

“Improving the management of violence experienced by women who use psychoactive substances”



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Paris, Rome, Madrid and Lisbon

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Thérèse Benoit:
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Marie Jauffret-Roustide:
sociologist, researcher at
Inserm (Cermes3).

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Contents

FOREWORD	5
I. BACKGROUND TO THE STUDY	7
1.1. Definition of concepts	8
1.2. Initial results of the literature review	9
1.3. Objectives	10
1.4. Project team	10
II. METHODOLOGY	13
2.1. Forming the groups	14
2.2. The composition of the focus groups	14
2.3. The conduct of the focus group meetings	16
III. RESULTS	19
3.1. Typology of violence: interdependence and mutual reinforcement of the different forms of violence	20
3.2. Determinants of the link between violence and psychoactive substance use among women	29
3.3. Actions to deal with violence	39
3.4. The obstacles to overall management of women users who experience violence	48
3.5. Recommendations for effective overall management of violence experienced by women who use psychoactive substances	57
IV. LIMITS AND STRENGTHS OF THE STUDY	67
Limits	67
Strengths	68
Conclusion	69
APPENDIX: FOCUS GROUP DISCUSSION GUIDE	71

Foreword

The Council of Europe's Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs ("Pompidou Group") promotes public health and the implementation of a drug policy which respects human rights and supports gender mainstreaming.

By holding a first symposium in 1988 on women and drugs, the Pompidou Group was a pioneer in Europe regarding the gender aspect of drug policies.

Within the framework of its 2014-2018 mandate, the Pompidou Group resumed its activities in this field with the introduction of a gender dimension in drug policies.

This would not have been possible without the political and financial support of the Department for Anti-Drug Policies of the Presidency of the Council of Ministers of Italy.

The activities cover three different fields consistent with the Pompidou Group's mission of promoting the link between research, policy and practice;

Research on the gender dimension in the Non-Medical Use of Prescription Drugs in Europe and in the Mediterranean Region (NMUPD)

which resulted in an ISBN 2015 publication covering data from 17 countries: The study reveals that women are a high-risk category for NMUPD and that no standardised monitoring system for NMUPD exists in Europe and in the Mediterranean Region. It addresses recommendations to national authorities and calls for a better understanding of the link between drug use among women and violence;

Research on violence, women and drugs

A review of literature on “violence (experienced or perpetrated) and psychoactive substance use among women in Europe and in the Mediterranean Region” was conducted in 2015. 63 articles published in 12 countries related to the issue of violence and the use of psychotropic substances among women were considered in this exploratory research.

Women, Violence and Drugs

In order to give an operational perspective to this review of literature, a consultation through focus groups on addiction treatment and risk and harm reduction professionals was undertaken in four countries: France, Italy, Portugal and Spain. The recommendations were presented during a seminar on Women, Drugs and Violence held on 10-11 December 2015 in Rome attended by Italian professionals working in the area of addiction treatment and harm and risk reduction, along with policy makers from 22 countries.

The details of these consultations and the recommendations appear in this report.

By its action on introducing a gender dimension in drug policies, the Pompidou Group contributes to the Council of Europe Strategy on Gender Equality 2014-2017 which aims at achieving the advancement and empowering of women and the effective realisation of gender equality in Council of Europe member States.

I. Background to the study

The life paths of women drug users are punctuated by traumas and violence suffered during childhood or adulthood. These women form a minority of the patients seen by addiction and harm reduction professionals, whose active patient lists consist mainly of men. The chaotic lives and traumas and violence experienced by women sometimes make treating them more complex¹.

This topic was extensively discussed and brought to the fore in the consultations held in 2014 by Eranid (European Research Area Network on Illicit Drugs; network of eleven organisations in six European Union member states, Belgium, France, Italy, the Netherlands and the United Kingdom) to identify research priorities in the field of illicit drugs². The question was approached from different angles, as a determining factor in the start of drug use and as a factor contributing to the addiction process or making the exit process more difficult. The researchers, treatment professionals and institutional stakeholders participating in these consultations regretted the limitations of research in this area, stressing that a lack of knowledge about this subject could limit the effectiveness of treatment for women drug users.

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1. Jauffret-Roustide M, Oudaya L, Rondy M, Kudawu Y, Le Strat Y, Couturier E, Emmanuelli J, Desenclos JC. Trajectoires de vie et prises de risques chez les femmes usagères de drogues, *Medecine/Science* 2008; 2(24), March: 111-121.
 2. Jauffret-Roustide M, Chauvin C, Santos A. Priorités de recherche dans le domaine des drogues illicites et des sciences humaines et sociales, ERANID report, September 2014.

At the Pompidou Group's initiative, as part of its activities aimed at introducing the gender dimension into drug policies (2015-2018 work programme), a first exploratory study on "Violence (experienced or perpetrated) and psychoactive substance use among women in Europe and in the Mediterranean region" was carried out in April 2015³. The principal aim of this stocktaking work was to initiate a review of the literature on the violence and traumas suffered by women drug users. Secondary aims were to identify lines of research in this area and suggest guidelines for professional practice.

1.1. Definition of concepts

The notion of "violence" needed to be defined in the light of these aims. It needed to be wide enough not to limit the research to an exploratory stage, but at the same time sufficiently delimited to enable it to be used in an operational context.

In the social sciences, and particularly in sociology, the concept of violence is viewed from two main angles: first, from the standpoint of physical violence analysed through the prism of state institutions tasked with controlling violence (the police, school, the courts etc.), and secondly on a symbolic level, with reference to the writings of Pierre Bourdieu, who explains social domination by a process of legitimation of inequalities through state institutions⁴. In this case, the violence is symbolic. More generally, there is no stable definition of violence in the social sciences. The difficulty stems from the relative nature of violence depending on the period and a society's rules and standards. Sociology is concerned less with violence itself than with its manifestations (delinquency, group aggression, war etc.). In this consultation, an inductive approach was adopted, leaving each participant free to define violence in their own way, without starting from a preconceived definition.

In the Council of Europe Convention on preventing and combating violence against women and domestic violence⁵, "violence against women" is defined as "a violation of human rights and a form of discrimination against women

3. Benoit T, Dambélé S, Jauffret-Roustide M, "Violence (experienced or perpetrated) and psychoactive substance use among women in Europe and in the Mediterranean region", 2015. This study followed the publication on "the gender dimension of non-medical use of prescription drugs in Europe and the Mediterranean region", based on a study conducted in 2014 which, in its recommendations, called for a better understanding of the question of violence and drug use among women.
4. Pierre Bourdieu, Jean-Claude Passeron. *La reproduction*. Editions de Minuit (1970); Sylvain Crepon, "La sociologie face à la problématique de la violence" in "Psychologie de la violence" (editors: Christophe Bormans and Guy Massat), published by Studyrama (2005), pp.147-155.
5. <http://www.coe.int/en/web/istanbul-convention>

and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". This convention, also known as the Istanbul Convention, "is based on the understanding that violence against women is a form of gender-based violence that is committed against women because they are women".

The term "psychoactive substances" covers all illicit drugs and psychotropic medicines delivered on prescription when they are used for non-medical purposes. The use of this term makes it possible to look beyond the licit or illicit status of substances and focus instead on the psychoactive effects procured through them and the adverse health and social consequences which may be associated with them. Although alcohol was excluded from the keywords in the search engines used for the literature review, it occurs very frequently in studies, which stress the fact that alcohol use is often combined with that of other substances.

1.2. Initial results of the literature review

The findings highlighted in the publications consulted during the literature review confirm a gender dimension in the phenomenon of violence and also establish a positive link between psychoactive substance use and violence experienced or perpetrated, based on three major findings:

- ▶ a higher prevalence of violence experienced among women drug users than among women in general ;
- ▶ a higher prevalence of violence experienced among women drug users than among men drug users ;
- ▶ greater use of psychoactive substances among individuals who have experienced violence in their lifetime than among those who have not.

Although its determinants are not yet fully understood, the hypothesis of a link between violence experienced and psychoactive substance use among women therefore appears to be confirmed by the various research projects carried out in Europe. So we felt it was important to explore the consequences and implications of this in terms of addiction and treatment in facilities catering for female psychoactive substance users.

In this exploratory research project, lines for action were accordingly identified on the basis of information gained from the studies available and the researchers consulted. They focused mainly on the need for an overall approach

incorporating the issue of violence experienced into the management of female psychoactive substance users in addiction treatment facilities. This involves:

- ▶ more widespread and systematic detection of violence experienced by women, particularly among certain vulnerable groups (such as prostitutes or pregnant women)
- ▶ a better knowledge of the socio-demographic characteristics of women who use psychoactive substances and have experienced violence, in order to determine the sociocultural factors contributing to violence and psychoactive substance use;
- ▶ a deeper knowledge of existing care systems for drug-dependent women who are victims of violence, the idea being to gain a better understanding of certain mechanisms so that health and social policy measures can be adjusted;
- ▶ the development of tools to enable health and addiction professionals to deal more effectively with the issue of violence and mitigate its effects on health.

To place this research in an operational perspective and comply with the Pompidou Group's mission of promoting links between research, policy and practice, a second phase was proposed in the form of a consultation of professionals working in addiction treatment and harm reduction.

1.3. Objectives

The consultation forming the subject of this report had the following objectives:

- ▶ evaluate the degree to which gender-specific aspects and violence experienced by women are taken into account in harm reduction and addiction treatment arrangements ;
- ▶ ascertain the difficulties faced by harm reduction workers and their needs;
- ▶ make recommendations for improving the management of violence among women drug users and the management of addiction.

1.4. Project team

Thérèse Benoît, health policy consultant, led the project, acted as facilitator for the focus groups, analysed the data collected and drafted the report.

Marie Jauffret-Roustide, sociologist and researcher at Inserm (Cermes3: Centre for research in medicine, science, health, mental health and society), provided scientific support, particularly as regards methodological aspects and rereading of the report.

II. Methodology

To gather the experiences and recommendations of professionals, consultations were held in four European countries of the Mediterranean region - France, Italy, Portugal and Spain - in September and October 2015.

The method of consultation chosen was the “focus group”, a qualitative technique whose purpose is to gather information from discussions centring on specific concrete situations, with opportunities for participants both to take the floor individually and to engage in group discussion. Participants are invited to express their views and talk about their experiences while following focus group discussion guidelines. This makes it possible to gather information while also noting the points of agreement or disagreement on the topics discussed. This type of methodology, based on an inductive approach, is designed to identify individual and collective perceptions, but may also identify pointers for action.

Questioning professionals about violence experienced by the women attending their facilities has several benefits:

- ▶ supplementing the findings of studies published in Europe on the link between substance use and violence among women with observations made in the field;
- ▶ correlating information gathered by people working directly with violence on the basis of their observations with the findings of quantitative or qualitative surveys among the users of facilities;
- ▶ identifying the difficulties faced by front-line professionals in their work, having regard to their public health responsibilities and the many different factors involved in their particular area of work.

2.1. Forming the groups

The target profiles for the focus groups were professionals of either sex working in facilities catering (exclusively or not) for women who use psychoactive substances, preferably performing a “counselling” role or involved specifically with women drug users. Institutions were contacted to invite them to the focus group meetings via networks or a snowballing-type method.

In the three participating countries which are members of the Pompidou Group (France, Italy and Portugal), the Group’s Permanent Correspondents were asked to help identify professionals. In Spain, it was the Health Ministry’s anti-drug department which helped in this task. In France, the fact that the members of the research team know people involved in harm reduction and addiction treatment made it possible to contact a large number of institutions directly. French professional networks also provide some voluntary sector contacts in Italy, Spain and Portugal.

Many people were subsequently contacted by email. The emails sent included a description of the project (with the literature review carried out in May as an attachment); an invitation to professionals working with female psychoactive substance users to participate in the focus group (with several possible dates for holding the focus group meeting, depending on when they were available); and a request for information about any other people to contact who might be interested in participating.

Enrolment was on a voluntary basis. The participants were therefore persons interested in the subject who had already engaged in thinking and/or had expectations regarding the issue of violence among women drug users and how it should be dealt with.

2.2. The composition of the focus groups

In the end, 33 people participated in the four focus groups. The breakdown was as follows:

	Date	Number of participants	Number of women	Number of men
Paris	16 sept.	8	8	0
Rome	28 sept.	9	9	0
Madrid	8 oct.	7	5	2
Lisbon	22 oct.	9	6	3
Total		33	28	5

A first point worth noting is the very high proportion of women in the focus groups, as 85% of the professionals who took part in the consultation exercise as a whole were women (100% at the focus group meetings held in Paris and Rome), whereas the invitations had been sent to heads of institutions, regardless of gender, asking them to identify persons working with them who played a “counselling” role with the target group or were involved in this area. There are several possible explanations for this overrepresentation of women: personal interest related to experience of gender social relations or, conversely, a difficulty for men in taking an interest in these issues, and more generally a lack of interest in gender issues in the field of addiction.

To enable us to collect as much information as possible, and to reflect the diversity of institutions’ operational arrangements and needs in relation to this issue, we took care to have a varied sample by approaching professionals working in different types of institution and doing widely varying jobs.

As regards the types of institution or service represented, they included both voluntary sector institutions and public services at central or local government level. As regards their functions, they mainly included institutions working with people who use illicit drugs:

- ▶ addiction treatment centres;
- ▶ low threshold centres for drug users – hence facilities reserved for women and transsexuals (Paris);
- ▶ mobile harm reduction units working with users in the street or in festive settings (Madrid and Lisbon) ;
- ▶ therapeutic communities/apartments;
- ▶ a parenthood support network helping people with health issues related to psychoactive substance use (Paris);

as well as organisations working with women who have been the victims of violence (Rome) in:

- ▶ units catering for abused women in hospital emergency departments;
- ▶ centres for women who have been the victims of violence of trafficking.

The positions held by the participants were also very varied:

- ▶ directors/chairs of associations;
- ▶ head of department/co-ordinator;
- ▶ psychiatrists and psychologists;
- ▶ educators, field workers, peer workers, social workers;
- ▶ researchers.

