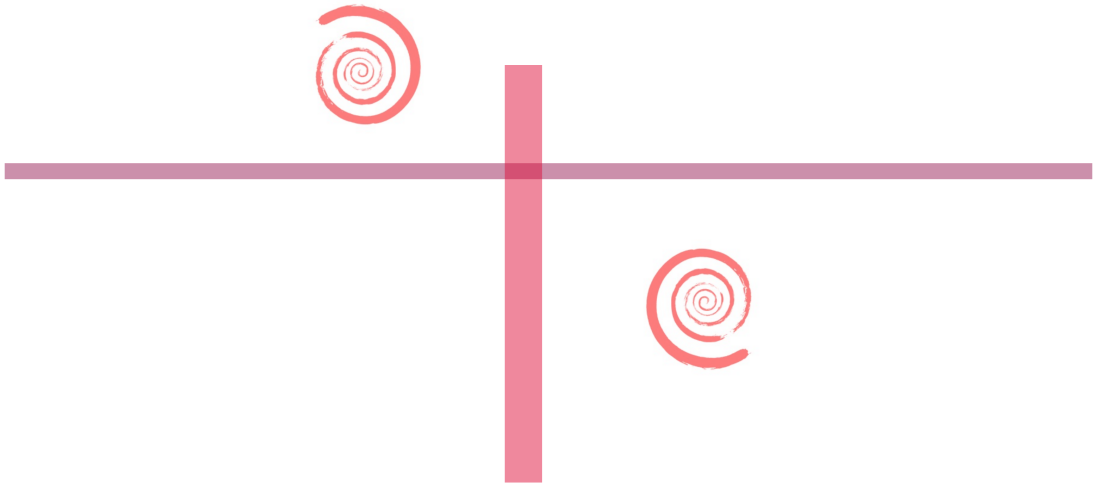
INTERLEAVE

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

Stop Violence against women drug users

TOOLKIT



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Partners involved

Comunità di Venezia: ComuVe is a social-services cooperative that operates in the Venice area helping people recover from addictions through both therapy facilities dedicated to assistance, rehabilitation and social reintegration of drug or alcohol addicts, and through research and training activities. Comunità di Venezia hosts patients in two therapy communities: "Villa Renata", located in Venezia, which offers intensive residential services for rehabilitation of men and women with addictions, and "Casa Aurora", located in Mestre, which provides specialized residential services for rehabilitation of drug-addicted mothers with children.

The co-applicant organizations:

Eu-Open: EU-OPEN is a company that provides consulting, planning, management and training activities on European institutions, in particular on the programs of the European Commission, to increase the competitiveness of Italian companies. The company was launched in 2013, bringing together the expertise of its partners and associates who have had over ten years professional experience thanks to the presence within European institutions and projects, the cultivation of international relations and the establishment of international reputation networks.

Therapieverbund Ludwigsmuehle, Germany: Since the 1990s the Centre provides one of the five special services for drug addicted woman present in the Rhineland-Palatinate county. It cooperates in a regional network with many facilities like women's shelters and Gender Based Violence- counselling services. The Center also educates various professional groups on prevention, and publishes informative and academic publications which seek to raise public awareness and promote prevention.

Therapiesalon im Wald, Austria: is a non-profit health organization in the field of prevention and residential treatment of psychosomatic diseases. The organization offers residential, ambulant treatment and counseling for persons with substance addiction problems in a wider framework of therapeutic measures for psychosomatic diseases. Therapiesalon im Wald is very active member of Euro TC - European Treatment Centers for Drug Addiction and Mental Health.

The Fundación Salud y Comunidad, Spain: is a non-profit organization based in Barcelona, engaged in actions at national and European level. It has a solid and broad experience in the promotion, design and management of services concerning several social-related issues. The FSyC has been leader in defining models of action in violence against women and drug addiction and their interactions. In the year 2000 a pioneer approach started which brought together the intervention in these two areas.

IREFREA, Portugal: IREFREA is an NGO established in Portugal since 1997 doing research in projects related to family and recreational contexts, involving European partners funded by the European Commission. Irefrea Portugal has been developing professional partnerships with national and European experts in the field of peer education, drug prevention and drug demand reduction. IREFREA Portugal integrates and cooperates with several national and international networks and organizations on prevention, and health promotion: IREFREA network, POMPIDOU Group, PEER, EURONET, UNDOC, ICPHR (International Collaboration on Participatory Health Research), EU-Society of Prevention and Research. Their main fields of activity are research, primary applied prevention, theoretical and scientific study of risk factors and evaluation.

Zajednica Susret, Croatia: is an humanitarian organization that has been operating in the Republic of Croatia for almost three decades now. Its core activity is prevention and out-of-hospital treatment of addiction to drugs, alcohol, gambling, and other forms of addiction. The activity of Zajednica Susret is based on the social program called "Projekt Čovjek" (Human Being Project) which places the focus first on an individual and only then on the problem at hand. The actions of the Organisation are aimed at strengthening positive attitudes toward marginalized groups, including the persons addicted to narcotic drugs, alcohol and gambling.

ENSA is a European network of Social Authorities, its aim is to promote international cooperation in the social field particularly in five subject areas of intervention each lead by a different Local Authority: elderly (Rotterdam), youth and Family (Veneto Region), child issues (Flanders), disability (Conseil Départemental du Val de Marne) and social inclusion transversal to all groups. The general coordination is led by the Veneto Region.

The Veneto Region's Brussels Office works jointly with the ENSA, European Network of Social Authorities in the INTERLEAVE project and is committed to support, disseminate and exploit the projects objectives, work and results through their networking capacaties

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Background and Context

Both the European Union and the different Member States have developed multiple laws and policies regarding the use and abuse of drugs; in this context, the European Union and the Member States have developed together, over the past two decades, a European approach to addressing drugs sustainably. This approach is enshrined in the EU Drugs Strategy 2013-2020 and two consecutive four-year Action Plans on Drugs, the first one covering the period 2013-2016 and the second one covering 2017-2020.

