*

However, while most of the women interviewed (especially those in integrated services for women who use drugs facing GBV) connected drug use with the violence they have experienced throughout their lives, some of them attributed drug use to different factors such as either the general effect of drugs on women, the type of drugs used, women's lower physical strength or low self-esteem:

***After substance use, women are more often affected from physical violence and rape**. There might be a higher risk of rape because women tend to be more submissive after using/abusing substances (woman/Therapeutic community/Austria).*

*A **loss of control is induced by party drugs e.g., knockout drops**. Due to lower physical strength concerning physiology of women compared to men, women are often easier to bear down and thus more often faced with sexual and physical violence. (woman/Therapeutic community /Austria).*

*Women are more affected by violence compared to men, **because of physical strength** (woman/ Therapeutic community /Austria).*

*It can be assumed that **people who suffer from low self-esteem in combination with alcohol abuse,** are more likely to be affected by psychological violence. (woman/ Therapeutic community / Austria).*

> Order of factors, drugs as a way to cope with GBV experienced or as a result of drug use:

Some of the respondents reported that the violence had started before their drug use did, meaning that the use of drugs was a way of coping with violence that was previously experienced.

I think that women firstly experience gender-based violence *and then find themselves in a position to use various means to alleviate the pain they experience due to the violence they have experienced (woman/Therapeutic community /Croatia).*

Also, other women reported that violence had started as a consequence of drug use or in drug use contexts:

More frequent drug and alcohol abuse leads to GBV*. Women move in circles in which they become victims and under the influence of various means have no tools to defend themselves (woman/ Therapeutic community /Croatia).*

Since we are addicted to drugs, ***drugs often put us in the position of HAVING to be physically and sexually abused in order to get drugs*** *(woman/Therapeutic community /Italy).*

My substance was cocaine... I wouldn't have to endure what I had to endure... but it didn't make me aggressive or anything, it took me to my world and I was the happiest woman in the world because I was in my world... 50 men could come along and put it in me because I was in my world... ***for me it was normal to consume in order not to accept all that pain that I was living through...*** *(Woman/ Integrated service/Spain).*

And finally, other women reported that the violence had occurred before and as a consequence of drug use:

Which comes first, the violence or the drug use? (facilitator) Both, yes, ***both options can be...*** *(Women/ Integrated service/Spain).*

In my experience, ***gender-based violence leads to drug and alcohol abuse, but the opposite often happens*** *(woman/Therapeutic community /Croatia).*

> Violence among women who do/ do not use drugs:

Women mainly expressed the idea that women who use drugs experience the same violence as women who do not use drugs:

There is mistreatment for those who use as well as for those who do not use... *there is a lot of news about women being killed, and these women do not use... so I identify myself as a woman... what we want is to continue living... (woman/Integrated and harm reduction service/ Spain).*

Speaking from my own experience, I think that ***women who use drugs or alcohol do not experience greater violence than women who do not use drugs or alcohol****. I experienced more violence before my addiction or before I started drinking (woman/Therapeutic community /Croatia).*

However, the idea that women who use drugs experience less or more violence than women who do not use drugs was also pointed out by some respondents:

I think women who use drugs experience less violence than women who do not use drugs. (woman/ Therapeutic community /Croatia).

I think women who use drugs experience more violence than women who do not use drugs. They are more vulnerable and prone to violence (woman/ Therapeutic community /Croatia).

> Types of gender-based violence experienced by women who use drugs:

Women also reported experiencing various types of violence throughout their lives:

Physical and psychological violence in several partners... I have been here for 3 months, ***I thought that the abuse originated when I started using, but I started to remember things from my childhood*** *and everything and the abuse comes from the family environment and with my husband... (Woman/ Integrated service/Spain).*

Various types of violence, ***physical, psychological, sexual, economic*** *(woman/therapeutic community/Croatia).*

If at 10 years old you are raped, at 12 years old you are prostituted and at 15 years old you are sold to a person who keeps doing the same to you... I think that I fell into drug use because I wanted to live like other people.... since I was 10 years old my life was destroyed, ***I have had a life of physical, psychological and sexual abuse****, and for me it was a life that I had normalised... (Woman/ Integrated service/Spain).*

Women also reported experiencing different types of violence in drug use contexts, such as sexual and economic violence:

A guy wants to fuck me... and maybe I'm a bit off, ***it happened to me, waking up and a guy is fucking me in a narco flat[13], you know?*** *And this happens... and it's something that... we're not going to go to a man and fuck him while he's sleeping, you know? It's disrespectful... well, it's rape, but it's full-blown rape.... (woman/Integrated and harm reduction service/ Spain).*

...one day a dealer called me saying: I have a client who is loaded [with money] and he always called me because I always say that I am a whore for money... then the dealer opens the door, takes me to the room with the guy and... in a cocky way, he takes out a wad of notes... I thought how nice, the dealer has already told him.... But you know what he says to me? I smoke a pipe and you blow me, come on... ***we smoke and we'll fuck all night, but I'm not going to give you the money...*** *(woman/Integrated and harm reduction service/ Spain).*

Additionally, women reported violence in the context of drug use and sexual and affective relationships. Abuse is described when the abuser does not use drugs and the victim does:

There is mistreatment that lasts for years... the guy sees the woman as vulnerable and rescues her and isolates her... then time goes by and this person has more and more paranoia and fears... and he becomes more aggressive... ***you are the bitch, if it wasn't for him who would love you, you are a junkie, at that time he was not using..*** *and one ends up prolonging the suffering... 17 years like this, what saved me was prison... I suffered a lot... (woman/Integrated and harm reduction service/ Spain).*

I think that if I hadn't been under the influence of drugs, I would never have let my partner do what he did to me, to be the victim of so much physical and psychological violence. (women/ Therapeutic community /Portugal).

Women have also reported situations in which the perpetrator uses drugs and drags the woman to consume with him:

I spent about 20 years with that person because I always fell again and he wouldn't leave me alone,

13 In Spain, apartments or houses where drugs are sold and also consumed.

*to the point of putting a restraining order against him because it was total harassment, he wouldn't let me live.... **He didn't stop until he got me to use, and then I used with him. He had me under control** (woman/Therapeutic community /Spain).*

***In order to be with him I had to use**, because when I was calm I couldn't stand him touching me... When he saw me well he would bring me drinks or whatever (woman/Therapeutic community /Spain).*

Finally, women have reported situations of violence by their partners when they were pregnant:

***Even when I was pregnant, I was the target of violence from my partner**, the father of my child. He did it more when he was high (women/Therapeutic community /Portugal).*

> Men who use drugs are not seen in the same light:

In general, women pointed out that being a woman who uses drugs is not the same as being a man who uses drugs. In this sense, women are seen as worse than men, as "bad mothers", prostitutes or sexually accessible, as desperate, disgusting and as an unattractive group because they have fewer economic resources than men who use drugs:

***Men who use drugs are looked at in a different way because they are men...** us women, look at this shameless one, look at this junkie, what a bad mother, what a bad person, look at that whore... that's the gender difference, they are here [points up] and we are here [points down] and we are trying to go up... but well... it's not looked at the same at all (woman/ Integrated service/Spain).*

*They were all men, and they judged me as a "bad mother"... for the fact that I was on drugs they called me a prostitute... **As a father you can have three children and be here and get high, but not if you are a mother** (woman/Therapeutic community /Spain).*

*If you are a woman who takes drugs they call you a **junkie whore** (woman/Therapeutic community / Spain).*

*The main problem is that the figure of the woman is stigmatised within society: the woman should take care of the house, the family, the husband. I**n the field of drugs, women, not reflecting the classic ideal of a woman, are seen as a desperate person**, a person who is worthless and who is therefore willing to do and suffer everything because she is alone and desperate (woman/Therapeutic community / Italy).*

*Hence, it seems that **drunkenness among women is seen as disgusting, although when men are drunk it is seen as funny**. I was ashamed every time, whether I was a little bit tipsy or fully drunk (woman/Therapeutic community / Austria).*

*Women who have experienced GBV and use substances don't have a lobby, **they are an unattractive group of people**. I assume they are a weak member of society because they have too little financial resources. Moreover, women are forced to stay with their partner to fund their drug addiction (woman/ Therapeutic community / Austria).*

> The gender of the perpetrator:

The majority of women who participated in the focus groups pointed to men as perpetrators of the violence they experienced throughout their lives:

*I think it was gender conditioned, at least in my case. **I think the violence was focused on me because I am a woman** (woman/Therapeutic community /Croatia).*
***I think violence is gender conditioned**. The woman is mostly in the position of a victim (woman/ Therapeutic community /Croatia).*

***…there is a lot of abuse from men to women**, especially in the last few years in narco flats and everything, **just because we are women…** the woman has to be, using vulgar vocabulary speaking badly, putting her pussy out, for a pipe, that we are less than them, they use force, abuse… (woman/ Integrated and harm reduction service/ Spain).*

***Yes, there is a lot of abuse from them (men) who have the power**, because they have the substance… and the girls who are vulnerable, of course… (woman/Integrated and harm reduction service/ Spain).*

***It's mostly men…** (Undocumented racialised trans women/ Integrated and harm reduction service/ Spain).*

***Yes, yes, all men…** (woman/ Integrated and harm reduction service/ Spain).*

***In this territory [drug use] it is them (men) the ones who have the upper hand…** I have seen women who are also very bitchy… but very few! (undocumented racialised trans woman/ Integrated and harm reduction service/ Spain).*

Some women explain or seem to justify men's violence on the basis of physical strength, hormonal characteristics and/or emotional needs:

***Men are physically stronger than women** (woman/Therapeutic community /Austria).*

*Men are more likely to be violent. Women are meaner in a verbal way. When I was younger, I have experienced that women wanted to go out with the aim to meet men. Whereas men wanted to go out to fight with other men. **Perhaps this is due to the hormone testosterone.** (woman/ Therapeutic community /Austria).*

*It may also be **an expression of helplessness for them**, it seems this is the only way to solve the conflict (woman/ Therapeutic community /Austria).*

*Annoying men, **could be a form of protection** (woman/Therapeutic community /Austria).*

Also, to a lesser extent, fewer women have reported women as perpetrators:

***Women also assault…** (woman/ Integrated and harm reduction service/ Spain).*

*I have been **mistreated by my mother together with my sister…** (Woman/ Integrated service/ Spain).*

In this sense, some women explain their experience through the stereotype of "women's rivalry":

*What there is…is a lot of **rivalry between women…** when a new one arrives in the neighbourhood I tell her, you don't know what has happened to me, be careful… but after a few months they go crazy… (woman/ Integrated and harm reduction service/ Spain).*

Also, under the gender myth of the "evil woman, even worse than men…", women are blamed for provoking violence in men:

*My experience is that **women can be very annoying towards men, then men lose control and become violent** (woman/Therapeutic community /Austria).*

And the focus of violence is also put on drugs in order to point the finger at women as aggressors:

*I have experienced **aggressive women in different groups for alcoholics** (woman/ Therapeutic community /Austria).*

Finally, few women pointed to the idea that both men and women can be perpetrators or that violence is genderless, a belief also found among the general population (Plaza et al., 2022):

***I cannot confirm that violence can be allocated to one gender**. In general, there are inhibited and adapted people when it comes to aggression (woman/ Therapeutic community /Austria).*

***I don't think violence is gender-based**. Both women and men experience it, perhaps only men talk less about it. Although I think that a different kind of violence is directed at remakes than men. They definitely experience more psychological and sexual violence. (woman/ Therapeutic community / Croatia).*

>Drugs as main risk factor of violence

On the other hand, the majority of women in the focus groups indicated that, either "drugs" in general or "certain drugs" such as alcohol and/or cocaine or even the lack of drugs could facilitate or even cause violence:

***Alcohol brings out the aggressiveness in anyone...** (undocumented racialised trans woman/ Integrated and harm reduction service/ Spain).*

*Alcohol might make you most aggressive, **the potential of aggression increases**, and you become unrestrained (woman/ Therapeutic community / Austria).*

*Last relapse was six years ago. I felt sorry for myself and in all my misery I didn't have experienced anyone being aggressive towards me. Although **I was aggressive towards everyone after consuming alcohol** (woman/ Therapeutic community /Austria).*

*Cocaine and alcohol are there; **cocaine makes you crazy...** (Woman/ Integrated service/Spain).*

*My impression is, that **people who consume cocaine and alcohol might be more aggressive** than people who consume cannabis and morphine (woman/ Therapeutic community /Austria).*

***Methamphetamine transforms you...** I can assure you... (woman/ Integrated and harm reduction service/ Spain).*

***MD makes some people very aggressive too..**. (woman/ Integrated and harm reduction service/ Spain).*

***The drug calms you down, but not having it makes you violent..**. (woman/ Integrated and harm reduction service/ Spain).*

*In the midst of heroin addicts, robbery can also occur **because of the need to procure the substance** (woman/ Therapeutic community / Austria).*

***Due to the illegal system of drug procurement**, it is different from legal procurement of alcohol (woman/ Therapeutic community / Austria).*

***A person's aggression isn't always related to substance abuse, but substances automatically lead to being aggressive** (women/ Therapeutic community /Italy).*
Drugs serve to justify men's violence and women's submission and vulnerability, without addressing the perpetrator's male chauvinism in a patriarchal context:

*Certainly, the abuse of knock-out drops needs to be pointed out. **After using it, men become violent in form of sexual abuse afterwards** (woman/ Therapeutic community / Austria).*

Guys when they start with alcohol they become abusive.. *(woman/ Integrated and harm reduction service/ Spain).*

My experience is, that ***cocaine increases men's propensity to violence*** *thus men feel very strong after consuming cocaine and alcohol (woman/ Therapeutic community /Austria).*

It is more common to give women ***party drugs, with the intent to make them more submissive*** *and willing (woman/ Therapeutic community / Austria).*

Drug use is also thought to be reinforcing male gender mandates such as feelings of power or possession in the context of a break-up:

A conflict escalates quickly after consuming alcohol. *A big problem is if someone, especially men, can't cope with a breakup (woman/ Therapeutic community /Spain).*

On the other hand, some women have expressed that drugs are not the cause of violence, but rather the patriarchal context in which they are consumed; note that this narrative is only expressed among women in gender perspective-integrated services:

But it is not the cause... it is explained because he is an abuser, a macho man (male chauvinist)... *for me one thing has nothing to do with the other, alcohol itself has nothing to do with it, because the person who was with me did not drink alcohol, he used drugs, he was nothing and in the street he was (is) a beautiful person and he took my life, I came here dead in life.... It's machismo, I am the man, I can do it, I am the one in charge here, and it's something that still needs to be worked on in this society... (Woman/ Integrated service/Spain).*

I think it's cultural, come on... *(Woman/ Integrated service/Spain).*

But this depends on the context and the ghosts you have... *(trans woman/ Integrated and harm reduction service/ Spain).*

I think it's cultural, come on... *(Woman/ Integrated service/Spain).*

But this depends on the context *and the ghosts you have... (trans woman/ Integrated and harm reduction service/ Spain).*

> Other axes of discrimination

Furthermore, some women have reported feeling made vulnerable by other axes of oppression in addition to the fact that they are women who use drugs:

Any form of discrimination *and therefore addiction exposes a woman to more violence because she is in a position to be viewed differently by society, she is much more vulnerable especially if she does not have a support network in her environment (woman/ Therapeutic community /Croatia).*

[About mental health] *in the context of drug use you cannot afford to be fragile, to show your weaknesses. The world of drugs is made up of bad people, all waiting for you to discover your weaknesses and use them to harm you (woman/ Therapeutic community /Italy).*
I know a lot of gay, lesbian, transgender people who started using drugs because they were angry with a society *that didn't accept them, that made them feel wrong (woman/ Therapeutic community /Italy).*

> Believed they deserved to be assaulted

Women in the focus groups also reported feeling that they deserved to be assaulted because they were drug users:

*Being an addict, **I was punishing myself and I was thinking that I deserved to be mistreated**, my lifelong pattern is a violent men... (Woman/ Integrated service/Spain).*

2.- Experiences in care services

In the second part of the focus groups, experiences in different care services, both specialised (such as drug or GBV services) and mainstream (such as health or social services), were discussed:

a) Specialised services:

> Integrated Services aimed at women drug users

Some women in integrated services have pointed out that important issues related to gender mainstreaming in drug services are being addressed; for instance, the connection between drug use and the violence experienced throughout life is revealed as liberating the sense of guilt and judgement that women who use drugs have been subjected to:

*...We are learning so many things, we have groups for everything, ...addiction group, empowerment group, abuse group, violence and addiction group, social skills... we do the **life line**, it took me 4 months to do it, but there I could see so many things... **that is, violence with addiction...** You know that you can speak, that **you are not judged**, that you can express yourself, be yourself, you feel reflected in the story of the companions... (Woman/ Integrated Service/ Spain).*

*I was blaming myself for everything, every act of aggression was my fault, my drug use was my fault... and when I **discovered here many things about violence, for me it was a relief because I was able to get rid of the guilt**, and not judge myself so strongly and start to improve my self-esteem... (Woman/ Integrated service/Spain).*

In addition, they point to the possibility of accessing treatment with children:

***I think it is very important what they are doing here to be able to bring their children here**, and that will give more strength to the mother, they are children who are with their mothers and they are doing their therapy here..... how nice isn't it? we help you... don't worry, we are here and we are going to help you (Woman/ Integrated Service/ Spain).*

Besides, women in integrated services positively point out that women's spaces are led by professional women who provide a sense of safety and to free speech:

*There is a need for more spaces like this, **where the therapists are women, the educators are women, who listen to you, don't judge you, you can open up more**, ...and your life changes... (Woman/ Integrated Service/ Spain).*

Finally, women in integrated services point out the idea of attributing agency / empowerment to women as the protagonists of their life processes:
***We choose objectives that we have to achieve in each phase and they are our objectives, not theirs... this involves you in the process because you are the protagonist...** they tell us that they are behind you, they accompany you, but we are the ones who decide... this empowers you because you see progress, you see that you can do it by yourself...I have freed myself from a lot of guilt, now I like myself, I like who I am... (Woman/ Integrated Service/ Spain).*

> Integrated and harm reduction service:

In the scope of an integrated and harm reduction service, the promotion of mutual support among women is pointed out by the women participants in the focus groups:

Here, we women support each other... *(undocumented racialised trans woman/ Integrated and harm reduction service/ Spain).*

> Women's shelters:

However, in relation to women's shelters in Austria, their lack of safety, the difficulties of access and the temporary nature of these services are pointed out:

I don't think so [whether or not they are safe] because, if a man is looking for a woman, he will find her easily because ***women's shelters are not sufficiently guarded*** *(woman/ Therapeutic community / Austria).*

From my own experience I know that you must be registered in advance, and ***there is a limited number of beds*** *(woman/ Therapeutic community /Austria).*

Women's shelters ***are just a temporary solution*** *and not made for a long stay (woman/ Therapeutic community /Austria).*

In addition, situations of institutional violence by mostly male professionals have been reported, in a shelter for women in Spain:

I suffered physical and verbal aggression, in a women's shelter... *there were many men (professionals), 70% male, in a women's centre where there was no respect for the girls' privacy... there was no respect... we are supposed to be there because we need this service... the women are not there only because of drugs, there are women there who have been abused, women who have suffered many other things and there is no empathy... like a prison... (undocumented racialised trans woman/ Integrated and harm reduction service/ Spain).*

> Therapeutic communities and/or residential centres:

In therapeutic communities, women have pointed out the lack of places for women or simply the lack of women:

In some cases, I have found myself in mixed therapeutic communities where there are ***4 places for women and 36 for men...*** *(woman/ Therapeutic community /Spain).*

In some cases, I found myself in mixed TCs where ***I was the only woman...*** *(Woman/ Integrated service/ Spain).*

It also points to the fact that they are more focused on addiction than on violence experienced that seems to be basically not considered:

I went to a mixed TC for 5 weeks and I don't know... it was different, ***more focused on addictions than on violence...*** *there were more men than women... (Woman/ Integrated service/ Spain).*

Difficulties of access for children and their consequences have also been pointed out:

I didn't accept therapeutic community because ***I didn't want to be separated from my daughter****, but I had no choice: either I came or they took my baby away (women/ Therapeutic community / Portugal).*

I was able to leave my daughter with my parents before entering therapeutic community but then I had a lot of obstacles to see her during the process... *They signed her up for dance lessons and then they wouldn't let me go to see her at an exhibition. They let me go to the doctor, but they didn't give me permission to go with my daughter and in the end, for work reasons, nobody from my family went to see her... I don't know, I had a very bad time, there were educators who didn't see that I wanted to see her, I had many problems to manage visits with my daughter... one day she came to see me and then there was nobody who could take her home and on top of that I was crushed... after a while I went back to that centre and they recognised that at that time there were things that were not contemplated... (Woman/ Integrated service/ Spain).*

Two women in therapeutic communities highlight the security that the service has provided them with the possibility of accessing them with their children, which is not common in most therapeutic communities, as shown above. One of them also highlights the fact that she has been able to talk about the violence she has experienced in her life:

If I hadn't found this therapeutic community, I would never have gotten out of my addiction, I would probably have lost my son and I would certainly still be close to the man who beated me, insulted me and treated me as if my life had no value... ***because without the certainty of having a place to take refuge, without being sure of having help for me and my son, I would never have left*** *(woman/ Therapeutic community /Italy).*

The survivors' centre collaborates with the therapeutic community where I am. In the community ***I am talking about the violence suffered and my son is also... with a psychotherapist*** *to process the violence he has seen. But the public services never ask me about this part of my journey, they are focused only on physical healing (woman/Therapeutic community /Italy).*

The lack of an LGTBIQ+ perspective in this type of services has also been pointed out by one of the women participating in the focus groups in Spain:

I couldn't even say my sexual orientation, and when they found out there were people who treated me bad psychologically*. I left this therapeutic community; the team didn't know how to stop it (woman/Therapeutic community /Spain).*

In addition, several situations of institutional violence have been reported in the context of these residential services. Fear of violence from other service users:

*It would be more helpful for women to visit a women's shelter. I****n one specific public facility in Austria, abusers and violent men are accommodated****. I didn't dare to talk about personal topics in the group therapy because I was afraid what would happen after the therapy sessions, when we will be back together. I assume that a facility only for women would improve the safety of the space (woman/ Therapeutic community / Austria).*

Sexual harassment by one of the professionals in a therapeutic community is also denounced:

I reported an educator to a colleague because he was rude... the colleague went to pick her up from a place to go to the centre, and instead of going to the centre, he went somewhere else... and then we were talking about it with the rest of the colleagues and it was the same... ***a nasty guy, what we say a nasty guy, looking you up and down and it seemed like he was drooling.... and then we knew of other cases of girls who had been in the centre and that the same thing had happened to them... I felt harassed by the guy****, then I understood it... The psychologist and the director told us that we could report it, that they supported us, at that moment I was a bit like this, like... how strange that they don't report it themselves, right? over the years I realised, of course, they didn't want to be involved... I don't know if this person had some kind of connection or what, but* ***the truth is that I was there in 2012... and this person was working in the centre until last year...*** *it was a public centre, free, it belongs to the State, then they transferred him to another service in the same centre.... (Woman/ Integrated service/ Spain).*

Or even the heart-breaking testimony of this woman speaking out about the physical violence experienced through the use of a restraint chair in one residential centre in Spain:

I was in a therapeutic community... in 2011-2014... the experience was good... I was in a therapeutic centre for behaviour modification... I didn't accept any rules, I was there for using joints, for running away from the supervised centre and aggressive behaviour.... they put me there and the first thing I hear, a chair... and I see 5 girls there... first when you arrived they had an admission protocol, they shaved you in case you had lice... they showered you, they made you piss in front of 3 people... and shower in front of them, you know? And then they would come with a little pot with crushed pills and you had to take it and if you didn't take it, the nurse would come and they would prick you in the ass, you know? I remember that this medication left you a cripple... the night medication was even worse... to annul you... and nothing, at the slightest restraint... ***once they tried to put me in the restraint chair and tie me up...*** *in fact there was a video on the internet because there is a girl who sneaked in with a camera pretending to be an educator, then she disappeared....* ***it was a huge wrought iron chair with 2 pieces of wood and then they had to tie you here and here [wrists] and to tie your feet here... the worst thing is that the restraint was not only done by an educator... it was done by an educator with 3 other people [3 users]...*** *I had to do so once... if you don't do that, you're not going to get out... for some things it's good, for others* ***it leaves you traumatised and super-medicated..*** *I entered at 16 and I left at almost 19... it was said that there were educational corrections, not punishments... and my family paid 3.000 euros a month... (woman/ Integrated and harm reduction service/ Spain).*

> Outpatient services:

Another woman denounces the lack of connection between drug use and the violence experienced in the context of an outpatient service:

I sometimes think that I don't know why I have been going to the CAS (outpatient service) psychologists for so many years... it is clear that if I use drugs it is my responsibility, but I don't know what is wrong, ***they just do not understand*** *[the relationship between drug use and violence]... (Woman/integrated service).*

> Dual pathology services:

Another woman pointed out the fear of encountering a perpetrator in the context of a dual pathology service:

I was waiting to enter a dual pathology service... but ***I was afraid of meeting whoever I met..*** *and I preferred to enter here (Woman/ Integrated service/ Spain).*

> Services aimed at homeless people:

The same applies to services aimed at homeless people, which are described as very masculinised and unsafe for women:

I speak for women who have passed through here... ***they have decided not to go to shelters aimed at homeless people.... due to fear of meeting people who would attack them****, not former aggressors but people who would attack them... because of the situation there, where there is zero control over consumption...and very masculinised environments... (Woman/ Integrated service/ Spain).*

I ***would rather go to the street than going to a shelter****, I'm telling you...besides there are men mixed with women, no, no, no, no... I don't see myself in a place like that...I think it's good that there are things like this...for women... (Woman/ Integrated service/ Spain).*

One day in a shelter home aimed at homeless people, a guy comes up behind me and punches me... *and I see him running away... (woman/ Integrated and harm reduction service/ Spain).*

> Other not defined specific services:

In general, the lack of connection between drug use and violence experienced in specialised services is reported:

I was in therapy doing therapies and I didn't realise that I was a victim of GBV, nobody told me... until here they taught me... I always said: I don't know if I have depression because I drink or I drink because I have depression... and the root of all this was violence... I was treating addiction in various ways in various centres in Poland, but the therapy was always based on guilt: you have done this, this and this, take responsibility... (Woman/ Integrated service/ Spain).

