Gender-Based Violence among Women who Use Drugs: A Quantitative and Qualitative Study in 6 EU Countries

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INTRODUCTION: The prevalence of gender-based violence (GBV) among women who use drugs (WWUD) is reportedly two to five times higher than among those who don't use. This study aimed to analyse GBV experienced by WWUD in 6 EU countries. **METHODS:** A survey was carried out with 261 WWUD, and additionally, 492 professional staff working with WWUD were surveyed. Fifteen focus groups with WWUD and staff and 120 interviews with staff and key informants were also conducted. **RESULTS:** WWUD reported a high lifetime prevalence of GBV (97.69%) of all types and in many contexts. Migrant, ethnic minorities, and low-income WWUD seem to experience even more GBV. Eighty-six per cent (86.22%) among WWUD experienced violence at the hands of men who were using alcohol or drugs. They also reported aggression from men who do not use drugs (51.97%). Structural violence against women is the main factor explaining GBV. GBV is further exacerbated when alcohol and drugs are involved. Only 18.4% (n = 46) of WWUD and 25% (n = 115) of the staff reported that the "early detection systems and protocols for GBV" defined the service they were working in. Fifty-four per cent (54.39%; n = 267) of the staff acknowledged the need to improve their knowledge about the intersection between drug use and GBV. **CONCLUSIONS:** WWUDs are confronted with a high prevalence of different types of GBV in various settings. However, WWUD and staff surveyed have pointed to the lack of systematic screening for GBV in drug services. This poses a barrier to access and success in treatments and re-victimisation by the staff. The authors suggest specific training for professionals on drug use and GBV as a must, establishing protocols for systematic screening of GBV, and incorporating gender intersectional perspectives in drug services.

Keywords | Gender-Based Violence – Women who Use Drugs – Gender and Intersectional Approach – Trauma-Informed Approach – Drug Services

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1 INTRODUCTION

According to United Nations Office on Drugs and Crime, the prevalence of gender-based violence[1] (GBV) among women who use drugs (WWUD) is two to five times higher than among women who do not use drugs (UNODC, 2018). Compared with men who use drugs, WWUD are more likely to have experienced sexual and physical assault and abuse as children or as adults and to be exposed to intimate partner violence, pointing to the structural inequality between men and women who use drugs (EMCDDA, 2019).

Previous studies (Malinowska-Sempruch et al., 2015; Gilbert et al., 2016, 2017; Stoicescu et al., 2020; El-Bassel et al., 2020; Valencia et al., 2020) have pointed to a high prevalence of Intimate Partner Violence (IPV) among WWUD in harm reduction services or scenes (28.70%– 88.55%). However, there is a lack of quantitative and qualitative data on different GBV types and contexts experienced by WWUD utilising different types of substance use services and GBV survivor services across different EU countries. Our study aimed: 1) to identify the prevalence of types and contexts of GBV intersecting the lives of WWUD linked to different types of drug and GBV survivor's services across six EU countries; 2) to analyse the profile of the most common aggressor according to gender identity, drug use, and types of GBV perpetrated; and 3) to explore the extent to which the different services involved in this study address the GBV experienced by WWUD.

2 METHODS

2.1 Design

Non-experimental, cross-sectional, observational and multicentric study.

2.2. Instruments, participants, and procedures

This is a multifaceted study that has incorporated the following six data collection instruments.