The Strategy is structured around two policy areas: drug demand reduction and drug supply reduction, and three cross-cutting themes: (a) coordination, (b) international cooperation and (c) information, research, monitoring and evaluation. While maintaining and updating the core policy areas and cross-cutting themes of the overall EU Drugs Strategy, the new Action Plan identifies new priority areas for action, including improved monitoring of new psychoactive substances (NPS), as well as the use of new communication technologies for prevention of drug abuse and evidence gathering on the potential connection between drug trafficking and financing of terrorist groups and activities, migrant smuggling and trafficking in human beings. (European Commission, 2019). The 2017- 2020 EU Action Plan on Drugs includes the following specific action directly related to the scope of the project: “Expand the provision of rehabilitation/reintegration and recovery services with an emphasis on services that: a. focus on providing a continuum of care through case management and interagency collaboration for individuals; b. focus on supporting the social re/ integration (including the employability and housing) of problem and dependent drug users including prisoners and ageing drug users, where relevant; d. take account of gender-specific needs; e. reach out to vulnerable communities/ populations”. In this sense, the 2017-2020 EU Action Plan suggests to consider the “extent of increase in the number of gender specific rehabilitation/ reintegration and recovery programmes” among its evaluation indicators.

In addition, both the European Union and the different Member States have adopted laws and policies against gender- based violence (GBV). In this sense, victims' rights have been reinforced at all stages of the criminal process through an EU directive establishing minimum standards on the rights, support and protection of victims of crime. This directive puts strong emphasis on access to appropriate support, including specialised support for women and children who have been victims of different forms of violence. EU countries are, for example, required to provide appropriate access to shelters for domestic violence victims and emergency support for victims of sexual violence (European Commission, 2019).

Nevertheless, these subjects seem to be treated separately whereas international organizations and recent research show the interrelation between both themes:

On the one hand, the United Nations Interregional Crime and Justice Research Institute (2015), call on governments to recognize the unique needs of women, when designing and implementing drug policies, given that there is extensive evidence of the differences between women and men regarding the use of substances – i.e. women are more exposed to sexual and physical abuse and violence. The Resolution 55/5 specifically invites governments "to consider incorporating female-oriented programmes in their drug policies and strategies" and encouraged them "to integrate essential female- specific services in the overall design, implementation, monitoring and evaluation of policies and programmes addressing drug abuse and dependence".

On the other hand, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has largely pointed out gender specificities in drug use. In this sense, the motion graphic entitled "Why gender matters in drug addiction" (EMCDDA, 2019) clearly show the specific needs faced by women who use drugs, including "intimate violence". Besides, the EMCDDA (2017) state that 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.

Finally, research has also pointed out the relationship between drug use/abuse and gender-based violence (GBV). In 2015, an investigation carried out by Thérese Benoit and Marie Jauffret-Roustide10 in Paris, Rome, Madrid and Lisbon, highlighted the violence (and GBV) experienced by women drug users. The research, among other themes, analyses the relationship between violence (GBV) and the use of drugs and highlighted the need of concrete actions for women drug users facing GBV. However, this project also points out some important obstacles in the scope of the intervention with women drug users facing GBV: the non-integration of the gender perspective; the saturation of the services of attention that also treat drug dependence and GBV separately; the weakness of support networks and social reintegration services; and, in general, the lack of financing of the actions. *In this sense, as reflected below, it is observed that, in general, in both the EU and its Member States, there is shortage of programmes aimed at women drug users facing gender- based violence (GBV).*

What is Gender Based Violence?

•Definition of GBV: an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

•Types of GBV: GBV can be physical, emotional or sexual. All types of GBV have long-term and serious consequences, but different responses might be needed for different types of violence.

- Consequences of GBV: GBV has emotional, health/physical and social consequences. In responding to a disclosure we need to ensure we are not creating further harm by exposing the survivor to retribution by the perpetrator or his family, stigma or further violence from the community or the survivor's family, or by further victimizing or blaming the survivor for the violence

source: https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_UserGuide_021618.pdf

Profile: Women who use drugs (WWUD) and victims of Gender Based Violence (GBV)

WWUD and other persons who experienced GBV are facing several difficulties:

Stigma: women with psychic problems and/or problems with substance abuse frequently perceive that hey are not fitting into their roles as mothers and caregivers. This situation is heavily connected with feelings of guilt and shame.

Socio-economic burdens: Women experience lower employment and income levels. The cost for treatment may be a barrier when services are not provided by the state or there is no insurance coverage.

Social support: Women frequently experience less social support than men because , especially if they already are at risk, coming from families with substance use problems or live with a substance-abusing partner. (For example, among English drug treatment-entrants, three-quarters of women had drug-using partners but only two- fiths of men.)

Drug-using partners: Women often are stuck in a co-dependent situation , frequent relapse after treatment interventions / blood-borne viral infections and violence, and are stuck in fear to loose the partner relationship if they become substance -free.

Children: It is evident that the relationship with their children is of utmost importance and willplay a central role in women drug use and recovery. Female treatment entrants are more likely than males to live with their children.

Compared with men, women who use drugs are more likely to experience **sexual and physical assault and abuse** as children or as adults and to be exposed to intimate partner violence.

Post-traumatic stress disorders and other mental health problems, such as anxiety and depression (as a possible result), are more common among women drug users.

Dual diagnoses: the exclusion of persons with multimorbity/psychosis from services may impact more on women than men.