...Violence experienced is not being assessed by services, rather symptoms are treated. (woman/ therapeutic community Austria).

I think that in our system the problem of experiencing violence and drug use as a link is not recognised as a problem. I have experienced this on my own and experts are usually not dedicated enough to this problem, i.e. they put some things under the rug. They focus more on addiction. (woman/ Therapeutic community /Croatia).

*With some good psychologists and social workers, I think [the relationship between use of drugs and GBV] is recognised. It depends on who you tu*rn to for help (woman/Outpatient care for people with drug-use related problems/Croatia).

In general, fear of violence from other users (former perpetrators or not) has also been reported:

In these adult facilities there are violent people, which is noticeable by the negative atmosphere. There is no relaxing at all. (woman/ Therapeutic community /Austria).

[avoiding services due to encounters with perpetrators] yes, yes, from my experience I can confirm that this happens (woman/ Therapeutic community /Croatia).

Even violence by service professionals again:

Yes, violence by professionals is often present, at least on a psychological level (woman/ Therapeutic community /Croatia).

> Public/ Private services:

Some women in Austria have also pointed to difficulties in specialised public services such as poorly trained professionals, lack of staff and long waiting lists, resulting in poorer quality treatment for those without financial resources:

People with less money cannot afford good therapy, because public health insurance schemes only cover part of the costs. *Sometimes the therapist hasn't even finished their finished with the education. Overall, wealthy people can afford better treatment (woman/ Therapeutic community / Austria)*

A lack of staff in the facilities *is a problem (woman/ Therapeutic community / Austria).*

Normally, there are ***long waiting lists*** *for public services (woman/ Therapeutic community / Austria).*

b) Experiences in mainstream services:

From the mainstream services, there have been multiple reports of neglect and/or institutional violence by the women who participated in the focus groups:

> Social services:

Again, support services did not consider the relationship between violence experienced throughout life and drug use:

*30 years knocking on doors... **if in 30 years I was not helped because of my sexual abuse...**, even the social worker who dealt with my case when my children were younger said she does not know me.... what can I say, everything is set up really poorly... I think that if they had supported me before as they are doing now maybe many things that have happened in my life would not have happened to me...it is called institutional violence (Woman/ Integrated Service/Spain).*

One woman says she felt she did something wrong by being taken away from her family when she reported violence perpetrated by her brother while he stayed with the family:

***I suffered violence from my brother. I, who was 10 years old at the time, was removed from my home, from my family, while my brother remained under police surveillance at home. The first thing I thought was, why did I report?** They pushed me away from my family, not him, so I'm the one who was wrong (woman/Therapeutic community /Italy).*

> Health services:

In the health services, one woman said that she was not believed in relation to the violence she had suffered, despite the marks of violence on her body:

*A forensic doctor saw me, I had bruises here on my fingers, on my thighs...but **the guy didn't want to believe me...** (Woman/ Integrated service/ Spain).*

Another woman explained feeling judged by sexual and reproductive health services:

The other day I went to the gynaecologist, because I wanted to get pregnant... And the woman told me in a few words that fuck, that I was under guardianship, ex-convict and ex-junkie... "DGAIA girl" told me ***(social services girl)...*** that's how clear she told me; and she told me that, for having gone to the CAS (outpatient service) for follow-up, the tests, what more reason would my child have to go to Social Services... you get all your records and ***they look at you badly and judge you...*** (woman/ Integrated and harm reduction service/ Spain).

In Italy, some women report feeling like "second class" patients to health professionals:

*[About the health services] We almost never have the precedence in receiving treatment, even when we feel really bad. Why? Because the first thought of health professionals is "you are a drug addict, you were looking for feeling bad. **You deserve to feel bad so now you'll wait to receive treatments** (woman/Therapeutic community /Italy).*
*[About the health services] **You already hurt yourself with your addiction, so even if you don't get treated right away it doesn't matter** (woman/Therapeutic community /Italy).*

[About the health services] it is as ***if we were "second class" people*** as if our health and well-being were not as important as that of others (woman/ Therapeutic community /Italy).

Another woman explains that she has felt blamed by health services for being a drug user when

seeking help for the physical violence she has received:

Many times, I have given up going to the emergency room to treat the wounds of the blows I have suffered. And many times, I have given up asking for help from the assistance services. I hated being looked at like that... as ***if they didn't see a wounded, broken woman just a drug addict. AS IT WAS MY FAULT*** *(woman/ Therapeutic community /Italy).*

Finally, another woman explains that she did not dare to go to the health services for treatment of physical injuries after an assault for fear of being blamed:

Once I was under the influence of ketamine, I was not aware of what was happening to me. When I regained my clarity, I did not remember anything. Only once I got up and started walking did I understand what had happened. ***I would have liked so much to access help, to be examined by a doctor etc. but I didn't have the courage... how do you go get help knowing they'll treat you like it's your fault?*** because if you weren't on drugs it wouldn't have happened, because if you were sober you could have prevented it. And so, I didn't ask for help because in addition to feeling bad about what had happened to me, I would have felt guilty (woman/ Therapeutic community /Italy).

> Police:

In addition, several women have reported situations of institutional violence in relation to the police:

I had an episode, so to speak, in which I was using and a car passed by with 3 boys, they closed in behind me, they pulled a knife on me, it was just to rob me but come on... I went to the nearest petrol station, they called the police there and the police just took me to my mother's house...and ***I imagine that maybe they noticed that I had been using or something... and they didn't give it the importance*** *it had because they didn't even want to go and see where the car was... (Woman/ Integrated service/ Spain).*

I was in my parents' house, my father raised his fist at me and cornered me against the wall and I was calling for them to come because I was afraid... in the end I wrote a WhatsApp to the police, but as they knew that I had a borderline personality disorder and this... ***and they knew that I had been to several police stations, and they knew that I had been to several psychiatric centres, they didn't listen to me****, I was the crazy one, I was the one who had to calm down, take a pill and put up with it because they were my parents and I had to understand them because they are also having a hard time.... and I told them, yes, but I called them because I was scared, I told myself that I would raise my fist and that I would kill myself...and they didn't listen...as you have a psychiatric background and you take pills...they think you are crazy, that you have forgotten your medication...have you taken all your medication? Yes, I have taken it all...I'm not crazy, don't treat me like I'm crazy...don't talk to me like that, they (police) told me, next time I'm not going to call you...and here let what happens, full stop... (Woman/ Integrated service/ Spain).*

I reported a rape and I was drunk and the policeman *who was standing behind the policeman who was taking my statement said:* ***I don't believe her!*** *(Woman/ Integrated service/ Spain).*

When I was filing the complaint against my last aggressor, he was harassing me a lot on the phone, threatening me... and he wrote the complaint, ***although I told him (to the police officer) that I did not have sexual relations with him, he told me "we are adults, it is not possible for a man to get like that if it is not because you are having sexual relations with him", and he put it in the complaint****. Then I read it in the underground and I felt very bad, and they didn't let me change it, that this is not important...Then at another time I didn't even dare to file a complaint because of how they had treated me the other time...then my psychologist called the chief of police to explain it and he*

called me and told me: "well, make yourself beautiful and come here and me with bruises all over my face...it's not serious...and I couldn't, I couldn't (Woman/ Integrated service/ Spain).

(in response to the previous experience another woman commented) ***It's institutional violence, from the State...***

(in response to the previous experience, another woman commented) If a woman goes to report a rape, for example, she doesn't go because she wants to go, it's something very personal...very intimate, and on top of that they don't believe you and they treat you as if you were the executioner, well, let them stay as they are... (Woman/ Integrated service/ Spain).

I was applying for protection because of the stalker and ***they asked me if I had a sexual relationship with him and when I said no, they denied my application.*** *Should I have sex with him to get protection? He keeps trying to stalk me... (Woman/ Integrated service/ Spain).*

They are bastards, especially the local police... the guys put me against a doorway and started to search me, they took my shoes off, I hadn't showered for a week and I told them, I wouldn't like to touch you, ***and then they beat me so badly that they left me on the floor...*** *when I went to the trial I told the judge: "Judge, for me this woman is neither a woman, nor a Mosso (local police), nor anything else, this woman is shit... because she has seen how 4 of her colleagues beat me up and how they have abused a junkie... because I was a drug user I was a junkie and they abused me... (woman/ Integrated and harm reduction service/ Spain).*

There was a national policeman who had a slimy face... one night he came with another colleague [policeman] who didn't know me... ***and he put a wad of cocaine in my hand and then he took it away... and he told me... because if I feel like it, there are your fingerprints and I say that you are a drug dealer...*** *if they want to fuck up my life... and they both looked like they had taken the "sweet" [have used drugs] and wanted to fuck me up.... (woman/ Integrated and harm reduction service/ Spain).*

Policemen... because they are men, because they have power, they carry weapons, they feel superior to us, it is male chauvinism at a higher level, they judge you... *and that is why there are many women at home who do not dare to report... how many women in their homes are silent, not daring... (Woman/ Integrated service/ Spain).*

I was raped by a stranger and was not under the influence of alcohol. I was just going home at night. But I have had bad experience with the police, ***they didn't believe that I had been raped and that I wasn´t high*** *(women/Therapeutic community /Portugal).*

[About the police] ***Why do they insult you? Because you are a drug addict and therefore you are You are worthless as a person****. You are quite meaningless for them (woman/Therapeutic community /Italy).*

> Law services

Finally, institutional violence in legal services is also reported:

Another very big problem is that the ***proceedings are too long!*** *It took them five years, from when we first reported the violence, to when they took me away... in five years they could have killed me (woman/Therapeutic community /Italy).*

3.- Improvements in care services

On the one hand, it was asked what should be done to improve specialised services and, on the other hand, mainstream services:

a) What can be done to improve specialised services?

On one hand, women have pointed to the need to create more spaces/services just for women who use drugs as safer spaces that are better able to address their specific needs:

There should be ***more spaces for women...*** *(Woman/ Integrated service/ Spain).*

There should be ***more places for women...*** *because there is a majority of men... (woman/Therapeutic community /Spain)*

.

I assume that a ***facility only for wome****n would improve the safe space (woman/ Therapeutic community / Austria).*

I think ***specialised treatment for women*** *is needed (women/Therapeutic community /Portugal).*

Again, women who have participated in the focus groups have reported the need to allow children access to facilitate women's access to treatment:

If the children can't go in with the mother, men's access to treatment is privileged*, what is that, male chauvinism again (Woman/ Integrated service/ Spain).*

Similarly, the need to allow access to pets, which can sometimes be a great support for women and/or limit women's access to treatment, has been reported:

There are women who don't go in because ***they don't want to give up their pets either*** *(Woman/ Integrated service/ Spain).*

On the other hand, women have suggested the need to make the criteria for access to services more flexible (in line with harm reduction services), so as to provide for drug substitution programmes and/or access for women who are (still) using drugs, including in women's shelters:

Furthermore, a ***drug substitute program*** *if needed would be helpful (woman/Therapeutic community /Austria).*

Only women should be accommodated, ***even while they still consuming substances*** *(woman/ Therapeutic community /Austria).*

An emergency service where women with drug-use related problems and violence experiences can stay for at least 48 hours. ***A place where they don't have to be afraid if they consume substances****. The aim should be a safe space to survive and escape from violent men (woman/Therapeutic community /Austria).*
Women have also insisted on the need for a less biomedical approach, in favour of approaches in which drug use and violence are addressed in a holistic way, pointing out the need for professionals in women's shelters to be trained on drug use as well:

More group therapies and conversations *than medications (woman / Therapeutic community / Croatia).*

Both issues, ***addiction and the experience of violence*** *are important and should be treated as one. It is important to consider them together (woman / Therapeutic community /Austria).*

***Staff of these facilities [shelters for women] must be appropriately trained**, to slowly figure out which kind of substances the client has used. If the staff is not appropriately trained, it will miss the target (woman/ Therapeutic community / Austria).*

Despite the results observed in relation to the empathy of professionals in the surveys (which obtained very high frequencies), some women have also pointed out the need to develop this professional skill:

*Staff should give clients patience, **understanding and be more sensitive** (woman/therapeutic community/ Austria).*

***...Empathy and perseverance** (woman/ Therapeutic community / Austria).*

In addition, some women have insisted that male professionals who care for women who use drugs in services should have to pass some kind of psychological test to prove their suitability; this was pointed out in relation to the experiences of sexual violence/harassment reported by some women:

***Psychological tests for the men who are in the centres...** (Woman/ Integrated service/ Spain).*

b) What can be done to improve care in mainstream services?

Firstly, women have indicated a desire to be cared for by women given the bad experiences they have had with male chauvinist professionals; on the other hand, with professional women they have generally felt safer, more confident, and this has given them greater confidence:

*T**hat we are care or supported by women, we will always be more heard...** there is a lot of male chauvinism, you go to the Mossos (the local police) and you are seen by a man... he is not going to assist you in the same way as a woman would, because I have been to the Mossos (the local police) here and the women have assisted me attended me wonderfully well; a man assists me, and I left crying.... and from the current service they had to call so that they could attend to me well; what there should be is more women facing up to all this...in hospitals, courts, police...we should defend ourselves amongst ourselves... (Woman/ Integrated service/ Spain).*

***With professional women it's like more, they treat you more as equals**, they look at you and understand you, it's different, you can talk to them and they understand you, they trust you, they believe you, they don't judge you... (Woman/ Integrated service/ Spain).*

On the other hand, women continue to insist on the need for psychological tests for professional men, especially policemen, pointing out that one-day training is not enough to change very male chauvinist's mind-sets:

***I would like to see the psychological test that police officers have to pass in order to have the accreditation they have...** with one day of training we are not going to change their mentality... (Woman/ Integrated service/ Spain).*

Finally, some women from the integrated services who participated in the focus groups displayed a feminist narrative pointing out the structural inequality experienced by women and the need to change this structure:

*There is a need for more training and more women in in higher up positions, more women in positions of power, more women as leaders' women who have studied and who stand up to them... **what happens is that in the political parties always have more men than women and the women are always***

behind, I would like to see women leading... *(Woman/ Integrated service/ Spain).*

As it is something cultural (patriarchy), the feminist movement, or the equality movement or whatever, is needed... *and going everywhere with messages about what is rape, oppression, how to report it. I think there has been a lot of progress in recent years and I don't think this is a thing that can get fixed overnight, this is a task that has to be done by raising the awareness of the governments so people can start changes... because I think we are starting, I think... it is clear that it still doesn't reach all contexts... (Woman/ Integrated service/ Spain).*

3.3.2. Focus groups with professional staff

Again, the first part of the focus groups focused on exploring the relationship between drug use and violence experienced by women throughout their lives:

> Connection between GBV and drug use:

Firstly, professionals point out that the relationship between drug use and GBV is not always understood:

They are ***two concepts (drugs and GBV) that are often conceived as unrelated*** *when they are very closely linked, and all the women I have worked with have survived violence (Women-Social Educator-In patient drug treatment centre-reinsertion apartments, Spain).*

Besides, gender perspective seems not to be considered:

Also, I find that when studies are carried out we always have the same participants, that ***the implementation of the gender perspective falls to one or two professionals****, it is always one person in a team who carries the baton and wears the [gender perspective] glasses, but that as professionals we get as far as we get, even the most high up person is worn out by this and there isn't a transversal or intersectional approach either... (Women-Social worker/ Director of a domestic violence shelter, Spain).*

> Order of factors, drugs as a way to cope with GBV or as a result of drug use:

Drug use is a way of coping with the violence experienced, a consequence of drug use, or both according to the staff who participated in the focus groups:

I find that GBV can more often lead to substance abuse in which women*, I guess, seek a way out of a difficult situation and try to ease what they are going through (woman/social pedagogue/Social welfare centre/ Croatia).*

I think addiction in women leads to GBV to the same extent as GBV to addiction*. In my work I encounter both cases and I would not say that something happens more often. It all depends on the woman, the environment in which she lives, the social network, and so on... (woman/peer worker/ Outpatient care for people with drug-use related problems/Croatia).*

> Violence among women who do/ do NOT use drugs:

Some of the professionals who were consulted consider that women who use drugs experience the same violence as women who do not use drugs:

Women who use drugs experience violence equally as women who do not use drugs*. At the*

social welfare centre we have both cases and in fact I think that violence against women is a general problem unrelated to the use of addictive substances" (woman/social pedagogue/Social welfare centre/ Croatia).

However, other professionals think that women who use drugs experience more violence:

***I think that women with addictions experience violence more often than women who do not use drugs** because they move in such societies where they are more exposed to violence. Likewise, many women with addictions are forced into prostitution in order to obtain drugs, and are thus exposed to violence on a daily basis (woman/social pedagogue/outpatient care for people with drug-related problems/Croatia).*

> Types of GBV experienced by women who use drugs:

In the case of the women who use drugs who were consulted, the majority of professionals who participated in the focus groups considered that women who use drugs experience different types of GBV, usually mixed:

***Sexual and physical violence** (woman/social pedagogue/Social welfare centre/Croatia)*

***All types of violence**, physical, psychological, sexual, economic... in general any type of conditioned violence, especially against women (woman/social pedagogue/outpatient care for people with drug-use related problems /Croatia).*

***Women with addictions are mostly faced with all kinds of violence**, psychological, economic, physical, sexual although not every woman goes through all kinds of violence at same time (woman/ peer worker/ outpatient care for people with drug-use related problems / Croatia).*

***Women with addictions experience all types of violence**. Although not all women addicts experience all types of violence, depending on life circumstances, I think they are most exposed to sexual and physical violence (woman/social worker/ outpatient care for people with drug-use related problems /Croatia).*

> Gender of perpetrator:

The majority of professionals consulted also reported that the perpetrators were mainly men:

*Y**es, I think violence is gender conditioned and women are more often victims of violence by men**. They are definitely less protected and the capacity to identify what is violence has been lost. A lot of what women experience is no longer seen as violence but as normal behaviour (woman/social pedagogue /Social welfare centre/ Spain)*

***I think that violence is gender-based and that women are more often victims of violence** (woman/social worker/ outpatient care for people with drug-use related problems /Croatia)*

However, some professionals indicated that both genders (male and female) or a non-specific gender could commonly be the perpetrators, so they pointed out to the belief that violence is genderless, as other studies have observed in the general population (Plaza et al., 2022):

***Violence is not necessarily gender conditioned**; it depends on the problem the person is facing. Although from experience I meet more often with women who seek help because of violence. On the other hand, men may not report violence or catch it when it happens (woman/social pedagogue/ outpatient care for people with drug-use related problems / Croatia).*

I think violence in this case is not gender conditioned especially when we are talking about addicts. *Women and men who have an addiction problem are, in my opinion, equally exposed to violence (woman/peer worker/ outpatient care for people with drug-use related problems /Croatia).*

> Axes of discrimination:

In addition, any discriminatory factors such as being a woman and using drugs are considered to expose one to a higher risk of violence:

I believe that any form of discrimination including drug abuse and addiction puts women at greater risk of violence *as in our society women are considered less valuable if they are addicted to drugs or on any other grounds. This is generally a problem of our society and non-recognition by institutions working with women, but generally the attitude of the public (woman/social pedagogue/ outpatient care for people with drug-use related problems /Croatia).*

> Women's care strategies:

Also, beyond the model considering women who use drugs as "bad mothers who need to learn how to care for their children", some professionals are able to recognise women's care strategies:

They keep the children from the moments of drug use, they leave them with their parents, neighbours, they don't even think about it if she is already there to take care of them*. Us professionals also have to work on that, we have to work on preserving the spaces, the situation, in what situations they can't be placed and when they can, but until that moment arrives, a lot of links have to be made, maybe you've been doing an intervention for a year before these conversations can take place... (Women-Social Worker- OutPatient treatment centre, Spain).*

2.- Experiences in care services

In the second part of the focus groups, experiences in different care services, both specialised (such as drug services) and mainstream (such as health services), were discussed:

a) Experiences in specialised services

> Good experiences in drug services:

Some good experiences have been reported by professionals in drug services:

We have a mixed space, we started to make the group of women and men, the mainstreaming of the gender perspective in the men's group is also clear, and it is interesting that the therapeutic discharges have increased in women and decreased in men, which means that men who are not prepared to challenge themselves do not support the programme, ***we have very few voluntary discharges in women and they are more sustained in the treatment*** *(Women- Psychologist/Therapeutic Community director/Spain).*
The work on the construction of new masculinities[14] is also positively noted:

I think that more work is being done*, I like that more work is being done on new masculinities, we have an educator on the floor who is challenging the hegemonic masculinity that is very important... in the teams we still have male figures that reproduce violence... (Women-Social Educator- In patient drug treatment centre-reinsertion apartments, Spain).*

14 Although this concept is being reviewed and criticised by some authors such as Bonino, L. (2022) in Análisis critico del modelo de las nuevas masculinidades: https://youtu.be/uL8Bmx8DoN4

It also points to the progress in addressing the unwanted maternity that women who use drugs have come to terms with:

***We have been able to work on it, that the children are products of rape**, that they didn't want to but they had to, or the proposal that the colleague said that I like mothering but I don't like having children, but this is the result of a long relationship as there is the fear that, depending on what they say, they can take their children away, normally older women with grown-up children do it, some of them are able to recognise that they have not made the decisions they have made or that they don't feel comfortable... (Women- Psychologist- In patient integrated drugs and violence service, Spain).*

> Gender perspective is not considered and/or even, in some cases, institutional violence seems to be promoted:

However, there has been a predominance of experiences reporting a lack of gender perspective in specialised services:

***We still have a lot of hierarchy in the teams, especially in mental health models and psychiatry figures where they have very little sensitivity and Gender Perspective**. We have made progress in some training and they are making progress, but others are not willing to train or question themselves and they are already satisfied with this system... (Women-Social Worker- Out Patient treatment centre, Spain).*

***We are becoming too flexible with the gender perspective**. (Idea of gender perspective vs Professional Rigour) (Woman- Psychologist/Therapeutic Community director/Spain).*

In reality, the lack of a gender perspective is seen as a barrier to women's access to services:

***The biggest barrier is the professional who thinks that nothing has to change**, who thinks that everything is a fad... and regardless of how many trainings they attend, they don't want to consider anything... it is very difficult to manage everything. These people are either leading teams or in specific work groups... the people on the front line are those of us who are in the shadows and we are the ones who have the most to say... It's a very flagrant barrier because they are people who have been in the teams for many years and don't want to change their ways of doing things, and who manage teams (Women-Social Worker- Out Patient treatment centre, Spain).*

***Maintaining norms because "it is therapeutic and it has worked all my life"**. (Women-Social worker/ Director on a domestic violence shelter, Spain).*

In this sense, the lack of training of professionals on the gender perspective is noted:

***They shouldn't be training for referents, they should be open to all professionals and not optional... you have attended training..**. (Woman-Social Worker- Out Patient treatment centre, Spain).*

***[Regarding "Snow Ball" approach, so training for referents] That's terrible and it doesn't work**, I played this role and it didn't go well... (Woman- Psychologist/Therapeutic Community director/Spain)*

***To work in services to work with women who have suffered violence you have to be trained in gender perspective...** otherwise one part of the team goes one way, the other part goes the other and that can't be... (Woman-Social Educator- In patient drug treatment centre-reinsertion apartments, Spain).*

If you don't have this training and this transformation (in gender perspective) your work will

***be incomplete and totally partial**. What does it mean that you don't have a gender perspective? That you are not doing your work well... (Women- Psychologist- In patient integrated drugs and violence service, Spain).*

*[Gender perspective and recruitment] In some profiles yes, and in some profiles no.... **it is also taken for granted that if you are a woman you have gender perspective...** (Woman-Social Worker- Out Patient treatment centre, Spain).*

The idea of "co-dependence" in women who use drugs is also highlighted as a bad practice in drug services:

***It is thought that if they have a partner, they are influenced by their partners to use drugs, even when they don't have partners**. We continue to give professional indications without aiming for them to be autonomous and work towards their empowerment. Us professionals have to review ourselves, criticise our intervention process, because we support this model that exists (Woman-Social Worker- Out Patient treatment centre, Spain).*

In addition, partners that in most cases are the perpetrators are taken as family members of reference in the treatment of women:

*When women come to therapeutic communities, **we often find that their partner, who is their contact person in the programme, is violent, but we don't know how to deal with it**. Last year 95% of the women who came to our service had a double problem (Women- Psychologist/Therapeutic Community director, Spain).*

It is also pointed out the difficulty for women to access proper mental health diagnosis; it is often confused with the myth of the "ideal victim" according to gender stereotypes:

***Since 2019, 93% of women have not had their diagnosis reviewed** and it has been many, many years since their diagnosis has been reviewed, and they have gone through different couples with very high levels of violence and almost nothing is ever recorded in the reports, how can this be overlooked in this way? (Women-Social worker/ Director on a domestic violence shelter, Spain).*

***It is very difficult for women to access a diagnosis, it is mixed with the myths we have, as if this could not happen to women... there are subtler stigmas, like the construction of the ideal victim**[15], like not understanding that women can also commit violent acts, etc... like there are things that we do not allow them to do... it is a difficulty that we have, I think, in spaces where we can even work from gender perspective. We have the privilege of having supervision, but we identify with the myths of motherhood above all... (Women- Psychologist- In patient integrated drugs and violence service).*

***.... the ideal victim is very difficult to perform, because violence is not put in context**. Women who have suffered a lot of violence have a brutal level of tolerance and there are things that they do not identify and that are happening... or that they identify that their first aggressor was their father, the figure that should protect them.... and the services are not prepared to accompany these processes... (Women-Social Worker- Out Patient treatment centre, Spain).*

***What happens to us as professionals when women are irreverent, they don't pay attention, we have two profiles:** those who pay attention to everything and those who don't, to whom all the doors are closed, there is this thing of not finding the perfect victim... (Women-Social worker/ Director on a domestic violence shelter, Spain).*

15 Ideal victims are those who fall directly within the parameters of victimisation, so that they do not have to prove their victimhood or go through the social filters of credibility (Sánchez Rubio, B., 2021).