It is impossible to give a precise breakdown by position held and by type of institution because some of the participants held different positions and/or worked for different institutions.

Thanks to this wide variety of professionals working on different aspects of psychoactive substance use among women, it was possible to gather a wide range of information on the many specific forms which violence can take, existing arrangements for managing violence and their limitations as noted by the participants.

2.3. The conduct of the focus group meetings

The consultations were conducted with the help of a focus group discussion guide drawn up on the basis of the issues identified in the literature review, with the aim of elaborating on the pointers for action suggested by the researchers consulted in the exploratory research project.

The topics for discussion were presented in the form of the following eight questions:

- ▶ Can you describe all the types of violence with which the women attending your institutions are or have been confronted?
- ▶ In your practice, do you observe characteristics or vulnerability factors specific to women who have been the victims of violence?
- ▶ In your opinion, what consequences do these situations of violence have for health and substance use?
- ▶ How are this violence and its consequences for health and addiction detected and then managed in your institutions?
- ▶ How does management of this violence and its effects contribute to successful treatment and follow-up and to a better life for the people concerned?
- ▶ Do certain vulnerable groups require specific approaches or actions?
- ▶ In your opinion, are there structural or institutional factors which limit the effectiveness of the work done by institutions to manage violence and its consequences?
- ▶ In your opinion, what additional resources or knowledge/information would be necessary to improve management of violence among women users?

The focus group discussion guide also contained sub-themes that could be used as prompts (*see appendix*) if they were not raised spontaneously at the meetings, but these questions were not immediately articulated. In practice, few prompts were given, mainly because of the richness of the discussions, but also because of the time constraints associated with the chosen method of gathering information. Moreover, we made sure that participants were able to talk spontaneously about topics not covered by the guide, in line with an inductive approach based on the participants own perceptions and concerns.

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III. Results

This part of the report sets out the points which emerged from the discussions during the four focus group meetings held in Paris, Rome, Madrid and Lisbon in September and October 2015 on the theme “Management of violence experienced by women who use psychoactive substances”.

The first section presents a typology of the violence experienced by women who use psychoactive substances, based on observations made by the professionals according to an inductive approach, without any prior definition being put to them. The discussions on types of violence brought out the different forms in which women can experience violence and the different settings in which this takes place, including not only close interpersonal relationships and institutional and social settings but also the interdependence and mutually reinforcing nature of these types of violence.

While the studies in the literature review establish a link between violence experienced and psychoactive substance use among women, we felt that it would be necessary to try and gain a better understanding of the determinants in order to be able to explore possible avenues for developing an overall management approach. While each case and each life path are unique, the observations made by professionals make it possible to see the experience of violence as a major determining factor in the start of use and the severity of addiction and as an obstacle to cessation of use, confirming that the management of violence experienced is an essential precondition for the success of treatment and the prevention of relapses.

In the face of the violence experienced by women who use psychoactive substances, professionals working in harm reduction and addiction treatment have undertaken a range of actions to respond to emergency situations, address the long-term physical and psychological consequences of violence experienced and build a network of the different players involved in dealing with violence issues, including protection and social reintegration arrangements.

All too often, however, these actions still depend on the involvement and commitment of the players concerned and are faced with obstacles in becoming established. The compartmentalisation of care, the stigmatisation suffered by women drug addicts in the general system, the lack of training, and sometimes the opposition, of staff working in harm reduction and addiction treatment services, but also the failure to recognise and give due prominence to these actions in public policies, are as many impediments to real and effective overall management of the violence suffered by women who use psychoactive substances. Furthermore, the structural dimension of gender, social and cultural inequalities represents a fundamental obstacle to improved management, and action also needs to be taken on this.

Based on the difficulties and obstacles encountered by professionals in helping women who use psychoactive substances, and with a view to ensuring that overall management of the violence experienced by these women is built both into operational arrangements and into public policies, with recognition of the need for a gendered approach taking into account the specific characteristics of a group particularly exposed to violence in a context of social, economic and cultural inequality, some recommendations are set out at the end of this part of the report.

3.1. Typology of violence: interdependence and mutual reinforcement of the different forms of violence

3.1.1. Interpersonal violence, ongoing or past

Violence in the private, family or marital sphere

Physical violence is the first to be detected in care facilities and was cited in all four focus groups. It is often perpetrated by a sexual partner in the context of a relationship and accompanied by psychological violence. Women often experience repeated violence within the couple or, in the case of women who have the same type of relationship with different partners, throughout their love lives. It was mentioned that physical violence inflicted on women by their partners can be serious, sometimes involving the use of weapons, including firearms. *“At the centre we have had several cases where a person died”* (centre director/Paris).

Violence experienced in childhood

The violence reported by women users of care services includes violence experienced in childhood. They describe often very chaotic lives punctuated

by experiences of violence and suffering starting in early childhood, including rape or incest committed by the father or other family members, being hit, and also more symbolic kinds of violence related to the lack of interest shown to them in their family. *“This violence experienced in childhood is often real physical violence, but it is often also a symbolic kind of violence, to do with the place women had in the family when they were young girls, a feeling of being unwanted by the father or mother, the way they were treated in the family, and sometimes by the social services too”* (psychologist/Paris).

3.1.2. Violence related to the social environment

Violence specific to drug addiction circles

Violence is closely bound up with the practice of drug use or the setting in which it takes place. In relationships revolving around the purchase and use of drugs, women may be regarded as a commodity by both dealers and users, who offer sexual relations in exchange for drugs. In other, more infrequent cases, women are also exposed to violence via other women users, who put them in touch with a man or group of men in exchange for money or drugs. This violence is perpetrated or experienced more or less directly and more or less vividly or consciously and is reported particularly by professionals working with women users living in highly precarious circumstances (open drug scenes, homeless women etc.).

However, this violence related to substance use is found in other settings too, including cases of occasional use. In festive settings, for example, substance use and the resulting decreased vigilance leave women more exposed to sexual abuse. *“Sexual harassment is common there, especially when there is intensive alcohol or substance use and when people are separated from the group of friends who offered them safety”* (educator/Lisbon) Often, in groups, it is the women who carry the drugs because they are considered less likely to be searched; so they are in the front line if there are checks and have to cope with the stress of having the drugs on them. When it comes to buying drugs too, they may be seen as being better placed to deal with it, once again because, as women, they are regarded as being potentially able to get better prices or better-quality drugs from dealers in exchange for sexual services, which, here again, exposes them to potential situations of violence.

Violence related to prostitution

Women users living in highly precarious circumstances encountered in outreach programmes or low-threshold centres often engage in prostitution to

finance their habit, and sometimes that of their partner. Prostitution, whether engaged in on an occasional or regular basis, can therefore be regarded as a form of violence in itself. *“Prostitution is violence on an everyday basis. It can be considered, in itself, as violence experienced by women, often motivated by the need to finance drug purchases. It can be a regular or occasional practice, trading sex for money or for a place to stay”* (psychologist/France).

Furthermore, it is commonly assumed that a woman user who engages in prostitution will provide sex for money whatever the context. *“Because I was a drug user people thought my body was for sale at any time. I found that extremely humiliating. The times when you’re working are one thing and the times when you’re scoring drugs are another. But people never see the difference”* (peer worker/Lisbon).

The environment in which prostitution takes place is also a source of exposure to violence. Cases of rape, theft and assault by clients, passers-by or the police and forced unprotected sex were cited. The penalisation of prostitution as such or of prostitution in certain settings or in certain forms increases still further the context of invisibility in which these women find themselves and, hence, their exposure to the risk of violence. These situations lead women to put in place protection systems whereby they give up part of their income (money or drugs). The effect of this is, on the one hand, to produce/reproduce/maintain relations of dependency and, on the other, to increase their prostitution activity as the income derived from it does not all go to them.

Women who are victims of trafficking

These women are a special case. Psychological and physical violence is inflicted on them by the organisations which exploit them. This violence, which often precedes prostitution work, is perpetrated specifically for exploitation purposes. It differs according to gender, nationalities, ethnic groups and age. *“Among prostitutes from Eastern Europe, violence is usually committed by men, who often use rape for this purpose. Among Nigerian women, former prostitutes exercise coercion on younger women of the same nationality. There is also a form of psychological coercion on the part of the family, which counts on the financial support of these women and so participates indirectly in the exploitation process. It is impossible for the victim to return home, which puts her in a situation of non-return”* (director/Rome). This violence is compounded by discrimination and racism on the part of the police, as reported by professionals. The fact of being in an irregular situation also considerably increases exposure to violence.

3.1.3. Institutional violence

In partner institutions and facilities

All the professionals present at the focus group meetings spontaneously raised the issue of the unwelcoming, hostile and even aggressive attitude shown towards women drug users by professionals in many partner services or institutions. *“I think we can also speak of violence in the health and social services. We know that women users face obstacles in having access to these services and even in using them. There are many prejudices and a lack of preparation on the part of professionals. I think that, generally speaking, in schools, in hospitals and in the workplace, there is an atmosphere and an environment which are very unfavourable to drug addicts and, in particular, women users”* (researcher/Lisbon).

Lodging a complaint for violence committed by one’s partner or for rape can be very complicated. Women who use psychoactive substances are perceived and treated above all as people who bear guilt for the violence they have suffered. This is confirmed by the lack of credence given to their story, the lack of enthusiasm to investigate the case and the priority given to other agencies (when, for example, the complaint concerns a trafficker who is under investigation). *“There is also the violence done by a law which fails to protect. How could our patients imagine that the law will protect them? It is more a case of the law condemning and assigning blame to them. So lodging a complaint and coming forward as a victim is quite illogical for some of them”* (psychologist/Paris).

In the case of women users who engage in prostitution, the lack of protection was also mentioned. *“Physically, as female sex workers, we have no protection in relation to men. I know girls who have risked their lives and the police don’t intervene in difficult cases. They always play down the situation because a drug addict is involved”* (peer worker/Lisbon).

It was also reported that women drug users who have just been raped or assaulted are treated very differently by the emergency services. The prejudice and aggressive attitudes shown towards them, the moralising comments to the effect that *“they were asking for it”* and the lack of responses offered to them are as many additional forms of violence for women.

These prejudices and aggressive attitudes are found in other institutions, such as maternity and child welfare services. Staff without specialist training in this area usually take a very dim view of pregnant women and mothers who use drugs. Although the professionals mentioned that progress has been made, perceptions of women drug users as *“bad mothers”* are still very present. *“In child welfare facilities, people are more aggressive than you think. There are*

prejudices on the part of the staff working in these facilities, who are very keen to take children away from women drug addicts” (psychiatrist/Lisbon).

In facilities catering for drug users

The professionals spontaneously mentioned the fact that some symbolic forms of violence could even be seen in facilities working with drug users. In the first instance, a lack of training or knowledge about the issue of violence and the responses to it on the part of professionals working with women users mean that this issue is not recognised or addressed, which constitutes an additional form of violence. *“In our treatment programmes we have not really dealt with sexual violence suffered by women drug addicts because we are not ready, as professionals, to face up to that, and it is a mistake to try and intervene if you are not prepared. But the fact that this problem is not addressed or mentioned in institutional care is another unspoken form of violence. It continues to cause trauma” (project leader/Madrid).*

Another form of violence is the failure of professionals to recognise women users as active protagonists and to recognise the strategies which they themselves develop. *“Researchers and care professionals approach this problem without taking account of women’s experience. This has something to do with the role we see them as playing in terms of symbolic representation. When we talk about violence in relation to this group, we describe a passive agent, as if there were no personal strategy for addressing the situation, as if it were for us to decide what we can call violence, how that violence is experienced and what kind of dependency it has given rise to, without acknowledging an ability on the part of these women themselves to manage situations” (educator/Madrid).*

There were many references to the question of male-dominated facilities. In terms of both users and staff, facilities catering for drug users are primarily dominated by the presence of men. The investment needed to deal with female users of facilities, and in particular the issue of violence experienced, is proportionally very large in comparison with the proportion of women on their active patient lists. *“There is a possibly rather subtle form of violence, which is not always called violence, namely the male domination of treatment centres” (head of department/Madrid).* The male users of facilities often include the perpetrators of violence against women, such as dealers who put pressure on them or demanded sex in exchange for drugs. The context of insecurity is therefore reproduced in the reception centre, which is supposed to be a safe place. *“In this male-dominated climate, women do not attend our centres. One very concrete example: many women are sex workers. When they come to our centres, they are faced with a majority of men, and many of our users are clients of their sex work. So it’s very unpleasant for them. They feel neither comfortable nor safe. Ultimately, they are face to face with their clients” (researcher/Lisbon).*

The particular situation with regard to therapeutic communities was mentioned at all the focus group meetings. The relations between women users, men users and the staff of these communities reproduce relations in the outside world: women are often stigmatised and harassed by certain male users, but also by some members of staff. Any friendly gesture on the part of the women may be perceived as an attempt to seduce. If they flirt, women are also judged and found guilty because of the deeply ingrained notion that they are using their bodies to get drugs in exchange. This sometimes leads women to accept, as they did before taking up residence, a relationship based on a protection strategy, to avoid harassment and violence on the part of other male residents and the staff of the centre.

These situations can also be seen in care facilities employing untrained male staff: *“There are what you might call institutional grey areas, especially in residential facilities, where there are staff members of the maintenance worker, healthcare assistant or night-watchman type, people who have no training at all. And the women we help also have the kind of profile where they go to the men looking for things, and it’s important for the men to have a different response. But when they are men who are not trained, who have the keys to the flats, who come round at any time... these are complicated situations and so we’ve already had a lot of hassles...”* (educator/Paris).

Via policies under the anti-drug laws

In several focus groups, the legislative framework was also described as possibly having an influence on exposure to violence. *“The illicit nature of drugs is also a factor for violence precisely because it creates this world outside the mainstream”* (project leader/Paris). *“It is true that drugs have been depenalised in Portugal, and that is a major step forward. But we still have an illegal, unregulated drug market. The people who use drugs are forced to move in an environment which is dangerous, and particularly dangerous for women”* (researcher/Lisbon).