2.2.1 Literature review

More than 80 papers were selected, and 50 were finally analysed. For the bibliographic search, Google Academic, Pubmed/MEDLINE, PsychINFO and Web of Science databases were used. Studies and monographs from international and European institutional bodies with extensive knowledge of the topic were also included. Inclusion criteria were established as follows: (1) the range of publication dates corresponded to 10 years, between 2010 and 2020; (2) the language chosen was English and Spanish; (3) theoretical and experimental studies were searched; (4) and the search terms were: ("intimate partner violence" OR IPV OR "sexual violence" OR "Gender-based violence" OR "battered women") AND (SUD OR "substance use", "drug addiction") AND ("comorbidity") AND ("treatment" OR "intervention" OR "psychotherapy") AND ("women" OR "gender" OR "gender-based treatment"). As a result, five different instruments were designed and implemented as part of this study:

2.2.2 Women's survey

A face-to-face survey addressed to WWUD and administered by a trained interviewer; included questions about the sociodemographic characteristics of the sample, questions about drug use and types and contexts of GBV experienced throughout life, the intersection of drug use and GBV, and the care received by different services about drug use and GBV experienced. Women were randomly recruited through the various types of drug services and/or targeted GBV survivor services accessible to partner organisations in the participating countries. Although an initial sample of 50 women per participating country was planned, in some countries, it was not possible to reach this number, among other reasons, due to COVID-19 restrictions.

Women's Survey Sample

The sample of WWUD facing GBV consisted of 261 participants, aged between 18 to 66 years (M = 38.87, SD = 10.40), residing in Austria (n = 34), Croatia (n = 50), Germany (n = 14), Italy (n = 64), Portugal (n = 30), and Spain (n = 69). Two hundred and fifty-five (97.7%) self-identified as cis-gender women, and six (2.3%) as transgender and non-binary; 74.71% (n = 195) self-identified as heterosexual, 14.18% (n = 37) as bisexual, 6.51% (n = 17) as lesbian, 3.83% (n = 10) preferred not to answer, 0.77% (n = 2) preferred to self-describe as pansexual. Most women (n = 144; 58%) reported being linked to a therapeutic community or residential centre for people who use drugs. This is followed by 66 (26.4%) and 22 (8.8%) of women who reported, respectively, being linked to an outpatient care/day centre for people with drug-use-related problems. Finally, and to a lesser extent, women who access a harm reduction service (n = 20; 8%), those who engage in integrated services for WWUD facing GBV (n = 19; 7.6%), those who are in an information and attention service for women survivors of gender violence (WSGBV) (n = 8; 3.2%) and those who are in a home/shelter for WSGBV (n = 1; 0.4%).

2.2.3 Staff survey

This survey addressed to 492 staff members (women: 78.25%; men: 19.31%; transgender and non-binary: 0.81%; preferred not to answer: 1.63%) from 6 EU countries working in different facilities where the treatment is aimed at women who use drugs and/or have experienced GBV. The services were randomly selected from the different types of services for people who use drugs and/or survivors of gender-based violence accessible to partner organisations in the participating countries; they were, therefore, not necessarily representative of the services provided by each country. Professionals from these services participated voluntarily in the research, and no se-

1 | Violence directed against a person because of that person's gender, gender identity or gender expression, or which affects persons of a particular gender disproportionately. Both women and men experience gender-based violence but the majority of victims are women and girls (EIGE, 2021).

lection criteria were established. This was a self-administered survey that contained information on the socio-demographic characteristics of the sample, type of service, type of intervention approach and best practices about WWUD and/or WSGBV. Although an initial sample of 100 professionals per participating country was planned, in some countries, it was not possible to reach this number.

Staff Survey Sample

The sample corresponding to the staff of professionals consisted of 492 participants (78.2% Women) residing in Austria (n = 110) and Germany (n = 14), Croatia (n = 91), Italy (n = 95), Portugal (n = 34), and Spain (n = 146). In terms of types of services, the professionals surveyed reported that they were mainly working in therapeutic communities/residential care for people with drug-use-related problems (n = 177; 35.44%) and outpatient care + day centres for people with drug-related problems (n = 100; 19.96%). It is closely followed by harm reduction services (n = 44; 8.96%); psychological-psychiatric care or mental health services (n = 41; 8.15%); home/shelter for WSGBV (n = 35; 7.13%); information and attention service for women (WSGBV) (n = 21; 4.28%); integrated service for women who use drugs facing GBV (n = 19; 3.67%); services aimed at homeless people (n = 4; 0.61%); and finally, prevention services (n = 2; 0.41%).