They are women who have suffered violence from early childhood, sexual violence repeated throughout their lives, the gender mandate is very present in being in a relationship with someone, ***they are women who end up managing very well in very hostile spaces*** *and when they find themselves in spaces that involve care they don't end up finding themselves because it is not their space, their space is highly hostile. When you talk to women they explain that (Women-Social worker/ Director on a domestic violence shelter, Spain).*

You find the two extremes: people in the teams who say that "women with addictions are much worse than men with addictions" and the ***over diagnosis of mental health*** *that they have (Woman-Social Worker- Out Patient treatment centre, Spain).*
In addition, several situations of institutional violence are reported in relation to the experience of motherhood of women who use drugs; or women with young children do not access therapeutic communities because the communities do not meet their needs or they are judged for various reasons, such as drug use during pregnancy or relinquishing custody:

Many women don't access support because they don't want to leave their children, it's complex*, it's not all thought out so that the woman can enter to therapeutic communities with her mother... (Women-Social Worker- Out Patient treatment centre, Spain).*

In therapeutic communities we have either very young women, who are very far away from motherhood, or very old women, who in fact are admitted and alarm bells go off because they don't play the role well, they don't fit the role... ***the middle age group with small children is almost non-existent,*** *the majority of our men with small children in the community... (Women- Psychologist/Therapeutic Community director, Spain)"*

In Mental Health Services we meet women who have given up custody of their children, and it is a protection, they know themselves and have ***given up custody and how this is experienced by the teams as an abandonment when it is a protective measure*** *(Women-Social worker/ Director on a domestic violence shelter, Spain).*

The programme from child protection services for a woman who use drugs takes two pages and for them (men) it was just not to use drugs *and to go to work... (Women-Social Worker- Out Patient treatment centre, Spain).*

When pregnant women are using, there is no clear policy either, the team goes into crisis*, if you are pregnant and have diabetes no one calls social services, but if there is THC consumption all the alarms are activated, and diabetes is very serious in pregnancy... (Women-Social worker/ Director on a domestic violence shelter, Spain).*

And there is also a lack of homogeneity in the criteria of health professionals*, we have found that some allow the controlled consumption of THC during pregnancy because abstinence is better for the foetus, but in the hospital protocol the alarms go off and hospital retention is carried out, can't we avoid that if we know that they are smoking? Isn't it possible to work with the woman beforehand? It would also be fantastic to be able to work with a specialised team (Woman-Social Worker- Out Patient treatment centre, Spain).*

Besides, economic violence in drug services is also pointed out:

When I worked in therapeutic communities many years ago, women's bank accounts were pooled, this is a reproduction of brutal institutional violence, they don't have free access to their accounts and this reproduces economic violence against women, ***NO ACCESS TO THE ECONOMY****, invalidating them (Women-Social worker/ Director on a domestic violence shelter, Spain).*

It is a debate between the teams, there are people who still think that the accounts have

***to be pooled**. It is a classic example of addiction treatment for men, and it is still maintained as something basic and important when it is something super-associated with male consumption (Woman- Psychologist/Therapeutic Community director/Spain).*

***It's economic violence**, if they don't have free access to money it leads them to make very hard decisions, to use their bodies as we are instructed by gender socialisation, and when they work in addictions we know that it's possible to consume with or without money (Women-Social worker/ Director on a domestic violence shelter, Spain).*

In addition, some professionals also report experiences of assaults on women who use drugs by other professionals:
***Although I have heard of cases of violence against women by experts** in addiction treatment services, I have not actually had a case where any of these women subsequently avoided the same service for that reason. I think these women actually think they have no choice but to go back to treatment, and out of fear or embarrassment they don't mention to the hospital staff that the violence happened (woman/social pedagogue/ outpatient care for people with drug-use related problems / Croatia).*

***… and I myself have been abused by experts in addiction treatment services**. I didn't see it as too much of a problem at the time since I was in a desperate state. Today, when I look back on that situation, I realize that it was something that could not have happened. Women are powerless in these cases because they are afraid or do not take the situation seriously enough (woman/peer worker/ outpatient care for people with drug-use related problems /Croatia).*

Finally, professionals also point out some of the consequences of misapplying the gender perspective as an institutional violence itself:

***I think it's institutional violence, we overreact with women, they have new referents, they have to explain their stories every time…** women can't cope any more… there are things we have to take better care of. T**he addiction services have ALWAYS responded to violence without a gender perspective**, a lot of work could have been done but has not been done…. There is such a biased model of health that does not work, it has to be more integrated… (Woman-Social Worker- Out Patient treatment centre, Spain).*

***The approach is not going for the integral but more and more biomedical and with very marked and unrealistic times…women are aware of their times…** (Woman- Psychologist/Therapeutic Community director/Spain).*

***And also, to what extent they have to carry the label of "victims of violence" in order to access other resources…** Also 80% of our client population are men and in all these years nothing has been done to prevent or detect violence in them. Because gender perspective is not just about opening a group of men and a group of women. We have a risk of continuing to assail women for the problems they are experiencing instead of pointing the finger at men (Women-Social Worker- Out Patient treatment centre/Spain).*

In this sense, the lack of an intersectional perspective is also pointed out by professionals:

***I thought about Roma communities, sub-Saharan and Latin women, where the motivations are so different to the European experience**, we don't have everything in addictions, these women are completely left out, we don't have the training nor the services are adapted, nor the documentation, the discourses, not even the evidence… (Woman- Psychologist/Therapeutic Community director/ Spain).*

*It is also necessary to introduce the concept of **intersectionality, the more complex the person is, the more they are stigmatised by the services** and the "Pandora's box" is quickly closed because*

they do not even know how to begin to intervene and they end up in multiple services, with multiple professional figures and hopefully some will have gender perspective, then from the will to help them we end up perpetrating institutional violence. The patterns of care are different, the spaces and places have to be considered from gender perspective, I have been working in a CAS (outpatient centre) for 16 years and we have made changes but the same protocol was applied to everyone as was applied to cis- men (Women-Social Worker- Out Patient treatment centre/Spain).

The programmes tell you that success is related to the way in which ***intersectionality can be implemented but there is a moment when there is no way, and even though we have gender perspective we do partial attention****, because with what we have we can't make really comprehensive interventions. We continue to be left without tools and strategies and with a very large lack of resources to offer women. Where can these women be linked to continue working with gender perspective, a relapse prevention group? (Women- Psychologist- In patient integrated drugs and violence service/ Spain).*

b) Experiences in mainstream services

Experiences in mainstream services were also asked about:

> Gender perspective is not considered and/or even Institutional violence seems to be promoted:

In mainstream services, the lack of gender perspective and the presence of institutional violence have also been pointed out; in general, not much attention seems to be paid to women who use drugs and the lack of awareness, training and empathy of professionals towards women who use drugs is highlighted:

In services that do not work directly with women with addictions, there is often a wall that puts these women in a position not to pay enough attention to their problem*. There is a mixture of ignorance, lack of education, empathy and fear of such women (woman/social worker/ outpatient care for people with drug-use related problems /Croatia).*

I definitely agree with the research results. Experts in these systems do not know enough about addicts nor are they sensitized to work with them*, they may even be afraid because they do not have specific knowledge to work with women addicts (woman/social pedagogue/Social welfare centre/Croatia).*

I can definitely confirm the results of research that show that women feel more condemned in services that are not directly related to addiction*. The reason for this, I suppose, is that in addiction services, professionals are more aware of the women who come to them for help, they are more educated and more aware of the problem. Unlike non-addiction services, professionals do not go so deep into the problem of addiction and have less empathy for what women are struggling with (woman/social pedagogue/ outpatient care for people with drug-use related problems /Croatia).*

Women are more often discriminated against in services that are not directly related to addiction treatment because the staff in these systems are insensitive to the issue, the lack of empathy, knowledge and skills to work with such women *leads to women being placed in a position where they feel discriminated against." (woman/peer worker/ outpatient care for people with drug-use related problems /Croatia).*

The legal system is also pointed out as revictimising by professional staff:

The judicial system doesn't go along with the support that is given to women from the services*, the sentences are laughable and the mistreatment that they suffer from the judicial system*

is undeniable (Woman-Social Worker- Out Patient treatment centre, Spain).

The fact that the relationship between drug use and gender-based violence is not recognised is again emphasised by Croatian professionals:

***I think that in the system and institutions the relationship between drug use and GBV is not recognized as a problem**, i.e. there is not enough education and knowledge on this issue. In systems where people with addictions are dealt with directly, the situation is a little different, as experts there are a little better at dealing with this topic, although there is a general lack of education and skills in this field (woman/social pedagogue/ outpatient care for people with drug-use related problems / Croatia).*

***The state and the system do not recognise the connection between drug use and violence**. As a rule, everyone shifts responsibility to someone else and the problem remains unresolved or insufficiently researched. Most of those who suffer in this are women who do not even know who to turn to for help (woman/peer worker/ outpatient care for people with drug-use related problems / Croatia)*

***The relationship between GBV and drug and alcohol abuse is not sufficiently recognised in our system.** A lot of problems are solved only superficially and we do not get too involved in the relationship between these two phenomena. Possibly in services that work directly with women with addictions who have experienced GBV, although a lot of work should be done on the skills of experts. (woman/social worker/ outpatient care for people with drug-use related problems /Croatia).*

3.- Improvements in care services

The professionals who participated in the focus groups identified some improvements that should be implemented in both specialised and mainstream services:

a) Specialised services:

Firstly, the need for training and supervision of professionals on gender and drugs, including managers, is suggested; the need for practical and situated training is pointed out.

***Mandatory training** for the teams and not making the single reference figure responsible. From scratch, from the beginning... (Women-Social worker/ Director on a domestic violence shelter/Spain).*

***More supervision, not just training**, and that supervision should be from a gender perspective... (Women-Social Educator- In patient drug treatment centre-reinsertion apartments/Spain).*

***Alert on the subject of academic training, because in the case of certain profiles, training must be grounded**, there is an excess of academia in our lives, we already fit in, we fit in, falling into academic training, and the reality becomes something else... **grounding the theoretical in the practical..** that goes beyond the workplace...educators who have mega top titles but that the users do not understand them... it is necessary that they know how to apply to the day to day also...it will be very good to share good practices, I find myself in an extreme loneliness as for innovative praxis... (Women- Psychologist/Therapeutic Community director/Spain).*

***That the people who mark the lines of work and manage the resources have gender perspective, the new contracts...** there needs to be a standardisation of common indicators for all the services... (Women-Social Worker- Out Patient treatment centre/ Spain).*

It also points to the need to tend to the mental health of professionals in the framework of regular supervision:

We also need to review the ***mental health of the professional team..****. we carry a lot of emotional baggage... (Women- Psychologist/Therapeutic Community director/Spain).*

Linking training with the mental health of the team*, there is supervision, which must be crossed by the gender perspective, which at the same time as training, transforms and takes care of itself (Women- Psychologist- In patient integrated drugs and violence service/Spain).*

The need for clear, systematised protocols to address GBV among women who use drugs is also emphasised:

I miss some guidelines in outpatient mental health services and outpatient services on ***what you should do in these services if you suffer violence****, something basic that you have and can put in your bag... what happens if you consume and suffer violence "Get out of the kitchen, don't go near a window, etc..." (Women-Social worker/ Director on a domestic violence shelter/Spain).*

The lack of housing resources within the framework of resources for social reintegration is also pointed out:

Housing resources *are key to receiving a benefit and do not have to be shared. Access to housing (Women-Social Worker- Out Patient treatment centre, Spain).*

The need for more resources specifically for women who use drugs who are survivors of GBV is noted:

Provide more services and services intended only for them*, addicted women who are victims of GBV (woman/Social welfare centre/Croatia).*

Finally, the professionals reported the need to establish structural changes, which question daily practice and the patriarchal structure of organisations, as a key element to incorporate a gender perspective in specialised services such as drug services:

To question the day-to-day practice itself, to break up the team to start again? *(Women-Social Educator- In patient drug treatment centre-reinsertion apartments/Spain).*

Mainstreaming gender perspective in everything that is done, plus structural changes*, taking the structure apart and putting it back together again to overcome the patriarchal structures of organisations... (Women-Social Worker- Out Patient treatment centre, Spain).*

b) Mainstream services:

As far as mainstream services are concerned, the need to train professionals who care for women who use drugs is also emphasised:

Professionals must be trained on gender-based violence *(how to recognize it, how it must be addressed and treated); professionals must be trained in the relationship between gender-based violence and substance abuse. it is necessary to create a psychological support network based on addressing the issue of violence (listening groups, confrontation) (staff/therapeutic community/ Italy).*

Education, education, education*. Work on protocols and ways of treating women who come for treatment (woman/social pedagogue/ outpatient care for people with drug-use related problems /Croatia).*

More professionals working with these women, ***better education and knowledge about working with women and more empathy****. Experts after a while become like robots as they are not offered any help or supervision (woman/peer worker/ outpatient care for people with drug-use related problems /Croatia).*

It is striking that there is an insistence on issues that would be part of a "traditional" model of intervention that would not necessarily include a gender perspective:

Greater importance must be given to mental health. The treatment approaches must not only be based on the care of the body and addiction. The patient's mental health must be taken into consideration. (staff/therapeutic community/ Italy).

We need to work on creating a collaboration between the various services*. Often private entities do not collaborate and do not dialogue with each other. This does not allow to create a safe and continuous assistance network. (staff/ therapeutic community / Italy).*

We need to work much more on the part inherent to social reintegration*. Once the treatment program is over, many women find themselves with nothing. They do not have* ***a home, they do not have a job, often they do not have a family and many of them have children…*** *how can we help them? How can we guarantee them that they can have a full and normal life? (staff/ therapeutic community / Italy).*

It also points to the need to establish systematised intervention protocols:

It is necessary to create standardized protocols *at a national level in order to guarantee assistance services to all and above all to SPEED up the procedures. (staff/ therapeutic community / Italy).*

3.4. Interviews aimed at professionals

As mentioned above, 120 interviews were conducted with professionals working with women who use drugs and other key informants. They were asked the following 2 questions:

Question 1 - *Which of the following points are NOT being implemented in services aimed at women who use drugs, why, and what other issues should be considered?*
Question 2 - *According to your experience, IN GENERAL which is the MOST DESIRABLE OPTION for women who use drugs facing GBV?*

The main responses are discussed below:
Question 1- Which of the following points[16] are NOT being implemented in services aimed at women who use drugs, why, and what other issues should be considered?

> Low thresholds/flexibility for service Access

In terms of flexibility of access to drug services, women seem to access services to a lesser extent than men and there are single waiting lists without addressing the different needs of both men and women; It is also noted that there are too few services for women who use drugs and even fewer for women who use drugs who are survivors of violence:

There is way more men in addiction centres than women*. I think the access should be easier*

16 a) Low thresholds/flexibility for service access; b) The empathy of professionals towards women participants/users of the service; c) The presence of peer-workers; d) Knowledge of professionals about drug use; e) Knowledge of professionals about gender violence; f) Knowledge of professionals about the interaction between drug use and gender violence; g) The existence of spaces only for women; h) Addressing issues that specifically affect women who use drugs and have experienced gender violence; i) Early detection systems and protocols for GBV are in place; j) Addressing gender violence experienced throughout the life of women, including the relationship with drug use; k) Service regulations take into account the specific needs of women and their children; l) The activity program takes into account the specific needs of women and their children; m) The design of the spaces/facilities takes into account the specific needs of women and their children; n) Mental health is taken into account; o) Sexual and reproductive health and rights are taken into account; p) Diversity is taken into account (sex orientation, ethnicity…); q) Women actively participate in the design, development and evaluation of the service; r) Mutual support among women in the service is promoted; s) The autonomy / empowerment of women is promoted; t) Social "reintegration" is actively promoted; u) The idea of belonging to a support network is promoted; v) There is coordination with local networks, social movements and services to support women and other community services/organisations; w) The coordination with peer networks for women who use drugs is promoted; x) Socio-political participation is actively promoted; y) Gender perspective approach is adopted; z) Harm reduction approach is taken into account.

(female, drug specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany).

***In most residential resources the waiting lists are still unique between men and women**, and their situations are very different, they start from very different social positions (Woman/Social educator/ Open family centre/ Spain).*

*There is still a lot to do in low-threshold services in Germany. **There are few services for women only and even less for women who have experienced violence** (female, gender specialist, director of a rehabilitation centre/ Germany)*

Specifically, issues such as drug use or the incapacity to access services with children are specifically pointed out by professionals interviewed:

***In women's shelters addiction/substance use is a reason for exclusion**. Due to lack of staff and ignorance, women's shelters are not open for women with addictions with experience of violence. Addiction facilities do exist, but they are not specialized for women with experience of violence, but it is considered, especially in women's shelters. If the woman is struggling with addiction, she has no chance (woman/addiction counsellor, therapist/psychological-psychiatric care or mental health service/Austria).*

***Those who are in active use of drugs cannot go to any resource**. This creates a lot of dilemmas for me, we have a moral and professional duty to change this (Woman/Social educator, women in harm reduction services/harm reduction centre/ Spain).*

*An overall social problem; **lone women are faced with the impossibility of caring for children** in order to give themselves the space they need. This would be in the best interests for child and mother (man/therapist/therapeutic community and harm reduction centre/Austria).*

***In most therapeutic communities women cannot enter with children**, which makes it difficult for them to access (Woman/Director/Therapeutic community/ Spain).*

Finally, it is indicated that access to services is limited by the social status of users, which hinders their access to certain rights:

*Our clients are part of this group with limited access to services precisely **because of their social status and this very often makes it difficult for them to exercise certain rights**. (woman/peer worker/Outpatient care for people with drug-related problems /Croatia).*

> The empathy of professionals towards women participants/users of the service

In terms of the empathy of professionals, the workload that professionals sometimes have to deal with is mentioned as a difficulty:

***Experts are mostly overwhelmed with paperwork and a large number of cases** to do everything without involving emotions (woman/social worker/ Centre for social welfare/Croatia).*

Difficulty in detecting mental health disorders is also reported by the professionals interviewed:

*So, I experience a **higher level of comorbidity with other disorders in women. And then it is sometimes difficult for the team to pick up on that.** And then it is not easy to treat that as well. (female, drug specialist, Outpatient care for people with drug-use related problems/Germany).*

We must understand the professional's ability to understand his patient with empathy. Create a climate of mutual trust so that the patient can feel safe. Unfortunately, this clinical evolution that deals with the issue of ***addiction as a purely medical pathology*** *is increasingly distancing the focus on the psychological impact of the same. It is a very worrying vision that will make rehabilitation programs increasingly geared to the patient's physical well-being without considering his or her mental health. (males / psychotherapists/therapeutic community/ Italy).*

Difficulty in empathising with younger women is also reported by professionals:

Women who are faced with situations of violence or who live in the context of drug addiction are ***younger nowadays****. This implies that in order to get as close as possible to their way of thinking, to the problems they face, it is also necessary that the* ***professionals who tend to these women are young, so that they can feel understood****. (Woman/therapeutic community/ professional educator/ Italy).*

Or the need to overcome institutional barriers:

The best way to get in touch with women and create a climate of trust is to ***minimize the institutional patient / professional gap****; the only way to do this is* ***to reach out to women directly on the streets****, etc. in order to bring them closer to the treatment path, to help them find a way out. (woman / psychologist/ Shelter home/Italy).*

> The presence of peer workers

Regarding the presence of peer-workers, the lack of peer-workers in drug services is generally noted by professionals in different country partners:

Besides street work, in some cases ***peer work is not included enough in-service provision*** */it exists to some extent in prevention and* ***gender-based violence is not a topic - normally****. It could be useful to enhance peer work also in the direction of* ***self-help groups*** *which can be very helpful to raise awareness (male psychiatrist /therapeutic community /Austria).*

We don't have peer workers here*, and I know very few places with peer workers. (female gender specialist, Day centre for people with drug-use related problems/ Germany).*

The presence of peer workers is low *(male, drug specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany).*

And the need to promote this figure is clearly indicated:

The presence of peer-workers at Drug Day centres ***could be a good option*** *because of the relationship that can be established due to the* ***similarity of life experiences*** *(woman/therapist /day centre for people with drug-use related problems/ Portugal).*

> Knowledge of professionals about drug use

The lack of drug knowledge of both social service professionals and professionals working in shelters for women is also noted by professionals interviewed:

Experts at the social welfare centre ***do not have any special education in the field of addiction*** *and very often do not deal with the problem of addiction but work on the accommodation of users in institutions that deal with it (woman/social pedagogue/Centre for social welfare/Croatia).*

Low. It is not that there is no knowledge, but there is little. They do not distinguish between

***the types of drugs**. The woman is a drug addict and full stop. Whether the person uses cannabis or cocaine, no distinction is made in **women's shelters** (female gender specialist, therapeutic community/residential centre for people with drug-use related problems/Germany).*

> Knowledge of professionals about gender violence

The lack of training of drug professionals on gender-based violence is also noted:

***Insufficient professional knowledge** and education (woman/psychologist/therapeutic community/ Croatia).*

*We have a lot of experience in this area, but definitely **too little additional education and supervision** (woman/social worker/Centre for social welfare/ Croatia).*

***There is a lack of awareness about GBV, so there is a need of training** and resources like psychological-psychiatric GBV related care. (woman/ psychology /outpatient care for people with drug-use related problems/ Portugal).*

***The bigger the institution and the more men there are, the more they look the other way**. (female gender specialist, rehabilitation centre/ Germany).*

*For staff who do not have a therapeutic background, **this knowledge should be promoted**. (female drug specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany).*

***It is necessary to train professionals on gender** (Woman/Social Educator/therapeutic community/ Spain).*

***There is a lack of training in gender perspective from the faculty and covering all the services/ social agents involved**, to ensure better coordination between services (Woman/Director/therapeutic community/Spain).*

> Knowledge of professionals about the interaction between drug use and gender violence

In general, a lack of training about the intersection between gender and drugs is noted, so that no connection seems to be made between drug use and GBV experienced by women:

*I think that this topic is still insufficiently discussed, especially at the professional level, and that it is **insufficiently connected with the problem of women with addictions**. Also, the legislation does not respond to real needs (woman/psychologist/therapeutic community/Croatia).*

*Primarily work is focused on the problem of addiction, and often **there is no information that these women are victims of domestic violence** (man/peer worker/therapeutic community/Croatia).*
***As two separate variables**, certain knowledge and skills exist, however; when it comes to the connection between these two issues, **I think that more education and skills are needed** to help us work with this group (woman/social worker/probation office/Croatia).*

*Although we work on both topics somehow it seems to me that there is **too little knowledge and skills in working with women who are addicted and who are facing GBV**. It needs a lot more education and skills (woman/social worker/therapeutic community/Croatia).*

***Would be essential, does not exist, is no key topic in Austria** (man, Clinical Psychologist, Psychotherapist, drug and gender specialist /therapeutic community/ Austria).*

***In the curriculum of professionals in the mental health field topics of substance abuse and GBV and especially the connection is not properly met**. Nevertheless, there is normally a very high degree of self-experience /self-therapy / meaning that professionals, on average, have excellent emphatic qualities and a very good understanding about the importance of personal history including traumatic experience. Still beside the necessary empathy **the very special relation of drug abuse and GBV needs better explanation and sharing of findings** (male psychiatrist/ Psychological-Psychiatric care and Information and Attention Service for Women survivors of GBV/ Austria).*

*We need train about drug addiction and specifically in addressing the **interaction between GBV and drug use** (woman/psychology /Day centre for people with drug-use related problems/Portugal)*

***The concept of gender-based violence in Italy is not very thorough, especially when related to the use of drugs** (...). But to date, I don't remember ever having attended a course that delves into the concept of gender-based violence and the relationship between GBV and substance abuse. (man / psychotherapist/therapeutic community/ Italy).*

***Professionals have no training on drugs and gender and how to implement it on a daily basis**: not blaming or judging women, generating a space of security and respect, flexibility in the process, that they are responsible and protagonists of their own change,...this is very important; however, **models that are still very assistance-based are still followed**...; in our case, we pass a questionnaire every 3 months where we ask about the service, the facilities, the therapeutic groups and the professionals and, a posteriori, we make improvements based on what the women have said (Woman/Social integrator/ integrated service/ Spain).*

In this sense, violence against women may be conceived so strongly connected to the use of certain drugs that, maybe as a reaction to a perceived excess of social activism, the role of gender and the structural oppression seems to be comparatively downplayed:

*As there is a focus on raising numbers of femicides in Austria there is strong activism and social focus on the topic of GVB. Nevertheless, **several of these femicides have a long history of violence and suppression which I believe is always connected to substance abuse, mostly alcohol and cocaine. The relevance of this connection is not tackled in social activism in fact there is a blind eye on it** (male, clinical psychologist and psychotherapist/ Psychologic and psychiatric care, information and attention service for women survivors and integrated service / Austria).*

In some cases, a connection is made between drug use and physical violence but not in relation to emotional/psychological violence (or other types of GBV); in any case, the approach seems to be more focused on a systemic/family perspective and not on a gender perspective:

***While physical violence and connection to drug consumption are quite well known many women suffer a high degree of also emotional violence, especially in a highly co morbid substance consuming environment**. While there is a difficult but still more easy coming out of physical violence the issue of emotional violence strongly connected to guilt is predominantly hidden. **In the curricula for professionals the topic is not met**. In further education there are initiatives into this direction (for example: Weiterbildungsakademie). **In fact, addiction therapists are frequently informed about the topic and know strategies, often from experience - they consider the family perspective, different for professionals working in gender specific focus** (man, Clinical Psychologist, Psychotherapist, drug and gender specialist/ therapeutic community and Psychologic and psychiatric care / Austria).*

The lack of systematised protocols for action to tackle both problems at the same time is also noted:

*While there is a quite functioning net of high-quality drug services, these services are often **not aware and have tools to handle issues related to gender-based violence. There is no structured***

strategy in individual treatment and counselling to address the topic, normally curricula for professional education to not address the high relation*. Nevertheless, there are numerous professionals working in the field who are interested to gain and share knowledge (male, psychiatrist / day centre for people with drug-use related problems/ Austria).*

> The existence of spaces only for women

In general, the lack of adapted and specific spaces and services only for women is also noted by professionals interviewed:

Women with addictions, and especially GBV victims, have their own specific needs especially if children are involved. ***Women only accommodation should be more adapted****. We are currently going to renovate the space in which we operate, so we will take care of that as well (man/peer worker/ outpatient care for people with drug-use related problems/ Croatia).*

Women with addictions themselves need special accommodation because of the sensitive situation and vulnerability, especially if GBV is involved. We have been at full capacity for a long time, and ***although women are separated from men in our department, that is far from what they really need*** *(man/doctor of medicine psychiatrist/psychologic and psychiatric care / Croatia).*

Our therapy centre is not fully adapted for the stay of women *especially when it comes to more sensitive topics. We should provide a space within our therapy centre where women can feel completely safe to express their emotions and GBV issues. (man/technical worker/therapeutic community/ Croatia).*

Group therapy only for women are temporary available *(man/therapist/outpatient and day centre care for people with drug-use related problems and psychological and psychiatric care/Austria).*

Services where only women with drug-use related problems are treated ***should be provided*** *(man/ therapist/therapeutic community and psychological and psychiatric care/Austria).*

Not enough women only spaces*, violence protection centres exist, but the whole system is overworked. "Freiraum" (shelter home) has hardly any capacity, other services support more men (woman/addiction counsellor, therapist/psychological and psychiatric care/Austria).*

It would be helpful. Women are different in causes and triggers related to violence and abuse issues. ***This should be more considered and included*** *(man/addiction counsellor/outpatient care for people with drug-related problems/Austria).*

There is a lack of Therapeutic Communities in the Republic of Croatia in which treatment can be provided with the gradual abolition of substitution therapy for women *who are in the problem of addiction (Woman / master of nurse /day centre for people with drug-related problems/ Croatia).*

FAST help is required not endless waiting times! Not getting the help you need NOW is frustrating. ***So, a separate area should be kept free for those women*** *(man, harm reduction/outpatient care for people with drug-related problems / Austria).*

There are few services for women only and even less for women who have experienced violence *(female, gender specialist, director of a rehabilitation centre/ Germany).*

We tried to provide a single room for women *but could not guarantee (female drug specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany).*

I think there need to be more facilities that are exclusively for women*. I can imagine that some*

women don't seek help because they already have a terrible experience. (female, gender specialist, Information and Attention Service for Women -victims/survivors of GBV/ Germany).