3.1.4. Social and cultural violence

Women drug users are stigmatised both as women and as drug addicts.

Gender-related inequalities and gender images

In all the focus groups, participants addressed the issue of structural, symbolic violence related to the patriarchal organisation of society, gender images and social and economic gender inequalities. *“Merely because they are women, because of the social fabric and power relationships, some women are the victims of structural violence, both physical and psychological. If they are drug addicts, the*

violence is greater. A weak or unstable socio-economic situation is another aggravating factor. If the woman is a prostitute, it's even worse" (researcher/Madrid).

Furthermore, roles and positions are culturally assigned according to gender, and women face a high degree of stigmatisation if they stray from their culturally and socially assigned place or do not adopt the attitudes expected of them. This social and cultural violence is a reality and has a significant impact on the situation of women users. *"There is also the question of misogynistic pressure, which is not necessarily physical abuse, but something that exists in society as a whole, and in the microcosm of the drug scene it's multiplied by ten, but it's more or less the same mechanism"* (psychologist/Paris).

Women themselves internalise these social representations. Some women users express extremely conservative views. They want to hang on to a patriarchal society at all costs. The discrepancy between their situation and the *"very high ideal aspired to"* keeps them in a state of permanent failure. *"It's violence they do to themselves, based on a violent social discourse"* (head of service/Paris). This situation leads women to play down the violence which they or other women users experience and to consider it as legitimate or even deserved. *"The victims of violence are strong and resilient. The problem is that, culturally, these things are accepted. In other words, 'if I was assaulted, abused or beaten, I deserved it, he was right'. This is a cultural problem. It's all to do with roles"* (director/Rome).

Even greater stigmatisation for women users

Women drug users correspond even less than other groups of women to the image of women conveyed by social and cultural norms. In fact, they are even more stigmatised than men on account of their drug use, this, like alcohol, being better tolerated among men than among women. *"For society in general, seeing a woman drug addict or a homeless woman in the street is not the same as seeing a man in the same situation. In general, society will point the finger more at the woman than at the man. She will be looked on very badly"* (psychiatrist / Lisbon).

The stigmatisation is still greater in the case of pregnant women and mothers. The idea that a woman user cannot be a good mother is deeply ingrained. There is always a strong risk that the child will be taken into care. Attitudes are extremely judgmental, including in drug use circles, where a pregnant woman who continues to use drugs and engage in prostitution may be violently rejected. *"The opprobrium is severe in the user community, where there are also many preconceptions. A woman who continues to use drugs is really rejected"* (educator / Paris). *"They come and tell you about her night, what she took, what she did, how many clients she had. People are very judgmental"* (head of service/Paris).

Focus: Violence committed vs. violence experienced

The question of violence perpetrated by female psychoactive substance users was also extensively discussed at the focus group meetings and is a factor which it is important to take into account in management actions.

Violence towards family members

Violence may be shown towards children, partners or the family (more and more young people under the influence of drugs commit acts of violence towards their parents). *“During pregnancy, violence translates into the effect which substances have on foetal development, with sometimes catastrophic premature births”* (psychologist / Paris).

Violence towards staff

It has also been observed that violence towards staff members is aimed more often at women than at men, which once again suggests a gender dimension. Violence may, for example, be directed against *“the image a woman staff member or educator gives of her life as a woman, whether she is pregnant, growing old, etc. That also needs to be taken into account”* (head of service / Paris). Women staff members may also be subjected to violence by male users. *“It also happens that female staff members are subjected to violence by male drug addicts. They are very often the targets of aggression, more so than men. I often see it my work”* (psychiatrist / Lisbon).

Women may also be seeking to test *“whether the institution in which they have just arrived is going to perpetuate the symbolic violence they experienced in childhood. Fairly soon they will try to find their place and check whether the male care staff will try to abuse them again in one way or another. I think they are quite clever at that. They set a lot of traps for us [...] It’s very repetitive. You can see clearly how they adopt strategies to check whether we are interested in them or have any desire for them, and whether we are caring for them as they would wish”* (psychologist / Paris).

Violence towards other women

In the context of street drug use, violence frequently occurs in the form of street fights, predatory attitudes towards younger female users or rivalry between women drug users. It is not uncommon for altercations to break out at the centre, in the reception area or in front of the centre. There is a certain desire to be seen, *“as if to find out who is going to be the care staff’s favourite. There are some really very childish things like that, like sibling relationships being repeated”* (psychologist / Paris). The phenomenon of violence by women towards other women *“is a very complex phenomenon because the women*

who exert psychological pressure on other women are usually victims of violence” (director / Rome) “Because they suffer violence and harassment by men, they behave in the same way towards other women” (director CAV / Rome). Also, while this phenomenon is still very much in the minority, some studies conducted in Italy seem to indicate that, in relative terms, violence perpetrated by women is increasing more than that perpetrated by men” (researcher/Rome).

Self-harm

Then there is the violence which women do to themselves. *“On their bodies, with the tell-tale marks of drug addiction, the sores they have at the injection site because of repeated injections in the same place. They are actually quite skilled at hurting themselves. There are some patients who try to do permanent harm to themselves, through scarification in many cases. All the familiar stigmata of drug addiction, teeth, hair, skin...”* (psychologist / Paris).

Self-harm is also observed increasingly frequently among adolescents, taking the form of scarifications: *“whether they use alcohol and drugs or not, there is an increase in the phenomenon of cutting among adolescents”* (director / Rome).

While violent behaviour is observed among women drug users, the determinants of that violence are nevertheless different from those of violence perpetrated by men, according to a study carried out in Sweden by the team of Professor Tom Palmstierna*. The study shows, among other things, that the factors contributing to violent behaviour among women include early victimisation, sexual abuse and, later, drug or alcohol use.

* Palmstierna T, Olsson D, “Violence from young women involuntarily admitted for severe drug abuse”, Acta psychiatrica Scandinavica, 2007.

What professionals working in the field describe on the basis of their observations shows how the violence experienced by women drug users can take different forms and operate in different contexts and at different levels. It can be physical or psychological violence, acted out or symbolic, experienced in private life or, on the contrary, in public space, perpetrated by close family members or acquaintances made in drug abuse circles, but also by institutions, including sometimes addiction treatment facilities, where both the failure to take account of violence and the fact of viewing these women as passive individuals unable to develop a personal strategy may, in themselves, constitute forms of violence.

This violence may fall within the scope of violence against women and not be specific to female psychoactive substance users. It may, on the contrary, be related to psychoactive substance use and affect all users, like violence experienced in childhood or the stigma attached to drug use. The participants

in the focus group meetings pointed out at regular intervals that men drug users were also affected by this violence. Nevertheless, the finding that there are differences in quantitative terms and, above all, that violence takes on specific forms when directed against women is shared by all the professionals who participated in the focus groups, as is the desire to go further in building this issue into their professional practice.

Being present in all the circles in which women drug users move, the types of violence they experience sustain and reinforce one another. The dual stigmatisation suffered by female psychoactive substance users as both women and drug addicts is compounded by other factors. The many interdependent forms of violence experienced by women who use psychoactive substances have implications in terms of management and treatment. It is therefore necessary to explore in greater depth the issue of the determinants of the violence-drug use link and of the violence itself, in order to improve management actions.

3.2. Determinants of the link between violence and psychoactive substance use among women

Treating addiction means knowing its determinants, both direct and indirect, in order to be able to act on the factors that contribute to the start of substance use, increase the severity and seriousness of addiction or hinder the cessation of use. The findings presented in the studies consulted in the literature review indicate that violence is a major determinant of psychoactive substance use and of changes in patterns of use. For example, researchers at the University of Navarre found in their study⁶ that the proportion of drug-dependent patients having experienced violence in their lifetime (46 %) is much higher than in the general population in Spain (5 %) and that the figure is significantly higher among women (79.6 %) than among men (37.8 %). Taking account not only of violence as a direct determinant of addiction but also of the specific determinants of violence experienced by women therefore becomes a key component of treatment for women who use psychoactive substances.

On the basis of the observations by professionals who participated in the focus group meetings in four European cities, this part of the report will seek to gain a better understanding of the link between violence and drug use, the determinants of that link, the effects of situations of violence on addiction and health, and what that means in terms of treatment.

6. Fernández-Montalvo J, López-Goñi JJ, Arteaga A, "Psychological, Physical, and Sexual Abuse in Addicted Patients Who Undergo Treatment", *Journal of Interpersonal Violence*, 2014.

3.2.1. Violence experienced: a determinant of the start and continuation of use

The first observation shared unanimously by the professionals is the causal link between experiences of violence, past and present, and use of psychoactive substances.

Substance use to cope with psychological trauma

If they are not addressed at the time they occur, psycho-traumatic events can have long-term psychological consequences. In such cases, psychoactive substance use may be seen as a strategy for forgetting the traumatic episode or putting up with its chronic psychological consequences. *“Women who suffered abuse in childhood say that they started to take drugs to lose contact with the emotion associated with the trauma because, in trauma, memories can suddenly return without warning. This experience is so unbearable and violent for them that they use substances to protect themselves, so as not to remember”* (director CAV / Rome).

Having witnessed, as a child, physical or psychological violence inflicted on another person, one’s mother or a sibling for example, can also be a factor contributing to the start of use. *“I forgot to mention another form of violence which is really significant, that experienced by children who witness physical violence. For children who witness violence for years until they reach adolescence, the risk of becoming drug-dependent is very high”* (director CAV / Rome).

Use of psychoactive substances to cope with trauma may also be seen in cases where young women were sexually abused in a festive context. *« Even if they are only occasional users, an increase in use may be observed during the weekend following an episode of sexual abuse, without them necessarily being aware of the link between the two things »* (project manager / Madrid).

Substance use to cope with situations of daily violence

Women subjected to violence by their husband or partner, particularly those least able to get out of the relationship for material or cultural reasons, frequently have recourse to psychoactive substances to put up with their situation. In many cases, violence experienced is the factor that triggered the start of use. *“Among women of a certain age, this is ultimately something which comes on top of the whole cultural and educational context. Alcohol and psychotropic medicines help women to cope with their situation without leaving and breaking their ties with others”* (psychologist / Madrid).

Substance use is often kept up and/or encouraged by a woman’s husband or partner because it enables her to be kept in a situation of dependency. *“The*

husband or partner tries to maintain the woman's drug addiction because that makes it easier to continue abusing her sexually and inflicting violence on her... If the woman was not on drugs she would not put up with these situations, and that is something we see quite often" (head of service / Madrid).

In the case of women who engage in prostitution, psychoactive substances are also used as a means of putting up with the work. It is interesting to note that, according to the professionals, substance use in this context is a means to a specific end, given that the women concerned come off drugs when they stop working as prostitutes: *"Young women or sex workers from Eastern Europe tend to use amphetamines and psychotropic medicines supplied by the organisations which exploit them. The medicines and drugs help them to cope with the work of prostitution. I think it's important to stress this point. It is important to say that women who escape from exploitation and come to welfare services cease their substance use almost immediately" (psychologist / Rome).*

However, the causal link is not always in the same direction. Substance use may also come first and lead women into situations where they expose themselves to violence, even in drug use contexts, when buying drugs or engaging in illegal activities to fund their habit. In these cases, we can say that it is substance use which, in order to be maintained, becomes a determinant of exposure to violence. In any event, women who use psychoactive substances very often get caught up in a vicious circle.

3.2.2. Implications in terms of access to addiction treatment

In situations of interpersonal and social violence, the strong stigmatisation experienced by women who use psychoactive substances has consequences in terms of access to addiction treatment arrangements.

"Hidden" female psychoactive substance use

A large proportion of women who experience violence and use psychoactive substances do not attend centres for drug users because they do not identify with this "category", especially when the substances they use are medicines: *"We have always suspected that we lose a large percentage of women, women who are the victims of violence, when they are women who use medicines which are legal and are given out on prescription. In other words, it is a silent population which engages in this type of use, a type of use which has all the ingredients of drug addiction and has effects on behaviour, but because of which the situation of violence is somehow tolerated. Ultimately, these women never have access to treatment, but we nevertheless suspect that a large percentage of women who*

are the victims of violence engage in this abuse of psychotropic medicines, pills, benzodiazepines and so forth” (head of service / Madrid).

Delay in seeking treatment

The stigmatisation faced by women drug users may result in delayed access to treatment. In the case of mothers, this is compounded by fear of losing custody of their children: *“Socially, it’s seen in a much more negative light among women than among men, so women take a very long time to make up their minds, because of the pressure, especially if there are children, because there’s the added worry of losing custody of the children, and some are actually threatened with this. Women are told that they’re going to lose custody of the child, and they’re afraid this will actually happen, and so that’s why they won’t admit to drug use”* (head of service / Madrid).

Another explanation for delay in seeking treatment is pressure by the woman’s partner not to seek professional help, either because the partner cannot come to terms with or denies the woman’s drug use, or because her drug use offers the opportunity for control over her and makes her more dependent on the couple situation, thus making her less able to escape from her partner’s violence.

Hidden use and delay in access to treatment facilities have major implications in terms of the seriousness of the addiction at the time when treatment is actually sought. *“If the addiction is so serious and so severe, that’s often due to the late stage at which treatment is sought and the advanced stage of the problem”* (researcher / Madrid).

3.2.3. Personal or psychological factors may be conducive to substance use and addiction, constitute an obstacle to cessation of use and contribute to relapses

Certain factors may have an influence on the start or continuation of use. In treatment, it is important therefore to identify each woman’s individual situation so as to be able to work on all the determinants of her addiction.

Co-dependence on substances and a relationship

There are situations which might be described as *“co-dependence”* or *“bi-dependence”* where addiction and emotional and material dependence are closely interlinked. *“Emotional domination can go to extreme lengths. Some women take such risks that you tell yourself they are going to end up being killed by their partner”* (psychologist/Paris). For some women, it is very difficult to distance themselves from a relationship in which violence is inflicted. *“Even in the*

case of serious physical violence, women – and sometimes children too – do everything possible to protect the partner when he is responsible” (researcher / Rome).