2.2.4 Women focus group

A qualitative survey using focus-groups methodology was undertaken with 66 women (12 focus groups in total, so 2 focus groups with 5/6 women per partner country) recruited from 11 different services, most of them from services working with WWUD, whilst one group from services working with GBV victims and 3 mixed services groups (drugs/GBV). The services were selected on the basis of their accessibility and interest in the research topic, and the women participants did so voluntarily and without any specific selection criteria. Focus groups addressed two areas: (1) the relationship between drug use and GBV and (2) experiences and areas for improvement in services for WWUD experiencing GBV.

2.2.5 Professional focus group

Three focus groups with professional staff from Croatia, Italy, and Spain. A total of 11 professional staff (8 women and 3 men) from 8 different drug services participated in these three focus groups. The services were selected on the basis of their accessibility and interest in the research topic. The professionals participated on a voluntary basis without any specific selection criteria. Focus groups examined (1) the relationship between drug use and GBV and (2) experiences and areas for improvement in services for WWUD experiencing GBV.

2.2.6 Key informant interviews

Key informant interviews were conducted with 120 individuals (20 per 6 EU countries). The interviewees represented 67 drug professionals; 31 individuals from the GBV field; 14 that worked with both populations; and 8 government officials. These interviews were conducted via a telephone survey. Key informants were asked their opinion about the programmatic intervention with WWUD and experience GBV specifically what aspects that are not being implemented along with those that should be implemented. A second question focused what is the most desirable option for WWUD. The informants were asked to choose among one of the following three options: 1) adaptation of services for GBV survivors to be able to serve women who use drugs from a gender perspective, 2) adaptation of drug services to improve care for women who use drugs or, 3) integrated services as services already adapted for WWUD and have experienced GBV.

Before starting this study, pilot tests of the two surveys in English were performed by administering them to small groups of WWUD and professional staff working with them in Spain to verify the understanding of the questions, the questionnaire's technical adequacy, and linguistic aspects. The Interleave Project partners translated the questionnaires into German, Portuguese, Italian, Croatian and Spanish. After that, the answers to the open-ended questions and the contents of the focus group were translated also by them into English.

A face-to-face paper questionnaire was used to interview the WWUD, whereas an online questionnaire aimed at professional staff drawn up by the software Google Forms© was disseminated through institutional web pages, e-mails, WhatsApp, Instagram, and Facebook. Double entries were checked by reviewing the dates of birth and the open-ended questions. Both focus groups and telephone surveys were anonymous, and the confidentiality of information was assured. After the agreement of the participants, informed consent was signed.

Finally, a quantitative and qualitative analysis of all the information collected was carried out from a gender and feminist perspective. Gender perspective considers gender-based differences when looking at any social phenomenon, policy or process (EIGE, 2021). In this sense, to the extent possible, this research disaggregated data by gender and interpreted both quantitative and qualitative data on the intersection of drug use and GBV on the basis of gender differences.

All data were collected in all the countries involved between May and December 2021.

In order to unify criteria, a guide on how to implement each of the three instruments was elaborated for the focal points in the partner countries (Plaza-Hernández et al., 2022).