In most mixed therapeutic communities there are no regular specific spaces for women... *(Woman/Social educator/integrated service/ Spain).*

*In general, the gender perspective is not incorporated, despite the fact that there are already many studies on the subject; for example, in the outpatient services, t**here are no groups for women, and in the mixed groups, the majority are men...** (Woman/Social worker of an integrated service/h). (Woman/Social integrator/integrated service/ Spain).*

It is also reported that women-only groups or spaces make it possible to address issues that would not otherwise come up:

In only women groups, topics like childhood sexual violence or about sexual preferences often come up *(Woman, Therapist/ integrated service/Austria).*

*There are different facilities, and of course, i**n a facility with more women, the women dare to talk about it more**. There are no gender-segregated groups, and it is difficult for women to say such things. There is often a man or no man at all, and then these issues can be discussed. (female gender specialist, Outpatient care for people with drug-use related problems/ Germany).*

The myths or gender stereotypes that some professionals hold about women in general, such as the need to "flirt" with men or the competitiveness among women, are surprising:

*When only women are in a facility - These women have more freedom to deal with their topics **and not thinking about how they affect men. Furthermore, competition between women is much lower** (man, therapist, founder of facilities beneath also facilities and houses only for women/ integrated service/ Austria).*

> Addressing issues that specifically affect women who use drugs and have experienced gender violence

Firstly, many treatments seem to focus only on the issue of addiction and do not go deep into the topic of gender-based violence:

Most treatments are based on the problem of addiction *and do not go too deep into the topic of gender-based violence especially if it causes bad emotions in the woman who survived it. There is a lack of education in this area (woman/social worker/therapeutic community/Croatia).*
***Drug abuse is above it all**. It should be kept in mind to treat human/women with their personal needs and not only the drug-use related problem itself (man/therapist/therapeutic community and psychologic and psychiatric care/Austria).*

It is also recognised by professionals interviewed the fact that the specific needs of women cannot be met due to many clients:

*I have the impression that **due to too many clients we do not manage to really deal with the specific needs and problems of women victims of GBV**. There is also paperwork, insufficient staff... (man/doctor of medicine psychiatrist/psychologic and psychiatric care/Croatia).*

Again, the need for specific protocols to address women's needs in terms of GBV experienced is noted by professionals:

*Services that help women who use drugs should introduce dedicated **protocols for gender-based***

***violence**. Specifically, they should help women to elaborate the reasons why they have suffered / endured violence (Woman, Therapist/ integrated service/Austria).*

Specific issues are also identified by professionals interviewed to address the specific needs of women:

***Issues that should be addressed**: Most women experience eating disorders as a result of the violence they have suffered; most women feel guilty for reporting the violence they have suffered (especially if there are children involved); Women must be taught to build a healthy relationship and, above all, to recognise any dangerous situations that can lead them to relive situations of violence (man / psychotherapist/ therapeutic community/ Italy).*

> Early detection systems and protocols for GBV are in place

On the one hand, the lack of legislation or protocols indicating the need to detect GBV is noted:

*In general, the **whole system lacks a little more detailed legislation**, for a lot of things in the treatment process we realize that it is lacking at a higher level. For that very reason, we are late with the adoption of the rulebook in our institution. (woman/psychologist/therapeutic community/ Croatia).*

*There are **no special regulations** related to the above. (woman/social worker/Centre for social welfare/ Croatia).*

*Although general protocols exist, **there is definitely too little attention being paid to specific protocols** aimed towards women with addictions who are victims of gender-based violence in order to detect the problem in time and prevent the long-term consequences (man/doctor of medicine psychiatrist/psychologic and psychiatric care/ Croatia).*

*T**he initial interview in drug addiction service does not cover violence experienced by women** and normally this question is **only tackled if the referring professional identify**. Women tend to omit sexual abuse, especially if it was perpetrated by a close relative (woman/therapist/outpatient care for people with drug-use related problems/Portugal).*

***There is a need of early detection systems and protocols** for drugs and also GBV (woman/ community nurse/harm reduction centre/Portugal).*

*People who come to us have been traumatised for years. **I doubt that such protocols are widely used in DE**. (Woman, drug specialist, day centre for people with drug-use related problems/ Germany).*

Besides, it is striking that GBV is only addressed if women are interested in it, according to the lack of systematised protocols:

*GBV is not something that is being worked on according to special protocols. As part of addiction, when women come to our hospital, GBV is also discussed, **if a woman wants to talk about it. Otherwise, we are not working on it as a separate topic** (woman/nurse/day centre for people with drug-use related problems/ Croatia).*

*In our therapy centre most of the work is based on the problem of addiction and there are no protocols for early identification of the problem and for dealing with women with GBV. Very often, the problem of GBV is found out only with the help of treatment, **if the woman herself decides to talk about it** (man/peer worker/therapeutic community/Croatia).*

There are no specific protocols in the therapy centre, but everything is focused on working on the

problem of addiction, so as part of that, GBV is ***discussed if the woman decides to talk about it*** *(woman/social worker/therapeutic community/ Croatia).*

However, before clear protocols for GBV screening can be established, there is a reported need to train professionals and improve services:

As far as I know, in Italy there are no specific protocols in any Service for the early diagnosis of gender-based violence; it would be very interesting to create them and I believe that they would be very useful in the implementation of the services, ***but at the same time I believe that before creating protocols it is necessary to do targeted and in-depth training on the concept of gender violence****. (woman /director/Shelter Home/Italy).*

Protocols for early diagnosis are useless if training is not done first and access to services is not improved*. The procedures for accessing help services are too long and too cumbersome. There are many cases of women withdrawing their request for help. Why? Because the* ***procedures are too long and women are afraid that the one who harms them may find that they have requested help before actually starting to be helped****. (man / psychotherapist/Shelter home/ Italy).*

The early diagnosis of gender-based violence can be implemented only and ***exclusively through the use of psychotherapy interviews; therefore, it is necessary to train*** *psychologists and psychotherapists so that they can recognize the cases of GBV and accompany the patients along their treatment path. (man/director/therapeutic community/ Italy).*

Immediately diagnosing cases of gender-based violence is fine for women who are already within a Service. But all those women who are not yet within the system of care and do not ask for help for fear of being abandoned by the system? ***There is a need to improve existing services before thinking about specific protocols. Making them more accessible to everyone****. (man / psychotherapist/ health service (private) /Italy) .*

Finally, it is relevant that some women prefer not to talk about the violence they have experienced for fear of being re-victimised by professionals:

It lacks a well-established system because women who are abused do not report because they are afraid that much more terrible things could happen to them while someone intervenes*. Sometimes it is not all about the threat but also the execution of the act (woman/social worker/ therapeutic community/ Croatia).*

> Addressing gender violence experienced throughout the life of women, including the relationship with drug use

In general, it appears that GBV throughout life is not explored and there is a lack of knowledge and skills on the part of professionals to address it:

No, I don't see this being done *(female, drug specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany).*

The trauma-informed care approach is not considered *(Woman/Social Educator of an integrated service/integrated service/ Spain).*

Insufficient experience and skills *in this area (woman/social worker/probation office/Croatia).*

This is a very important topic that is not talked about enough and I think that ***greater knowledge on this topic can prevent the consequences*** *(man/doctor of medicine psychiatrist/psychologic and psychiatric care/ Croatia)*

***There is no specific training in trauma and violence**, especially in conjunction with the issue of addictions, and the intervention is either partial or wrong, which can re-victimise (Woman, Social Educator/ therapeutic community/ Spain).*

Again, GBV is only addressed if women or therapists address it, not because systematic protocols are in place:

*We have Outpatient Day Care Centre. However, as in addiction treatment centres, there is no sensitivity to these issues. **For example, child abuse is often the root cause of self-destructive behaviours, but this is not detected because of the patient's omission and because the therapist does not explore this possibility**. There is a need for specialisation in this area (woman/ psychology / outpatient care for people with drug-use related problems/Portugal).*

***GBV is dealt with depending on the moment, if it has been dealt with before in another resource or not, if she needs it...but it is not compulsory** (Woman/Director of residential centre/therapeutic community/ Spain).*

It is surprising that, as some professionals commented in the focus groups, perpetrators are sometimes assumed to be leading figures in the treatment of women:

***Sometimes even male abusers assume the role of family referents for women, until we realise that there is a history of violence**. In this sense, it is important to consider that there may be a history of violence and the need to widen the network of family referents (Woman/Director of Therapeutic Community/therapeutic community/ Spain).*

> Service regulations take into account the specific needs of women and their children

In general, it is assumed that service standards do not take into account the specific needs of women and their children:

More work needs to be done on regulations to protect women and their children (woman/doctor of science/Information and attention service for women survivors of GBV/ Croatia).

***There is no individualised approach and recognition of specific needs** (woman/social worker/ Croatia).*

***The internal regulations do not take into account the specific needs of women**; for example, until recently there were no sanitary towels in the TCs (Woman/Social educator, women in harm reduction service/harm reduction service/ Spain).*

***There is a need for an in-depth revision of the regulations in general**, which do not take into account the gender perspective. (Woman/Director/Therapeutic Community/Spain).*

> The activity program takes into account the specific needs of women and their children

Likewise, children either do not have access to drug services, or their needs are not taken into account:

*In therapeutic services it is more difficult to respond to personal needs. **Professional childcare would be good** (woman/therapist, educator/Outpatient care for people with drug use-related problems and therapeutic community /Austria).*

***There are almost no places where women are accepted with their children**. And when they are accepted, there is the problem of who takes care of the children during treatment. (female, gender specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany)*

*We have seen that the fact that if the children can come at least one day a week to visit the mothers, this helps them a lot in the treatment, but **in general, the children are not considered**. (Woman/ Director/Therapeutic Community/ Spain).*

*Why doesn't this happen in other structures? **Because creating a structure like this means having professionals trained to follow and accompany women** in their treatment journey from addiction and in their psychological rehabilitation, **then it means having professionals who follow the development and growth of the child** from a physical and motor point of view, psychological and development of social relationships and then it means training professionals to help and accompany mothers in the development of the relationship and the parenting process. It is a very complex job. It would take more structures like this, not only because they do a very important job, but also because having children and taking care of them is one of the main reasons that push mothers not to ask for help. Why? They are afraid that the baby will be taken away from them. (director/woman/therapeutic community/Italy).*

***Need to teach moms not only to take care of themselves, but also of their children. You have to teach them how to establish a parental relationship**, how to respond to the emotional, psychological and material needs of the children (Psychologist/woman/therapeutic community/ Italy).*

It is also pointed out that the "time" needed by women in treatment is not taken into account:

The time needed by women is not taken into account, and in fact a very great expectation is generated on them, about what they have to achieve in X amount of time, and maternity is not taken into account either, even in projects aimed at women, the gender perspective is not incorporated... (Woman/ Director of the Therapeutic Community). (Woman/ Director of harm reduction service/harm reduction service/ Spain).

Worryingly, there is a certain tendency to consider that needs are "genderless":

***It is necessary to take into account the specific needs of each person, regardless of gender...** (Woman/Director of residential centre/therapeutic community/Spain).*

*Our therapeutic program is specially developed to take into account the health and physical and psychological needs of both women and their children, **but we are the only facility in the whole national territory**. (woman / director/ therapeutic community/ Italy).*

> The design of the spaces/facilities takes into account the specific needs of women and their children

Again, children are not taken into account:

***There is no specific space for women and children to feel more free and safer**, I think this is not discussed and cared for enough, but we are generally filled with the capacity of the hospital and we do not have too many opportunities to change anything on this issue (woman/nurse/day centre for people with drug-use related problems/Croatia).*

***As said before, there are very few places where children are accepted**. In those places where*

children are admitted, the structure is made according to the children's needs. (female, gender specialist, day centre for people with drug-use related problems/ Germany).

> Mental health is taken into account

It seems that in some countries, such as Italy, biomedical care still predominates, neglecting mental health, even though mental health is one of the "traditional" pillars of most drug services:

***Unfortunately, mental health is and will continue to be less and less taken into consideration**, giving priority to monitoring the patient's clinical condition. (psychotherapist/man/health service (public)/Italy).*

>Sexual and reproductive health and rights are taken into account

In general, according to professionals interviewed, this is an issue that is not taken into account:

*This is something that we as employees don't talk about too much. Of course, sexual and reproductive health and rights are taken care of, but this is **something that is discussed and reacted to if a crisis situation arises** (man/peer worker/therapeutic community/ Croatia).*

It is also pointed out that women are the main victims in the context of sex-affective relationships in the context of services, especially residential services. They are often judged, blamed, expelled and are the first to relapse:

***In many therapeutic communities, women are the first to relapse and the first to be expelled** when there is a sexual-affective relationship with another user (Woman/Director of Therapeutic Community/therapeutic community/Spain).*

***In relationships between users, they (women) are the ones who suffer the worst consequences**, they are expelled and relapse... (Woman/Social Educator/therapeutic community/ Spain).*

***We continue to apply sexist regulations**, they are expelled for having sex or they are accused of provoking them, with the consequent expulsion (Programme Coordinator, psychologist, woman/ Spain).*

> Diversity is taken into account

In general, diversity is not taken into account as it seems that we do not work from an intersectional approach:

*Rather not for both (woman and children). In my facility there is **only one place, where children from mentally ill people are cared for**. More focus on that would be certainly an advantage (woman/ addiction counsellor, therapist/psychologic and psychiatric care/Austria).*
*To avoid that **young adults**, fall into substance use again, more offers for their special needs should be provided. It is difficult to support the clients, because otherwise they will go back where they came from (woman/therapist/therapeutic community/Austria).*

*While integrated harm reduction exists at different degree and quality with local differences, there is very little appropriate help for women who seem self-dependent with little addiction problems but confronted with party consumption or consumption from side of partner, social group, main drugs alcohol and cocaine and some new drugs. I am in charge to develop a protection centre for **"middle class" women**, women who are not motivated and willing to use the exist in services because they do not see their needs met and fear stigmatisation (man, Clinical Psychologist, Psychotherapist, drug and gender specialist /therapeutic community/Austria).*

There is a lack of more types of resources that contemplate intersectionality *in the SIE (Specialised Intervention Service on GBV). They have a lack of vision of addictions... In drugs... they don't have the perspective of consumption and GBV, they don't intervene from the perspective of gender inequalities... (Woman/ Director/ Gender Violence and Addictions/Spain).*

> Women actively participate in the design, development and evaluation of the service

Likewise, women's participation in the design, development and evaluation of services is practically non-existent:

Women rarely participate in any of the above*. Sometimes a certain evaluation is done, but it is too rare to show the real state of the problem. I think that service users themselves should be more involved in the evaluation and encourage us to make changes, it is just important that they are allowed to do so. (woman/nurse/day centre for people with drug-use related problems/ Croatia).*

Treatment program is not under control of women*. Treatment is depending on client's topic. There is a specified basic program and if necessary, family or couple therapy will be offered. Of course, adaptions are made as needed during treatment (man/therapist/outpatient and day centre for people with drug-use related problems and psychologic and psychiatric care/Austria).*

Professional work in very few cases integrates the perspective of users, victims of GBV and their ideas about program necessities. This is maybe typical for Austria *which has no history of integration of self-help into the professional help system of mental health.* ***Professionals should much more ask the persons /women affected about their views and needs and respect them in designing helping strategies*** *(male, clinical psychologist and psychotherapist / other services / Austria).*

[It is needed to] Listen women about how to improve services (woman/therapist/outpatient care for people with drug-use related problems/Portugal).

They [service users] can make proposals regardless of gender, but we rarely change the regulations..., because they are historical rules that already work*, they integrate them and they agree, the treatment is individual and then there are permanent elements for everyone, everyone is treated individually; men can propose the same as women, it is independent of whether you are a man or a woman, regardless of your age.... (Woman/Director of residential centre/therapeutic community/ Spain).*

Rather, there is a tendency to infantilise women who use drugs considering that they do not have the capacity to actively participate in the design and evaluation of services:

Some self-initiative is not constructive for therapy process *(man/therapist/outpatient and day centre for people with drug-use related problems and psychologic and psychiatric care/Austria).*

It would be important to involve the women in order to know what they like and what they don't like. It is always better to listen to their opinions to evaluate and improve the program. ***Of course, you must be careful, because they don't always know what's good for them, otherwise they wouldn't be here*** *(man/addiction counsellor/outpatient care for people with drug-use related problems/Austria).*

Mostly clients are only consumers, they accept the programme. ***Most of the women are traumatised and it would be chaos if they had to decide it [the content of the programme] due to missing resources****. In the form of groups and mutual support groups towards the end of care it would possibly make sense (woman/therapist/psychologic and psychiatric care/Austria).*

Also, the idea of participation is confused with the assumption of more care tasks that only highlight the lack of consideration of the needs of women and their children:

As we are a small institution, women play a role in the therapy programme. ***They take care of each other's children, for example****. (female, gender specialist, Therapeutic community/residential centre for people with drug-use related problems/ Germany).*

> Mutual support among women in the service is promoted

This is an aspect that is being promoted, although it has not been commented on much. In this case, certain gender stereotypes are observed in terms of the idea of "competitiveness" between women:

It comes to a positive experience when women start to support each other - ***because in the past they were more competitors*** *(Woman, Therapist/ other services/Austria).*

> The autonomy/ empowerment of women is promoted

It has not been a much-commented issue, either. It is striking in this case that women's empowerment/autonomy is not part of a collective/political strategy but is dealt with on an individual basis in relation to particular situations:

In general, we do not work from the collective*, as women who use drugs and the violence that affects them,* ***but from the individual****, what has happened to me in particular in relation to another user.... (Woman/Director/Therapeutic Community/ Spain).*

> Social reintegration is actively promoted

In general, it is reported that social reintegration is not actively promoted in services, despite being one of the "traditional" aspects of services:

Difference in quality between public and private services. ***In public services improvements are needed related to aftercare operations****. Capacity of resources must be considered (man/therapist/ therapeutic community and psychologic and psychiatric care/Austria).*

Many clients are dismissed without a fixed job, structure, and an outside network*. The relapse is often already pre-programmed (woman/therapist, educator/outpatient care for people with drug-use related problems and therapeutic community/Austria).*

Social workers are trained but *when I listen at the regulars' table conversation:* ***they have not noticed what has been going on in the last 10 years*** *(man/peer worker/ outpatient care for people with drug-use related problems/ Austria).*

There is a lack of specialised housing and employment services... *such as autonomy flats, social insertion companies, specialised counselling services with professionals trained in drugs and gender where they are really offered contracts... (Woman/Psychologist/ day centre for people with drug-use related problems/Spain).*

Social reintegration is not a priority of care services, while it should be a fundamental point*. Treating a person without then putting them in a position to return to having a "normal" life, without giving them the opportunity to build a future and be independent means losing them as soon as the treatment program is over. (man/psychologist /therapeutic community/Italy)*

A way should be found to create a protected environment for girls, not so much because they are unable to reintegrate into society, ***but because in Italy society is still too closed-minded****. If you have had drug addiction problems, they will always see you as a drug addict and it will be difficult to find someone willing to give you a chance or a job. (woman/occupational therapist/therapeutic community/ Italy)*

To reintegrate women into society it is necessary to find them a job, but unfortunately most of these women have a low level of education because they abandoned their studies very early. The best way to bring about social reintegration would be to ***study and promote training services so that women can increase their level of education****, understand what their aspirations are and find a job that makes them feel satisfied with themselves (psychologist/woman/therapeutic community/Italy)*

> There is coordination with local networks, social movements and services to support women and other community services/organisations

Coordination with local networks, social movements and women's support services and other community services seems rather weak:

Too little cooperation with the local community. There has been a lot more collaboration ***before*** *(woman/doctor of science/information and attention service for women survivors of GBV/ Croatia).*

Specifically, communication takes place ***only when a situation of resolving a particular isolated case arises****. (Woman / master of nurse / day centre for people with drug-use related problems/Croatia).*

In the area in which we operate, there are very ***few such organisations****. It would be positive for our clients to cooperate with such because they could get the wider range of help. (man/peer worker/ therapeutic community/ Croatia).*

We do not cooperate with the above as we are in an area where ***such organisations do not operate****, and it is very complicated to drive our customers to more remote areas to get the stated support. (woman/social worker/therapeutic community/Croatia).*

We are not in contact with the above because we are, ***geographically, in a very isolated area*** *(woman/social worker/therapeutic community/Croatia).*

I believe that we, as an organisation that provides this type of help to people with addictions, ***should cooperate more with the local community****, because in that way we would contribute much more to the well-being of our users (woman/peer worker/outpatient care for people with drug-use related problems/Croatia).*

We used to cooperate a lot more*, nowadays we are not so much in cooperation with the local community. Simply, the whole situation around the* ***COVID-19 affected our cooperation*** *(man/ technical worker/therapeutic community/Croatia).*

No one feels responsible for coordination *between community service/organisation (woman/ therapist/therapeutic community/Austria).*

The worst for a counsellor is when you feel alone *- also for the clients (man, harm reduction/ outpatient care for people with drug-use related problems/Austria).*

[It is needed a] Better coordination in-between Police, Legal services and Child protection and health/drug services *(woman/therapist/day centre for people with drug-use related problems/ Portugal).*

Unfortunately, collaborations between services in Italy are very scarce. Services often do not communicate with each other and above all there are no unified protocols*. (nurse/ woman/ therapeutic community/Italy).*

The Veneto region is quite a particular reality because the collaboration between public and private is well structured. In other regions of Italy is not like that (educator/ man/health service (public)/Italy).

The collaboration with the public service is not excellent but it is good. This is because the work of the private sector depends on the public (patients are first taken care of by the public health service and subsequently sent to private organizations) (doctor/woman/therapeutic community/Italy).