The question of emotional bonds is therefore a key aspect to be taken into account in treating the addiction of women who are the victims of violence. *“When the question of violence experienced in the couple is not taken into account, the risk of a relapse after the cessation of use is particularly great, even more so when the partner is also a psychoactive substance user. Work therefore needs to be focused specifically and consistently on all aspects of emotional dependence. Otherwise the results will not be satisfactory. In the case of women who have been subjected to violence, we must try as far as possible to avoid the repetition of links with the people responsible for that violence or with other people who intervene later” (psychologist / Madrid).*

The risk of relapse goes hand in hand with the repetition of relations of emotional dependence. *“A woman coming out of a relationship in which she is abused for the purpose of supplying drugs may tend, once she has stopped using, to go back to the same kind of relationship. Although the relationship is emotionally unrewarding, the fact of being once again in the position of the person who obtains money is a source of power because she is the one who supplies the couple with drugs. Even if it’s a misguided perspective, it’s something she finds rewarding» (peer worker / Lisbon).*

Emotional domination may be compounded by the influence of the drug use environment in which the violence takes place. Some women find it hard to leave this environment, and return to it even after spending long periods away from it, in aftercare or in a therapeutic apartment, for example.

While some personal or psychological factors have an influence in terms of the start or continuation of use, others were presented as factors increasing exposure to situations of violence, and may in practice constitute obstacles to the cessation of use or complicate treatment.

Psychiatric comorbidities

At the focus group meetings held in Paris, Rome and Lisbon, psychiatric comorbidities were cited as a factor making female psychoactive substance users more exposed to violence. *“There are psychiatric comorbidities. We have had young women diagnosed as schizophrenic and there was a never-ending succession of men with the same profile who they met and who were always the kind of men from whom they would suffer violence. It’s extremely complex because there is another specific aspect, which is the psychiatric aspect, on which it is complicated to work” (educator / Paris).* *“We often find comorbidities, disorders such as anorexia, mental disorders and psychosis, among these abused women. This sometimes leads them into prostitution” (psychologist / Rome).*

Low self-esteem

The low self-esteem and sense of “shame” seen in many women users are further exacerbated in those who experienced violence in childhood. These are among the greatest obstacles to be overcome. *“The great majority of the women we help experienced violence in their period of drug use which echoes violence that they experienced as children”* (educator / Paris). There may be a revictimisation or repetition process related to a loss of self-esteem which is difficult repair: *“We observe that violent relationships are reproduced. So women tend to find themselves repetitively in relationships with violent men. They tend to provoke and re-live trauma, to repeat these situations almost as if they were something necessary. They virtually ask to be victims»* (psychologist / Rome). *“The earlier they are exposed, the lower their self-esteem and their image of their body will be in future. So they will see themselves in negative terms. And that will lead to acts against them or others in future”* (director / Rome).

Denial of the situation of violence

Awareness and acceptance of what has been endured, the damage that has been done, over a period of many years are also very difficult for women, who may, for that reason, be unable to come to terms with it. *“There is also a destructive effect, when you wake up and see – I’m thinking in particular of a young woman I accompanied to court – the photos of the consequences of the violence inflicted by your partner, the man you called your partner, psychologically it’s very hard to ask yourself ‘but how could I have stayed with this guy, what image do I give to the world with the life I’ve led, how can I love myself again when I’ve let myself...? How can I look other people in the face?’ It’s a terrible thing, which can result in drug use issues, so I think that when there’s a link, this is the kind of violence involved. [...] it’s the person’s very structure which is weakened and undermined in an extremely violent way”* (psychologist / Paris). This type of situation calls for very specific support. Failing that, the continuation or reproduction of the same situations may be felt to be less painful than facing up to the relationship as it was, the image one gives to others and the implications for the future.

Focus: The link between substance use and violence applies to all types of substance

What emerges from the consultations is that the link between violence and substance use applies to all types of substance. What may differ is the nature of the link.

Some substances induce violent behaviour

At the focus group meeting in Paris, crack and alcohol were described as drugs with sexual effects, triggering extreme sexual behaviour, unlike heroin. In the crack scene in particular, instances of gang rape are reported. More generally, stimulants – the category to which crack, cocaine and amphetamines belong – are often associated with violent behaviour. Alcohol is also identified as the source of much violence, and in all contexts, in the home and in the street.

In Lisbon, *“benzodiazepine injection”* was identified as inducing violence. *“The flash which is felt makes the person violent. By being violent, he or she engenders violence and is on the receiving end of violence”* (researcher). This drug was therefore presented as being *“worse than cocaine. People who inject benzodiazepines have both a very defensive and a very aggressive attitude, suicidal tendencies. Suicide comes up a lot in their conversation”* (peer worker).

Some substances are used to cope with situations of violence

In Rome, the input provided by women working in centres for women who have been the victims of violence reveals that the very great majority of women who experience violence and do not use illicit drugs use alcohol and psychotropic medicines such as anti-depressants and anxiolytics (director). Use of psychotropic medicines as a means of coping is also seen frequently among East European prostitutes.

The “social” nature of some drugs engenders violence indirectly

Over and above the effects produced by psychoactive substances, the “social” nature of some drugs induces situations of violence. For example, *“women who use heroin end up being in far worse social situations than women who use alcohol”* (head of service / Madrid). These situations of degradation of the social situation, which leave women exposed to violence and which also constitute violence in themselves, may be caused by all types of substance when addiction is involved, since the loss of control may lead to withdrawal from conventional professional and social circles.

Substances used for the purpose of committing violence

Some drugs, such as alcohol and GHB, are deliberately used with the aim of committing violence in a context of “chemical submission”, involving in particular young women in festive settings. In the same context, alcohol abuse or the combination of alcohol and synthetic drugs may also cause states of unconsciousness among young women, *“who find physical traces of sexual assault when they regain consciousness, but don’t remember what happened”* (director CAV / Rome).

3.2.4. Social or cultural factors may encourage substance use and addiction or constitute obstacles to the cessation of use and contribute to relapses

Other factors related to women's social and cultural environment need to be taken into account because they may increase women's exposure to violence or keep them in a situation of "co-dependence" on a relationship and on substances.

The routinisation of violence

Drug addiction circles are an environment in which violence is an ordinary occurrence and part and parcel of life. This routinisation of violence, which represents an internalised symbolic violence, is a major obstacle to the management of violence, which is perceived as legitimate, deserved and unexceptional. Being perceived by women users as something normal, *"the overall climate of violence also makes it difficult for professionals to identify the specific forms of violence experienced by women"* (educator / Paris).

Precarious living conditions

The women who frequent the low-threshold centres for drug users and addiction treatment centres represented in the focus groups form a specific group composed essentially of women living in precarious circumstances and facing multiple hardships. Although it is not possible in this study to establish socio-economic distinctions because of the significant bias involved in the choice of target population, precarious circumstances were nevertheless cited as a contributory factor in exposure to violence.

In Paris, some focus group participants who are in contact with more socially integrated women, either as part of a research project or in the course of their work, observed that, although these women are also affected by violence, it is less present and less systematic.

Precarious living conditions were also mentioned as *"an obvious and significant factor for vulnerability and exposure to violence, women living in the street being particularly exposed"* (psychologist and researcher / Lisbon). Precarious living conditions are a factor for exposure to violence, but also a factor which limits opportunities for distancing violence. A lack of income and material dependency encourage situations of violence and restrict the possibility of escaping from them. *"There are situations of violence in which women do not leave their aggressor and tolerate intolerable violence"* (director/Rome). *"I also think, and I have seen for myself, that women who are the victims of violence have great difficulty in calling for help and in following through on their calls for help because*

the women in question depend on their aggressor and it is therefore very uncommon for them to follow through on any complaints they lodge with the authorities, because they will run the risk of being subjected to even greater violence and they also depend materially on the man, their partner” (psychologist / Lisbon).

Material dependency: an obstacle to cessation of use

Consideration of just the psychological and emotional aspects is not enough for a satisfactory response to the question of managing violence and addiction. In addition to medical treatment and psychological work, social reintegration work must be undertaken to facilitate a successful withdrawal from addiction and exposure to violence.

“As regards the treatment of people who experienced very strong trauma in childhood and adolescence, there is an initial stage in which it is possible to discontinue substance use, but it is difficult to do so on a lasting basis because of the suffering that comes from the past. The tendency to relapse is therefore greater.

That is something very difficult, and then there are also very great difficulties in terms of reintegration when the person has been weaned off drugs. So, first, there is the difficulty of coming off drugs, and then there is the difficulty of becoming reintegrated, developing competencies and tools which will enable them to keep up this abstinence, and it’s very difficult to obtain resources in this field, we don’t have enough” (psychologist / Lisbon).

Envisaging cessation of use in the case of women who are not working therefore means ensuring their material self-sufficiency, without which relapses are virtually inevitable. *“Everything you’ve said is true. My relapses were always due to the lack of opportunities for social reintegration. Treatment is one thing, and that’s fine, but when it’s a case of recovering some autonomy, a sense of purpose in life and some self-worth, there are no answers, and someone who already has self-esteem issues without those resources quickly goes back to drug use. I agree with you about therapeutic counselling. After years of abstinence, I still have counselling sessions, and that’s very important, but not being socially reintegrated or being badly reintegrated is actually a factor for failure of all treatments, among both women and men. Today we are talking about women who have been the victims of violence” (peer worker / Lisbon).*

Focus: groups most exposed to violence

Some groups of people, life stages and situations were mentioned at the focus group meetings as being particularly exposed, or involving particular exposure, to violence.

Women who engage in prostitution

Laws that penalise prostitution or certain prostitution practices may also increase the risk of violence being experienced by women, who are forced to work in less visible places where the potential for and risk of aggression is greater in practice. *"I think that, in general, one can also talk about violence in the policy context. As I have already said, the fact that sex work is not legal, is not recognised as work and is not regulated is a form of violence for women"* (researcher/Lisbon).

Foreign women in an irregular situation

They are over-exposed because of their illegal status. Because they cannot take the risk of lodging a complaint for fear of being deported, they are prime targets of aggression.

Transsexuals

Transsexuals, who are subjected to a lot of aggression by men, were also mentioned in the focus groups as a highly exposed group which must not be neglected.

Pregnant women

Pregnancy was also mentioned in the focus groups as being a period of increased psychological and physical violence, as also emphasised by the cohort study carried out in the Valencia region in 2008 by the team of the public health research centre in Valencia⁷ (described in the literature review).

Women in a relationship with a drug-using partner

Women in a relationship with a drug-using partner are also reported to be more exposed to situations of violence, including both psychological violence in the couple caused and/or amplified by psychoactive substance use and exposure to violence in other contexts (entry into prostitution to pay for the couple's consumption).

3.2.5. Cessation of violence: a factor conducive to cessation of use

The protection of women who have been the victims of violence appears to be a prerequisite for the successful treatment of addiction, although it does not guarantee success. The input provided by the focus group participants in

7. Ruiz Pérez I, Plazaola Castaño J., *"Intimate Partner violence and mental health consequences in women attending family practice in Spain"*, Psychosomatic Medicine, 2005.

Rome working with women who have been the victims of trafficking shows that when women start using medicines in order to cope with violence, they can quickly give them up again once they are in a safe place. *“It is important to say that women who come to the protection services to get away from exploitation stop using substances almost immediately. The women who come to our centre, which receives women who have been the victims of trafficking, generally stop using substances when they are no longer being sexually exploited, because the drugs are used to enable them to cope with the work of prostitution or to enhance their performance in their sex work”* (psychologist/Rome).

The information gathered during the consultation of professionals shows how closely violence and substance use are linked, but without ever enabling the nature of the link to be precisely determined. Exposure to violence and the start of use can have common determinants. Violence can be a determinant of the start or continuation of use, while, conversely, use and addiction can be contributory factors in exposure to violence or the occurrence of violent behaviour. These factors and determinants may be of an individual psychological nature, they may be social and cultural, and they may fall within the policy sphere. Treating a person means being able to address all the different aspects keeping that person in a situation of violence and/or addiction, which in turn means resources adapted to a range of interrelated situations.

3.3. Actions to deal with violence

To treat women who use drugs and are the victims of violence in a comprehensive way it is necessary to work not only on all the determinants of addiction but also on those of violence, which, as we have seen, is a contributory factor in substance use, an obstacle to the cessation of use and a contributory factor in relapses. Professionals working with women users who are experiencing, or have experienced, violence are accordingly confronted with people presenting multiple problems. Now, although the management of violence experienced by women is a precondition for the success of treatment and the prevention of relapses, it is not included in the mission statements of institutions working with drug users. This issue still receives insufficient recognition today and is relegated to a secondary position.

Often, therefore, responses to violence in facilities catering for female psychoactive substance users are the result of decisions or initiatives taken by the facilities themselves, their managers or one or more members of the teams dealing with this issue. Owing to the lack of recognition given to their work in this field, or the fact that they come up against structural or institutional

obstacles outside their sphere of operation, these actions may be limited in terms of their implementation.

This part of the report will explore in depth the violence management actions undertaken by harm reduction and addiction professionals and the limits, endogenous or exogenous, they come up against when implementing them.

3.3.1. Emergency management actions

The first level of response consists of actions to address situations of acute violence on which it is necessary/possible to take immediate action.

Support

Support for women who have experienced violence is one of the activities widely implemented by facilities catering for this group.

In the case of rape or physical assault, this support may be provided at the police station, in forensic units or in trauma units. The testimony of a woman user is rarely given much consideration, especially if she is under the influence of the substance and/or engages in prostitution, and it is important for a member of the support staff to come and back her complaint, if only, sometimes, to show the woman who has been assaulted that one or more people believe her story.

Furthermore, violence is often taken for granted among women themselves, who have internalised the notion of their own guilt and do not see themselves as victims, and work needs to be done on them to persuade them to lodge a complaint. Because women think it *“normal”* to undergo acts of violence when they are living in the street, *“a complaint makes it possible to put the act of violence in context and work on the fact that it is not normal to be subjected it”* (psychologist/Paris).