<u>General problem</u>: Most drug user services are male-oriented

Women in difficult live situations suffering drug problems have special needs. These sub-groups, which often overlap, (including pregnant and parenting women; women involved in sex work, who more frequently experience violence and stigma; women from ethnic minorities, who may have suffered human trafficking , women in prisonand other difficult life situations). Women drug user victims of GBV are more likely to share injecting equipment with more people. Women drug user victims of GBV are also more likely to **trade sex** for drugs or money and have difficulties negotiating condom use with sexual partners.

Within the project these facts have been further evaluated through research providing the view of women in a respective situation as well as the experience of professionals assisting these women . The results can be studied on the project website…….

The practical toolkit developed is based on these results and the staff exchange and expert workshops in the program

Toolkit presentation

The general objective of the project is a contribution to the implementation of coordinated and coherent efforts across the different countries participating in the project, by improving knowledge and awareness about gender-based violence (GBV) faced by women who use drugs, and to produce recommendations to better tackle the problem. To achieve this objective, the specific actions mentioned have been performed in order to investigate and evaluate the violence suffered by these women and identify the most effective approaches and existing services within the territorial framework that encompasses the project.

The toolkit aims in delivering a long term positive impact in terms of:

(a) enhanced quality standards that will facilitate the constitution of cooperating networks, entities and professionals and will stimulate cooperation and collaboration;

(b) enhanced policies and practices in drug addiction treatment as well as enhanced capacities of relevant actors facing these problems (such as policy makers, legal experts, medical and social professionals);

(c) dissemination of guidelines and studies.

Again hast to be highlighted: Literature and evidence show that women suffering addiction are significantly disadvantaged: structural and social barriers make it more difficult for them to receive counselling and therapy. Women represent around one third of drug consumers world-wide, but only one fifth of the persons receiving counselling and treatment. It is still evident that frequently treatment facilities are male oriented and do not meet the special needs of women.

Who should use this toolkit?

There are four target groups: - policy makers and other decision makers

: - directors and management of respective facilities

- staff / professionals working with the target group

- peers / Women affected

TOOL - Review your organizational structure!

Does an implementation of a gender perspective in your organization / service exists ?

Target Group:	Professionals / Staff
Objective of the tool:	Status quo of strengths and weaknesses
How to use the tool:	Mark per each question between 0 and 5 your individual implementation level.
Estimated time:	30 min.
Trigger warning:	-
How the results are evaluated:	0 … not implemented at all ; 5 … implementation done Score at the end

Knowledge of our professionals about drug use	0 - 1 - 2 - 3 - 4 - 5
Knowledge of our professionals about gender violence	0 - 1 - 2 - 3 - 4 - 5
Knowledge of our professionals about the interaction between drug use and gender violence	0 - 1 - 2 - 3 - 4 - 5
Do we offer specific treatment for the target group ?	0 - 1 - 2 - 3 - 4 - 5
Level of empathy of our professionals towards women /using our service	0 - 1 - 2 - 3 - 4 - 5
Is there staff members who have experience and a professional expertise in dealing with the difficulties women who use drugs and experienced GBV are facing?	0 - 1 - 2 - 3 - 4 - 5
Do we collect a specific medical record regarding GBV ?	0 - 1 - 2 - 3 - 4 - 5
Do we have a specific program for the specific needs of the target group?	0 - 1 - 2 - 3 - 4 - 5
Do we share GBV Experiences in staff meetings ?	0 - 1 - 2 - 3 - 4 - 5
Do we include the gender perspective addressing violence and drug use ?	0 - 1 - 2 - 3 - 4 - 5

Do we have peer workers?	0 - 1 - 2 - 3 - 4 - 5
Do we involve women actively in the design, evaluation and development of the service?	0 - 1 - 2 - 3 - 4 – 5
Do we have an early detection system	0 - 1 - 2 - 3 - 4 – 5
Are we offering integrated therapy counselling support taking into account the overlapping connection of drug use and GBV	0 - 1 - 2 - 3 - 4 – 5
Are we using survivor-centred communication /have tailored behavioral measures	0 - 1 - 2 - 3 - 4 – 5
Are we adhering to the “do no harm*” principle?	0 - 1 - 2 - 3 - 4 – 5
Do professionals share knowledge how a repressive system (frequently backgrounded by a combination of trauma effects and addictive behaviour) / works	0 - 1 - 2 - 3 - 4 – 5
Do we take diversity into account? (sex. orientation, ethnicity, etc.) / checkllist LGBTQ, cultural, intersectional issues ..	0 - 1 - 2 - 3 - 4 – 5
Do we offer flexible access criteria e.g. low threshold, women with children, multimorbidity , special ethnic background..	0 - 1 - 2 - 3 - 4 – 5
Do we offer support for Parenting skills, further supervision and follow-up /aftercare	0 - 1 - 2 - 3 - 4 – 5
Is GBV as a topic reflected and discussed in all levels? (bottom up/down) ● Do we raise awareness of the financial benefit of a functioning organization with gender perspective. ● Do we integrate the topic into all levels of therapy and counselling ? ● Is there gender balance within our hierarchical structure ? ● Does external coaching /counseling/ training and supervision of our organization in terms of gender perspective exist? ● Is there any scientific evaluation /output of our work ? Does ongoing research, evaluations and identification of good practices determine, what needs to be tackled in further steps.	 0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 - 5

Do we actively promote … ? • social reintegration • empower women • autonomy of women • mutual support	0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 - 5 0 - 1 - 2 - 3 - 4 – 5
Do we have specific trainings?	
• How to deal with traumatized women.	0 - 1 - 2 - 3 - 4 - 5
• Are the topics addiction, medical consultation, knowledge of substitution, and the impact of violence through GBV part of the therapeutic treatment and counseling?	0 - 1 - 2 - 3 - 4 - 5
Do we engage in professional networking ,share information and have mutual exchange ?	0 - 1 - 2 - 3 - 4 – 5
Do we Express the gender and intersectional approach in our ethics – on our homepage ?	0 - 1 - 2 - 3 - 4 - 5
TOTAL SCORE 175 max.	