Collaboration between private social entities (associations, organisations, cooperatives) is much more difficult*. This is because the budget that is provided to private organizations depends on the number of guests assisted each year, so instead of creating a collaboration it becomes a c**ompetition for more funding from the region. To improve things, management and organizational policies should change****. (director/woman/health service (public)/Italy).*

> The coordination with peer networks for women who use drugs is promoted

Coordination with peer workers' networks is assessed as "too complex" for women who use drugs in what is a somewhat infantilised assessment of them:

*Conditionally, in the phase where the clients are at the services **it would make sense for the reintegration into everyday life. Before that it doesn't make much sense because it would overwhelm them** (woman/therapist/therapeutic community/Austria).*

***This might be too complex, some of them are very impaired and have no interest in cognitive challenges; furthermore, they wouldn't understand either** (woman/therapist, educator/ outpatient care and therapeutic community /Austria).*

> Socio-political activism is actively promoted

Same for the promotion of socio-political activism among women who use drugs:

***The women in our institutions often have young children, and they have other worries than being actively involved somewhere** (female gender specialist, Outpatient care for people with drug-use related problems/ Germany).*

> Gender perspective approach is adopted

In general, it is reported that the gender perspective is not being implemented in services, according to data reported by surveys and focus groups; surprisingly, only Spanish professionals interviewed commented on this issue, suggesting that the gender perspective in the field of drugs is still less well implemented in the other country partners:

The gender perspective is not a requirement *for recruitment (Woman/Director of Therapeutic Community/therapeutic community/Spain).*

*I**n general, the gender perspective is not being incorporated, it is just starting**... this is exactly the reason why the idea of our service was born: we saw that in GBV services, women who use drugs were not allowed access and in drug services a very masculinised model prevailed.... (Woman/Social Educator/integrated service/Spain).*

It falls short, it is not implemented in a real way, proof of this is that in drug services women do not come, they feel judged*... it is even worse in services for active drug users (Woman/Social educator in a women's programme in a harm reduction service/harm reduction service/ Spain).*

In general, the gender perspective is not incorporated, despite the fact that there are already many studies on the subject*; for example, in the outpatient services (CAS), there are no groups for women, and in the mixed groups, the majority are men... (Woman/Social worker in harm reduction service/d). (Woman/Social integrator integrated service/ harm reduction service / Spain).*

*There has been a lot of advocacy for the gender perspective but t****he issue is that not only is it not being implemented but trying to do it in any way..., without training etc****., important ethical issues are transgressed, rights are violated at the level of intervention and we are re-victimising women (Woman/Director/Therapeutic Community/ Spain).*

There is a part of the teams that are undergoing an active transformation in gender perspective *but as not all the people are undergoing this process of transformation at the same time, difficulties arise and the attention offered is partial (woman/psychologist, SIAD and residential resource for addictions/ Spain).*

In this sense, the idea of 1 or 2 people in the service as "gender referents" is questioned as bad practice as this Spanish professional points out:

Only 1 or 2 people are the 'gender specialists' in the service, so, in addition to the overload that this entails for them, it is not possible to mainstream the gender perspective *(Woman/Director/ Therapeutic Community/ Spain).*

In addition, several issues are pointed out that are not being implemented in gender perspective:

There are several things that are not being implemented*: the continuous training of all the teams in Gender Perspective and case supervision, the qualitative analysis of the data collected (it would be necessary to see what data is collected because, for example, everything related to violence and what types of violence, this is already difficult to rectify), to preserve common spaces in the centres for women (and here we could talk about a non-masculinised gymnasium, to have a space for example for reading and/or TV. ...), to have a small library in the schools with books, articles... related to Gender Perspective. Take affirmative action decisions related to income. Take into account the need of women to keep in touch with their children from the beginning (by video calls, that their children can go out and have spaces such as meeting points to maintain or restore the link....). (Programme coordinator, woman, psychologist/ Spain).*

There is a lack of diagnostic tools *with gender perspective that allow us to really see and grasp the complexity of the phenomena. (Woman/ Psychologist, programme coordinator/Spain).*

In mixed services, they don't work on the relationship with men and GBV, new masculinities, etc. in a gender perspective *(Woman/Social educator, women's programme in harm reduction services/harm reduction service/ Spain).*

> Harm reduction approach

The harm reduction approach does not seem to be among the most implemented and the need to be accompanied by "treatment" is pointed out:

Harm reduction is not an explicit approach for us *(female, drug specialist, Day centre for people with drug-use related problems/ Germany).*

There are specific harm reduction organisations (providing clean syringes, allowing people who live on the street to wash and eat, first aid for wounds, injuries, etc.) Harm reduction is certainly very

important, ***but it is a service that should work at the same time as the treatment*** *and above all prevention services. (educator/man/therapeutic community/ Italy).*

Harm reduction should also apply to psychological support services. ***By giving the possibility of having listening desks to which women can turn to find support from professionals****. (director/ woman/ therapeutic community/Italy).*

> Trauma-oriented approach

As for the trauma-oriented approach, in general, it does not seem to be very systematised, although, as indicated in the staff survey, it seems to be very widespread, especially among male professionals (who in turn are the least likely to report implementing a gender approach compared to women):

The topic of GBV needs more clarity, education, give courage to women who experienced injustice. Stigmatization combined with propensity to trivialize the topic in a still androcentric world. Women tend to assume the guilt by themselves; therefore, a further sensitisation is necessary. ***It should be questioned why clients use substances, is it to seemingly deal adequate with traumatic experiences?*** *What does the substance use replace in someone's life? (man/therapist/therapeutic community and psychologic and psychiatric care/Austria).*

Psychosomatic diseases are strongly on the rise with a snowball effect of the dynamic of substance consumption, GBV and related post-traumatic stress disorder. Drug and violence - essential to be explored in therapeutic relation, ***special guidelines do not exist****, would be helpful (man, Clinical Psychologist, Psychotherapist, drug and gender specialist / psychological and psychiatric and shelter home for women survivors of GBV/Austria).*

In our facility, we look very much at trauma. In our main facility, I would say somewhat less. ***It depends very much on the institution where the woman ends up*** *(female, gender specialist, Day centre for people with drug-use related problems/Germany).*

The trauma-informed care approach is not considered *(Woman/Social Educator of an integrated service/integrated service/ Spain).*

There is no specific training in trauma and violence, especially in conjunction with the issue of addictions, and the intervention is either partial or wrong, which can re-victimise *(Woman, Social Educator/ therapeutic community/ Spain).*

> Institutional Violence

Some situations of institutional violence are reported in the services, along the lines of what was reported by women in the survey and focus groups:

In the health services, especially in family planning or termination of pregnancy, they are treated very badly *(by men and women, including young women), even when we accompany them as professionals. It would be necessary to see why the equality plans of some of these institutions are very old... (Woman/Social educator, women's programme). (Woman/Social educator, women's programme in harm reduction services/harm reduction service/ Spain).*

*When you intervene with women who have suffered violence and have an addiction problem and y****ou don't know how to intervene well, or you do it from a stigmatising view of them, that is reproducing institutional violence*** *(Woman/Social educator/ therapeutic community/ Spain).*

Question 2-According to your experience, IN GENERAL which is the MOST DESIRABLE OPTION for women who use drugs facing GBV?

Consistent with the results of the survey, some professionals have opted for this first option:

> **Option A: "Existing centres for women survivors of violence should be adapted to include women who use drugs".**

***Existing centres for women survivors of violence should be adapted and include women with addiction**, precisely in coordination with the relevant services (woman/master of nurse/day centre for people with drug use-related problems/Croatia).*

*The existing centres have a built-in infrastructure for surviving domestic violence and would **only be upgraded with the knowledge and skills to work with addicted women and would be more financially viable than building new ones**. The problems arising from domestic violence are a little more delicate than the problem of addiction. (woman/social pedagogue/Centre for social welfare/ Croatia).*

***I believe that the existing centres for women survivors of violence should also work on addiction in women** as part of their treatment, given that this area is closely linked (man/peer worker/outpatient care for people with drug use-related problems/Croatia).*

***Existing services for women should include more clients with drug-use related problems**. Regarding these, concepts would be very helpful. In general, both are important issues that can't be separated. From my previous work inpatient service for alcoholics, I can say that almost all women were victims of violence (woman/therapist/psychologic and psychiatric care/ Austria).*

This was then the second most reported option, despite the fact that most professionals who have participated in this research have indicated their lack of knowledge about the intersection of drugs and gender:

> **Option B: "Existing centres for people who use drugs need to better integrate a gender perspective, and specifically the GBV issue".**

*Since there are already women in our treatment centre on addiction treatment, **I think that part of the treatment is dealing with GBV** (woman/psychologist/therapeutic community/Croatia).*

*Since addiction treatment centres work on comprehensive treatment, **I think that GBV should be one of the topics** (man/doctor of medicine psychiatrist/psychologic and psychiatric care/Croatia).*

*Because clients with drug-use related problems are in good hands and the **topic of violence should be integrated** (woman/therapist, educator/outpatient care and therapeutic community / Austria).*

Note that 70% of the professionals interviewed in Italy agreed that this is the best option.

Finally, this was the option most highly rated by the majority of respondents, as was the case in the survey of professionals:

> **Option C: "Integrated specific centres for women survivors of violence that incorporate a drug rehabilitation or/ and harm reduction perspective should be incorporated".**

I believe that in special integrated centres, women would receive better care and professional staff

would have ***better knowledge and education on the issues they deal with****. (woman/nurse/day centre for people with drug-use related problems/Croatia).*

I think that the best and ***highest quality support*** *can be obtained in integrated women's centres. (woman/doctor of science/information and attention service for women survivors of GBV/ Croatia).*

Better care, better service, more professional staff *(man/peer worker/therapeutic community/ Croatia).*

In this way it is provided a better service for women *(woman/social worker/therapeutic community/Croatia).*

In integrated centres there is a better opportunity to provide ***comprehensive support*** *(woman/social worker/therapeutic community/Croatia).*

I think that only in this way can women get the support they deserve, ***since these centres are staffed by professionals who have some education and knowledge*** *on how to deal with this problem (woman/social worker/probation office/Croatia).*

I think that the experts in these centres have the ***most knowledge and skills*** *to work with this population. (woman/social worker/probation office/Croatia).*

In this way, ***comprehensive help*** *would be provided to women. (woman/peer worker/a/Croatia).*

This option seems like the best possible idea for women who have faced ***both problems****. (man/ technical worker/therapeutic community/ Croatia).*

I think that knowledge ***from both areas should be opened and integrated*** *in order to help women addicts who have survived GBV in the best possible way. (woman/social worker/therapeutic community/ Croatia).*

Integrated work and facilities are the best option*. They should be strongly connected to and also deliver data for research. Based on research the topic can only be necessary work in progress (man, Clinical Psychologist, Psychotherapist, drug and gender specialist /therapeutic community/ Austria).*

Services for women with drug-use related problems should be expanded*. Existing offers should be expanded, and the addiction sectors merged. Then it is more difficult not to get lost in the health care system and women can get help more easily (woman/therapist/therapeutic community/ Austria).*

Integrated services are necessary and need to have a clear identifying feature*. A person affected should know: this is the place to go l- like I go to dentist for teeth problems (female, psychotherapist /therapeutic community/ Austria).*

The alone existence of integrated services will raise attention and give victims a much better chance to personally understand in which problem they are in *(male, psychiatrist /therapeutic community/ Austria).*
It is better to work together as the two issues are interrelated*: drug use is often a consequence of the violence experienced. (Woman/Director/Therapeutic Community/Spain).*

We think that it is better to work from a ***perspective that is as intersectional*** *as possible and that provides a broader perspective (Woman/Social Educator of an integrated service/integrated service/ Spain).*

Because of the similarity of the group*, they can share their experiences better; in mixed therapeutic communities, when there are many women there are more conflicts between them because of the role*

they have to assume, the problems of couples that are formed... (Woman/Social Educator from an integrated service/integrated service/ Spain).

***Because we have to take into account intersectionality**, the 2 axes of discrimination overlap. The stigma attached to women who use drugs is very high, so they need a safe space where they are not judged, free from prejudice... (Woman/Social Educator from an integrated service/integrated service/ Spain).*

***It is important to take into account the 2 aspects, which comes first, the chicken or the egg?** We don't know, so it is better to tackle it together, it changes the vision completely, it takes the blame off the women (Woman/Director of day centre for drug users/day centre for people with drug-use related problems/ Spain).*

***However, not enough resources are being allocated for this**, for example cooperative flats, because if, after being in an integrated residential service, we have to send them to a traditional shelter, they will find themselves back with their aggressors... (Woman/Director/Day centre for people with drug-use related problems/ Spain).*

***Because they get better results... but its implementation depends on political sensitivity** which translates into subsidies and concrete resources that are allocated, so that it doesn't remain on paper... (Woman/Social educator/ women's programme in harm reduction service/Spain).*

***Because it is a problem that cannot be looked at from a single perspective**, it is better to do it in an integrated way because drug use and GBV are interrelated (Woman/social worker integrated service/integrated service/ Spain).*

***It is impossible to work on both aspects separately** (Woman/Psychologist/day centre/Spain).*

***Because the fragmentation does not respond to reality**, there is no coordination within and outside the network, we have simplified for the sake of rigour but we do not respond to the complex needs... and we end up saying that if it does not work (e.g. women do not come to the services), it is their fault... (Woman/Director/Therapeutic Community/Spain).*

***Resources have to be adapted to work with women who use drugs and many other situations such as dual pathology, trauma, mental health...** to have spaces for women with children... everything will depend on how much information, training and transformation we professionals have and what is the willingness of the professionals to claim ourselves and change to provide a good response adapted to the real needs (Psychologist of the residential centre of the centre for addictions and violence/ Spain).*

4.
Discussion of findings

In relation to children reported by WWUD, 39,85% of the women surveyed reported not having children, while 60.15% reported having children. In this sense, it is interesting to highlight the barriers to access for women with children to certain types of treatment, as well as to observe the type of intervention carried out with mothers with children.

In the case of the question on relationships with partners who use drugs, 33.33% of the women surveyed reported being in sex-affective relationships with partners who use drugs or alcohol, while 27.34% reported having relationships with partners who do not. In this sense, it is important to note that gender-based violence (GBV) is structural violence, beyond the use or non-use of drugs; in any case, drug use can be a catalyst for situations that already exist. It is important to highlight that women receive violence for being women and that this situation becomes more serious and complex when interacting with other axes of vulnerability/ discrimination.

Actually, overall, 33% of women in the EU has been a victim of physical (24%) and sexual (8,5%) violence by a partner, a non-partner or both; 43 % of women have experienced some form of psychological violence by an intimate partner; Some 12 % of women indicate that they experienced some form of sexual violence by an adult before the age of 15; and 5-13% have experienced economic violence in current or past relationships (FRA Survey, 2015). Thus, violence among women who do not use drugs also responds to a structural character that goes beyond drug use itself and/or drug use by their partners, although the prevalence seems to be higher among women who use drugs (psychological: 86,54%; physical: 74,23%; sexual violence during adulthood: 44,62%; sexual violence during childhood: 24,62%), according to our survey.

Besides, according to United Nations Office on Drugs and Crime (UNODC, 2018)[17], the prevalence of gender-based violence among women who use drugs is two to five times higher than among women who do not use drugs. Compared with men who use drugs (EMCDDA, 2022)[18], WWUD are more likely to have experienced sexual and physical assault and abuse as children or as adults, and to be exposed to intimate partner violence, pointing to the structural inequality between men and women who use drugs. Besides, a number of sub-groups of WWUD have specific needs. These sub-groups, which often overlap, include pregnant and parenting women; women involved in sex work, who may often experience violence and stigma; women from ethnic minorities, who may have been trafficked; and women in prison among other complex situations.

In terms of mental health there could be a bias in the responses as they were self-reported, so we cannot verify the diagnoses. In any case, there is a high prevalence of self-reported depression, that could be associated with gender discomfort and the overburdening of women in their daily lives (Altell, 2022)[19], as well as the over self-reported diagnosis of Borderline Personality Disorder (BPD). This could be linked with not fulfilling gender mandates, what it means, not acting according to gender mandates and, therefore, in accordance with "deviant behaviour" as also has been found in Martinez-Redondo and Arostegui Santamaría (2021)[20].
On self-reported physical health, almost half (41,48%) of the sample preferred not to answer, so no conclusions can be drawn. The question was probably also perceived as very intimidating by the respondents, since it asks about physical health diagnoses related to diseases that are highly stigmatized such as HIV, hepatitis, etc.

In relation to the question on drug use, a certain bias is observed at the time of answering, taking into account that more than half of the sample was in abstinence-oriented services (therapeutic communities and other residential treatment programs) and, therefore, they answer in terms of current drug use. Therefore, it is very important to be cautious when cross-referencing data and not to over-interpret. However, in accordance with previous literature, it is observed that women

17 https://www.unodc.org/wdr2018/en/women-and-drugs.html
18 https://www.emcdda.europa.eu/best-practice/briefings/women-drug-problems_en
19 «Violències Masclistes dins l'àmbit de l'ús problemàtic de drogues» (Altell Albajes, 2022)
20 https://pnsd.sanidad.gob.es/profesionales/publicaciones/catalogo/catalogoPNSD/publicaciones/pdf/2021_DGPNSD_Violencia_genero_abuso_sustancias.pdf

use more legal and prescription drugs (benzodiazepines and opioids), which could be related with a medicalisation of a problem that is more of a social problem, as other authors pointed out, such as Altell (2022), and Martinez-Redondo and Arostegui Santamaría (2021)[21].

As for the axes of discrimination, beyond the idea of being a WWUD, poverty stands out. In this sense, an intersectional approach to interventions and the design of public policies is important. We are surprised that, contrary to the literature, only 39.69% of the women surveyed reported that "my personal condition (*ethnic background, sexual orientation, mental health, homelessness, migration...*) made me more vulnerable to violence". Perhaps this is due to the wording of the question or the lack of awareness of the women interviewed about the axes of oppression that run through them. We can hypothesise that given that in the process of recovery from violence, realizing how oppressions operate is a complex issue that deserves frequent and significant accompaniment from a gender perspective. It is also possible that this can be related the characteristics of our sample, where WWUD from harm reduction services are scarce.

Regarding GBV by contexts, the women interviewed mainly reported violence in the context of sex-affective relationships (29.81%), institutional violence (26.54%) and violence in the context of drug use (24.36%), followed by violence in the context of the family of origin (20.39%). Violence by an unknown aggressor (12.37%), in party settings (11.91%), drug trafficking (9.73%) and work contexts (8.64%) were reported less frequently. Finally, women respondents reported low frequencies of violence in the context of sex work (6.54%), homeless context (6.23%), early/forced marriages (1.95%), armed conflicts (1.40%) and female genital mutilation (0.39%).

So, a high percentage of women (29,81%) reported having suffered violence in the intimate partner sphere, while 27,34% said they did not have a partner who used drugs. As we pointed out before, this would break the myth of the abuser-consume, putting the point of responsibility for the aggression back on the aggressor without excusing these behaviours from substance use.

Institutional violence appears to be the second highest GBV context, although normally tends to be under-reported, due to ignorance about the concept or the complexity of defining it. In this sense, it is important to be able to ask about institutional violence in a clear and non-cryptic way so that the magnitude of the problem is made visible. In fact, it is very significant that, beyond the qualitative data provided by Benoît and Jauffret-Roustide (2015)[22], we could not find data on this issue, despite the international declarations and conventions that suggest addressing this type of violence as GBV. Article 5 of the Istanbul Convention also states that: "State parties shall refrain from engaging in any act of violence against women and ensure that State authorities, officials, agents, institutions and other actors acting on behalf of the State act in conformity with this obligation", in accordance with various international conventions that precede it: Convention on the Elimination of all forms of Discrimination Against Women[23] (Treaty of 18 December 1979), Article 2: "To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation". Declaration on the Elimination of Violence against Women[24] (1993) of the General Assembly of the United Nations which refers to physical, psychological and sexual violence perpetrated or tolerated by the State. Art 4: more than 17 State duties to protect against violence against women: "b. Refrain from engaging in violence against women"; Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará, 1994)[25]: Article 2 "Violence against women shall be understood to include physical, sexual and psychological violence: c. that is perpetrated or condoned by the state or its agents regardless of where it occurs".

21 https://pnsd.sanidad.gob.es/profesionales/publicaciones/catalogo/catalogoPNSD/publicaciones/pdf/2021_DGPNSD_Violencia_genero_abuso_sustancias.pdf
22 https://rm.coe.int/improving-the-management-of-violence-experienced-by-women-who-use-psyc/168075bf22
23 Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 | OHCHR
24 Declaration on the Elimination of Violence against Women | OHCHR
25 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women

It is important to understand that to deny institutional violence or tray to diminish its impacts in people lives, it is, in fact to perpetuate it, and to contribute to make this problem invisible. It should be noted that more than a quarter of the sample identifies institutional violence, which we consider to be a very high percentage, even though we know that it is an underreported concept for both women and staff. It is also important to point out the relationship between stigma and institutional violence suffered by women who use drugs and the gender barriers to accessing specific treatments. All of this would undermine quality standard, on which there is currently unquestioned agreement.

As far as institutional violence or perceived barriers to receiving help are concerned, 52,85% of women reported that *"I have been afraid of being considered a bad mother by child protection services and having my children taken away from me"*; 39% reported that "I have been afraid to go to health and social services for using drugs"; and 36,17% reported that "I did not explain the violence I was suffering to the social/medical staff because I was afraid of not being believed, especially because my use of drugs".

On the other hand, the gender of the perpetrator is mainly male, regardless of whether they use drugs or not, within the framework of a patriarchal power structure. Therefore, gender identity seems to be the predictor variable of GBV, beyond other axes of discrimination such as drug use.

Regarding violence experienced in the context of drug use itself, 66.67% of the women surveyed stated that *"often the person who assaulted me was under the influence of alcohol or other drugs"; 57.14% stated that "often when I was assaulted I was under the influence of alcohol or other drugs"*; and 56.64% stated that "my drug/alcohol use worsened after experiencing gender-based violence". However, we should not be confused by this data, as it need to be contextualised to be properly analysed.

In terms of satisfaction with mainstream or specialised services, there is a response bias. On one hand, they are responding from the same services that are accessing and/or should be compared with the time and diversity of services they have been in; on the other hand, they may be more demanding with the mainstream services. Therefore, the sample that answers about the specific services is found at that exact moment of the answer, it could be a convenience sample by choosing those people who are more cooperative or satisfied with the program.

The aspects that best define the service seem to be those that are more traditional and less linked to gender mainstreaming, such as professionals' knowledge of drugs, consideration of mental health and social reintegration programmes. On the other hand, there seems to be a lack of spaces for participation that give a voice to the users of the services, there are no systems or protocols for early detection of GBV and the design of the spaces does not seem to be considering the specific needs of women and their children. As seen in relation to staff results, this seems to contradict the idea that staff professionals are mainly from a trauma-oriented approach. Rather, they seem to be working from a biopsychosocial approach that falls short of being comprehensive; in this sense, authors such as Martinez-Redondo and Arostegui Santamaría (2021)[26], Benoît and Jauffret-Roustide (2015)[27], Greenfield et al. (2010) and Castillo et al. (2005) state the idea that a truly trauma oriented and biopsychological approach should consider gender and GBV as a must. In fact, all manuals on intervention with women in addictions contemplate the work on trauma and gender, so GBV from a gender perspective, as necessary aspects for addiction recovery (Greenfield et al., 2010; Arostegui & Martínez-Redondo, 2018; 2022). Thus, the processes are developed from a transformative perspective and have teams made up mainly of women, trained and supervised from a gender perspective.

26 https://pnsd.sanidad.gob.es/profesionales/publicaciones/catalogo/catalogoPNSD/publicaciones/pdf/2021_DGPNSD_Violencia_genero_abuso_sustancias.pdf
27 https://rm.coe.int/improving-the-management-of-violence-experienced-by-women-who-use-psyc/168075bf22

About the survey aimed at staff:

Again, we found a staff sample with a majority of cis-women (78,25%) and very disparate between the participating countries (Spain 25,31%, Germany and Austria 25,31%, Italy 19,39%, Croatia 18,57% and Portugal 6,94%), which makes comparison between countries very difficult. Besides, the services in which they work are mostly therapeutic communities (56,84% men and 35,51% women) and day care centres (22,4% women and 12,63% men); from the high percentage of men working in therapeutic communities we can infer that this may be contributing to the masculinisation of this type of services (Hansen, 2020), even if no generalisable gender-disaggregated data on staff in therapeutic communities has been found.

Services are mostly publicly funded, but one of the exclusion criteria is not being able to pay the fees (5.95%). In this sense, it is important to review the accessibility criteria for programmes in order to guarantee rights in accordance with quality standards stated by EMCDDA (2011)[28], UNODC/ WHO (2020)[29].

Also, drug use, represents an exclusion criterion in 15,20% of answers, despite the fact that this is a majority sample of professionals working in therapeutic communities, which makes it necessary to investigate more about the access criteria to these specific services across Europe and validate if they really are realistic and respect the accessibility quality standards.

Regarding the question about different professional roles in services, the survey did not consider the gender of these roles, so we cannot see which roles are more masculinised/feminised or how the patriarchal structure is replicated in the services. This would have provided us with a lot of information about the patriarchal structures of organisations that often reproduce intervention models along the same lines.

The majority of professionals have reported to be attending to "women and men who use drugs" (65.15%), so they may not be considering GBV experienced by the women they attend, a must in terms of efficiency efficacy and human rights approach as suggested by existing literature (Benoît & Jauffret-Roustide, 2015).

The approach seems to be mostly self-reported "biopsychosocial" (holistic) (51,06% of men staff and 55,26% of women staff) although with a superficial approach as it does not take into account neither trauma nor gender perspective nor trauma with gender perspective. Following an analysis by staff's gender, it is noteworthy that more female professionals have reported that their services are working from the gender-based/feminist approach (27.63%) compared to 11.7% of men ($p < .01$). In contrast, the opposite occurs in the case of the trauma-oriented approach, reported by more male professionals (31.91%) than female professionals (23.68%). Therefore, it seems that trauma is being addressed without considering the gender perspective, and considering both concepts as disconnected or not intrinsically related, which is a conceptual mistake. In this sense, it is necessary to insist on the error of not doing so from gender-based approach and without considering WWUD rights, ethics and therapeutic efficacy.

Regarding general aspects defining the staff's current service, the professionals surveyed reported the highest frequencies for specificity (50%), innovation (39.96%), sustainability (59.83%), transferability (44.77%), networking (59.41%) and evaluation of the effectiveness and efficiency (54.39%) of the services in which they work. In this sense, a lack of clear definition of this constructs, and a high degree of social desirability could impact in those responses.