Before accompanying a woman to lodge a complaint, however, one must make sure that the complaint will not put the woman in greater danger. In some cases, if no further action is taken on the complaint and the woman is not placed under protection, her return to the situation preceding the complaint, i.e. to the person responsible for the violence, may have serious consequences.

Protection

Accommodation in shelters whose address is not disclosed is therefore a key component of violence management. However, the traditional facilities for women who are the victims of violence are not always adapted to the specific requirements of women users. Either they do not accept women who

are active users, or it is too hard for these women to comply with the house rules. *“In these facilities, there are not always specific care arrangements that take account of all the problems of the particular case which is about to be accepted. So things become difficult and, indeed, it cannot always be guaranteed that the woman in question will stay in this shelter, this facility, because, ultimately, her case cannot be dealt with properly”* (project manager/Madrid). To meet this need, *“a specific type of facility has been created, shelters in which women users are accepted, together with their children”*⁸.

Focus: the detection of violence

“Women show the violence experienced more than they talk about it. Putting it into words is difficult” (psychologist / Paris).

Violence is often detected in facilities when it leaves visible marks. *“We also witness manifestations of conjugal violence. You were talking about that. They don’t talk about it very much, I find. They come and show us, with black eyes of course, and it’s for us to talk about it, but the words don’t come easily”* (psychologist / Paris). Nevertheless, the subject cannot necessarily be broached at that particular point. Also, other forms of violence are less visible and the question of how to detect them therefore arises.

Should women be asked if they are or have been the victims of violence when they are admitted to harm reduction or addiction treatment facilities? This question was extensively debated, particularly at the focus group meeting in Paris. The great majority of participants said they do not broach the subject directly, although many other delicate subjects can be raised at the first interview. In this group, the question of whether or not to ask about violence is currently under discussion among care teams, some of which have also called on outside operators. In general, the latter are more in favour of asking the question, in order to find out what the woman’s circumstances are. The question of the response then arises, because in the absence of a response, the violence may be increased, both for the woman who has shared the information and for the care worker, who feels disarmed in relation to the situation.

People also need to be given time. As well as having a problem of addiction to psychoactive substances, some women also experience violence. When they come to harm reduction or addiction treatment facilities, they come in the first instance to talk about their substance use. They come looking for solutions to this problem.

8. Malva project: www.fsyc.org/malva.

If, at the same time, they experience violence, they may prefer not to broach the subject, for various reasons: because it is premature for them to broach it, because they have developed their own “coping” strategies, or because they have been to another institution specialising in this particular problem.

Very often, the woman user will, at her chosen time, reveal the situation she is currently living in or violence experienced in childhood. The person receiving her testimony may be any member of the team. Here again, it is very often the woman who chooses who to confide in, and in what setting. This may be in informal circumstances, when chatting or smoking a cigarette, when accompanied to an appointment with the gynaecologist, or at the swimming pool, where the question of the body arises more naturally. Or in activities reminiscent of childhood, a cookery workshop or a session with a psycho-aesthetician. This information may subsequently be shared with the other members of the team, who will be able to devise a strategy for dealing with the issue.

Without going so far as to talk about formal detection protocols, various strategies have been developed to encourage women who have experienced violence to talk about it. The participants in the focus group meetings all say that the question of violence management has come increasingly to the fore in the last few years. *“It’s a bit like in other branches of medicine, in fact you diagnose what you are looking for”* (head of service / Madrid).

The B 18 low-threshold centre in Paris has set up an observatory of violence in partnership with the Lotus Bus programme run by Médecins du Monde. *“The purpose of this observatory is to record all instances of violence reported by women, whether it is intimate partner violence, client violence or woman-on-woman violence. Everything is noted down subject to the agreement of the woman concerned (with whom, when, how, the blows received, whether they have left visible marks or not, has a complaint been lodged, then the whole judicial process, but always with the woman’s agreement, so they can sometimes be persuaded to go to a police station). And you can see how far things have been taken, whether proceedings have been started. Some women have been so far as to confront their aggressor in court, but they are a small minority. We’re working on it”* (head of service / Paris). This observatory, which was originally set up to document the situation of women engaging in prostitution and to assess changes in risk-taking according to the legal classification of certain activities (penalisation of soliciting, clients etc.),

has proved to be a useful medium for engaging in discussions with many women, and in particular working on situations of repetition where avoidance is important. Women's input to the observatory has gradually increased: *"Initially our message was that we were particularly concerned about the violence they experienced. That we had difficulties in getting them to talk [...], that it was complicated for us and that we had thought of conducting a survey of these issues to take stock of the situation in prostitution and drug-use circles, but that it was also a tool for them in the case of repeated violence. The file can be used to pinpoint past acts of violence and show that the current violence is not new or an isolated event. At a given time we can go back to the file and say, you remember, three months ago you came to see us, you had such and such a mark on your face, such and such a thing had happened, it's the same thing over again."*

In Madrid, the staff of the Instituto de Adicciones (run by the municipality) have drawn up a protocol for dealing with women who have been the victims of violence, which is about to be published. *"The protocol is the outcome of a study which took about two years, and it was done with what we call an improvement group, with professionals from different branches to gain a comprehensive view and produce a much richer document. We worked with people who are particularly aware of the problems and who have prior experience because their centres have already worked with that vision. All this is part of a municipal plan, one of the strategic objectives of which is to incorporate a gender perspective in all areas – prevention, direct treatment, reintegration etc. When the document is ready, the institute plans to provide systematic training in all centres to give all the professionals working there the necessary tools, so that they have this gender perspective and can detect violence and get down to work on it. The document contains different approaches, such as how to deal with the issue of violence prevention"* (head of service / Madrid).

Another way of getting women to broach the subject of violence is to adopt an approach described by some participants as "feminist", although not all participants give the same definition to this term. For the proponents of this approach, it means talking about violence in the broad sense - not just its most serious, visible or spectacular manifestations such as assault, rape or murder – and addressing *"all the usual subtle, structural violence against women [...]. When this latent violence against women in general is taken into account, that encourages women to stay, continue their treatment and open doors to things we had the impression they were not ready to talk about. This is because we avoid confrontation and approach things in a more indirect way. And this also makes it possible to improve management. So this feminist approach is undoubtedly necessary to treat women who are victims of violence and drug addicts"* (researcher / Madrid).

3.3.2. Long-term management actions

Individual therapeutic monitoring

Many of the institutions which participated in the focus groups, including some in low-threshold programmes, provide psychological or psychosocial counselling or monitoring for women users. This counselling is not specific to women who are experiencing, or have experienced, violence and is not always, as we have just seen, the setting in which violence is discussed. However, psychological monitoring forms part of the healing process of many drug-dependent women subjected to violence and helps women to recognise the reality of the situation of violence in which they are, before they are guided towards change. It also answers the question of psychological trauma, mentioned by many participants in all the focus groups as a major problem facing women who have experienced violence.

Spaces reserved for women

Women who go to centres for drug users often find themselves once again in the presence of the men responsible for violence towards them, or even if that is not the case, in a male environment seen as potentially dangerous. To enable women to avoid these situations, centres offer dedicated spaces or timeslots in various forms.

Some facilities, such as the B18 centre in Paris, have actual premises reserved for women and transsexuals. Others have certain timeslots *“reserved for women when they can come with their children, but it is not specifically during that time that they will report the violence they have experienced, it’s more a space in which we try to do activities to make them feel better about themselves and more self-confident, such as hairstyling, and a space in which they can feel safe and comfortable”* (psychologist / Paris).

Other facilities open to both sexes offer workshops specifically for women. These can be opportunities for activities on specific health-related topics or on questions of image and self-esteem. Workshops led by a psycho-socio-aesthetician may, for example, be the opportunity for women to accept the visible signs of the violence they have experienced. In some cases the topic is chosen by the women, and teams sometimes call on contributors from outside. *“It’s not necessarily here that personal issues arise. These are more moments of conviviality focusing on shared issues”* (director / Paris).

The question of support groups was also raised, with significant differences observed depending on whether the groups are mixed-gender or not. *“There*

are groups reserved specifically for women where everything can be discussed. Treatment follow-up, which is an important part of the process, is much easier when you have these specific resources for women. So then you can broach the subject of violence, and they can put these things into words much more easily in a context where they feel better understood because of this highly feminist approach. This is not something which has been studied in an analytical way, but it is nevertheless something which we appreciate and which we have observed. The women who come to this group stay in the group for a long time. Usually they come to all the sessions and things go well" (head of service / Madrid).

The complex issue of mixed-gender teams was also addressed. In Paris, the experience of the teams that have put in place spaces reserved for women leads them to favour mixed-gender teams. The presence of women in the teams is both necessary and reassuring for the women, some of whom do not wish to talk with the men in the team. *"As regards the question of the presence of men and women in the team, it's true that they talk about it a lot, much more easily with women in fact. Sometimes my colleagues tell me, 'when you're there, such and such a girl won't come in. She stays by the door, asks for the thing she wants and then leaves'"* (psychologist/Paris). Nevertheless, the image that women who experience violence have of men can also be an interesting subject to work on, via relations with the male staff, when they are trained in, and aware of, this issue. *"Work on relations with the men in the team, whose attitudes are different from those of their clients, can have an impact. Support work can be done by men, provided the girls are asked if that's OK with them. But when they agree, that creates a different kind of relationship and a different perception, in which the man is no longer an aggressor, and it's quite interesting to see that this can trigger a kind of shift towards recovery, or at least an attempt at recovery."*

Associations of users, self-help

Access for women to self-help groups or associations of users is another action offered by some institutions, although it is still very marginal. In Paris, for example, women who use the services are directed towards a specific meeting organised on the initiative of an association working with prostitutes, which works very well.

The recruitment of peer workers can obviously change the attitude of women users towards the institution. *"Some women I knew on the drug scene, which I left some time ago, came to the institution where I work out of empathy, because they realised that there was someone like them. That enables them to feel comfortable and safe when they come into contact with the institution"* (peer worker / Lisbon).

Despite that, it has to be acknowledged that women users are still relatively uninvolved in developing projects and play little part in organisational aspects and activities in institutions. This raises once again the issue of the perception of these women as being passive agents, victims and not autonomous individuals.

3.3.3. Actions to support cessation of use and distance women from situations of violence

Work with close family members

As already mentioned, the role of the family is crucial if women are to escape or extricate themselves from existing or potential situations of violence. *“I would also like to mention the work done as far as possible in parallel with important family members. Because it’s not just a question of what the woman does, but also what her family allows her to do. Work needs to be done with the families, husbands and partners. That’s also very important”* (psychologist / Madrid).

In addiction treatment facilities, the emphasis is naturally placed on monitoring and the progress of treatment. *“As regards the resurgence of violence, the less support women have, the more exposed they are. The violence is therefore proportionally greater when they receive less support, be it the support of the family or institutions. That is perhaps more serious than addiction itself”* (researcher / Lisbon).

Reintegration and self-sufficiency

Material self-sufficiency is therefore a precondition if women are to get out of addiction and leave behind situations of violence. The input provided by the participants in the Rome focus group working in centres for women who have experienced violence is very instructive in this regard since what is proposed is an overall approach seeking to address the different determinants of violence, and in particular the social and political dimension, so as not to restrict treatment solely to the psychological dimension. *“A study was carried out to try and determine the social cost of violence. The results show clearly that if a woman is not given the opportunity to break the cycle of violence, she cannot cope with and overcome the various difficulties and maladjustments with which she may be confronted: unemployment, loss of her home, special needs for her children when, for example, they suffer from hyperactivity or attention disorders. [...] The social services address specific issues, but they do not have an overall approach or strategy. And that obviously does not improve the situation because it is essential for the woman to recover a social identity, an autonomy that will enable her to tackle her personal problems. This is what we believe to be the distinctive feature of the anti-violence centres. The approach we adopt in our anti-violence*

centre is not individual psychotherapy, but analysis of the social implications of the phenomenon and the organisation of an alternative life programme involving different activities, linking them up with institutional and non-institutional partners” (director CAV / Rome).

3.3.4. Indirect actions to improve management

Building partnerships

To implement activities it is first necessary to identify facilities offering those services and develop links with them. Considerable progress has been made in the area of dialogue with associations or organisations catering for women who have experienced violence, and partnerships have been established without protocols having necessarily been set up on a formal basis. Consultation meetings with agencies concerned with these questions, including the police, judges, social workers and shelters for women who have experienced violence, have been organised in Seine-et-Marne (suburbs of Paris) and Madrid. *“There is a forum bringing together different municipal services and different organisations. It’s what we call the technical forum on drug addiction. There are different groups in this forum, including a group on gender violence. There are also round tables where we deal with all the issues”* (head of service / Madrid).

But these partnerships still depend too heavily on the goodwill of local stakeholders and the links between the staff of the different facilities. In addition to the problems involved in raising awareness of drug use issues among shelter staff, administrative regulations and protocols sometimes prevent the women concerned from actually being admitted to these facilities.

Training

Some associations have also begun to plan or actually put in place training courses on violence in order to encourage the involvement of professionals by familiarising them with this issue which they may not dare to address for fear of not being competent in this area: *“Lately we have been taking a close interest in psychological trauma. So we are in the process of receiving training. Some team members have been on training courses and now there is in-house training for the team as a whole”* (director / Paris). Other training courses have been held on addiction management with a gender perspective: *“For several years now, at least three or four years, we have been organising these training seminars for professionals on the gender perspective and working with drug addicts, and this is reflected in what we have achieved”* (psychologist / Madrid).

According to professionals, the question of overall management including the detection of and response to violence experienced by women who use psychoactive substances is taking on increasing importance in the institutions concerned. Activities are being put in place on a non-systematic basis, at the initiative of project or management teams with a particular awareness of this issue. However, these actions remain isolated cases and their impact is limited by a number of structural, institutional or socio-cultural factors.