2.3 Data analysis

For the quantitative analysis, an Excel file was used and cleaned of double entries and blank questions by checking dates of birth and open-ended questions. Descriptive analyses were carried out. Normality tests were conducted to identify each variable's distribution type (Shapiro-Wilk and Shapiro-Francia), finding that most variables do not present normal distribution. Due to some groups of variables containing few people, non-parametric statistics were performed using the Chi-square test. Fisher's exact test was used to compare differences between variables and groups. To analyse the association of nominal variables when their categories are of two or three classes, Cramer's V was calculated. For all analyses, p values < .05 were considered statistically significant. Analysis was performed using STATA 16 software. The qualitative analysis included 15 focus groups aimed at WWUD (12) and professional staff (3) and 120 call interviews aimed at professional staff and other key informants. NVIVO was the software used for the qualitative analysis. A semi-inductive coding strategy was used, and common categories or themes were discerned from the qualitative data collected. The following categories of analysis were obtained from focus groups: Category A: Relationships between GBV and drug use. Subcategories: A1. Women who use drugs and GBV; A2. Violence between women who do and do not use drugs; A3. Types of GBV experienced by women who use drugs; A4. Contexts of GBV experienced by women who use drugs; A5. Which comes first: GBV or drug use; A6. Hidden drug use among women; A6. Beliefs about women who use drugs; A7. Beliefs about men who use drugs; A8. Gender of the perpetrator; A9. Drugs or gender as causes of violence; A10. Other axes of discrimination besides drug use and gender identity; A11. Women's care strategies. Category B: Experiences in care services. Subcategories: B1. experiences in drug, survivors or integrated services. B2. Experiences in non-specialist services. Category C: Improvements needed in care services. Subcategories: C1. Improvements in drug, survivors or integrated services; C2. Improvements in non-specialised services. In addition, the following categories of analysis were obtained from the interviews: Category A. Aspects not implemented in services for women who use drugs. Subcategories: A1. Low thresholds/flexibility for access to the service; A2. The empathy of professionals towards women service users; A3. The presence of peer workers; A4. Professionals' knowledge of drug dependence; A5. Professionals' knowledge of gender-based violence; A6. Professionals' knowledge of both drug dependence and gender-based violence; A7. Existence of women-only spaces; A8. Addressing issues specifically affecting drug-dependent women who have suffered/suffer gender-based violence; A9. Addressing gender-based violence experienced throughout women's lives, including in relation to drug use; A10. Service regulations consider the specific needs of women and their children; A11. The programme of activities considers the specific needs of women and their children; A12. The design of spaces/facilities considers the specific needs of women and their children; A13. Mental health is considered; A14. Sexual and reproductive health and rights are considered; A14. Diversity is considered; A16. Women are actively involved in service design, development and evaluation; A17. Mutual support among women in the service is promoted; A18. Women's autonomy/empowerment is promoted; A19. The idea of belonging to a support network is promoted; A20. There is coordination with local networks, social movements and women's support services and other community services/organisations; A21. There is coordination with peer networks for women who use drugs; A22. Social reintegration is actively promoted; A23. Socio-political activism is actively promoted; A24. Gender perspective approach is adopted; A25.Harm reduction approach is adopted; A26. Trauma-oriented approach is adopted; A27. Institutional violence is pointed out. Category B: Most desirable option for women who use drugs by the staff. Subcategories: B1. Existing centres for women survivors of violence should be adapted to include women who use drugs. B2. Existing centres for people who use drugs need to better integrate a gender perspective, and specifically the GBV issue; B3. Integrated specific centres for women survivors of violence that incorporate a drug rehabilitation or/and harm reduction perspective should be promoted.

3 RESULTS

3.1 Types of GBV reported by WWUD and their contexts.

The WWUD[2] reported a high prevalence of various types and contexts of GBV. A significant 97.69% of WWUD reported having suffered at least one type of GBV in their lifetime. By types, psychological violence, 86.54% (n = 225); physical violence, 74.23% (n = 193); and sexual violence in adulthood, 44.62% (n = 116) and in childhood, 62 (24.62%)[3] stand out. By contexts, sex-affective relationships (68.09%; n = 175); the context of drug/alcohol use (58.37%; n = 150); family of origin (56.81%; n = 146); unknown aggressor (38.13%; n = 98); party environments (35,80%; n = 92); and institutional settings (35,02%; n = 90) stand out.

Table 1a details the types and contexts of GBV reported by WWUD.