As specific aspects defining the staff's current service, the empathy of the professionals towards women drug users facing GBV (87,76%) stands out, but is important to note that women scored

28 https://www.emcdda.europa.eu/publications/manuals/prevention-standards_en
29 https://www.unodc.org/unodc/en/prevention/prevention-standards.html

them lower on empathy; also mental health is taken into account (85,27%); the knowledge of professionals about drug use (81,12%); the autonomy/empowerment of women is promoted (78,01%); social "reintegration" is actively promoted (77,39%); and the idea of belonging to a support network is taken into account (72,41%). Again, aspects that have traditionally defined most services and do not necessarily indicate that a gender perspective is being implemented. With regard to social reintegration, however, it is important to assess how it is conceived and whether these programmes contemplate all the necessary tools and resources in a broader sense that includes, for example, housing resources.

As aspects to be improved, respondents have highlighted the knowledge of professionals about the interaction between drug use and gender violence (54,39%); knowledge of professionals about gender violence (39,96%); the empathy of professionals towards participants/users of the service (34,52%); low thresholds/flexibility for service access (31,8%); addressing issues that specifically affect women who use drugs and have experienced gender violence (31,50%); and the existence of spaces only for women (31,50%). These aspects are therefore very representative of the implementation of a gender perspective in care services. In this sense, it is important that all these aspects are addressed.

Regarding the most desirable option for women who use drugs facing GBV, integrated services are indicated especially by professional women respondents to the survey (56,18% vs 34,04% of men). However, in case such services are not widely available, it would also be interesting to consider the possibility of addressing the two other options in parallel. In this sense, it is necessary to consider what can be done to adapt violence and drug programmes to women who use drugs and survive GBV (Martinez-Redondo & Arostegui Santamaría, 2021)[30].

About the cross-overs:

It seems that, according to the staff (83.97%) and the women consulted (76.32%), the "integrated services for women who use drugs and face GBV" seem to bring together more quality indicators, better incorporating the gender perspective. The gap with other services, including harm reduction services (according to staff: 62.50%, and women: 36.04%) is striking, especially in the case of women respondents. This would suggest that, despite the flexibility that characterises harm reduction services, they may be seen by women as masculinised spaces that do not consider the needs of women and their children, and are insecure. This is consistent with the scientific literature (Shirley-Beaven et al., 2020), as well as with the results of the focus groups and interviews obtained in the framework of this research. "Shelter for women" and "information and attention services for women" score less well because they do not integrate traditional aspects of drug services such as "professionals' knowledge of drugs"; also, the samples for these two types of services were very small, so it is difficult to extrapolate conclusions.

About the focus groups:

a) Women focus groups

The first part of the focus groups focused on exploring the relationship between drug use and violence experienced by women throughout their lives:

Regarding the connection between drug use and GBV, women who participated in the focus groups pointed to the relationship between the violence they had experienced throughout their lives and drug use, either as a cause or as a consequence of the violence they had experienced. These statements, together with the literature reviewed and the questionnaires administered,

30 https://pnsd.sanidad.gob.es/profesionales/publicaciones/catalogo/catalogoPNSD/publicaciones/pdf/2021_DGPNSD_Violencia_genero_abuso_sustancias.pdf

highlight the complex relationship between violence and problematic substance use. It is important not to fall into a simplistic relationship of this phenomenon, given that, as various authors commented on throughout the text (Martinez-Redondo & Arostegui Santamaria, 2021; Hansen, 2020; Plaza et al., 2022) underline, violence and addictions involve a higher complexity, which, regardless of whether the use of substances begins to face violence, or that violence begins in the context of consumption, the result is that both issues intertwine, generating a question worthy of complex analysis to design interventions and before starting to dig into that situation.

The participants of the focus group, indicate having suffered various types of violence throughout their lives, such as sexual violence in childhood and adulthood, violence within the couple, domestic violence of various kinds and institutional violence. All of them comment that once the cycle of violence is established, the use of substances calms the discomfort, and in turn, anesthetizes one's ability to react and request help, which ends up contributing to a worsening of the situation, and the progressive decrease in one's own resources constituting a real maze.

A core issue is the identification of the dehumanization they suffer throughout their lives, having suffered physical, psychological, and sexual violence since childhood. They comment on the sexual violence that is exercised against them in consumer environments and how men do not suffer the same type of violence even though they are consumers in the same environment. The participating women argue, and accurately, the consequences in terms of the violence they suffer due to the fact of being women, although it is aggravated by the use of drugs, but fundamentally they identify the gender variable as the basis of the experienced double stigma and inequality.

The majority of women who participated in the focus groups pointed to men as perpetrators of the violence they experienced throughout their lives.

The results of this focus group help make visible that, although there are women in situations of violence or who may act violently, especially in the field of drug use, it is men who are identified as the main perpetrators regardless of whether they use drugs or not. Again, the gender variable for the exercise of violence is evident, focusing on this sense and not on the mere use of substances. Furthermore, some women have reported feeling made vulnerable to violence by other axes of oppression in addition to the fact that they are women who use drugs like poverty, lack of social support, mental health issues, guilt, and motherhood, and the fear of losses their child's if they ask for help regarding, above all, for drug use.

Finally, note that in this part of the groups the concept of guilt was very present, and how this contributes to the circle of abuse, and makes it difficult to ask for help.

In the second part of the focus groups, experiences in different care services, both specialised (such as drug services) and mainstream (such as health services), were discussed.

Related with specialized services, some women in integrated services have pointed out that important issues related to gender mainstreaming in drug services are being addressed; for instance, the connection between drug use and the violence experienced throughout life is revealed as liberating the sense of guilt and judgement that women who use drugs have been subjected to.

In the specific resources of harms reduction and shelters, the feeling of insecurity stands out, the low prevalence of the presence of women, which is a dissuasive in many cases to continue in these services.

On the other hand, it is highlighted that certain programs are temporary solutions and do not really provide specialized care in a continuum of care, are not oriented to the medium and long term, and that it contributes to relapses and low perception of self-efficacy, increasing the lack

of support, low self-esteem and distrust in the system. They also comment on the lack of places in "mixed" services, since there is much more offer for men. Another fundamental issue, and one that the focus groups from different countries insist on, is the difficulty or inexistence of services where you can go with your children, which represents a barrier to access and permanence for women who are raising their children and want or need this type of treatment.

Positive and negative experiences within services are described. As for the positive ones, they highlight the importance of addressing violence together with addictions, they perceive that this type of approach is really liberating and contributes to a real recovery. On the other hand, regarding the negative experiences, the lack of a gender approach, the lack of knowledge of dual pathology, the lack of LGTBIQ+ perspective, and even situations of harassment by male users in the same program or male staff are described.

Related with mainstream services, there have been multiple reports of neglect and/or institutional violence by the women who participated in the focus groups. Mainstream services, according to participant's answers, did not consider the relationship between violence experienced throughout life and drug use. Many times, when they manage to explain the situation of violence, they are not believed by the professionals. Finally, note that they have the feeling of being "second-class patients" in services, especially health services, and that they feel judged.

In relation to the results of the survey and the content of the focus group, multiple situations of institutional violence related to not believing the victims of violence, ignorance of the cycle of violence, stereotypes related to people who use drugs and double stigma are described in female users.

Last, but not least, women state what should be done in order to improved specialised services. Women have pointed to the need to create more spaces/services just for women who use drugs as safer spaces that are better able to address their specific needs, such as: To allow children access to facilitate women's access to treatment, suggested the need to make the criteria for access to services more flexible, so as to provide for drug substitution programmes and/or access for women who are (still) using drugs, including in women's shelters, increase the specific training of drug and violence (and their interaction as well) in professional staff from specific and mainstream services, and overcome stigma toward the women who use drugs. Finally, they repeatedly underlined the need of a truly holistic approach, not just a "psychobiosocial" one which is not taking account trauma oriented from a gender perspective view, or an approach that main focus is drug use, and not the multiple axes of vulnerability.

b) Staff focus groups:

Firstly, professionals point out that the relationship between drug use and GBV is not always understood, due that drug use is a way of coping with the violence experienced, a consequence of drug use, or both, it is a very complex relationship as we described before. The participant staff stated that there's a significant lack of gender perspective mainstreaming in the design and implementation of drug treatment programs.

It is also highlighted that women with addictions receive violence for the fact of being women, and even more violence for the fact of being women who use drugs, and violate the expected role for them, violence being an instrument of instruction and power over them. As for the perpetrators, there is an agreement among the majority of the participating professionals that violence is exercised by men towards women, this being a structural issue that responds to the organization of the sex-gender system. Even so, there have been certain inputs that said that "violence has no gender" contributing to a discourse of delegitimizing violence against women, which we cannot deny is also in the professional imaginary and that we must generate strategies to overcome it and bring it down. Denying structural violence against women, especially women drug users, is part of institutional violence.

Another issue collected, and which prevails among the ideas of the professionals, is the need to overcome the direct relationship between consumption and being "a bad mother" in a unidirectional way, given that according to the professionals this has to do with the fact that women they bear the burden of care and their consumption becomes disruptive when they cannot exercise that role, unlike male consumers. When we talk to men who are consumers, the gaze is not focused on the exercise of paternity, nor is their action finalized in the same way as mothers.

Regarding the experience in different types of services, the professionals highlight the benefit and the need to include the gender perspective in the work with men, addressing diverse motherhoods not from the perspective of the desire to mother but from responsibility, among other good initiatives. Even so, professionals indicate that these are isolated actions and that much remains to be done given that the implementation of the gender perspective is unequal in addiction services and there are even discourses against its implementation arguing that they are ideological issues, when really It is a rigorous framework that increases the efficiency and effectiveness of programs from a rights perspective.

The lack of specific training, continuing to consider women with more complex and difficult addictions to treat, ignorance of violence and its interaction with drugs, some treatment strategies based on the "traditional" approach contribute to gender barriers to access and remain in treatment, as well as the reproduction of institutional violence from the own drug specific services and mainstream services.

The professionals who participated in the focus groups identified some improvements that should be implemented in both specialised and mainstream services, such as: Firstly, the need for training and supervision of professionals on gender and drugs, including managers, is suggested; the need for practical and situated training is pointed out. It also points to the need to attend to the mental health of professionals in the framework of regular supervision. The need for clear, systematised protocols to address GBV among women who use drugs is also emphasised. And the professionals reported the need to establish structural changes, which question daily practice and the patriarchal structure of organisations, as a key element to incorporate a gender perspective in specialised services such as drug services. As far as mainstream services are concerned, the need to train professionals who care for women who use drugs is also emphasised, it is striking that there is an insistence on issues that would be part of a "traditional" model of intervention that would not necessarily include a gender perspective. Again, it is a must to mainstream gender perspective in all structures of organizations, staff, training, design, and implementation of mainstream services and drug treatment programs.

About the interviews:

120 interviews were conducted with professionals working with women who use drugs and other relevant key informants. Two key points have been explored: Firstly, points that are not being implemented in services aimed at women who use drugs and related issues that should be considered, and the second main point regarding the most desirable option treatment for WWUD facing GBV.

Regarding the first point, it is necessary to mention the flexibility of access to drug services, the fact that women access services to a lesser extent than men and that there are single waiting lists without addressing the different needs of men and women; contributes to a gender inequality access in drug specific services, that many authors has pointed out (UNODC, 2015).

In terms of professional skills, the empathy of professionals towards WWUD must be promoted while guaranteeing care spaces for professional teams and avoiding the burn out process when

managing situations of great emotional calibre. There's a need to overcome different barriers such as: detecting properly mental health disorders, encourage the participation of users in the services. Also, it is a must to increase the knowledge of professionals about gender violence and overcome the lack of training of drug professionals on gender-based violence, and the interaction between drug use and gender-based violence. According to the interviewed staff, GBV is sometimes connected to the use of certain drugs, without taking into account that GBV is based on structural oppression between men and women in a patriarchal context ("we are assaulted because we are women") and that in reality drugs act as a mere facilitator of violence.

As seen in previous sections, professional teams can have simplistic views about the process of GBV and drugs, and this can contribute to blaming women themselves for receiving violence, or for not getting out of that situation, or also to play down the phenomenon of violence against women. In other words, once again, denying violence and its causes contributes to institutional violence. Regarding the design and implementation of drug treatment programs, there's a lack of systematised protocols for action to tackle both problems at the same time, like the lack of adapted and specific spaces and services for women and their children's, it is crucial to include gender specific content when addressing GBV and drugs. In line with this issue, it is identified that the problem of violence in specific drug services is addressed, depending on the will of the professional involved in the process, rather than on a mainstreaming of this good practice. Again, GBV is only addressed if women or therapists address it, not because there are protocols in place.

Also, diversity is not taken into account as it seems that we do not truly work from an intersectional approach that take into account. An intersectional approach acknowledges systemic discrimination due to sexual orientation and identity, gender and gender identity, race, economic status, immigration status, national origin, and ability, among other aspects of one's identity, and that this systemic discrimination impacts access to opportunity.

It is necessary to point out that there are many challenges that are still present in the imaginary of professional teams, such as the discourse of the denial of structural gender-based violence, based on the fact that what is neutral and rigorous is "treating everyone the same" regardless of their gender, which contributes to perpetuating inequalities. The stereotypes related to WWUD are still present, the fact of considering them more complicated, manipulative or disruptive generates a bias in the professional intervention that it is necessary to review. There's a need to promote the autonomy/empowerment of women in treatment.

Regarding the social reintegration concept, staff sometimes think that it is actively promoted but from a very simplistic conception of this concept, due that treatment programs still working in separated silo from other services o care networks.

In general, it is reported that the gender perspective is not being implemented in services, according to data reported by surveys and focus groups, which coincides with the interviews with the professionals, the idea of 1 or 2 people in the service as "gender referents" is questioned as a good practice. There is a lack of diagnostic tools with gender perspective that allow us to really see and grasp the complexity of the phenomena, but some good experiences are being carried out in order to systematise those dimension that are key to consider that a drug programme is designed and implemented from a gender perspective (FCD, 2018).

As for the trauma-oriented approach, in general, it does not seem to be very systematised, although, as indicated in the staff survey, it seems to be very widespread, especially among male professionals, but not considering this approach as a fundamental proposal from the gender perspective, which invites us to think about whether trauma is really being considered from the appropriate approach. Finally, some situations of institutional violence are reported in the services, along the lines of what was reported by women in the survey and focus groups.

The second key point of this section, was to explore the most desirable option for WWUD

who face GBV regarding the treatment modality. The most desirable option, according for the sample interviewed was **"Integrated specific centres for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective should be incorporated"**. Then, the second most reported option was "Existing centres for people who use drugs need to better integrate a gender perspective, and specifically the GBV issue". And last, the option which corresponds to "Existing centres for women survivors of violence should be adapted to include women who use drugs". It seems that there is an "ideal" option in terms of the design and implementation of the appropriate program, but at the same time, in parallel, drug-specific programs must address violence adequately and correctly, and violence services must be more aware of the drug phenomenon and address it, also correctly without it meaning a barrier in access to said treatments.

Limits of the research:

We would also like to point out some limits detected in this research:

> Cross-referencing and extrapolating conclusions cannot be done at random, but the data must be analysed from a rights and research ethics perspective.

> Some country partners such as Germany or Croatia have had specific difficulties in reaching the target group. Croatia faced the closure of hospitals and drug services because of COVID-19 in the period when the focus groups were to be carried out; Germany encountered a lot of resistance in disseminating the questionnaires among specialised services. Therefore, the samples have been very disparate and hardly comparable across countries.

> Also, a more intersectional view of GBV is needed, as the sample is not very diverse (74.71% heterosexual and 89.27% from partner countries, only 3.45% from outside the EU).

> The survey aimed at WWUD asks for very sensitive information in an interview/self-report format which, at times, might not be ideal. At times it may have been assumed that the sample was aware of specific concepts such as intersectionality, innovation and/or specificity of services.

For further research:

Finally, to note some ideas for future related research:

> On institutional violence: data needs to be made visible and research needs to be systematised in order to address this type of violence, which is also included in many international declarations and conventions as a specific form of GBV.

> On the custody of children of women who use drugs: Do women who use drugs have custody of their children taken away from them or not (with respect to women who do not use drugs and with respect to men who do and do not use drugs)? How do you ask about this issue? Is it being registered in any way in child protection services? Actually, we think that it would not be necessary to ask the mothers, but to have objective data to analyse to what extent this type of institutional violence is being exercised towards mothers who use drugs in this sense.

> On satisfaction in specialised services: It would be necessary to collect the treatment history of women who use drugs in different care services and the time spent in each of them, in order to be able to compare satisfaction in each of the services. It would also be

necessary to work with women from a feminist perspective beforehand so that they can analyse their experience from a gender perspective.

> On the staff of the specialised services: it would be interesting to ask about the proportion of men and women in the staff for different training profiles and positions in order to analyse from a gender perspective the possible patriarchal structure in the care services and how this affects the interventions.

> On the more precise interaction (when existing) between violence and certain types of drug use. Even if the information provided by WWUD in the focus groups does provide very useful inputs, the lack of precision of the questionnaire in estimating the types of problem drug use that could be linked to the violence when it was occurring (instead of a "lifetime use") is hampering seriously the possibility of using current quantitative data for this purpose.

> There is a need for research on WWUD facing GBV with an intersectional design and analysis that takes into account sexual identity and orientation, poverty and migration/ refuge and ethnicity.

5. Conclusions and final recommendations

5.- Conclusions and final recommendations

The INTERLEAVE PROJECT strives to better understand gender-based violence against women who use drugs (WWUD), to map the best intervention practices from participating countries in this regard and, based on these findings, contribute to improve the assistance and support provided to these women through the production of a toolkit addressed to professionals and institutions.

As stated by the United Nations Office on Drugs and Crime, UNODC (2018)[31], the prevalence of gender-based violence among women who use drugs is two to five times higher than among women who do not use drugs; and according to some authors, among people who use drugs, women face much more violence than men who use drugs (Roustide, B. 2015). This risk factor is very significant in itself because the structural unbalanced gender-related distribution of power, which induces violence, interacts in a significant way with other drug-related factors (as the possible facilitating role of many substances towards aggression, its impact on mental disorders or to the specific issues that surround drug traffic and the scenes of their use), and others like poverty, ethnicity or migration.
To shed light on this **intersectionality**, a complex **set of research actions** have been done in order to explore this relationship between drug use, abuse and dependence and the different types and contexts of gender-based violence, aiming to learn more about its relevance and improve the actions to be implemented in order to prevent, detect and confront it.

Our initial idea was to have a wide sample from different services, some of them working with women who use drugs, whilst others working with victims of violence (therefore not necessarily drug users), or also from mental health services. This should have allowed us to better comparison of different situations. However, finally our sample has been mainly biased to the side of drug centres and women drug users. Therefore, the validity of our data and conclusions will be limited accordingly.

The following **research actions** have been performed:

1.- Literature review: more than 80 scientific articles and grey literature were analysed.

2.- Women survey: survey addressed to women almost all of them confirmed drug users, with a sample of **N=261** from 6 EU countries, mostly composed by 97.7% Cis-Women, 74.1% heterosexual and 89.27% nationals from partner countries (only 3.45% of respondents reported being born outside the European Union); besides, most of the women were in therapeutic communities (58%) or outpatient drug care/day centres (35.60%), which has also conditioned the results. A very disparate sample between the participating countries makes cross-country comparison or inferences quite difficult. Therefore, our sample was not as diverse as we would have liked, so a more careful intersectional approach related with data collection seems to be needed in order to better explore gender-based violence particularities among diverse WWUD and differences with women not using drugs.

3.- Staff survey: survey addressed to **492 staff members from 6 EU countries** working in different facilities where the treatment is aimed at women who use drugs and/or have experienced GBV. The staff sample had a majority of cis-women (78,25%) working in mostly therapeutic communities (56,84% men and 35,51% women) and day care centres for drug users (22,4% women and 12,63% men). Besides, the disparity between the participating countries (Spain 25,31%, Germany and Austria 25,31%, Italy 19,39%, Croatia 18,57% and Portugal 6,94%), makes comparison between countries difficult. So, again, a more intersectional and better-balanced approach is needed.

31 https://www.unodc.org/wdr2018/en/women-and-drugs.html

4.- Women focus group: A **qualitative survey** using **focus-groups methodology** was undertaken with **66 women (11 groups)** recruited from 11 different services, most of them caring about WWUD, whilst one caring about GBV victims and 3 mixed ones (drugs/GBV).

5.- Professional focus group: Analysis coming from **3 focus groups with professional staff** (1 in Croatia, 1 in Italy, and 1 in Spain). In total, 11 professional staff (8 women and 3 men) from 8 different drug services participated.

6.- Individual interviews with key-informants: Last information-collection initiative was developed through **120 individual interviews** (20 per country) with professional staff and other **key-informants** (drug professionals: 67; from the GBV field: 31; from both drugs and GBV: 14; professionals with a political profile: 8).

We will present **conclusions and recommendations** arising from the joint analysis of such sources of information.

On the intersectionality between drug use and gender-based violence

The majority of the women's sample (almost all current or past drug users) reported having experienced gender- based psychological (86,64%) and/or physical violence (74,23%); 44,62% sexual violence in adulthood and 24,62% sexual violence in childhood. These results are consistent with previous research (Valencia et al., 2020; Benoît & Jauffret-Roustide, 2015).

Among respondents, 29,81% do report having suffered such violence in the context of intimate partner violence, 26,54% in institutional settings, 24,36% in contexts of drug use, and 20,39% in family settings. Physical and sexual violence were most frequent in sex-affective relations and in alcohol/drug use settings. Among those having suffered violence in the intimate partner sphere, 27,34% said they did not have a partner who used drugs, while 33,33% had a partner who did use "drugs or alcohol". In this sense, **men** who use drugs and/or alcohol (86,22%) and who do not use drugs and/or alcohol (51,97%) are more often reported as **perpetrators** compared to women (33.47% / 21.65% who do /do not use drugs). This difference looks much stronger if we look at those reported as **frequent** male aggressors (50,39% users – 15,75% not users). 66,6% of the Women "agree or strongly agree" to the sentence "often the person attacking me was under the effects of alcohol or other drugs", whilst 57,15% say that "often when I was attacked I was under the influence of alcohol and other drugs". So, respondents are pointing out to a relevant intersection between both phenomena, especially with the **more severe-frequent forms of aggression**, with **gender (male)** accounting for **most of the aggression**, but with an **apparent effect with drug/alcohol use as facilitator**. Properly understanding the factors that in a verified way do facilitate GBV is very far from meaning "to justify" that violence out of drug use, and even farther to blame the victim, but must inform our actions intended to prevent or to help for being truly effective.

In the **focus groups**, **women** accurately identify the complex relationship between violence and addictions. They identify the use of drugs as strategies for coping with violence, or the increase in violence against them due to being drug users (because increased vulnerability and other factors), but they emphasize that there is a lot of complexity in the relationship between both phenomena. The participants highlight the gender variable, so being women, as the main factor to receive violence and then this is a situation that is aggravated by the consumption of substances, also most often by the perpetrators (mainly men). Violence is suffered for being women and is aggravated for being women with addictions. The biography of all the participating women is marked by having experienced various forms of violence from childhood to adulthood. Guilt is very present in their recovery processes and must be considered in the therapeutic process.

Drug use appears then to be sometimes preceding the violence, in other cases following it, in some cases being intensely related while in others seem to be only partially linked or even unrelated. And all this being variable according to the drug (not obviously the same for alcohol, cocaine tobacco or benzodiazepines), to modalities or circumstances of its use.

In the **focus groups** with **professionals**, in general, there is a fairly majority agreement on the reality of gender violence, that the main perpetrators are men and that women with addictions receive violence for the fact of being women and also drug users. Even so, there are inputs that confirm that in the professional imaginary some denial of gender violence persists, hiding behind neutrality or scientific rigor.

Simplistic approaches point out to drug use as "the cause" in any case of violence against women where this factor does exist, then ignoring structural relevant factors, as the gender related ones. A truly inclusive approach that considers the different axes that generate synergies in the relationship between drug use and violence must consider, in addition to gender, other issues such as ethnicity, age, and socioeconomic status, among many others. Focusing on a single variable can give partial explanations of the phenomenon.

Either as a reaction towards a too much drug-centered approach perceived as beneficial for perpetrators because "excusing" them, or because the wish to stress the gender factor, denial and underestimation of drug contribution, irrespectively if used by perpetrators or victims, has also often been reported among professionals providing help to victims in some countries, and will need further investigation with a bigger appropriate sample.

Looking into the **intersectionality between three or more factors**, then adding to gender identity and drugs, **poverty** (32,41%) stands out, even if only an overall of 39.69% of the women surveyed reported that "my personal condition (ethnic background, sexual orientation, mental health, homelessness, migration...) made me more vulnerable to violence". In any case, again, an intersectional approach for a better design of public policies and intervention systems seems to be necessary, especially when coming to the interaction with poverty.

In terms of **mental health** there is a high prevalence of self-reported depression, that could be associated with gender discomfort and the overburdening of women in their daily lives (Altell G., 2022), as well as the over self-reported diagnosis of Borderline Personality Disorder (BPD). This could be linked with the idea of not fulfilling gender mandates and in accordance with "deviant behaviour" as also has been found in Martinez-Redondo and Arostegui Santamaria (2021). Let's remark that overdiagnosis of personality and bipolar disorders is also very common among male drug users, because the confusion of their symptoms with many of their addiction-related behaviours. Again, on the intersectionality with mental disorders, in the focus groups, professionals consider that the complex relationship between trauma, violence and addictions is not always understood by professional staff and this directly impacts the lack of design and implementation of trauma-sensitive and gender based interventions.

Experiences from the care services

In the **survey, women** report feeling **less satisfied and more judged in mainstream services**, especially police, legal, health, social, and child protection services. Gender-based violence, the specific needs of women and non-binary people, and their ability to decide (personally and politically) seem to be poorly addressed in all kind of services, according to the women surveyed. This opens up the possibility of improving intervention strategies.

The high frequency of **institutional violence** reported in that survey opens up the possibility of improving intervention strategies in both mainstream and specialised services for women who use drugs, from an intersectional gender perspective, according to the many international

declarations and conventions that suggest addressing this type of violence as GBV.