**DO NO HARM: Do not share information about a survivor*

Service providers always need to protect the identity and safety of a survivor by not sharing any personal or identifying information about the survivor or the incident to anyone without the survivor's explicit permission to share information about them and/or their experience. Personal or identifying information includes the survivor name, perpetrator name, date of birth, home address, work address, location where their children go to school, the exact time and place the incident took place, etc.

„Score" now! - How many points can you count ? (150 max.)

In which areas are you doing well, where are the lacks? What has to be improved ?

< 30 Points	Low implementation - time to getting started!
30 - 70 P	Okay - but further improvement needed
70 - 110 P	Already quite good !
> 110 P	Implementation Champion!

TOOL: Self-assessment test for Organisation's Management

Target Group:	Board, CEO
Objective of the tool:	Status quo of strengths and weaknesses
How to use the tool:	Mark per each question between 0 and 5 your individual implementation level.
Estimated time:	15 min.
Trigger warning:	
How the results are evaluated:	0 … not implemented at all ; 5 … implementation done Score at the end

Does your organisation have an Equality Plan?	0 - 1 - 2 - 3 - 4 – 5
Has an analysis of sex-disaggregated salaries been carried out?	0 - 1 - 2 - 3 - 4 – 5
Is the management team composed of an equal number of women and men (parity)?	0 - 1 - 2 - 3 - 4 – 5
Does the entity take any measures to counteract possible gender barriers when promoting individuals to management positions?	0 - 1 - 2 - 3 - 4 – 5
Is a gender perspective considered in the recruitment of staff?	0 - 1 - 2 - 3 - 4 – 5
Is gender equality in decision-making processes guaranteed ?	0 - 1 - 2 - 3 - 4 – 5
Does the organisation have guidelines or protocols defining the application of a gender perspective?	0 - 1 - 2 - 3 - 4 – 5
Do we request/offer training for professionals in gender perspective?	0 (0%) 1 (app 20%) 2 (app 40%) 3 (app 60%) 4 (app. 80%) 5 (100%)
Does the organisation include gender training in an Annual Working Plan?	0 - 1 - 2 - 3 - 4 - 5

Do we request/offer training for the intersection of gender perspective and use of drugs/ addiction?	0 (0%) 1 (app 20%) 2 (app 40%) 3 (app 60%) 4 (app. 80%) 5 (100%)
Is a gender perspective considered in the recruitment of staff?	0 - 1 - 2 - 3 - 4 – 5
Are peer-workers involved?	0 - 1 - 2 - 3 - 4 – 5
Does the organisation allocate an annual budget for gender mainstreaming?	0 - 1 - 2 - 3 - 4 - 5
Does your organisation carry out actions to ensure that inclusive, non-sexist language, pictures or images are used?	0 - 1 - 2 - 3 - 4 – 5
Do the mission and statutes of your organisation consider gender perspective as a tool for social change?	0 - 1 - 2 - 3 - 4 – 5
Does your organisation include/interpret sex-disaggregated data?	0 - 1 - 2 - 3 - 4 – 5
Does your organisation carry out concrete actions to promote changes in drug policies from gender perspective?	0 - 1 - 2 - 3 - 4 – 5
TOTAL SCORE 110 max.	

„Score“ now! - How many points can you count ? (150 max.)

In which areas are you doing well, where are the lacks? What has to be improved ?

< 20 Points	Low implementation - time to getting started!
20 - 40 P	Okay - but further improvement needed
40 - 60 P	Already quite good !
> 80 P	Implementation Champion!

TOOL: Self-assessment test for Programm Management

Target Group:	Therapeutic directors - leaders
Objective of the tool:	Shows the degree of implementation of intersectional gender perspective in drug services
How to use the tool:	Mark per each question between 0 and 5 your individual implementation level.
Estimated time:	20 min.
Trigger warning:	-
How the results can be evaluated:	0 … not implemented at all ; 5 … implementation done Score at the end

Are actions taken to eliminate unequal power relations between users?	0 - 1 - 2 - 3 - 4 - 5
Are there actions to include users into the decision process ?	0 - 1 - 2 - 3 - 4 - 5
Is the relational style of professional's gender sensitive?	0 - 1 - 2 - 3 - 4 - 5
Do women face barriers to accessing treatment?	0 - 1 - 2 - 3 - 4 - 5
Do LGBTIQ+ people face barriers to accessing treatment?	0 - 1 - 2 - 3 - 4 - 5
Do women face barriers to attend aftercare?	0 - 1 - 2 - 3 - 4 - 5
Do LGBTIQ+ people face barriers to attend aftercare?	0 - 1 - 2 - 3 - 4 - 5
Does the programme promote actions to create safe spaces for women and other gender identities?	0 - 1 - 2 - 3 - 4 - 5
Are there spaces only for women?	0 - 1 - 2 - 3 - 4 - 5