Focus groups[4] with WWUD and professional staff also pointed to diverse types and contexts of GBV among WWUD, including sexual violence in childhood and the family of origin:

2 | It should be noted that the 261 women surveyed reported mainly legal drug use: alcohol (83.52%; n = 218); tobacco (80.84%; n = 211). Followed by the use of cannabis (63.22%; n = 165), cocaine (59.39%, n = 155) and prescription benzodiazepines (tranquillisers) (51.34%; 134). About 30% use of MDMA (36.02%, n = 94); amphetamines (36.02%, n = 94), non-prescription benzodiazepines (33.72%, n = 88), prescription opioid drugs (32.95%, n = 86) and heroin (32.18%, n = 84). To a lesser extent, non-prescription opioid drugs (20.31%; n = 53), ketamine (19.16%; n = 50); methamphetamines (17.62%; n = 46), GHB (10.73%; n = 28) and New Psychoactive Substances (8.43%; n = 22). Regarding the ways of consumption, 100% (n = 261) of the women surveyed reported using sniffed drugs, while oral (n = 159; 60.92%), injected (n = 151; 57.85%), and smoked/inhaled (n = 127; 48.66%) ways of consumption reported lower frequencies.

3 | No distinction was made between *drug sexually-facilitated assaults* (Olszewski, 2009) and other types of sexual violence experienced by WWUD.

4 | For more information on GBV reported by WWUD in focus groups in

Table 1a | Gender-Based Violence (GBV) types reported by WWUD (Women who Use Drugs) (n = 262)

GBV types	n (%)
Psychological violence	225 (86.54)
Physical violence	193 (74.23)
Sexual violence in adulthood	116 (44.62)
Economic violence	91 (35)
Sexual violence in childhood/adolescence	62 (24.62)

Table 1b | Gender-Based Violence contexts and types reported by WWUD (Women who Use Drugs)

	Types of GBV ever experienced in lifetime					
GBV Contexts	**ANY n (%)**	**Physical n (%)**	**Psychological n (%)**	**Sexual n (%)**	**Economic n (%)**	**Other n (%)**
Unknown aggressor	98 (38.13)	50 (19.5)	36 (14.0)	58 (22.6)	10 (3.9)	5 (1.9)
Sex-affective relationship	175 (68.09)	112 (43.6)	141 (54.9)	67 (26.1)	57 (22.2)	6 (2.3)
Family of origin	146 (56.81)	83 (32.3)	108 (42.0)	33 (12.8)	34 (13.2)	4 (1.6)
Labour context	74 (28.79)	16 (6.2)	52 (20.2)	15 (5.8)	22 (8.6)	6 (2.3)
Use of drugs/alcohol context	150 (58.37)	94 (36.6)	101 (39.3)	76 (29.6)	36 (14.0)	6 (2.3)
Drug traffic (sell/purchase)	67 (26.07)	35 (13.6)	42 (16.3)	27 (10.5)	18 (7.0)	3 (1.2)
Party environments	92 (35.80)	44 (17.1)	43 (16.7)	47 (18.3)	10 (3.9)	9 (3.5)
Sex work context	36 (14.01)	16 (6.2)	22 (8.6)	22 (8.6)	17 (6.6)	7 (2.7)
Human trafficking or sexual exploitation	25 (9.73)	15 (5.8)	16 (6.2)	20 (7.8)	14 (5.4)	2 (0.8)
Female Genital Mutilation (FGM) context	5 (1.95)	0	0	1 (0.4)	1 (0.4)	3 (1.2)
Early/forced marriages context	13 (5.06)	5 (1.9)	7 (2.7)	7 (2.7)	3 (1.2)	3 (1.2)
Armed conflicts	11 (4.28)	4 (1.6)	7 (2.7)	2 (0.8)	2 (0.8)	3 (1.2)
Homeless context	37 (14.40)	23 (8.9)	19 (7.4)	17 (6.6)	15 (5.8)	6 (2.3)
Institutional contexts, ANY	90 (35.02)	31 (12.06)	72 (28.02)	14 (5.44)	12 (4.66)	0
Institutional contexts: police	53 (20.62)	25 (9.7)	37 (14.4)	5 (1.9)	1 (0.4)	3 (1.2)
Institutional contexts: justice services	39 (15.18)	2 (0.8)	32 (12.4)	2 (0.8)	2 (0.8)	6 (2.3)
Institutional contexts: prison	19 (7.39)	7 (2.7)	14 (5.4)	2 (0.8)	2 (0.8)	3 (1.2)
Institutional contexts: health services	37 (14.40)	3 (1.2)	30 (11.7)	2 (0.8)	2 (0.8)	2 (0.8)
Institutional contexts: sexual and reproductive services	21 (8.17)	1 (0.4)	16 (6.2)	2 (0.8)	2 (0.8)	4 (1.6)
Institutional contexts: social services	39 (15.18)	5 (1.9)	32 (12.4)	3 (1.2)	4 (1.6)	3 (1.2)
Institutional contexts: child protection social services	34 (13.23)	1 (0.4)	27 (10.5)	3 (1.2)	2 (0.8)	5 (1.9)
Institutional contexts: services for people who use drugs	22 (8.56)	0	16 (6.2)	2 (0.8)	1 (0.4)	3 (1.2)
Institutional contexts: services dealing with GBV	8 (3.11)	0	3 (1.2)	2 (0.8)	0	3 (1.2)
Institutional contexts: anti-drugs laws	13 (5.06)	2 (0.8)	8 (3.1)	2 (0.8)	4 (1.6)	3 (1.2)