3.4. The obstacles to overall management of women users who experience violence

While the need to address the issue of violence experienced by female psychoactive substance users is increasingly recognised in harm reduction and addiction treatment facilities as a factor influencing the process of managing and ending substance use, professionals are in a situation where the actions they put in place in response to the concrete situations with which they are confronted come up against obstacles in an existing system which has not yet taken this dimension on board.

3.4.1. Failure to incorporate a gender perspective

Addressing the issue of violence experienced by female psychoactive substance users means developing a specific approach to the needs of women in harm reduction and addiction treatment services. However, such an approach is far from being universally and systematically adopted, both for reasons internal to these facilities and because of the lack of political impetus and support.

Focus: Gender mainstreaming

Background

The concept of gender mainstreaming emerged in the 1990s. “The 1980s saw the introduction of specific/positive actions addressing the disadvantages experienced by women. It was the start of women oriented policies, be it at the margins. They focused on what women ‘lacked’ – the implicit assumption being that the problem rested with women, and so women needed to change. [...] Specific actions in favour of women also proved to be a partial solution. They prepared women for operating in a male dominated culture but did not challenge it. This led to a new period, the period of gender mainstreaming, where the focus shifted to systems and structures themselves, to the relationship between

women and men and to their individual needs. This approach gained world-wide acceptance at the 1995 UN fourth World Conference on Women in Beijing. Gender mainstreaming recognises that existing structures are not gender-neutral but favour one sex or another in a variety of subtle and not so subtle ways. The result is that apparently gender-neutral policies can in fact reinforce divisions and consequently further disadvantage women or men.” EQUAL Guide on Gender Mainstreaming, http://ec.europa.eu/employment_social/equal_consolidated/data/document/gendermain_en.pdf, also available in French, Spanish, Portuguese and Italian.

Definitions

Gender mainstreaming is “the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetrated. The ultimate goal is to achieve gender equality.”

(United Nations, Ecosoc, 1997,

<http://www.un.org/documents/ecosoc/docs/1997/e1997-66.htm>)

“Gender mainstreaming is the (re)organisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies at all levels at all stages, by the actors involved in policy-making”.

(Council of Europe. Gender mainstreaming: conceptual framework, methodology and presentation of good practices. Strasbourg. 1998.

http://www.coe.int/t/dghl/standardsetting/equality/03themes/gender-mainstreaming/index_fr.asp)

Obstacles within facilities

The problem is developing specific actions for people who are a minority on active patient lists: *“On the question of women, except in specific places which cater only for women, they are a minority, so it’s complicated for the people in the teams. There is also the question of the so-called profitability of the actions proposed, of keeping them up in the long term, and there I think it’s important also to be able to support the professionals”* (psychologist / Paris).

Another difficulty hindering the adoption of this approach is confusion between *“the need to treat for specific treatment of women and men and*

inequality of treatment. Equality of treatment would mean treating everyone in the same way. The question of specific treatment is very complex" (project manager / Paris). For some team members, *"having a specific approach would therefore mean calling into question equal access to rights"* (psychologist/Paris) or considering women *"necessarily as victims, as weak people"* (project manager/Paris).

Lastly, this approach calls into question not only relations with users but also gender relations as a whole and can be unsettling for some staff members because it leads them to question not only their own identity and their career so far, but also their own prejudices and how they might help to exacerbate gender social inequalities : *"I think it makes you question things, whether you're a man or a woman, that's why I found it interesting to work on the question of women, it also taught me things about myself, about my attitudes and about how, without realising it and without wishing to, you are part of it... that's what I found interesting, but that makes it difficult for the teams too, because it prompts questions... and then it also takes you into areas that are often linked to suffering and hardship"* (psychologist / Paris).

A necessary approach according to the professionals

Violence primarily affects women, as the statistics prove. *"In Portugal the issue of violence against women is a general concern. One woman dies there every week as a result of domestic violence, in other words 50 women a year on average, so we are alerting society to the problem"* (psychiatrist / Lisbon).

The risks run by women living in extremely precarious circumstances are obviously greater and more serious and it is important to have a differentiated response. *"I think we need to take account of specific situations and have specific responses, for example a homeless man living in the street does not run the same risks as a homeless woman, but when they are put on a waiting list, they are treated in the same way. So I think these specific aspects need to be taken into account, and if, into the bargain, the woman has experienced violence, that's another specific aspect that should also be given special consideration"* (head of service / Madrid).

The failure to factor in the gender dimension helps to keep women users away from facilities for drug users, especially because of the high proportion of men received in these services. *"We have services run by men and used by men, and that creates a very male atmosphere, even if the staff are often women. But those who receive support are mainly men. And we know that there are women who don't even make it as far as the harm reduction service, which is the front line, or the treatment services. There are many factors which have already been identified in the literature which explain the reasons for this, as we have said, the woman's*

role in the family, the greater stigmatisation, which makes women less likely to seek help. So what are we doing wrong? [...] As far as I know, in terms of harm reduction, we have no specific services for women only” (researcher / Lisbon).

The “equal treatment” approach has shown its limits in other fields, which are also starting to incorporate a gender perspective. *“It’s like in medical research, depending on whether the patient is a man or a woman, the reaction to the same treatment is not necessarily the same, in the case of tritherapy for example. You can have stigmata related to tritherapy, for example, which are more difficult for a man to handle than a woman, and we are starting to realise this” (head of service / Paris).*

A lack of data for evaluation

Incorporating the gender dimension means being able to evaluate the impact which actions taken in treatment facilities have on men and on women, including as regards the issue of violence. It is important, therefore, to collect sufficient data to be able to present all the indicators and results with a breakdown by gender, in order to evaluate, on the one hand, the impact of actions not incorporating the gender dimension and see the differences, if any, according to gender, and on the other, the impact of specific actions aimed at women in relation to non-specific actions, and any differences. But such indicators do not actually exist. *“I think a gender perspective is crucial for preventing situations of violence, but also in general for addressing the problem of drug addiction, whether it is a question of identifying the different models of masculinity and femininity or the implications this gender perspective has for drug use and addiction. I don’t want to offend anyone, but I think we still have a lot to do in this area, and I think that once we take this path, we will see that more things are needed, such as special arrangements for women. We will see that there are women who experience severe violence, women who are active users [...] It’s absolutely essential to have a gender perspective and be capable of understanding what implications these gender aspects have in terms of the mental health and behaviour of both men and women. [...] In my opinion, in relation to the criteria that have been discussed, neither the action plan currently in force nor the national strategy incorporates this gender perspective. The intention is there, but it’s not the reality. Data reflecting the social reality of drug addicts, in other words the entire policy basis for detection, treatment, etc., are not even broken down by gender. Obviously these data are not interpreted and analysed, because they do not even exist. So if we don’t even have that, what do we have? Little things here and there, people at different levels of the care process, small-scale practical actions which actually have this vision and which obtain funding from various sources; but if the political strategy which determines how to detect, prevent and treat the problem of*

drug addiction took account of the gender perspective in the proper way, and if we went beyond mere intentions, I think things could change completely. Objectives, measures, actions – everything would change, and this document would be the basis for all other policy documents” (researcher / Madrid).

3.4.2. Compartmentalisation of addiction treatment and care services for women who experience violence

Compartmentalisation may be seen at all levels, and this is a point on which all the focus group participants are in agreement. *“There is a fundamental problem, which is that if a woman is a drug addict, she does not have access to the facilities that another woman would have access to, because, as a drug addict, she is referred immediately to the network responsible for addiction issues. In other words, a woman who is a drug addict is not on an equal footing with other women who have access to facilities for the general population. These facilities exclude women who are drug addicts, even if there is co-ordination between the different facilities. In practice, a woman who is a drug addict only has access to facilities specifically for women drug addicts” (project leader / Madrid).*

The virtual impossibility of accommodating women who are active users in shelters

The fact that women who are active users cannot be cared for in anti-violence centres is a major problem. On the one hand, women users cannot obtain places in shelters or apartments for women who experience violence, which keeps them in situations of exposure to violence. On the other, women who are the victims of violence and are accommodated in shelters have to keep quiet about their, in many cases, problem use of psychotropic medicines for fear of being excluded. *“In fact, in public tenders, we are not allowed to accommodate drug-dependent persons. They may be victims of trafficking or violence, but we have no mandate to work with them” (director CAV / Rome).* Yet these two problems are often linked and an overall management approach is the only satisfactory way of dealing with them.

Making accommodation in a shelter conditional on lodging a complaint

The restrictions with regard to shelter accommodation may go beyond the question of drug addiction. Under the formal protocol used in the Florence region, a sexually abused woman who goes to an emergency department can only be accommodated in an anti-violence centre if she first lodges a complaint. *“No, she can't, not yet, the protocol doesn't allow it. Because the*

police have to be involved. That's a big problem. We consider this to be a major weakness of the system. Because, as my colleague pointed out earlier on, it would be desirable if women who have not reported crimes nevertheless had access to anti-violence centres. But that's not the case for the time being" (researcher / Rome). Here again, this restriction may have significant consequences in terms of keeping women in situations of exposure to violence.

Compartmentalisation related to psychiatric disorders

Management of drug users suffering from psychiatric disorders is also problematical. *"In our Malva project, one of the things we noticed was that there were many women who started to use drugs or alcohol, and who concealed it for the most part, but it was actually to cope with the situation of violence to which they were exposed. When the women were heroin users or were in a position of exclusion or marginality, or suffered greatly from physical, sexual and psychological violence, they often came to the institution after being diagnosed with a personality disorder. These women ended up leaving institutions because the treatment was not adapted to their problems or because they could not adapt to the treatment, and they fell back into an even worse cycle of violence. That is a fairly accurate profile of these women suffering from a personality disorder, for whom it is difficult to provide help"* (project manager / Madrid).

Management still segmented according to substances

Despite the fact that the phenomenon of poly-drug use seems to be an established fact on which many participants agree, the idea still sometimes persists that some substances are drugs and others not (this is usually related to the licit or illicit status of the substance), which has an impact in terms of referral and segmentation of care. For example, psychotropic medicines are often not regarded as drugs, and co-dependence on alcohol is often dealt with as a secondary problem. *"I would like to add something. In Italy, there is a misinterpretation of the concept of drug abuse. Heroin use is referred to as an addiction, but people do not consider alcohol and cocaine to be dangerous. And psychotropic medicines, legal drugs, are often not reported as being a problem. Alcohol abuse is underestimated, very seriously underestimated"* (director CAV / Rome).

Lack of cross-disciplinary training

The compartmentalisation described above is also the result of a lack of training, or even awareness-raising, for professionals on questions not dealt with specifically in their respective areas of work. For example, professionals working in centres for women who have experienced violence are trained neither in the detection of addiction nor in drug use issues. *"Our approach,*

for example, does not take into account or does not include a detailed knowledge of substance use, because our professionals were trained for years before working in our centres, and drug addiction and other forms of addiction were very rarely mentioned in their training” (director CAV/Rome).

On the other hand, the staff of facilities for women drug users also receive very little training in the detection and management of violence: *“Let’s say that, in the treatment we provide, we do not really address sexual violence experienced by women drug addicts because we are not ready as professionals to deal with that, and it’s also a mistake to attempt to intervene if you’re not prepared” (project manager / Madrid).*

Lack of networking

Some participants also criticise a lack of co-ordination and networking on the issue of violence experienced by female psychoactive substance users among people working in the same local area. *“There are shortcomings in relations between the different facilities. The resources exist, but there is no networking, contrary to what there is in other fields, on the questions of abortion and genital mutilation. Perhaps women drug addicts have never been regarded as a sub-group with specific needs. We always think about the case of a woman when she comes to a centre, but perhaps we should think about it in a more global way” (psychologist / Lisbon).*

3.4.3. Effectiveness of management limited by the inadequacy of support networks and social reintegration arrangements

In addition to the segmentation and compartmentalisation of care, professionals are confronted with people experiencing difficulties which increase their vulnerability to the risks of violence and relapse after a period of abstinence without being able to influence these determinants, which derive from factors of a personal and social nature, and for which they observe an inadequacy of the existing arrangements. As a result, the actions put in place by harm reduction or addiction treatment facilities, or by centres for women who experience violence, and the results of those actions, are limited by the lack or inadequacy of arrangements for consolidating the results in the long term. Professionals therefore see a repetition or even a worsening of the situations which brought the women to them and a lack of prospects or positive outcomes in the absence of appropriate and adequate responses.

Inadequate support arrangements

If women are to escape from situations of violence, there must be complex and comprehensive support arrangements. However, *“the automatic procedures for women who experience violence are very strict. The problem is not that these women refuse to lodge a complaint because they have a problem of self-confidence or because they are attached to their aggressor, but because a woman cannot really put her experience of violence behind her unless she has a reliable and lasting alternative. Unfortunately, services which are not specialised in dealing with cases of violence approach the issue in terms of personal motivation, when, objectively, the problem is that it is really necessary to have a network to support these women. And if a woman does not have this support network, she won't be able to break the cycle of violence. Forcing a woman to lodge a complaint after being assaulted when she has no alternative means exposing that woman to the risk of actually being killed. We have many cases of women who have been killed. [...] We need a network of support, care, legal aid services, social integration, parental support. We need to have a support network for women. The problem is that we encourage women who have experienced violence to lodge a complaint, but no one cares about what happens to them afterwards where the children are concerned, or where they are going to live afterwards, whether they will have any financial assistance. This is all very problematical. We need to have a comprehensive approach”* (director CAV / Rome).

Lack of opportunities for social reintegration

Female psychoactive substance users attending the harm reduction and addiction treatment facilities represented in the focus groups are often in highly precarious situations. In the absence of any prospects for social reintegration, they have little chance of achieving material self-sufficiency and a return to relationships in which they are dependent and therefore more vulnerable to potential violence is often their only solution. This aspect was discussed in particular at the Rome and Lisbon focus group meetings.