Are there spaces only for men?	0 - 1 - 2 - 3 - 4 - 5
Are there spaces only for other gender identities?	0 - 1 - 2 - 3 - 4 - 5
Are gender contents included when working with women?	0 - 1 - 2 - 3 - 4 - 5
Are gender contents included when working with men?	0 - 1 - 2 - 3 - 4 - 5
Are gender contents included when working with other gender identities?	0 - 1 - 2 - 3 - 4 - 5
Are detection systems and protocols for GBV in place?	0 - 1 - 2 - 3 - 4 - 5
Are detection systems and protocols for GBV considering different types (psychological, physical, sexual, economic…) of GBV in place ?	0 - 1 - 2 - 3 - 4 - 5
Are detection systems and protocols for GBV considering different contexts (sex-affective relationships, institutional settings, drug use contexts, family of origin, …) of GBV in place ?	0 - 1 - 2 - 3 - 4 - 5
Is gender violence experienced throughout the life of women addressed, including the relationship with drug use?	0 - 1 - 2 - 3 - 4 - 5
Is gender violence experienced throughout the life of women addressed from gender perspective, including the relationship with drug use?	0 - 1 - 2 - 3 - 4 – 5
Is institutional violence both in mainstream and drug services addressed?	0 - 1 - 2 - 3 - 4 – 5
Are service regulations considering the specific needs of women and their children?	0 - 1 - 2 - 3 - 4 – 5
Are service regulations considering the specific needs of LGBTIQ+ people?	0 - 1 - 2 - 3 - 4 – 5
Is the activity programme considering the specific needs and/or interests of women and their children?	0 - 1 - 2 - 3 - 4 – 5
Is the activity programme considering the specific needs and/or interests of LGBTIQ+ people?	0 - 1 - 2 - 3 - 4 – 5
Is the design of the spaces/facilities considering the specific needs of women and their children?	0 - 1 - 2 - 3 - 4 – 5
Is the room design of the facilitiy considering the specific needs of LGBTIQ+ people?	0 - 1 - 2 - 3 - 4 – 5
Is mental health considered from a gender-sensitive approach?	0 - 1 - 2 - 3 - 4 – 5

Are sexual and reproductive rights of women and other gender identities considered?	0 - 1 - 2 - 3 - 4 – 5
Is intersectionality considered in terms of…?	
Poverty (class)	0-1-2-3-4-5
Ethnicity	0-1-2-3-4-5
Migration/ Refugee	0-1-2-3-4-5
Culture of origin	0-1-2-3-4-5
Disability	0-1-2-3-4-5
LGTBIQ+	0-1-2-3-4-5
Other	0-1-2-3-4-5
Is mutual support among women and other gender identities in the programme/service promoted?	0 - 1 - 2 - 3 - 4 - 5
Is the agency of women and other gender identities promoted?	0 - 1 - 2 - 3 - 4 - 5
Is there coordination with local networks, social movements and services to support women and other community services/organisations?	0 - 1 - 2 - 3 - 4 - 5
Is the coordination with peers/networks for women /self help groups / promoted?	0 - 1 - 2 - 3 - 4 - 5
Is social "reintegration" considering gender-sensitive issues supported ?	0 - 1 - 2 - 3 - 4 - 5
Is socio-political activism promoted?	0 - 1 - 2 - 3 - 4 - 5
TOTAL SCORE 175 max.	

„Score" now! - How many points can you count ?

In which areas are you doing well, where are the lacks? What has to be improved ?

< 30 Points	Low implementation - time to getting started!
30 - 60 P	Okay - but further improvement needed
70 - 110 P	Already quite good !
> 110 P	Implementation Champion!

TOOL - Action Plan

Target Group:	Professionals / Staff
Objective of the tool:	How to implement gender mainstreaming, according to the results obtained in the previous tools.
How to use the tool:	Fill in the asked topics in the headline
Estimated time:	continuing process
Trigger warning:	No
Evaluation of the results	

ASPECTS THAT NEED TO BE IMPROVED	OBJECTIVES	INDICATORS	EXPECTED RESULTS
1 E.g. Knowledge of professionals about gender and drugs	To improve knowledge of all the staff, including managers…	At least 1 training per professional (so 50) per year (10 hours). Evaluation.	…
2 Eg Spaces only for women			
3			
4			

PRIORITY (1/2/3: 1rst year, 2nd year…)	CALENDAR	PERSON / DEPARTMENT IN CHARGE	FOLLOW-UP *	EXTRA
1	Month 1-6		42 people trained. Managers were not finally trained…	

* A Gender and Intersectional Commission will meet e.g. annually to follow up on the implementation of the plan…Choose a responsible person or implementation team in charge of the topic to make sure the action plan will be carried out.

TOOL: Checklist - Mapping resources

Target Group:	Professionals / Staff / Facilities / Services
Objective of the tool:	What are the resources of our facility? Shows weaknesses and strengths
How to use the tool:	Check individually and then discuss with your colleagues in a meeting
Estimated time:	60 min.
Trigger warning:	no

- ☐ Safer space - protection, awareness of the staff, speaking openly, etc.
- ☐ Safer space for only women e.g. specific therapeutic women group
- ☐ Are mental health diagnoses gender sensitive?
- ☐ Amnestic diagnoses from the gender perspective and/or participatory involvement of WWUD with GBV experience
- ☐ Therapeutic interventions
- ☐ Existence of a holistic approach?
- ☐ NETWORKING: are we in cooperation with other services ?
- ☐ Is there enough Knowledge about other services for possible cooperation :
  E.g. drug services, survivor services/self help groups, police, health care services, legal services, etc.
- ☐ Supporting our own visibility / we deliver regularly information about our work ,hand outs, leaflets, eg
- ☐ Is there Personal contact and experience with other facilities ,can we recommend services?