Note. N = 257. Data reflects the number and percentage of participants answering "yes" to each option.

Table 1c | Comparison of prevalence of types and contexts of Gender Based Violence (GBV) among Women Who Use Drugs by diverse authors

	Samples of WWUD				
Authors/year	**Plaza-Hernández et al. (2022) Interleave**	**Sarah Morton et al. (2023)**	**Palamar and Griffin (2020)**	**Balasch et al. (2018)**	**Plaza-Hernández et al. (2022) Sexism Free Night**
Data collection service/location	Diverse services	Domestic violence service	Nightlife environments-Electronic Dance Music parties	Nightlife environments-Heavy episodic drinking among young adults	Nightlife environments
LIFETIME GBV					
GBV Types					
Psychological violence	86.54%				-
Physical violence	74.23%				-
Sexual Violence in Adulthood	44.62%				-
Sexual Violence in Childhood	24.62%	27%			-
GBV Contexts					
Sex-affective relationships / Interpersonal Violence (IPV)	68.09%				-
· Psychological	54.86%				-
· Physical	43.58%				-
· Sexual	26.07%				-
Use of drugs context	58.37%				-
Family of origin / Adverse Childhood Experiences (ACE)	56.81%	58%			-
Unknown aggressor	38.13%				-
Party environments	35.80%		15.20%	14.90%	32%
Institutional violence, any	35.02%				-
· Psychological	28.02%				-
· Police	20.62%				-

[1] EU Fundamental Rights Agency (FRA) - Gender-based violence against women survey (2015).

If at ten years old you are raped, at twelve years old you are prostituted, and at fifteen years old you are sold to a person who keeps doing the same to you... I think I fell into drug use because I wanted to live like other people.... since I was ten years old, my life was destroyed, I have had a life of physical, psychological, and sexual abuse, and for me, it was a life that I had normalised... (WWUD/Drugs-GBV Integrated service);

I thought that the abuse originated when I started using, but I began to remember things from my childhood ... and the abuse comes from the family environment (WWUD/Drugs-GBV Integrated service);

In only women groups, topics like childhood sexual violence ... often come up (Woman, Therapist/Drugs-GBV Integrated service).