The positive aspects that, according to the women, best define the services where they receive care seem to be those that are more traditional and less linked to gender mainstreaming, such as professionals' knowledge of drugs, consideration of mental health and existence of social reintegration programmes. On the other hand, there seems to be a lack of spaces for participation that give a voice to WWUD, there is a shortage of systems or protocols for early detection of GBV and the design of the spaces does not seem to be considering the specific needs of women and their children. As seen in relation to staff survey results, this seems to contradict the idea that staff professionals mainly adhere to a trauma-oriented approach. Rather, they seem to be working from a biopsychosocial approach that falls short of being comprehensive; in this sense, authors such as Martinez-Redondo and Arostegui Santamaria (2021), Benoît and Jauffret-Roustide (2015), Greenfield et al. (2010), and Castillo et al. (2005) state the idea that a truly trauma oriented and biopsychological approach should consider gender-based violence from a gender perspective as a must.

On **focus groups** carried out with **women** who use drugs (WWUD), the experiences in care services are identified as negative and positive. The refusals have to do with the feeling of insecurity, the lack of empathy of the professionals, the lack of approach to gender content, especially violence, and the high presence of men among clients, which generates the feeling of minority.

The positive experiences have to do with variables that consider the gender perspective in the treatment: the approach to trauma from the gender perspective, the non-confrontational but humanistic therapeutic style, and the adaptation of services to the needs of women and not only of men, among many.

Many programs defined as biopsychosocial are not perceived as comprehensive by women, with the feeling that they are partial solutions to more complex and long-term problems.

From the **survey** carried out with **staff**, it's important to underline that only 24,49% of the professionals surveyed said that they work in a service that applies a gender perspective (11.70% of men compared to 27.63% of women). The trauma-oriented approach, mainly adopted by male professionals (31,91% face to 23,68% of women), does not seem to incorporate enough a gender perspective. The approach "biopsychosocial" (holistic) (51,06% of men staff and 55,26% of women staff) is mostly reported, although with an apparent superficial approach that, as happened with trauma-oriented approach, does not consider the gender perspective.

As specific positive aspects defining the staff's current service according to themselves, aspects that have traditionally defined most drug services and do not necessarily indicate that a gender perspective is being implemented, are highlighted: the empathy of the professionals towards WWUD facing GBV (87,76%), although women scored lower on perceived empathy; mental health consideration (85,27%); the knowledge of professionals about drug use (81,12%); the autonomy / empowerment of women (78,01%); social "reintegration" promotion (77,39%); and the idea of belonging to a support network (72,41%).

Cross-referencing the positive aspects that best define the service by type of service **(staff survey)** shows that the **"integrated service for women drug users facing gender-based violence"** obtains higher percentages for all aspects (83.97% of all the positive practices listed are reported by the staff as existent in these services). This compares to other services such as harm reduction (63.50%), the second best rated; this includes both aspects that are "traditional" in drug centres and those that are considered to have to do with gender mainstreaming. This is the case even when we look only at the "traditional" aspects (integrated services: 88.89%) and when we focus only on the more gender mainstreaming aspects (integrated services: 83,08%). A similar pattern is observed in the case of **women respondents**, where integrated services obtain higher frequencies for all the positive aspects defined (76.32%), both for the "traditional" aspects

(78.95%), and for the aspects most linked to the gender perspective (75.79%. This is followed by 42.71% (information and attention service for women), 57.50% (harm reduction services), and 42.50% (information and attention service for women), respectively.

From the professional's and **key informant's interviews**, besides coincidence with already quoted concepts, it is stressed the lack of flexibility of access to drug services, the fact that women access services to a lesser extent than men, and that there are single waiting lists without addressing the different needs of men and women, which is thought to contribute to a gender inequality.

Aspects to be improved

As aspects to be improved, professionals have highlighted aspects that are very representative of the implementation of a gender perspective in care services: the knowledge of professionals about the **interaction** between **drug use and gender violence** (54,39%); knowledge of professionals about **gender violence** (39,96%); the **empathy** of professionals towards participants/users of the service (34,52%); **low thresholds / flexibility** for service access (31,8%); addressing **issues that specifically affect women who use drugs** and have experienced gender violence (31,50%); and the existence of **spaces only for women** (31,50%). In this sense, it is important that all these aspects are properly addressed.

Regarding the **most desirable option** for women who use drugs facing GBV, **integrated services** are indicated especially by professional women respondents to the survey (56,18% of women vs 34,04% of men). However, in case such services are not widely available, it would also be interesting to consider the possibility of addressing other options in parallel, as creating specific programmes or sections inside the existing services. In this sense, it is necessary to consider what can be done to adapt violence and drug programmes to women who use drugs and experience GBV (Martinez-Redondo & Arostegui Santamaria, 2021).

From the **focus groups with staff**, it is stressed the significant lack of gender mainstreaming in the design and implementation of addiction programs and also in mainstream (not specialized) services.

The need to review the imaginary and stereotypes of professional teams is highlighted in order to really work from a gender perspective. The conception of motherhood and the automatic link of the "bad mother" and "consumer woman" must be overcome by seeking other explanations and exploring the different possibilities of the situation, without limiting it to a single stigmatizing direction.

The urgent need to include the gender perspective in work with men, considering such issues as their gender mandates and new masculinities, and not just relegate it to work with women is highlighted, given that it is a matter of social transformation.

The lack of specific training, the biases and stereotypes themselves contribute to generating institutional violence, which is often difficult to define and identify. It is a must to mainstream gender perspective in all structures of organizations, staff, training, design, and implementation on mainstream services and drug treatment programs.

From the **interviews with professionals**, it emerged the need to overcome different barriers, such as detecting properly mental health disorders from gender perspective, or encouraging the active participation of WWUD in the services.

It is a must to increase the knowledge of professionals about gender violence and overcome the lack of training of drug professionals on gender-based violence, and the interaction between drug use and gender-based violence.

Gender approach implies trauma-oriented approach but not always happen the same in different direction. A trauma-oriented approach that does not consider gender variable is not being an effective and ethical approach.

According to the sample interviewed, the most desirable option of treatment for WWUD surviving GBV was again the **"Integrated specific centre for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective"**.

The lack of training, specific knowledge or denying the structural violence against women and structural inequality may contribute to a bigger gender gap in the right to access to specific programs and to increase institutional violence.

Final recommendations

> The line of **research-action** started with this project must be **supported and continued without interruption** in order to produce a **deeper understanding** of the relationship among specific drug uses and the gender-based violence experienced, something which was difficult in this case because the surveys limitations, as well as the intersection with other axes of discrimination such as class, sexual orientation and migration, which remains to be explored in future research. It would also be important putting gender-based violence in the context of the **multiple violences** experienced by WWUD in this specific field of intersection. As our choice has been to explore the gender-based violence, and to do so from a gender-feminist approach, its interaction with other- based violence remains a matter for further exploration and analysis, which limitations of this study didn't allow us to carry out.

> The interaction with such other risk / discriminating factors as mental health diagnoses, sex-affective orientation, poverty or ethnicity, among other, will need to be studied with specific methods and sampling. When it comes to research in this topic, sensitivity towards possible revictimization of respondents to interviews has to be applied in the design of procedures. In this research, however, it was a wide agreement among interviewers on the fact that most women were ready and even satisfied on having the possibility of talking about the issue. And the possibility of not asking questions because the risk of incommoding respondents has always to be weighed off against the risk of not having answers that could help to solve our ignorance in significant points to understand, to help or to prevent.

> A gender and intersectional approach to gender-based violence experienced by WWUD is needed in order to improve intervention systems and public policies. It is suggested that special attention be paid to poverty, sexual identity/orientation and ethnicity as axes of discrimination.

> Both trauma-informed and biopsychosocial interventions should consider gender-based violence from a gender and intersectional perspective.

> Gender and intersectional approach should involve both **specialised services** such as drug and GBV, and **mainstream services** such as police, legal, social, and child protection services with the aim of ensuring access to and maintenance of WWUD in programmes and services, as well as ethical interventions fully respecting human rights.

> In this sense, it is essential to **train professionals** from specialised services and mainstream services about the i**ntersection between gender and drugs, and gender perspective in general**. This should be a theoretical and practical training that involves the revision of one's own gender stereotypes and myths, and that has continuity through

gender-sensitive supervision of daily professional practice. This will enable professionals to become more aware about the complex relationship between trauma, violence and addictions and that working with WWUD necessarily involves working with women who have survived multiple types of violence in different contexts. Also, about the fact that, as we have pointed out, suffering violence, and above all, from a certain type/context, does not have so much to do with the type of substance used, but rather with the gender variable in the context of systemic and structural patriarchal system.

> Given that **cis-men** are reported as the main perpetrators in the framework of a (hetero) patriarchal society, it seems essential to **develop preventive and intervention strategies aimed at this specific group**, whether or not they use drugs.

> Systems should be developed to systematically **detect gender-based violence against WWUD**, focusing on psychological, physical and sexual violence against intimate partner, institutional, drug use and family of origin settings. The high frequency of institutional violence opens up the possibility of improving intervention strategies in both mainstream and specialised services for women who use drugs, according to the many international declarations and conventions that suggest addressing this type of violence as gender-based violence. Strategies such as "lifelines" seem to be a good dynamic tested in integrated services to address all types of violence experienced by WWUD throughout their lives.

> Mental health **diagnoses should be gender-sensitive** to avoid misdiagnosis and the tendency to over-medicate WWUD.

> It is also suggested that more attention should be paid to the **specific needs of WWUD and their children**, and therefore the rules of access and stay in the programmes should be reviewed, as well as the facilities of the services, kind/approach of professionals recruited, and the offer of activities. The flexibility regarding access rules such as drug use, access for mothers with children and attention to the needs of both, and women-only spaces are among the issues most highlighted by both WWUD and the professionals who participated in this research.

> It also seems essential to give **WWUD a voice** in the design, development and evaluation of programmes and services (not only in terms of their treatment objectives), and to promote their political participation in community or WWUD/Women Survivors of GBV networks. This will help to enhance the action of WWUD as political subjects, which has been found to be very supportive in the reparation and recovery processes of women who experienced GBV.

> Given that **integrated services for WWUD survivors of GBV** are the ones that bring together the most "traditional" positive aspects of drug services as well as those related to gender mainstreaming, we suggest the **promotion and generalisation of this specific type of services** from the European drug treatment network. On the other hand, the fact that there are integrated services does not exclude the idea that the existing ones must take a step forward to incorporate comprehensive approaches: it is essential to incorporate the gender perspective in existing drug treatment services and adapting services for women survivors of GBV so that they can provide care for WWUD. it is necessary to start designing treatment services based on people's needs and not the other way around.

Interleave Research Report

Women Who Use Drugs Facing Gender-Based Violence in Europe

July 2022

6. References

6. References

Altell, G., & Mollón S. (2020). *Cómo incorporar la perspectiva de género en la reducción de daños.* G360, cartografies humanes i socials. Formación Federació Catalana de Drogodependències (FCD).

Altell, G. (2022). *Violències masclistes dns l'àmbit de l'ús problemàtic de drogues*. G360. Cartografies humanes i socials. Formació Generalitat de Catalunya. https://dixit.gencat.cat/web/.content/home/04recursos/03dixit_tv/01ressenyes/Webinars_DGSS/20220118_violencies_masclistes_i_drogodependencies/formacio_violencies_masclistes_i_drogodependencies.pdf

Arostegui Santamaría, E., & Martinez-Redondo, M. (2018). *Mujeres y drogas. Manual para la prevención de recaídas con perspectiva de género.* Instituto Deusto de Drogodependencias, Universidad Deusto. https://www.drogasgenero.info/mujeres-y-drogas-manual-para-la-prevencion-de-recaidas-con-perspectiva-de-genero/

Arpa, S. (2017). *Women who use drugs: Issues, needs, responses, challenges and implications for policy and practice. Background paper commissioned by the EMCDDA for Health and social responses to drug problems: A European guide.* European Monitoring Centre for Drugs and Drug Addiction. https://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Women-who-use-drugs.pdf

Benoît, T., & Jauffret-Roustide, M. (2015). *Improving the management of violence experienced by women who use psychoactive substances. Consultation of professionals in September and October 2015 in four European cities: Paris, Rome, Madrid and Lisbon*. Council of Europe. https://rm.coe.int/improving-the-management-of-violence-experienced-by-women-who-use-psyc/168075bf22

Biglia, B., y Jiménez, E. (Coord.). (2015). *Hagamos nuestra la prevención. Guia de apoyo para la prevención de profesorad*o. URV, Tarragona.

Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction,* 113(12), 2261-2270. doi: 10.1111/add.14417

Bretherton, J. (2017). *Reconsidering Gender and Homelessness*. Centre for Housing Policy, University of York, UK. https://www.feantsaresearch.org/download/feantsa-ejh-11-1_a1-v045913941269604492255.pdf

Caldentey, C., Tirado Muñoz, J., Ferrer, T., Fonseca Casals, F., Rossi, P., Mestre-Pintó, J. I., & Torrens Melich, M. (2017). Intimate partner violence among female drug users admitted to the general hospital: screening and prevalence. *Adicciones*. 28; 29(3), 172-179. English, Spanish. doi: 10.20882/adicciones.738

Castillo, A., Stocco, P., Rebollida, M., & Llopis, J. J. (2005). Uso de drogas y violencia de género en mujeres adictas en Europa. Claves para su comprensión e intervención. *Salud y drogas,* 5(2), 137-157. https://www.redalyc.org/articulo.oa?id=83905208

Council of Europe (2011). *Council of Europe Convention on preventing and combating violence against women and domestic violence.* Council of Europe Treaty Series- No. 210. https://rm.coe.int/168008482e

Da Silva Carvalho, M. R., de Oliveira, J. F., Pereira Gomes, N., Campos, L. M., Guimarães de Almeida, L. C., & Rodrigues Santos, L. (2019). Coping strategies for domestic violence: Testimony of women involved with drugs. *Escola Anna Nery*, 23(2), e20180291. https://doi.org/10.1590/2177-9465-ean-2018-0291

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2011). *European Drug Prevention Quality Standards (EDPQS). A manual for prevention professionals*. https://www.emcdda.europa.eu/system/files/publications/646/TD3111250ENC_318193.pdf

EMCDDA (2021). *Policy and practice briefings. Women with drug problem*. www.emcdda.europa.eu
Fox, S., & Galvani, S. (2020). *Briefing: Alcohol and domestic abuse in the context of Covid-19 restrictions*. Manchester Metropolitan University. https://www.mmu.ac.uk/media/mmuacuk/content/documents/rcass/Briefing-on-alcohol-and-domestic-abuse-in-context-of-Covid-19-1st-April-2020.pdf

Fundación Atenea. (2016). *Hombres, Mujeres y Drogodependencias. Explicación social de las diferencias de género en el consumo problemático de drogas*. Departamento de Investigación, Innovación y Desarrollo con la financiación de la Delegación del Gobierno para el Plan Nacional sobre Drogas. https://pnsd.sanidad.gob.es/ca/profesionales/publicaciones/catalogo/bibliotecaDigital/publicaciones/pdf/Hombres-mujeres-y-drogodependencias.pdf

Gadd, D., Henderson, J., Radcliffe, P., Stephens-Lewis, D., Johnson, A., & Gilchrist, G. (2019). The Dynamics of Domestic Abuse and Drug and Alcohol Dependency. *The British Journal of Criminology*, 59(5), 1035–1053. https://doi.org/10.1093/bjc/azz011

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L. M., & Gadd, D. (2018). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *Int J Drug Policy*, 65, 8-23. doi: 10.1016/j.drugpo.2018.12.009. Epub 2018 Dec 20. PMID: 30580114.

Goldenberg, S. M. (2020). Addressing Violence and Overdose Among Women Who Use Drugs-Need for Structural Interventions. *JAMA network open*, 3(10), e2021066. https://doi.org/10.1001/jamanetworkopen.2020.21066

Greenfield, S. F., Back, S. E., Lawson, K., & Brady, K. T. (2010). Substance abuse in women. *Psychiatr Clin North Am*, 33(2), 339-55. doi: 10.1016/j.psc.2010.01.004. PMID: 20385341; PMCID: PMC3124962.

Hansen, G. (2020). *Perspectiva de género aplicada al tratamiento de las adicciones*. Formación Proyecto MALVA.

Hansen, G. (2020). *Mujeres en Comunidades Terapéuticas de Adicciones: Perfil Psicosocial, prevalencia de violencias de género en el ámbito de la pareja y barreras de tratamiento*. [Doctoral dissertation, Universitat Autónoma de Barcelona]. https://www.tdx.cat/handle/10803/670557#page=1

Jessell, L., Mateu-Gelabert, P., Guarino, H., Vakharia, S. P., Syckes, C., Goodbody, E., Ruggles, K. V., & Friedman, S. (2017). Sexual Violence in the Context of Drug Use Among Young Adult Opioid Users in New York City. *Journal of interpersonal violence*, 32(19), 2929–2954. https://doi.org/10.1177/0886260515596334

Lozano-Verduzco, I., Romero-Mendoza, M., & Marín-Navarrete, R. (2016). Violence narratives of Mexican women treated in mutual-aid residential centers for addiction treatment. *Substance Abuse Treatment, Prevention, and Policy*, 11 (39). https://doi.org/10.1186/s13011-016-0083-0

Martinez-Redondo, M., & Arostegui Santamaría, E. (2021). *Situación en España de la violencia de género y el abuso de sustancias. Revisión de la evidencia y propuestas para el abordaje conjunto de la violencia de género y el abuso de sustancias en los servicios de atención*. Madrid: Ministerio de Sanidad. Delegación del Gobierno para el Plan Nacional sobre Drogas https://pnsd.sanidad.gob.es/profesionales/publicaciones/catalogo/catalogoPNSD/publicaciones/pdf/2021_DGPNSD_Violencia_genero_abuso_sustancias.pdf

Organisation of American States. (1994). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women. (Convention of Belém do Pará).* https://www.oas.org/en/mesecvi/docs/belemdopara-english.pdf

Observatorio Noctambul@s. (2018). *Quinto Informe Anual 2017-2018.* https://www.drogasgenero.info/wp-content/uploads/5InformeNoctambulas_2017-18.pdf

Plaza, L., Ferrer, R. & Vale Pires, C. (2022). *Sexism Free Night Research Report. Sexualised Violence in European Nightlife Environments*. Sexism Free Night European Project. Available online at: www.sexismfreenight.eu

Roig Forteza, A. (2019). *Metzineres: Sheltering and empowering women who use drugs, survivors of violence.* Gender and Drug Policy: Exploring Innovative Approaches to Drug Policy and Incarceration. https://womenanddrugs.wola.org/wp-content/uploads/2020/10/Metzineres-ENG.pdf

Sánchez-Rubio, B. (2021). THE IDEAL VICTIM IN CRIMES OF RAPE AND SEXUAL ABUSE Is it possible to avoid the secondary victimization? https://doi.org/10.20318/universitas.2022.6576

Shirley-Beavan, S., Roig, A., Burke-Shyne, N., Daniels, C., & Csak, R. (2020). Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain. *Harm Reduction Journal,* 17(78). https://doi.org/10.1186/s12954-020-00429-5

Tirado-Muñoz, J., Gilchrist, G., Fischer, G., et al. (2018). Psychiatric comorbidity and intimate partner violence among women who inject drugs in Europe: a cross-sectional study. *Arch Womens Ment Health*, 21, 259–269. https://doi.org/10.1007/s00737-017-0800-3

United Nations General Assembly. (1979). *Convention on the Elimination of All Forms of Discrimination against Women New York (Treaty of 18 December 1979).* United Nations Human Rights Office of the High Commissioner. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women#:~:text=On%2018%20December%201979%2C%20the,twentieth%20country%20had%20ratified%20it.

United Nations General Assembly. (1993). *Declaration on the Elimination of Violence against Women.* United Nations Human Rights Office of the High Commissioner. https://www.ohchr.org/en/instruments-mechanisms/instruments/declaration-elimination-violence-against-women

United Nations Office on Drugs and Crime (UNODC) (2018). *WOMEN AND DRUGS. Drug use, drug supply and their consequences. World Drug Report 2018*. United Nations publication, Sales No. E.18.XI.9 https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_5_WOMEN.pdf

United Nations Office on Drugs and Crime (UNODC) (2019). *Policy and practice briefings Women with drug problems.* https://www.emcdda.europa.eu/best-practice/briefings/women-drug-problems_en

United Nations Office on Drugs and Crime (UNODC) (2019). *Were you really raped, or did you just not get paid? A needs assessment of women who use drugs in four cities in South Africa.* https://www.unodc.org/documents/southernafrica/Publications/Health/WWUD_In_our_own_words_2019_web.pdf

United Nations Office on Drugs and Crime (UNODC) (2020). UNODC/ WHO International Standard on Drug Use Prevention. Second Updated Edition. https://www.unodc.org/unodc/en/prevention/prevention-standards.html

Valencia, J., Alvaro-Meca, A., Troya, J., Gutiérrez, J., Ramón, C., Rodríguez, A., et al. (2020) Gender-based vulnerability in women who inject drugs in a harm reduction setting. *PLoS ONE*, 15(3). e0230886. https://doi.org/10.1371/journal.pone.0230886

Valls, E., Geldschläger, H., & LaFarga, S. (2013*). Violència contra la parella i consum de substàncies: Guia per a professionals de la XAD.* Generalitat de Catalunya. Agència de Salut Pública de Catalunya. https://www.drogasgenero.info/wp-content/uploads/00_84_GUIA_VCP_PROFESSIONALS-1.pdf

Weaver, T. L., Gilbert, L., El-Bassel, N., Resnick, H. S., & Noursi, S. (2015). Identifying and intervening with substance-using women exposed to intimate partner violence: phenomenology, comorbidities, and integrated approaches within primary care and other agency settings. *Journal of women's health*, 24(1), 51–56. https://doi.org/10.1089/jwh.2014.4866

Interleave Research Report

Women Who Use Drugs Facing Gender-Based Violence in Europe

July 2022

7. Annexes

Annex 1 / List of tables

Annex 2 / List of figures

Annex 3 / Surveys templates

a) Women's survey:

*Mandatory question
INTERLEAVE SURVEY
WOMEN DRUG USERS AND GENDER-BASED VIOLENCE

This questionnaire is part of the European INTERLEAVE project, which aims to improve the care offered to women who use drugs facing gender-based violence.

Eight organisations are involved in the project: Comunità di Venezia (Italy), Fundación Salud y Comunidad (Spain), Therapieverbund Ludwigsmühle (Germany), Therapiesalon im Wald (Austria), IREFREA (Portugal), Eu-Open (Italy), Zajednica Susret (Croatia) and ENSA (European Network
of Social Authorities).

The questionnaire will be administered in the form of an interview by trained professionals.

Your participation in this study is entirely voluntary. All the answers are anonymous and confidential.

Some questions may be very sensitive for you. Feel free to decide whether or not to answer them. Feel free to stop the interview at any moment if you prefer not to continue with the interview.

The data collected through this survey will be analysed and used in scientific in technical reports and papers and will inform a toolkit aimed at professionals working with women drug users facing gender-based violence.

Your participation in this questionnaire is very valuable to improve the care offered to women who use drugs or alcohol and who have experienced some form of gender-based violence in their lifetime.