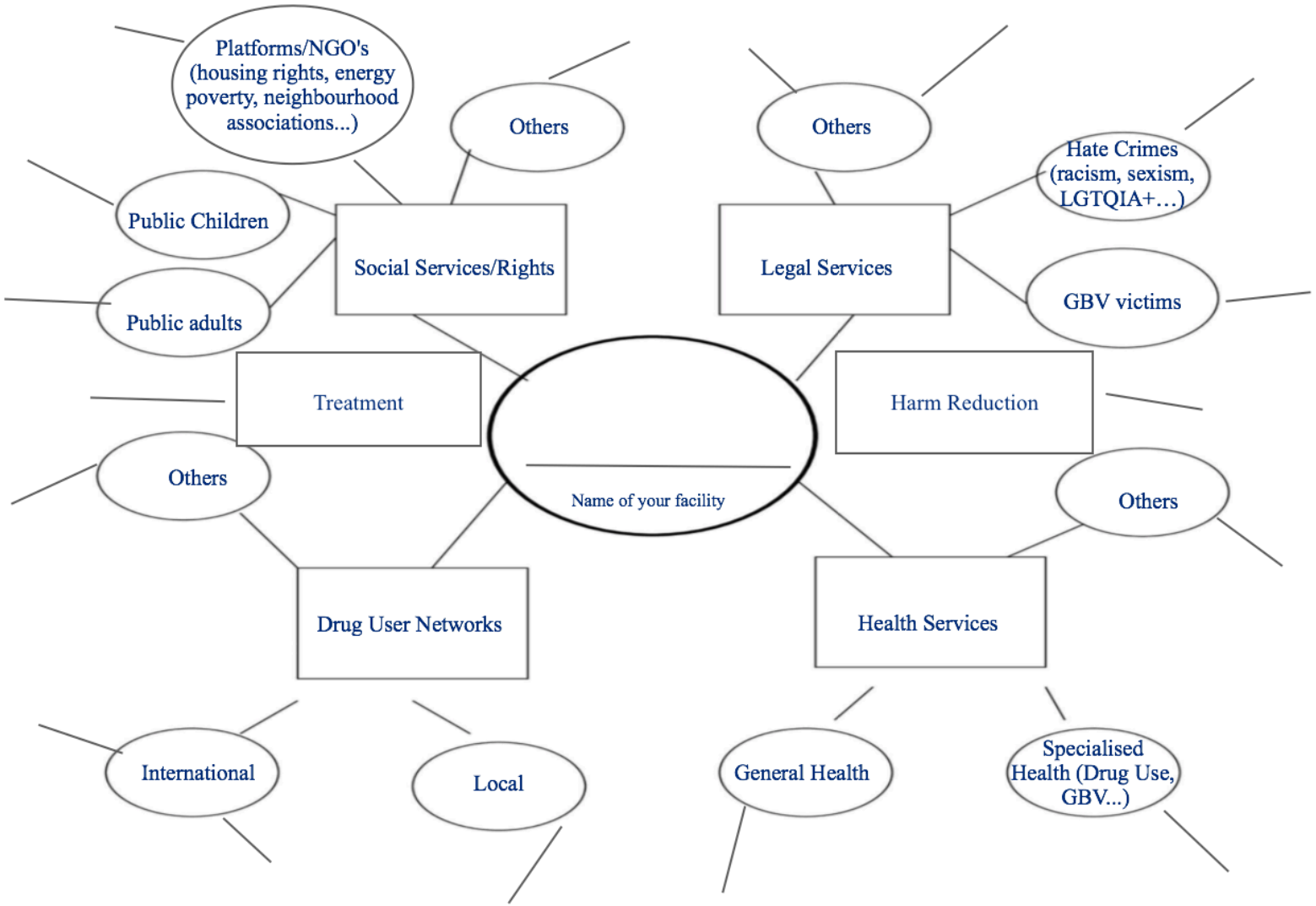
Recommendation

To achieve a structured gender perspective in the institution, external coaching and supervision for the entire organization is desirable. A best practice example could be a “gender team group”, which involves directors, managers and executive staff members. In this team knowledge about the gender perspective should be shared in both directions – bottom-up and top-down approach. A realistic example shows that in average institutions up to 80% of women are in lower positionsthenm men There is frequent lack of support from top management, and therefore unrealistic to achieve successful gender perspective training. Women should be encouraged to reflect and discuss the process and participate in the design and evaluation of the gender perspective.

TOOL: Mapping your Network - Local Resources

Target Group:	Professionals / Staff
Objective of the tool:	How does your existing Network look like? Shows weaknesses and strengths
How to use the tool:	Check individually and then discuss with your colleagues in a meeting
Estimated time:	60 min.
Trigger warning:	No
Evaluation of the results	Fill in your existing network

Additional bullet points: e.g.women shelter, activism,..


Platforms/NGO's (housing rights, energy poverty, neighbourhood associations...)
Others
Others
Hate Crimes (racism, sexism, LGTQIA+…)
Public Children
Social Services/Rights
Legal Services
Public adults
GBV victims
Treatment
Harm Reduction
Others
Name of your facility
Others
Drug User Networks
Health Services
International
Local
General Health
Specialised Health (Drug Use, GBV...)

TOOL - Target Group Interview Guide

Target Group:	Professionals / Staff
Objective of the tool:	Sensitive and structured Interview / Anamnese
How to use the tool:	Go through the questions with your client
Estimated time:	20 - 40 min.
Trigger warning:	Yes

While conducting the interview use open-ended questions to really understand how the individual is thinking and feeling. In case more clarity and information are needed, ask the person to elaborate more, ask specific and follow-up questions related to information received. Keep in mind to avoid re-traumatizing the person by going too fast into detail. Offer a normal reaction to an abnormal event.Make clear that you evaluate a status quo and further therapy will go into detail. Do not overburden the individual in a first evaluation session .

To Avoid	Good examples
“Don’t be afraid”	“I believe you.”
“Don’t cry”	It’s okay for you to cry here.
“It’s not as bad as it seems”	I will be with you and we can talk when you are ready.”
“Everything is going to be fine”	“You have every right to be upset and sad.
	“I am glad that you told me.”
	“I am sorry this happened to you.”
	“This is not your fault.”
	“You are very brave to talk with me.”

Interview

- Can you tell me about your present/past experience with drugs/substance abuse?
- Can you remember having any negative experiences with other people while under influence of drugs/alcohol?
  (your partner, family, people you were spending time with when you were taking drugs,
- If the person struggles to understand give them examples- were there any situations where somebody was behaving violent, were you forced to do something you didn't want to do…)
  - Can you elaborate more?
    (depending on what a person discloses/mentions and knowing what are the types of GBV, ask to elaborate more on particular behaviors/situations that you recognize as potential GBV)
- Have you ever shared what you experienced with somebody? Can you tell me more about how it went?
- Have you ever felt you were treated differently when asking for support for substance abuse issues? (different treatment because you are a woman/LGBTQ person with substance abuse issues)
  - Can you elaborate more?
    Did you ever report or in other way address this different treatment?