Table 1c indicates that these studies found a high prevalence of intimate partner violence (17.70%–88.55%). Violence in institutional settings (35.02%; n = 90), especially psychologically (20.62%; n = 53), also stood out. In this regard, WWUD reported multiple situations of institutional violence in both mainstream services and drug services (Plaza-Hernández et al., 2022):

I reported rape, and I was drunk, and the policeman standing behind the policeman who was taking my statement said: I do not believe her! (WWUD/Drugs-GBV Integrated service).

A forensic doctor saw me; I had bruises on my fingers and thighs, but the guy did not want to believe me... (WWUD/Drugs-GBV Integrated service).

In one specific public (drug) facility are violent, and aggressor men accommodated... (WWUD/Therapeutic Community)

relation to mainstream and drug services, see the INTERLEAVE Research Report (Plaza-Hernández et al., 2022).

Samples of WWUD								Women of the general population
Valencia et al. (2020)	**El-Bassel (2020)**	**Stoicescu et al., (2020)**	**Tirado-Muñoz et al. (2017)**	**Caldentey et al., (2017)**	**Gilbert et al. (2017)**	**Collazo-Vargas et al., (2018)**	**Malinowska-Sempruch et al., (2015)**	**FRA Survey [1]**
Harm reduction	Diverse services/ street -Sex Workers	Harm reduction	Drug treatment and Harm reduction	General Hospital	Harm reduction	Diverse services	Harm reduction	-
-	71.50%	-		-	-	-		-
-	87.50%	-		-	-	-		31%
-	78.80%	-		-	-	56%		11%
-		-		-	-	-		-
-		73%	70%	50%	73%	-	-	22%
88.55%	17.70%	-		-	-	-	-	-
71.20%	38%	-		-	-	-	-	24%
49%	28.70%	-		-	-	-	81%	9%
-	-	-		-	-	-	-	-
-	-	-		-	-	-	-	-
-	-	-		-	-	-	-	-
-	-	-		-	-	-	-	-
-	-	-		-	-	-	-	-
-	-	-		-	-	-	-	-
-	24%	-		-	50.70%	-	-	6.75%

[About drug centre professional staff] I felt harassed by the guy (WWUD/Drugs-GBV Integrated service).

Approximately 21% (20.62%; n = 53) of WWUD reported police violence (Table 1b: Plaza-Hernandez et al, 2022) which was also broadly confirmed at focus groups. As shown in *Table 1b,* high rates of police violence against WWUD have also been documented worldwide (Gilbert et al., 2016; El-Bassel et al., 2020; Stoicescu et al., 2020). In the same vein, 33.52% of WWUD respondents answered that they "did not report the violence I was suffering to the police because I was afraid they would not believe me, especially because of my drug use".

It was not considered appropriate to cross-reference GBV results by country and type of service given the disparity of samples[5].

3.2. Intersecting factors

The cross-reference of different self-reported axes of discrimination by WWUD beyond gender and drug use yielded the following results *(Table 2)*:

5 | Women surveyed were mainly from Spain (n = 69; 26.44%), Italy (n = 64; 24.52%) and Croatia (n = 50; 19.16%). They are followed by Portugal (n = 30; 11.49%), Austria (n = 34; 13.03%) and Germany (n = 14; 5.36%). The majority of women (n = 144; 58%) reported being linked to a therapeutic community or residential centre for people who use drugs. This was followed by 66 (35.60%) and 22 (20%) of women who reported, respectively, being linked to an outpatient care/day centre for people drug-use related problems. Finally, and to a lesser extent, women who are/were in harm reduction services (n = 20; 8%), those who engage in integrated service for women who use drugs facing GBV (n = 19; 7.60%), those who are in an information and attention service for women victims/survivors of GBV (n = 8; 3.20%) and those who are in a home/ shelter for women survivors of gender violence (n = 1; 0.40%).