Professionals running centres for women who experience violence agree on the inadequacy of arrangements for guiding female psychoactive substance users towards material self-sufficiency and the need to establish such arrangements in order to prevent them from returning to situations of violence and suffering relapses after a period of abstinence: *“Another problem is that women can't break the cycle of violence because they don't see themselves as economically independent. And in most cases they aren't. So if there were arrangements for guiding women towards economic independence, that could help them to break this cycle of violence. Because, economically, many women are totally*

dependent on their partners” (director / Rome). This view is shared by those working in harm reduction and addiction treatment facilities: “Women drug addicts, whether they have been subjected to violence or not, are women who have few job openings because they have a very low standard of education. They have minimal job openings. So we have to work on changing their lives. They have very little income, and that only compounds the situation. I think it’s essential to have resources for helping people when they stop using drugs, because stopping drug use is one thing, but keeping it up is another things, and it’s more difficult” (psychologist / Lisbon).

These observations are confirmed by the testimony of a peer worker who suffered several relapses due to the lack of opportunities for social reintegration. *“I agree that whenever there’s a relapse after treatment, the relapse is always more destructive, so a woman will be all the more prepared to accept more violence and humiliation because her self-esteem has fallen still further. So you always come back to your starting point and it’s always more destructive. Everything you said is true, my relapses were always due to a lack of opportunities for social reintegration. Treatment is one thing, and that’s fine, but when it’s a case of recovering some autonomy, a sense of purpose in life and some self-worth, there are no answers, and someone who already has self-esteem issues without those resources quickly goes back to drug use. I agree with you about therapeutic counselling. After years of abstinence, I still have counselling sessions, and that’s very important, but not being socially reintegrated or being badly reintegrated is actually a factor for failure of all treatments, among both women and men. Today we are talking about women who have been the victims of violence” (peer worker / Lisbon).*

3.4.4. Non-funding of actions

The question of the financial resources allocated to actions for managing violence experienced by female psychoactive substance users was also discussed as a factor limiting facilities’ scope for action.

Uncertainty over the renewal of budgets

The question of budget sustainability and renewability is a major concern of participants in a period of crisis where funding earmarked for social aspects is increasingly under threat. *“Methadone treatment is a core component of addiction management and it’s guaranteed by various arrangements across the country, but where the social aspect of addiction management is concerned, there are huge disparities between the different regions, and even in the same region things can change depending on the government’s political leanings. Basic treatment is guaranteed throughout Spain, but addiction management is not confined to basic treatment.*

When it comes to comprehensive management, there are many components which are not dealt with in the same way across the country” (educator / Madrid).

Non-recognition of specific actions to manage violence

Actions to manage situations of violence are not accorded value as such in harm reduction and addiction treatment facilities. On the one hand, they do not appear as such in associations’ budgets: *“We have a general, overall budget and we have to manage it. There are things we are obliged to do, and there are others where we are free to call on other services to supplement our own. This is what we have done for screening, for example”* (director CAV / Rome); and are not presented as specific activities in projects: *“No, we don’t have that kind of service. We can do activities aimed more specifically at women, but we don’t have a specific service in financial terms. There’s no provision for that. For example, we do have a specific service for men who have sexual relations with other men”* (researcher / Lisbon). *“As far as the addiction field is concerned, I don’t think the question of violence is even mentioned. The question of gender violence among drug users is never mentioned”* (director / Rome).

On the other, networking is not really taken into account or recognised in activity reports. *“For us, a half-day spent in the Dapsa network [parental support network] by two professionals means 40 medical acts which will not be in the activity report. The question of violence is not dealt with solely with the victim and solely in terms of treatment. It is also dealt with in the social network. Because these are complex treatments, which necessarily demand more energy, in other words they are customised...”. Similarly, each medical act is counted as a single act regardless of the time spent on it: “we record all the acts we perform with patients, and whether we spend half a day with them or receive them for five minutes, it’s the same rate, as it were, whereas all the team meetings and consultations etc. count for nothing”* (psychologist / Paris). This is paradoxical because, on the one hand, *“professionals are encouraged to put in place these actions, but their work is not actually recognised, so that puts people in awkward situations”* (psychologist / Paris).

3.5. Recommendations for effective overall management of violence experienced by women who use psychoactive substances

In view of the link established between violence and substance use, and because violence affects a large proportion of female users attending harm reduction and addiction treatment services, the response to violence experienced should be regarded as forming an integral part of the overall management of female psychoactive substance users. However, there are many

limitations internal to services, but also structural limitations, which cause female psychoactive substance users to be excluded from the general arrangements for managing violence, without specific resources being put in place within facilities for women users to compensate for this lack of access. In establishments catering for particularly vulnerable psychoactive substance users, the routine nature of violence in drug use circles, the small proportion of women on active patient lists and the lack of recognition given to all the complex, long-term work that is done on this issue mean that managers are reluctant to propose specific measures and misgivings persist even among the staff.

The management of violence experienced by female psychoactive substance users therefore needs political support to ensure that it no longer depends on individual initiatives but is part of an overall strategy involving the different players working with this group, and creating the social and political conditions necessary for this. While this view is already shared by many policy-makers, the input provided by this consultation of professionals helps to identify, on the basis of actual practice, what does not work or works less well and what could be put in place to ensure truly effective overall management.

3.5.1. Incorporating the gender dimension in harm reduction and addiction treatment facilities

Existing facilities are not gender-neutral. They prioritise one gender or the other in different ways and with varying degrees of subtlety. To ensure optimum care, it is therefore necessary to have specific approaches aimed at each of these groups.

Viewing violence in a context of social and economic inequality

“Although the legal status of women in Europe has undoubtedly improved during recent decades, effective equality is far from being a reality. Even if progress is visible (educational attainment, labour market participation, political representation), gender gaps persist in many areas, maintaining men in their traditional roles and constraining women’s opportunities to affirm their fundamental rights and assert their agency.

The most pronounced expression of the uneven balance of power between women and men is violence against women, which is both a human rights violation and a major obstacle to gender equality.”

Excerpt from the “Gender Equality Strategy 2014-2017” of the Council of Europe’s Gender Equality Committee (GEC).

The violence experienced by women cannot be explained solely in terms of psychological and individual factors, but needs to be viewed in a context of social and economic inequality where roles are determined by social norms. *“Right at the start, I referred to these structural factors. In society, there is gender inequality on several levels which has knock-on effects on the specific situation of women drug addicts. It was pointed out that labour market access is more difficult for women, and women earn less than men, they are more dependent, and for the same reason they are more dependent in relationships. There are social norms which, as I have said, are much more burdensome and stigmatising for women”* (researcher / Lisbon).

This approach offers an alternative to the sometimes moralising and guilt-provoking discourse conveyed in particular by some professionals, both male and female, according to which women bear full responsibility for their situation. The adoption of this “feminist” approach with women who have a very low self-image can also help them to better understand the situations of violence to which they are exposed, to get over their guilt, improve the way they see themselves and develop strategies for extricating themselves from these situations.

Changing perceptions and recognising personal strategies

It is also important not to reduce women exclusively to an identity of victim, but to recognise their ability to adopt personal strategies and take these into account in the care provided. *“Attention must be paid to the risk of an overly systematic discourse which necessarily puts people who have been through these terrible things in the position of a victim, when there are a number of them who, faced with trauma, have started a healing process...”* (psychologist / Paris).

Involving men in the violence prevention process

Incorporating the gender dimension means developing approaches that take account of the specific features resulting from interaction between two groups whose roles are socially determined. To say that is to recognise that social and cultural norms also force men to behave according to the roles assigned to them, and that it is therefore necessary to get them involved in analysing the motives behind the use of violence in order to prevent it. *“The gender issue cuts across absolutely everything. It is no coincidence that 80% of drug addicts are men. So if I managed to introduce this gender perspective, perhaps I would be able to provide better treatment for male drug addicts too, and not just female drug addicts”* (researcher / Madrid).

3.5.2. Creating at institutional level the conditions for effective overall management of women who use psychoactive substances and experience violence

Ensuring unconditional access for female psychoactive substance users to protection arrangements

Whatever their circumstances, women who use psychoactive substances should be entitled to the same safety arrangements as other women who are victims of violence. Whether or not they are active users, whether or not they have lodged a complaint, whether or not they have social security cover, whether or not their papers are in order, all women who suffer violence must have unconditional access to protection arrangements. In countries where the legislation does not allow active female users in centres providing accommodation for women who have experienced violence, specific resources should be created.

In addition, professionals playing a role in access to protection arrangements for women who have experienced violence should be required to receive women who have been subjected to violence, and especially sexual abuse, in an unprejudiced way, and be trained to do so. The difficulties facing women wishing to report a rape because of the way they are received in police stations are by no means confined to the female drug users group and are criticised by many organisations which help women who have been the victims of violence. But the fact of being a user or being under the influence of a substance, or the fact of being a prostitute, detracts still further from the credibility of women who have suffered this abuse. *“The police and the emergency services need to act as bridges. I’m very angry. I think there’s a lack of training. You should see how the emergency services treat a female drug user who has just been raped. There’s a difference of treatment. I think a lot of work needs to be done with the police and the emergency services ...”* (head of service / Paris).

Encouraging the inclusion of activities to identify and address violence with a gender dimension in institutions’ mission statements

Violence suffered by female psychoactive substance users must be taken into consideration in facilities receiving them, whether in the form of direct treatment, detection or counselling. To ensure that this issue is addressed in all harm reduction and addiction treatment services, and to secure the support of the staff of these services, responding to situations of violence experienced by women should be part of their mission statement. *“I would say it’s a question*

of teamwork and organisation. That's why, if there is something that should really be recommended, it's that this should be part of the institution's mission statement. This is something that should really be institutionalised because, here again, in the end it's really a question of individuals, of who is in the team and who the managers are" (director / Paris).

Improving co-ordination and networking between different players

Every woman seeking treatment brings with her a whole range of problems which an institution cannot deal with by itself. Political support is needed to ensure co-ordination between players working in the same area, in addition, dealing with women who have been the victims of violence or their reintegration etc., but also GPs, hospitals and the police. *"It is also necessary to forge institutional links going beyond individuals, for this to be recognised in its own right, worked on and placed on an institutional footing" (director / Paris).*

Overall management strategies must be built on working groups or management committees bringing together all the players, be they public agencies or voluntary organisations, working in the same area on the specific issue of violence and the specific female drug users group. This will make for better management of the violence suffered by women users attending harm reduction or addiction treatment facilities, but the links created will also provide tools for professionals dealing with women who have suffered violence, enabling them to address the issue of the use of psychoactive substances, including psychotropic medicines.

Female psychoactive substance users should be invited to these co-ordination forums in order to be involved from the start in developing and building protocols and projects. *"I would also like to mention another factor which we have already discussed, namely changes in society. I think that activism and advocacy by associations can be very useful for the empowerment of women drug users. Often, drug users, and women in particular, are not given a role in the development of policies and programmes. In Portugal, there is a shortage of activism in general, and particularly in the drugs field. We think, therefore, that women who use drugs should be involved in finding solutions" (researcher / Lisbon).*

Incorporating the management of violence experienced by women users into national strategies and plans

To guarantee comprehensive treatment for women who use drugs and experience violence, provision needs to be made for mainstreaming of the gender dimension and the question of violence in national anti-drug strategies and programmes, but also for the inclusion of the question of addiction to

psychoactive substances in programmes to combat violence. *“I think we agree that the questions of drugs and violence against women should be present in drug policies and policies to combat violence. Mainstreaming is what we need”* (director / Rome).

Securing sustainable funding

In a context of economic recession, it is important to secure the funding of addiction treatment and anti-violence institutions, particularly as regards the social aspects, which are the most threatened.

Making consideration of the question of violence standard practice in institutions means not only appreciating the time needed to carry out this work, but also allocating the necessary human resources and time to it and providing for these activities as such to be given a prominent place, and quantified, in activity reports. *“There has to be recognition of the time spent and the extra staff”* (director/Paris). *“The common factor is physical accompaniment. That means a member of the team being constantly on hand. We provide support at the police station and in the forensic unit... So that needs to be taken into account. We are fairly much in agreement on that”* (head of service / Paris).

In addition to physical presence, the time devoted to building networks and forging links with partners also needs to be taken into account. *“The work of linking up professionals should be given due recognition and resources should be allocated to it. It’s already been said, but I want to stress the point again, because in situations like that, which are so difficult, the work necessarily has to be collective, and collective work is real work which takes time, and so a cost is involved ...”* (psychologist / Paris). This work is all the more time-consuming in that it has to be kept up and constantly repeated as teams change.

To ensure that these activities are taken into account, calls for projects must incorporate the gender dimension and violence management and specific budget lines must be created.

3.5.3. Supporting actions through training programmes

Detecting and addressing violence experienced by women means being able to offer appropriate responses to it, in terms either of treatment or of referral to a facility specialising in such treatment. Failing to recognise an obvious situation of violence or having no response to offer after hearing an account of violence may constitute a form of violence in itself, in the first instance for the women concerned, but also for the professionals who find themselves powerless in the face of an alarming situation.

Making teams aware of gender-specific aspects and the question of violence

Although many associations have given a prominent place to addressing the issue of violence and the treatment of drug users from a gender perspective, this perspective is still far from being unanimously shared among the staff of harm reduction facilities. All too often, violence is still seen as unexceptional and as being part of the everyday life of psychoactive substance users living in precarious circumstances. It is therefore necessary to work with staff on gender specificities, gender-related perceptions and gender relations within a system based on a patriarchal model.

Developing training in dealing with psychological trauma

The question of the presence of psychological trauma in female psychoactive substance users attending harm reduction and addiction treatment services came to the fore again and featured prominently in all the focus groups. According to some professionals, however, psychological trauma is still insufficiently studied on training courses for psychologists. *"I also think that psychologists should concentrate more on trauma than they do at present because it is difficult to find people with a special knowledge of the subject. Training for psychologists should focus more on the question of trauma. There is no specific training. Psychologists should be made aware of the different types of trauma"* (director / Rome).