☐ **I consent to the use of the information provided in the framework of this research*.**

General information
This section includes information about your sociodemographic profile

1. **Year of birth*:**

2. **What gender do you identify with? ***

a) Woman
b) Trans [32]
c) Non-binary
d) I prefer not to answer
e) I prefer to self-describe: _____ _____

32 Transsexual or transgender

3. What sexual orientation do you identify with? *

a) Lesbian
b) Heterosexual
c) Bisexual
d) I prefer not to answer
e) I prefer to self-describe: _____

4. Which is your country of birth?*: _____

5. Which is your country of residence?*

a) Austria
b) Croatia
c) Italy
d) Germany
e) Spain
f) Portugal

6. Nationality* ***(if there is double nationality, prefer that of the country of residence)***

7. What is your highest level of study? (highest degree completed) *

a) Primary studies not completed
b) Primary studies
c) Secondary studies
d) Vocational training
e) University studies: degree
f) University studies: master or higher
g) I prefer to describe: _____

8. What is your main source of income? *

a) Full time job
b) Part time job
c) Informal economy (full /part time job)
d) Social benefit (for unemployment, others ...)
e) Family support (parents, siblings ...)
f) I depend on my partner
g) Other activities: asking for money in the street, theft/sale of stolen goods, selling drugs, sex work, collecting things from the street (scrap metal)...
h) I prefer to describe:_____

9. What is your current housing situation? *

a) Own home
b) Rental housing
c) Room / Housing shared with other people (not family)
d) Hostel
e) Institution/residential centre (Shelter home, Therapeutic Community...)
f) Someone else's house or flat
g) Squat
h) Prison
i) I live in the street
j) I prefer to describe: _____

10 . Who do you live with? (you can check more than one option)*

a) Partner
b) One or more of my children (of legal age)
c) One or more of my children (minors)
d) Parents
e) Other adult relatives
f) Friends
g) Other (former) users
h) I prefer to describe: _____

11. **Which is your current sex-affective situation?* (you can check more than one option):**

a)
☐ "Stable" relationship
☐ "Occasional" relationship
☐ No sex-affective relationship
☐ I prefer not to answer
☐ I prefer to describe: _____

b)
☐ Monogamous relationship
☐ Polyamorous relationship
☐ I prefer not to answer
☐ I prefer to describe: _____

c)
☐ With a man/men
☐ With a woman/women
☐ With different people regardless of their gender identity
☐ I prefer not to answer
☐ I prefer to describe: _____

d)
☐ Who use drugs or alcohol
☐ Who do NOT use drugs or alcohol
☐ I prefer not to answer
☐ I prefer to describe: _____

12. Number of children? *

_____

a) If it is the case, did you have an abortion? Yes/No/I prefer not to answer
b) If it is the case, have you taken care of your children? Yes /No/ I prefer not to answer
c) If no, who assumed the custody? _____
d) Did you voluntarily gave up custody? Yes/No/ I prefer not to answer

13. Have you been diagnosed with a mental illness?*:

a) No
b) Yes, which one? _____
c) I prefer not to answer
d) I prefer to describe: _____

14. Other relevant illnesses (you can check more than one option) *:

a) Cancer
b) HIV/Aids
c) Other STD (Sexual Transmitted Diseases) includes syphilis, gonorrhoea, chlamydia, papilloma...
d) Hepatitis C
e) Tuberculosis
f) I prefer not to answer
g) I prefer to describe: _____

Substance use

In this section we ask about your problems related to drug/alcohol use

15. Use of drugs (you can check more than one option)*:

	Occasionally	Often	Daily	Never
a) Alcohol				
b) Tobacco				
c) Cannabis				
d) Cocaine				
e) Ketamine				
f) GHB				
g) MDMA (Ecstasy, Pills, Crystal, MD)				
h) Amphetamine (Speed)				
i) Methamphetamine				
j) Heroin				
k) Opioid drugs (i.e., methadone, codeine...) with prescription				
l) Opioid drugs without prescription				
m) Benzodiazepines (tranquilizers) with prescription				
n) Benzodiazepines without prescription				
o) NPS (New Psychoactive Substances). Detail which one:.....				
p) Mephedrone				
q) Other: _____				

16. Ways of consumption (you can check more than one option)*:

	Oral	Smoked/Inhaled	Sniffed	Injected
a. Cocaine				
b. Amphetamine (Speed)				
c. Methamphetamine				
d. Heroin				
e. Opioid drugs (i.e., methadone, codeine...)				
a) Other: _____				

Gender violence

In this section we ask you about the gender violence experienced throughout your life

17. What type(s) of gender based violence (GBV)[33] have you experienced throughout your life (you can check more than one option)*:

a) Physical violence
b) Psychological violence
c) Sexual violence during adulthood
d) Sexual violence/"abuse" during childhood / adolescence (including FGM...)
e) Economic violence
f) I prefer to describe: _____

18. In what contexts did you experience gender-based violence? (you can check more than one option)*:

Physical violence- Psychological violence- Sexual violence -Economic violence

a) Unknown aggressor
b) Sex-affective relationship
c) Family of origin
d) Labour context
e) Use of drugs/alcohol context
f) Drug traffic (sell/purchase)
g) Party environments
h) Sex work context
i) Human trafficking or sexual exploitation
j) Female Genital Mutilation (FGM) context
k) Early / forced marriages context
l) Armed conflicts
m) Homeless context
n) Institutional: police
o) Institutional: juridical
p) Institutional: prison
q) Institutional: health centre
r) Institutional: sexual and reproductive services
s) Institutional: social services
t) Institutional: child protection social services
u) Institutional: services aimed at people who use drugs
v) Institutional: services dealing with GBV
w) Institutional: anti-drugs laws
x) I prefer to describe: _____

33 We are not referring to any kind of violence experienced in these contexts, if that violence is not gender-based (e.g. drug use scene, criminality world...). "GBV is all those forms of violence that have their origin in a stereotypical vision of gender and in the power relations that this entails. Because of this, gender violence in our society affects mainly and more strongly the bodies of women and sexually non-normative people (lesbians, bisexuals, gays ...) or generically (trans, queer ...)". BIGLIA, Bárbara and JIMÉNEZ, Edurne (Coord.). Jóvenes, género y violencias: hagamos Nuestra la prevención. Guía de apoyo para la prevención de profesionales. URV, Tarragona, 2015.

19. What was the most common profile of the person (s) who attacked you and how often?*

Frequent Sometimes Never

a) Male drug or alcohol user
b) Man NOT a drug or alcohol user
c) Woman drug or alcohol user
d) Woman NOT a drug or alcohol user
e) I prefer to describe: _____

20. What aspect(s) (other than being a woman drug user) do you feel most discriminated against?* (you can check more than one option):

a) Poverty
b) Ethnicity
c) Migration
d) Ability/functional diversity
e) Age
f) Sexual orientation
g) Gender identity
h) I prefer to describe: _____

21. From 1-5, where 1 means "strongly disagree" and 5 means "strongly agree", which of these experiences do you identify with regarding gender-based violence experienced in the scope of consumption? you can check more than one option). When appropriate, please point also out the items that do not apply to your case

1 2 3 4 5 Do not apply

21.1. Use of drugs

a) Often the person attacking me was under the effects of alcohol or other drugs.
b) Often when I was attacked I was under the effects of alcohol or other drugs.
c) Since I was under the influence of drugs and alcohol, sometimes I question myself whether some aggressions really happened or not.
d) Sometimes I felt so guilty about my drug / alcohol use that I felt the violence I was receiving was well deserved.
e) My use of drugs/alcohol worsened after experiencing gender violence.
f) I have been sexually assaulted after using drugs (including alcohol) in a public place with a friend/stranger.
g) I have sometimes felt that I am not worthy of sexual respect and that I am always ready to exchange sex for drugs or money.
h) I have often been offered drugs for free as a means of coercion/pressure to obtain sexual favours.
i) The eager desire to consume/withdrawal led me to experience unwanted or violent sexual practices to finance the use of drugs.
j) My problems related to my drug use increased during the confinement.

21.2. (Former) Partner

a) Often my partner was telling that his violence against me was because my use of drugs.
b) My account of violence was questioned because my partner was not a user.
c) Having a partner who also used drugs made me more vulnerable to violence.
d) My partner justified his violence because he was "helping" me to stop using.

e) My partner encouraged me to use in order to continue his violence towards me.
f) I felt so sad because the violence experienced from my partner, that I used alcohol or other drugs (including tranquillizers/painkillers) to get some relief for these feelings.
g) I have been forced to be on the street after escaping violence from my partner.
h) The need to be "protected" by a man (in the street, a hostel...), made me experiencing unwanted or sexual violence from him.
i) The confinement health measures increased gender-based violence.

21.3. Sex work

a) I have often been forced to exchange sex for drugs/money/ a place to stay.
b) People believe that sex workers are willing to exchange sex for money/drugs in any context of consumption.
c) I have often been raped or robbed by my sex clients in consumption contexts.
d) I have often used drugs as a means to cope with my sex work.
e) I am satisfied with my sex work and it has no relationship with my use of drugs.

21.4. Other axes of discrimination

a) My personal condition (ethnic background, sexual orientation, mental health, homelessness, migration...) made me more vulnerable to violence.

21.5. Institutional violence / perceived barriers to receive help

a) When I was on addiction treatment, the treatment staff downplayed the importance of my abuse because I was using drugs.
b) I have been afraid to go to health and social services for using drugs.
c) I have felt judged as a "bad mother" by sexual and reproductive health services for using drugs during my pregnancy.
d) I have been afraid of being considered a "bad mother" by child protection services and having my children taken away from me.
e) I have avoided some drug services for fear of meeting a former aggressor.
f) At some services for people who use drugs, male drug users requested from me sexual "services.
g) In some services for people who use drugs, I have experienced assaults from my fellow users of the centre.
h) In some services for people who use drugs, I have experienced assaults from some member/s of the staff.
i) I did not explain the violence I was suffering to my family/friends because I was afraid of not being believed, especially because my use of drugs.
j) I did not explain the violence I was suffering to the social/medical staff because I was afraid of not being believed, especially because my use of drugs.
k) I did not explain the violence I was suffering to the police because I was afraid of not being believed, especially because my use of drugs.
l) My family/ friends did not believe my report of violence due to my drug or alcohol use.
m) The social/ medical staff did not believe my report of violence due to my drug or alcohol use.
n) The police did not believe my report of violence due to my drug or alcohol use.
o) My family/friends didn't help me to get out of the situation of violence due to my use of drugs.
p) The social/ medical staff didn't help me to get out of the situation of violence due to my use of drugs.
q) The police didn't help me to get out of the situation of violence due to my use of drugs.
r) At addiction treatment, I was ashamed to say that I was abused by a partner who was also a person who use drugs.

s) When I went to treatment for my problems related to my use of drugs, they did not ask me about my history of violence.
t) My access to GBV treatment or shelter home was denied due to my use of drugs.

22. When would you say you started using drugs and experiencing GBV? (màx. 1 sentence)

Attention received in relation to drug use and gender-based violence
In this section we ask about the relationships between drug use and experienced gender violence

23. Score from 1-5 (1 = very unsatisfactory and 5 = very satisfactory) the care received any time from these areas of care in relation to DRUG USE + GENDER VIOLENCE*:

1 2 3 4 5 I did not receive attention from this area

a) Health services
b) Sexual and reproductive services
c) Social Services
d) Child Protection Services
e) Legal services
f) Police
g) Other relevant service: _____

24. Regarding the previous areas of care, at some point did you feel judged as a woman who used drugs? *:

Yes No

a) Health services
b) Sexual and reproductive services
c) Social services
d) Child Protection Services
e) Legal services
f) Police
g) Other relevant service: _____

25. Score from 1-5 (1 = very unsatisfactory and 5 = very satisfactory) the care received any time from these services in relation to DRUG USE + GENDER VIOLENCE*:

1 2 3 4 5 I did not use this type of service

a) Outpatient care for people with drug-use related problems
b) Day centre for people with drug-use related problems
c) Therapeutic community/residential centre for people with drug-use related problems
d) Harm reduction centres or services for people who use drugs
e) Psychological-psychiatric care or mental health services
f) Information and Attention Service for Women (victims/survivors of GBV)

g) Home / Shelter for women survivors of gender violence
h) Integrated service for women who use drugs facing GBV
i) I prefer to describe: _____

26. Regarding the previous services, at any time did you feel judged as a female who use drugs/alcohol??*

Yes No

a) Outpatient care for people with drug-use related problems
b) Day centre for people with drug-use related problems
c) Therapeutic community/residential centre for people with drug-use related problems
d) Harm reduction centres or services for people who use drugs
e) Psychological-psychiatric care or mental health services
f) Information and Attention Service for Women (victims/survivors of GBV)
g) Home / Shelter for women survivors of gender violence
h) Integrated service for women who use drugs facing GBV
i) I prefer to describe: _____

27. What type of service are you <u>currently</u> in to address your DRUG USE + GENDER VIOLENCE? * (May be used more than one service at this time)

a) Outpatient care for people with drug-use related problems
b) Day centre for people with drug-use related problems
c) Therapeutic community/residential centre for people with drug-use related problems
d) Harm reduction centres or services for people who use drugs
e) Psychological-psychiatric care or mental health services
f) Information and Attention Service for Women (victims/survivors of GBV)
g) Home / Shelter for women survivors of gender violence
h) Integrated service for women who use drugs facing GBV
i) I prefer to describe: _____

28. Regarding the service you are currently in, indicate which aspects define it better (you can check more than one option)*:

a) Low thresholds/flexibility for service access
b) The empathy of professionals towards women participants/users of the service
c) The presence of peer-workers
d) Knowledge of professionals about drug use
e) Knowledge of professionals about gender violence
f) Knowledge of professionals about the interaction between drug use and gender violence
g) The existence of spaces only for women
h) Addressing issues that specifically affect women who use drugs and have experienced gender violence
i) Early detection systems and protocols for GBV are in place
j) Addressing gender violence experienced throughout the life of women, including the relationship with drug use
k) Service regulations take into account the specific needs of women and their children
l) The activity program takes into account the specific needs of women and their children
m) The design of the spaces/facilities takes into account the specific needs of women and their children
n) Mental health is taken into account
o) Sexual and reproductive health and rights are taken into account
p) Diversity is taken into account (sex orientation, ethnicity...)
q) Women actively participate in the design, development and evaluation of the service

r) Mutual support among women in the service is promoted
s) The autonomy / empowerment of women is promoted
t) The idea of belonging to a support network is promoted
u) There is coordination with local networks, social movements and services to support women and other community services/organisations
v) The coordination with peer networks for women who use drugs is promoted
w) Social "reintegration" is actively promoted
x) Socio-political activism is actively promoted
y) Other that I prefer to describe: _____

29. What has helped me the most to continue in treatment has been ...

30. What has made it most difficult for me to continue in treatment has been ...

31. Do you want to either add or clarify any aspect?

Thank you very much, your answers are very important to us and may help other women facing drug use and gender-based violence.

b) Staff survey:

*Mandatory question

Good Practice Questionnaire of the INTERLEAVE project
WOMEN DRUG USERS AND GENDER-BASED VIOLENCE

This questionnaire is part of the European INTERLEAVE project, which aims to improve the care offered to women who use drugs facing gender-based violence.
Eight organisations are involved in the project: Eight organisations are involved in the project: Comunità di Venezia (Italy), Fundación Salud y Comunidad (Spain), Therapieverbund Ludwigsmühle (Germany), Therapiesalon im Wald (Austria), IREFREA (Portugal), Eu-Open (Italy), Zajednica Susret (Croatia) and ENSA (European Network of Social Authorities).
Your participation in this study is entirely voluntary. All the answers are confidential.
The questionnaire will be self-administered online.
The data collected through this survey will be analysed and used in scientific in technical reports and papers and will inform a toolkit aimed at professionals working with women drug users facing gender-based violence.
Your participation in this questionnaire is very valuable to improve the care offered to women who use drugs or alcohol and who have experienced some form of gender-based violence in their lifetime.

☐ I confirm that I understand the purpose of the questionnaire and agree to the use of my answers in the reports that may be produced and published*.

General information

What gender do you identify with? *

a) Woman
b) Man
c) Other
d) I prefer not to answer
e) I prefer to self describe: _____

General characteristics of the service you are working in

1. Type of service*:

a) Outpatient care for people with drug-use related problems
b) Day centre for people with drug-use related problems
c) Therapeutic community/residential centre for people with drug-use related problems
d) Harm reduction centres or services for people who use drugs
e) Psychological-psychiatric care or mental health services
f) Information and Attention Service for Women (victims/survivors of GBV)
g) Home / Shelter for women survivors of gender violence
h) Integrated service for women who use drugs facing GBV
i) Other: _____

2. Beneficiaries* (you can check more than one option):

a) Social excluded people in general
b) Women facing GBV
c) Women and men who use drugs
d) Women who use drugs
e) Women who use drugs facing GBV
f) Families
g) Other: _____

3. Are there exclusion criteria?* (you can check more than one option):

a) Severe mental disorders
b) Drug use
c) Sex work
d) Not able to pay established fees
e) There are no exclusion criteria
f) Other: _____

4. What professional profiles are working in this service?* (you can check more than one option)

Number

a) Educators
b) Social workers
c) Psychologists
d) Nurses
e) Lawyers
f) Physicians
g) Psychiatrists
h) Volunteers
i) Peer workers
j) Auxiliary staff
k) Other: _____

5. How is the service financed? *

a) Mainly with public funds
b) Mainly with private funds
c) Other: _____

Description of the intervention you are working in

6. **Which approach/es best define your service and why? (you can check more than one answer)***

a) Juridical approach
b) Biomedical approach
c) Trauma-oriented approach
d) Biopsychosocial approach
e) Abstinence-oriented approach
f) Harm reduction approach
g) Gender-based/ feminist approach
h) Integrated social care approach
i) Providing the adequate information regarding rights and support
j) "Reintegration" into society (training/employment opportunities)
k) Other: _____

7. **Has the service/project been adapted to the needs in time of COVID-19 pandemic?***

a) A lot
b) Enough
c) A little
d) Not at all

8. **Please, indicate (1 =totally disagree to 5 =totally agree) to what extent these aspects define your service in relation to WOMEN WHO USE DRUGS FACING GBV (you can check more than one option)*:**

1 2 3 4 5

a) Low thresholds/flexibility for service access
b) The empathy of professionals towards women participants/users of the service
c) The presence of peer-workers
d) Knowledge of professionals about drug use
e) Knowledge of professionals about gender violence
f) Knowledge of professionals about the interaction between drug use and gender violence
g) The existence of spaces only for women
h) Addressing issues that specifically affect women who use drugs and have

experienced gender violence

i) Early detection systems and protocols for GBV are in place
j) Addressing gender violence experienced throughout the life of women, including the relationship with drug use
k) Service regulations take into account the specific needs of women and their children
l) The activity program takes into account the specific needs of women and their children
m) The design of the spaces/facilities takes into account the specific needs of women and their children
n) Mental health is taken into account
o) Sexual and reproductive health and rights are taken into account
p) Diversity is taken into account (sex orientation, ethnicity...)
q) Women actively participate in the design, development and evaluation of the service
r) Mutual support among women in the service is promoted
s) The autonomy / empowerment of women is promoted
t) Social "reintegration" is actively promoted
u) The idea of belonging to a support network is promoted.
v) There is coordination with local networks, social movements and services to support women and other community services/organisations
w) The coordination with peer networks for women who use drugs is promoted
x) Socio-political activism is actively promoted
y) Gender perspective approach is adopted
z) Harm reduction approach is taken into account
aa) Others that you consider important. Which:

1._____
2._____
3._____

9. According to your experience, what aspects of your service HELPED women who use drugs facing GBV to continue in treatment?

10. According to your experience, what aspects of your service DID NOT HELP women who use drugs facing GBV to stay in treatment?

11. Please score 1 to 5 (1=very low and 5= very high) your service in relation to the CARE OFFERED TO WOMEN WHO USE DRUGS FACING GBV in terms of*:

12345

a) Specifity of the service
b) Innovation of the service
c) Sustainability for a long time
d) Transferability to another territory
e) Networking and cooperation with other organisations for common good
f) Evaluation of the effectiveness and efficiency

General best practices

12. **According to your experience, IN GENERAL, which 5 aspects need to be improved to ensure access to and maintenance of treatment for women drug users facing GBV? (you can check more than one option)***

a) Low thresholds/flexibility for service access
b) The empathy of professionals towards women participants/users of the service
c) The presence of peer-workers
d) Knowledge of professionals about drug use
e) Knowledge of professionals about gender violence
f) Knowledge of professionals about the interaction between drug use and gender violence
g) The existence of spaces only for women
h) Addressing issues that specifically affect women who use drugs and have experienced gender violence
i) Early detection systems and protocols for GBV are in place
j) Addressing gender violence experienced throughout the life of women, including the relationship with drug use
k) Service regulations take into account the specific needs of women and their children
l) The activity program takes into account the specific needs of women and their children
m) The design of the spaces/facilities takes into account the specific needs of women and their children
n) Mental health is taken into account
o) Sexual and reproductive health and rights are taken into account
p) Diversity is taken into account (sex orientation, ethnicity...)
q) Women actively participate in the design, development and evaluation of the service
r) Mutual support among women in the service is promoted
s) The autonomy / empowerment of women is promoted
t) Social "reintegration" is actively promoted
u) The idea of belonging to a support network is promoted.
v) There is coordination with local networks, social movements and services to support women and other community services/organisations
w) The coordination with peer networks for women who use drugs is promoted

x) Socio-political participation is actively promoted
y) Gender perspective approach is adopted
z) Harm reduction approach is taken into account
aa) Others that you consider important. Which:
1._____
2._____
3._____

13. According to your experience, IN GENERAL which is the MOST DESIRABLE OPTION for women who use drugs facing GBV? (you can check only ONE option) *

a) Existing centres for women survivors of violence should be adapted to include women who use drugs.
b) Existing centres for people who use drugs need to better integrate a gender perspective, and specifically the GBV issue.
c) Integrated specific centres for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective should be promoted.

14. Do you want to add any comments?

15. **If you would like to be contacted to participate in further phases of this research, you can leave your contact details here:**

Thank you very much for your contributions and participation!
INTERLEAVE PROJECT

Annex 4 / Focus Groups templates

FOCUS GROUP WITH WOMEN WHO USE DRUGS / PROFESSIONAL STAFF
INTERLEAVE- OCTOBER 2021

Guidelines for focus groups

The following are some suggested points to consider in guiding the focus groups:

-As planned, each partner will conduct 2 focus groups with women who use drugs facing GBV. In addition, a total of 3 focus groups aimed at professionals will be carried out by Country Partners in Spain, Italy and Croatia.

-It is suggested that focus groups last approximately between 1-2 hours, depending on the dynamics.

-Focus groups of 6-8 people are suggested.

-The focus group can be made up of professionals from the same service or from different services (recommended). For women, the fact that they are part of the same service can facilitate the dynamics.

-It is suggested to prioritise the face-to-face format although, if this is not possible due to the global pandemic situation, they can be conducted remotely by a video call meeting.

-It is suggested to have 2 facilitators in the focus groups: one to conduct the session and the other to focus on data collection. Priority will be given to professionals with experience in the research topic and in conducting focus groups.

-At the beginning of the session, the context of the research, its objectives and the main results obtained so far can be briefly introduced.

-It is important to create a welcoming, relaxed and safe atmosphere where participants can feel comfortable to express their opinions freely. In this regard, it is important to note that there are no right or wrong answers and that the anonymity of the participants will be guaranteed.

-If necessary, the session can be recorded to facilitate data collection. In this case, the participants will be asked for permission beforehand.

-Participants will sign a data and image protection form.

-A basic template for data collection will be provided (see annex 1). This template has been elaborated on the basis of the preliminary results obtained from the questionnaires with the aim of clarifying and/or deepening some aspects. It is important to summarise the most relevant information in order to facilitate ex-post analysis of the information.

-The focus groups are planned to take place during the month of October 2021. By 31/10/2021, partners will have to deliver the data collection template translated into English to the WP2 lead team.

Part 1. Drug use and GBV

In general, do you think that women who use drugs experience violence as much or more than women who do not use drugs? What kind of violence? Before and/or once they have started using drugs?

Do you think that the relationship between drug use and violence experienced by women has always been taken into account? Why?

Do women who use drugs experience the same violence as men? What is usually the gender of the perpetrator? Do you think violence is gendered? Why?

Does using drugs + being crossed by another axes of discrimination (gender identity, ethnicity, poverty, mental health...) expose you to more violence? In what way?

Do you think that the use of certain drugs is the cause of GBV? (both from exercising it and from having it exercised on you) why?

Part 2. Experiences and improvements in care services

In the preliminary results, it has been observed that, in general, women feel more judged in general care services (especially health, social, child protection and police services) than in services for people who use drugs/GBV care. Why do you think this happens? How can care for women who use drugs in general care services be improved?

Do you think it is common for women to avoid drug/homeless services for fear of encountering perpetrators? Is it common for women to be assaulted by other clients in these services, and by professionals? How can care for women who use drugs in drug/GBV services be improved?

Annex 5 / Interviews templates

Guidelines for interviews

The following are some suggested points to consider in guiding interviews aimed at professionals:

-As it was said in the proposal, 20 interviews per partner will be carried out with different kind of professionals.

-The suggested professional profiles will be the following:
(a) Professionals in the field of drugs (any type of service).
b) Professionals in the field of gender-based violence (any type of service).
c) Technical and/or political profiles of the local public administration in the field of drugs and/or gender equality.

-It is suggested that interviews last approximately 15-30 minutes, depending on the dynamic.

-Given the large number of interviews to be carried out per partner, it is suggested to conduct them in a remote format (video call or telephone); however, partners can decide on the format that suits them the best.

-As interviewers, priority will be given to professionals with the highest possible profile, experience in the research topic and in conducting interviews.

-Before the call/ interview or at the beginning of it, the context of the research, its objectives and the main results obtained so far can be briefly introduced.

-It is important to create a welcoming, relaxed and safe atmosphere where interviewed people can feel comfortable to express their opinions freely. In this regard, it is important to note that there are no right or wrong answers and that the anonymity of the interviewed will be guaranteed.

-If necessary, the call can be recorded to facilitate data collection. In this case, the interviewed will be asked for permission beforehand.

-A basic template for data collection will be provided (see annex 2). This template has been elaborated on the basis of the preliminary results obtained from the questionnaires with the aim of clarifying and/or deepening some aspects. It is important to summarise the most relevant information in order to facilitate ex-post analysis of the information.

-The interviews are planned to take place during the month of October 2021. By 31/10/2021, partners will have to deliver the data collection template translated into English to the WP2 lead team.

(1) *Which of the following aspects are* **NOT being implemented** *in services aimed at women who use drugs?* **Why? and what other issues should be considered?**

a) Low thresholds/flexibility for service access
b) The empathy of professionals towards women participants/users of the service
c) The presence of peer-workers
d) Knowledge of professionals about drug use
e) Knowledge of professionals about gender violence
f) Knowledge of professionals about the interaction between drug use and gender violence
g) The existence of spaces only for women
h) Addressing issues that specifically affect women who use drugs and have experienced gender violence
i) Early detection systems and protocols for GBV are in place
j) Addressing gender violence experienced throughout the life of women, including the relationship with drug use
k) Service regulations take into account the specific needs of women and their children
l) The activity program takes into account the specific needs of women and their children
m) The design of the spaces/facilities takes into account the specific needs of women and their children
n) Mental health is taken into account
o) Sexual and reproductive health and rights are taken into account
p) Diversity is taken into account (sex orientation, ethnicity...)
q) Women actively participate in the design, development and evaluation of the service
r) Mutual support among women in the service is promoted
s) The autonomy / empowerment of women is promoted
t) Social "reintegration" is actively promoted
u) The idea of belonging to a support network is promoted.
v) There is coordination with local networks, social movements and services to support women and other community services/organisations
w) The coordination with peer networks for women who use drugs is promoted
x) Socio-political participation is actively promoted
y) Gender perspective approach is adopted
z) Harm reduction approach is taken into account

(2) *According to your experience, IN GENERAL which is the MOST DESIRABLE OPTION for women who use drugs facing GBV?* **Why?**

a) Existing centres for women survivors of violence should be adapted to include women who use drugs.
b) Existing centres for people who use drugs need to better integrate a gender perspective, and specifically the GBV issue.
c) Integrated specific centres for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective should be promoted.

INTERLEAVE

AN INTERVENTION TOOLKIT TO DEAL WITH WOMEN DRUG USERS VICTIMS OF GENDER BASED VIOLENCE