TOOL - Checklist for policymakers to take the gender perspective into account

Why is it useful for policymakers to include gender perspective in facilities for women using drugs

Target Group:	Policymakers
Objective of the tool:	Point out the value to support the gender perspective in addiction facilities
How to use the tool:	Suggestions for funds Checklist
Estimated time:	20 min.
Trigger warning:	no
Evaluation of the results	Implementation of the gender perspective

Preface

There is little systematic approach within addiction services concerning the impact of gender specific violence, and resulting traumatic experiences. Gender oriented services for women suffering violence are mainly not familiar with the impact of substance use, abuse and addiction.

Despite the relevance of **femicides** and upcoming prevention efforts in the European Union, gender issues and the impact of substance abuse is not focused and highlighted in a sufficient way. Public Health in the field of substance abuse is neglecting to substantially address and integrate gender issues even if professionals working in these facilities point out significant need. Quality is connected to motivation and working skills of the individual professional, not to a systemic structure.

Unfortunately we are still in a predominately male oriented support system in the field of prevention and treatment on drug related harm. Connected to gender based violence this implicates high barriers for women in need of help. In fact gender issues within health institutions are rarely represented by women in key managing positions, decision makers are predominantly men.

Raise awareness: to have commitment to build specialized facilities on the topic GBV and women who use drugs, or to connect the specialized services

e.g. Flyer / Folder with important informations about drugs, GBV, integrated, health, social and legal services

Professionals demand:

a) Centres for women survivors of violence should be adapted to include women who use drugs.

b) 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.

Checklist

The contextual analysis of the different circumstances related to gender are reviewed	☐
It is considered that a strategy has different impact on different gender groups	☐
Outcomes and results are designed that they can be flexible adapted for all gender groups	☐
Training and supervision on gender and drugs are carried out regularly	☐
There are clear, systematised protocols to address GBV.	☐
WWUD have flexible access to drug services.	☐
The specific needs of WWUD and their children is taken into account.	☐
Mental health diagnosis are considering the gender-perspective.	☐
Existence of spaces and services only for women.	☐
There is specific work with men.	☐
WWUD get encouraged to participate in programs, including political participation.	☐
In all structures of organizations gender mainstreaming is considered	☐

TOOL: Orientation Helper

Target Group:	Clients / Peers
Objective of the tool:	What can a Client ask to feel save and make sure to be at the right place?
How to use the tool:	Ask the Questions
Estimated time:	10 min.
Trigger warning:	yes
Evaluation of the results	-

- Do you deal with women who use drugs ?
- Do you deal with women who experienced GBV / traumatized women?
- Do you have professionals who know or have experience regarding the interaction between drug use and GBV?
- Is there flexible access criteria e.g. low threshold, children, ..?
- Do you have medical consultation / possibility for substitution?
- Do you have psychological counseling and therapeutic treatment?
- Do you have specific treatment /program addressing my specific needs?
- Do you actively promote … ?
  - social reintegration
  - empowerment of women
  - autonomy of women
  - mutual support
- Do you include peer workers?
- Do you take diversity into account? (sex. orientation, ethnicity, etc.) / checklist LGBTQ, cultural, intersectional issues.

- Do you offer a safe space: protection, awareness of the staff, encouregement to speak openly, etc. Do you offer safe space for only women e.g. specific therapeutic women group
- Do you offer a holistic approach?
- Do you consider intersectionality?

Recommendations

… to increase the cross knowledge of professionals

- Conferences for professionals on GBV and the relation to drug addiction
- Scientific publications / journals and informal magazines
- Working group within existing networks
- Long-term and stable cooperation between the services (GBV and addition care)
- Internships, extern counseling, supervision between the services
- Qualification in gender and addiction field
- Training of professionals at universities in related educational fields (medicine, sociology, law, police office, social worker, etc.)
- Exchange in European projects between services
- Awareness campaigns on the target group
- Informal education and training

Target Group and Epidemiological Data

Survey

Based on the different sources of information, a quantitative and qualitative analysis with gender and feminist approach was carried out.

The **women questionnaire** has been carried out taking into account factors as age, sexual orientation, nationality, education, income, housing situation, children, sex affective situation, self-reported mental health and illnesses, drug use, types and context of violence, including institutional violence. The legal framework and scientific literature have been considered as basis for the research and disseminated through the 6 countries of the partnership.

The **staff questionnaire** has considered factors such as country of residence, type of service, professional role or financial treatment sources. Criteria such as the service approach, the most desirable treatment option have been taken into account.

Besides, **15 focus groups** with women who use drugs and staff and **120 interviews** with key informants have been carried out. In addition, a scientific and grey literature review of more than 80 papers was conducted.

About the survey's samples

Survey aimed at women who use drugs, 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.

Survey aimed at 492 staff members working in different facilities where the treatment is addressed to 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

These are some of the most salient results

The majority of the Women Who Use Drugs (WWUD) 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. By contexts, the high prevalence of institutional violence (26,54%) stands out and opens up the possibility of improving intervention strategies in both mainstream and specialised services for Women Who Use Drugs (WWUD). Focus groups with WWUD have revealed numerous examples on this regard. 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) compared to women (5,12% users – 4,33% not users).

Looking into the intersectionality between three or more factors, then adding to gender identity and drug use, poverty (32,41%) stands out. Only 24,49% of professional staff (27,63% of women and 11,7% of men) reported working from gender perspective. 54.39% of professional staff acknowledged that they had no knowledge of drug use and gender-based violence.