Fostering exchanges of practice between professionals in the addiction and violence management fields

Knowledge sharing between teams working in facilities for women users and those working in centres for women who are victims of violence should be encouraged and become standard practice in view of the apparent close link between the issues of violence and psychoactive substance use. *"I did an internship in a hospital, in the psychiatry department, and someone from a laboratory came to talk about clozapine (a drug) and violence. And I realised that there is a lot to learn about violence"* (psychologist/Lisbon). *"We could organise mutual training programmes. It's a great opportunity for exchange you are giving us here. All these forms of exchange involving training are important"* (director CAV / Rome).

3.5.4. Incorporating the gender dimension into the health surveillance system

Professionals adapt and create responses to the situations they encounter on the basis of their observations and their expertise. Nevertheless, some regret the lack of a health surveillance system for collecting standardised

data broken down by sex which would make it possible, on the one hand, to evaluate the long-term impact of actions and, on the other, to build strategies according to set criteria while incorporating a gender dimension, leading to a better understanding of the social, economic and demographic determinants of violence.

Evaluating the impact of strategies

The question of evaluation was addressed in the focus groups in terms of being able to formalise and ensure the transferability of field experiments that work: *"I think the culture of evaluation should also be encouraged because we have concrete projects that involve knowledge sharing, meetings and publications. I don't know if you agree with me, but I think there should be systematisation exercises. It's not just a question of me evaluating and publicising my project. We should be able to carry out evaluations to see what worked well and what worked badly because, sometimes, we adapt our projects in relation to what we observe in our day-to-day work, but it would be a good idea to have an evaluation methodology from the start, with a gender perspective too, stand back for a time and then evaluate the end result"* (psychologist / Madrid).

Documenting and analysing the phenomenon of violence

It is also important to be able to document the phenomenon of violence in a systematised way, and hence to put in place a health surveillance system including specific indicators. *"As regards drug users, since we are talking about the short-term view and weaknesses, we have not sufficiently analysed this problem. We count cases, but we do not have a structured analysis of this phenomenon. In our health services we have public addiction treatment services, but we do not address this problem in its totality. So, yes, I think it's a major problem. We need to analyse the problem in its totality, because if we observe and listen to what these women say, we have no data on this phenomenon. And there is no dedicated service or reception centre which addresses the problem in an overall way. Problems of violence do not involve questions about psychoactive substance abuse. If you fill in a questionnaire about violence, there will be no questions about drug use, and if you fill in a questionnaire about drug use, there will be no questions about violence"* (researcher / Madrid).

Some discussions also gave rise to exchanges between people with irreconcilable viewpoints, but these discussions reveal the wealth of ideas among people working in the field, and the progress of their thinking, about responses, and the organisation of responses, to the question of violence experienced by women who use psychoactive substances. Among these important discussions, we may mention those concerning:

- ▶ the desirability of developing specific resources for female psychoactive substance users or, on the contrary, of arranging for female psychoactive substance users, including active users, to be received in facilities for women who are victims of violence;
- ▶ the advantages of integrated management as opposed to diversity of provision, the idea being to offer a range of responses meeting each woman's specific needs;
- ▶ the use of the word "feminist" in approaches incorporating the gender dimension does not meet with a consensus either, some speakers pinpointing the many different ways in which this word can be interpreted, while others stress the need to view individual situations in an overall context, whose very structure generates inequalities and encourages violence towards women, and the fact that this word permits recognition of this social reality;
- ▶ the balance to be struck between public service set-ups, ensuring greater sustainability of funding, and non-governmental bodies, which are often more responsive to specific situations demanding greater flexibility of implementation;

It is worth continuing these discussions in greater depth. They highlight the wealth of ideas and proposals already produced by professionals who work with female psychoactive substance users and are confronted with the question of the violence suffered by these women, and the need to create meeting and discussion forums with a view to building strategies and action plans in the light of the realities observed in the field and on the basis of the different viewpoints defended by different players depending on their place in the care process.

IV. Limits and strengths of the study

Limits

Taking as its starting-point the joint findings of professionals in the consultations held by Eranid in 2014 to identify research priorities in the field of illicit drugs⁹ and the lines of action identified in the exploratory study on “Violence (experienced or perpetrated) and psychoactive substance use among women in Europe and the Mediterranean region” conducted in April 2015¹⁰, the consultation of professionals focused mainly on violence experienced by female psychoactive substance users attending harm reduction and addiction treatment facilities, in line with an operational approach.

As a result, issues related to the non-medical use of psychotropic medicines obtained on prescription received very little attention in this study, as women who only use these substances, which, because they are legal, are often considered unproblematic, do not attend, or attend very infrequently, centres specialising in addiction treatment. These medicines are often prescribed in private medical practices, and a study bringing together general practitioners, psychiatrists and professionals working in centres for victims of violence could be carried out to explore the issue of violence detection in doctors’ surgeries.

9. Jauffret-Roustide M, Chauvin C, Santos A., *op. cit.*

10. Benoit T, Dambélé S, Jauffret-Roustide M, *op. cit.*

Neither was it possible to deal in depth with the specific situations of particularly vulnerable or exposed groups such as pregnant women or women users who engage in prostitution.

Furthermore, the method chosen proposes an analysis of professional discourse based on an inductively oriented empirical approach, focusing on the perceptions and practices described by the players themselves, which are not compared with the data in the literature.

As regards the terrain of study, the methodology chosen is qualitative and the sample small and unrepresentative. However, we took care to have a varied sample in each city in order to cover a range of different professional contexts. The composition of the groups was different in each focus group in terms of female/male representation, the type of facilities represented and people's jobs.

The consultations took place in four capitals. The findings presented are therefore based on the experience of professionals practising in situations that are both specific (unrepresentative of what is done at country level and non-exhaustive) and disconnected from an analysis of the public policies specific to each country.

The findings presented must therefore be used neither to make generalisations nor to draw comparisons between the policies and actions implemented in the different countries covered by the study.

Strengths

The approach adopted made it possible to gather a wealth of valuable information from professionals directly in tune with the issue studied.

The group discussion dynamics aimed for in the focus group approach left little scope for delivering pre-prepared statements and helped to ensure that those questioned spoke very freely. Participation being voluntary, the groups included people from diverse backgrounds adopting a reflective approach to their own practices and particularly involved with the theme of the consultation. A wealth of data was collected, bringing out points of both agreement and debate between the different players and highlighting the complexity of the determinants linking violence, psychoactive substance use and gender.

Most of the focus groups consisted of professionals practising in facilities specialising in addiction and harm reduction, but the participation in the focus group meeting held in Rome of professionals involved in arrangements for

the reception and protection of women who experience violence provided an additional viewpoint which proved highly instructive.

The consultations were marked by high-quality discussions which, drawing on situations experienced and shared in professional practice, brought out complex social processes, leading to a better understanding of the determinants linking violence, psychoactive substance use and gender, and suggested some possible lines of action.

Conclusion

The consultation of professionals at four focus group meetings held in September and October in Paris, Rome, Madrid and Lisbon on the question of “management of violence experienced by women who use psychoactive substances” yielded many positive results.

Far from keeping to a narrow definition of violence, the participants describe a continuum of violence inflicted on female psychoactive substance users in different forms and at all levels of society. This violence may be violence suffered in the context of a relationship, often echoing violence experienced in childhood; violence associated with drug use or prostitution, due partly to the criminalisation or penalisation of these practices; violence experienced during the protection process, in institutions where women users are constantly reminded of their delinquent, and hence guilty, status, but also sometimes in addiction treatment facilities, when women are relegated to the status of passive individuals, without any recognition or consideration of their own coping strategies; social and cultural violence, which keeps women in situations of dependency and denies them the same access to employment and public space as men, while accusing them of behaving in a way that is not expected of them according to certain norms or accepting situations of violence because of their weak character.

They highlight the interdependence of these different forms of violence, which are mutually sustaining and mutually reinforcing, the complexity of this phenomenon and the wide range of determinants to be taken into account in dealing with women who use their services, while recognising that each situation is unique.

Professionals working with psychoactive substance users are confronted on a daily basis with the issue of violence, especially when these are people living in precarious circumstances or in situations of material dependency. Having for a long time been considered part and parcel of the world of drug addiction, the issue of violence and how it is dealt with has begun to acquire

a more prominent place in harm reduction and addiction treatment facilities, despite numerous misgivings among the staff themselves, unconvinced as they are of the benefits of making specific arrangements for a group who often form a minority on active patient lists. However, while dealing with violence is not the main function of harm reduction and addiction treatment services, violence is a major determining factor in the start of use and the severity of addiction and an obstacle to the cessation of use. As such, it should be taken systematically into account in the process of treating addiction.

Harm reduction and addiction treatment services have undertaken numerous actions to respond to the issue of violence, but these complex, long-term actions, which are resource-intensive in terms of staff and time, still receive little recognition from public institutions, are given too little prominence in activity reports and are insufficiently funded. Furthermore, owing to the compartmentalisation of care arrangements, there is often no suitable response to the specific situations of female psychoactive substance users, who are excluded in practice from general protection arrangements. Both the prejudices existing in partner facilities towards psychoactive substance users and the lack of training in violence issues in harm reduction and addiction treatment facilities are also impediments to effective management of these issues. Lastly, the cessation of use and the distancing of violence can only be maintained if the conditions are created for material self-sufficiency.

Faced with this situation, professionals emphasise the need to increase links and co-ordination between all players working with women who experience violence and support training and awareness-raising for partners on drug use issues in order to combat preconceptions and thus permit unconditional access for all women to protection arrangements, whatever their situation in terms of substance use. Within harm reduction and addiction treatment facilities, it is important that a gendered approach to violence should become standard practice. Such an approach should set the issue of violence in an overall context taking account of its social and cultural determinants so as not to reduce the causes of violence to exclusively psychological factors.

What emerges from this consultation is that professionals have high expectations of politicians. To create the conditions for real and effective management of violence among female psychoactive substance users, a first step might be to recognise the link between violence and psychoactive substance use by including the question of violence in national anti-drug strategies and programmes and the question of addiction to psychoactive substances in national strategies and programmes for combating violence against women.

Appendix: Focus group discussion guide

Consultation on “managing violence experienced by women drug users”

1. I will first ask you to describe all the types of violence with which the women attending your institutions are or have been confronted.

You should cover at least the following topics:

- ▶ Psychological, physical and sexual violence,
- ▶ Current or childhood and other past experiences of violence
- ▶ Domestic or institutional violence (employment, police, street, prostitution, illegal migration, stigmatisation of women etc.)

2. In your practice, do you observe characteristics specific to abused women, whether in terms of profiles, behaviour or substances used?

You should cover at least the following topics:

- ▶ Patients’ histories (other than their drug use histories)
- ▶ Substances used (crack vs. opiates, illicit drugs vs. psychotropic medicines)
- ▶ Violent behaviour
- ▶ Situation in terms of employment, housing and education
- ▶ Addiction in the family, the couple, lone use
- ▶ Vulnerability factors: parenthood

3. In your opinion, what effects do these situations of violence have on health, entry into drug use, the severity of addiction and the cessation of use?

You should cover at least the following topics:

- ▶ Mental health
- ▶ Vicious cycle of violence - drug use - violence (addiction as a factor in exposure to violence)
- ▶ Acceptance by women of the violence they suffer, which comes to be seen as something normal
- ▶ Increased risk-taking (prostitution, exposure to danger)
- ▶ Severity of addiction
- ▶ Delay in seeking treatment

4. How does your institution detect and/or deal with this violence and its effects on health and addiction?

You should cover at least the following topics:

- ▶ Psychological monitoring/treatment
- ▶ Workshops to restore self-esteem
- ▶ Work with men
- ▶ Protection from harm
- ▶ Partnership with associations (planning, urban health workshops)
- ▶ Support groups, self-help

5. In your opinion, how does management of this violence and its effects contribute to successful treatment and follow-up and to a better life for the people concerned?

- ▶ You should cover at least the following topics:
- ▶ Better adherence to treatment
- ▶ Less risk of relapse
- ▶ ...

6. In your opinion, what additional resources or knowledge/information would addiction treatment of harm reduction facilities need to improve management of violence?

You should cover at least the following topics:

- ▶ Sharing of practices

- ▶ Scientific studies
- ▶ Role of partnerships
- ▶ Knowledge of existing arrangements
- ▶ International connections

7. In your opinion, are there structural or institutional factors which limit the effectiveness of the work done by addiction treatment and harm reduction centres in this field?

- ▶ You should cover at least the following topics:
- ▶ Social issues: discrimination in access to employment etc.
- ▶ Access to housing
- ▶ Legislation: e.g. prostitution, migrants, law enforcement etc.
- ▶ Police, street, prostitution, illegal immigration etc.
- ▶ Gender social relations unfavourable to women
- ▶ Delay by women in seeking treatment because of stigmatisation

8. What are the specific needs of certain high-risk groups?

- ▶ Pregnant women and mothers (link between separation and continued use)
- ▶ Prostitutes
- ▶ Migrant women
- ▶ Young women
- ▶ Women living with a drug-dependent partner

9. Before concluding this focus group meeting, are there any topics which have not been mentioned and which you consider important?

The lives of women who use drugs are punctuated by traumas and violence suffered during childhood or adulthood. These women form a minority of the patients seen by addiction- management and risk and harm-reduction professionals, who mainly take care of men.

The 2015 Council of Europe publication *The gender dimension of non-medical use of prescription drugs in Europe and in the Mediterranean region* called for a better understanding of the link between drug use among women and violence.

A review of literature on violence experienced by women who use drugs established that, among the general population, drug users are confronted more with violence and that their drug use increases when violence is experienced, in particular among women.

In order to give this research an operational perspective, the Pompidou Group, at the initiative of Italy, launched a consultation process among professionals in four countries: France, Italy, Portugal and Spain.

This document presents the recommendations of the study, which aim at improving care for women who use drugs and are victims of violence.

The professionals interviewed ask policy makers, first and foremost, to recognise the link between violence and psychoactive substance use, by including the question of violence in national drug strategies and programmes and by including the question of addiction to psychoactive substances in national strategies and programmes for combating violence against women.

The Council of Europe is the continent's leading human rights organisation. It comprises 47 member states, 28 of which are members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

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