According to both WWUD (75,79%) and professional staff (83,78%) integrated services for women who use drugs facing GBV seem to bring together the most “traditional” aspects of drug services as well as those related to gender mainstreaming.

Staff Exchanges and Workshops

In general the meeting proved the high relevance and also high practical interest for the topic. Especially the teamwork in small groups showed a valuable outcome with the definition of key necessities which are not met.

The average situation is characterized of high motivation of professionals to take the background of clients with experiences of violence, often traumatic, serious , as well as the gender issue. In fact the relevant tools are mostly personal skills and experience. There is little systematic approach within most institutions, addiction services are not focused and trained enough concerning the impact of

gender specific violence, and traumatic experiences, gender oriented services for women suffering violence are mainly not familiar enough with the impact of substance use, abuse and addiction.

Despite the relevance of femicides and upcoming prevention efforts in the European Union, gender issues and impact of substance abuse is not an enough supported topic yet. Health facilities in the field of substance abuse are slow in substantially addressing and integrating gender issues even if professionals working in these facilities see significant need. Quality is connected to motivation and working skills of the individual professional, not only a team strategy.

Unfortunately we are still in a predominately male oriented support system when it comes to tackle drug related harm prevention and treatment. Connected to gender based violence this implicates high barriers for women in need of help. In fact gender issues within health institutions are rarely represented by women in key managing positions, decision makers predominantly men. This seems to be an outcome of the research in the study and was seen as key problem during the meetings and mutual exchange of staff members from the respecting project partners.

There have been ongoing efforts through international networking and raising awareness on gender issues over more than 30 years by NGO´s especially through Euro TC members (all project partners are also connected through Euro- TC) the topic is still neglected, the reality man oriented: Also through the structure of many institutions. Even seen a key issue by the European Commission there is little focus when it comes to practice.

On the European level it is a reality, that there is no consistent funding for initiatives and networks working on gender issues connected with drugs. The Participants of the meetings shared the necessity to give priority, not only on a voluntary but systemic level. Organisations should install „gender team groups „involving executive staff members featuring a bottom-up/top down approach to raise expertise and awareness of gender and violence issues. Further on the idea of integrated units necessarily has to be elaborated and installed through the responsible health system.

In fact the staff exchanges and the workshops did not only have an important intellectual output regarding the development of a toolkit but also a very practical impact in mutual learning from the others, recognition of numerous similarities and understanding the importance of networking to identify and furthermore better implant best practice.

Public Policy: Health system and policies

„Why does gender makes a difference ?“ We compared and investigated the EMCDDA & UNODC Manuals. We captured together differences and lacks of important aspects regarding the topic. The Importance and Necessity of this project quickly became clear.

Many drug services are male oriented. Women are facing specific difficulties in stigma, socio-economic burdens, social support. In addition, their partners are often drug users and these women have the responsibility to raise children. Compared with men, women who use drugs 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. Post-traumatic stress disorders and other mental health problems, such as anxiety and depression (as a possible result) are more common among women drug users.

The EMCDDA Manual showed that the words women, gender, violence, pregnant, children, girls etc. are indicated only a few times. So there is even less information or actually no explicit mentioning of the project topic. The UNODC Manual showed more results regarding the keywords. There are more women orientated and sensitive results also sometimes in connection with violence but likewise doesn’t has any information in particular regarding women facing GBV.

Best Practice collection

A fundamental necessity is that women shelters must also be available for women drug users (even if they have children). Therefore, the services need to recognize the real needs and adapt the service. High and low threshold integrative offers would be necessary. More precisely e.g. the availability of safe spaces that can be entered according to personal choice. Despite the spatial design there should be intersectional trainings for professionals. If it is a non- integrative service there is a need for knowledge of the topic.

The treatment requires specific therapeutic intervention, amnestic diagnoses or participatory involvement of GBV victims as well as the knowledge how a repressiv system works. From the statement that after detecting first signals the services want to pass the women on, the question arose where to forward them. An early detection system is missing. Networking and cooperation between women's shelters and treatment centers should be established. Certainly, the political narrative of prejudices against women drug users must be countered.

There are many ways to anchor cross knowledge among professionals and cooperation between institutions: In general, it's about communication, scientific work, seminars and the dissemination or exchange of the results. This can be conferences, publications, connecting to existing networks, working with universities and eventually building long-term and stable cooperations.

Assessment, monitoring and evaluation

The project is based on a gender approach that considers drug-dependent women victims/survivors of gender-based violence as active political subjects able to decide on their own process.

Thus, the project seeks to define the best practices in the care of drug-dependent women victims/survivors of gender violence from a holistic or integral care model (eco-systemic approach), taking into account the recovery factors of women and the different types of intervention, such as individual and group intervention; besides, the children and the mother-child relations are also taken into account. This model requires three types or axes of action: attention to women, care for their children and attention to women as mothers.

The above-mentioned implies participatory strategies, experts consulting and networking. Participatory strategies refer to how women who have suffered violence and their sons or daughters as well as all the staff and experts involved are conceived as active agents in the definition of all the actions of the project, including the preparation, development and assessment/dissemination phase. In particular, all these people involved must participate in the initial survey, the training and international meetings, the creation of the toolkit and finally, the dissemination of the results of the project. Likewise, external consultancy actions will be carried out for the different WPs, especially for the review of the quantitative questionnaire, the analysis of the discussion groups, the training plans, and the toolkits produced.

Literature and recommendation

How to support a survivor of gender-based violence when there is no GBV actor in your area, pocket guide

https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_UserGuide_021618.pdf

Information about survivor- centered communication and attitudes can be adapted as a handout included in the toolkit as reference information for non-GBV specialised staff working with women.

https://www.researchgate.net/publication/325297112_New_Terrain_Tools_to_Integrate_Trauma_and_Gender_Informed_Responses_into_Substance_Use_Practice_and_Policy