Table 2 | Axes of discrimination and GBV reported by WWUD and by Women in the General Population

Axes of Discrimination	n	Lifetime GBV Experienced by WWUD (Interleave)						by Women of General Population (FRA survey, 2015)
		Physical violence	Psycho-logical violence	Sexual violence in adulthood	Sexual violence in childhood	Economic violence	Any violence	
Low-income level (1)	82	67%	88%	60.98%***	26%	53.66%***	99%	30%
Non-heteronormative sexual orientation (1)	36	61%	92%	42%	19%	50%	100%	57%
Ethnicity (1)	22	68%	91%	77.27%**	33%	59.09%*	100%	
Migrant background (1)	20	85%	85%	70%*	40%	50%	100%	36%
Disabilities (1)	48	77%	83%	46%	29%	38%	100%	
Age (1)	41	71%	83%	37%	24%	39%	98%	
Mental disorder (2)	118	76%	90%	48%	28%	37%	99%	50%

(1) Presenting this potential discrimination among the global sample answering this item (N = 253); (2) N = 261

***p < .000, **p < .001 and *p < .05 significant differences compared to WWUD who had NOT experienced these types of GBV.

The results suggest that the axes of discrimination are amplified among WWUD, especially regarding low-income, ethnic minority [6]and migrant background levels. The latter significantly increases the GBV experienced by WWUD. More specifically, low-income (p < .001), ethnic minority (p < .001), and migrant (p = .019) WWUD appear to experience significantly more sexual violence during adulthood than WWUD not affected by these axes of discrimination. Similarly, low-income (p < .001) and ethnic minority (p < .018) WWUD appear to experience more economic violence. However, no significant differences were observed between WWUD affected and unaffected by non-heteronormative sexual orientations, disabilities, age or mental health.

3.3 Reported profiles of aggressors

A total of 69.09% of WWUD reported being assaulted mainly by men (66.14% n = 168, frequently and 72.04% n = 183, sometimes). In total, 51.96% (n = 132) of WWUD reported receiving violence from men who did not use alcohol or drugs (36.22% n = 92, frequently and 15.75% n = 40, sometimes). In contrast, 86.22% (n = 119) reported being assaulted by men who used drugs or alcohol (35.83% n = 91, frequently and 50.39% n = 128, sometimes). Only 27.55% of WWUD reported being assaulted by other women (9.4%, n = 24, frequently and 45%, n = 116, sometimes). Assaults by women who used drugs were only 5.12% (n = 13), and by women who did not use drugs, 4.33% (n = 11) *(Table 3).*

In the context of sex-affective relationships, 28% (n = 73) of WWUD respondents reported that their current partner was not using drugs compared to 33.33% (n = 87) who stated that their partner was using drugs; 31.8% of WWUD preferred not to answer this question or didn't have a current sex-affective relationship (this does not mean that those current partners are the same pointed out as perpetrators, which may be previous ones). Throughout the focus groups, women also reported situations of GBV in intimate partner contexts as follows:

...this person has more and more paranoia and fears...and he becomes more aggressive...you are the bitch; if it was not for him, who would love you, you are a junkie; at that time, he was not using... (WWUD/ Drugs-GBV Integrated harm reduction service).

Among WWUD, 149 out of 225 (66%) "agree or strongly agree" that "often the person attacking me was under the effects of alcohol and other drugs". Simultaneously, 130 (57,8%) WWUD reported that when attacked, they were also under the effects of alcohol or other drugs. When we examine the cases where both aggressor and victim reportedly were under the effects of alcohol or drugs, there are 105 out of 225 (46.7%). On the contrary, in only 22 out of these same 225 cases (9.8%), neither the perpetrator nor themselves were under the effects of psychoactive substances. Throughout the focus groups, women also reported situations of GBV in drug/alcohol contexts as follows:

...waking up, and a guy is fucking me in a "narco flat"[7], you know? We will not go to a man and fuck him while he sleeps, you know? well, it is rape... (WWUD/Drugs-GBV Integrated and Harm Reduction service).

6 | We use this term to refer to racial and ethnic groups that are a minority in the population. Thus, in Europe, all ethnic groups except the "white" population.

7 | Housing where drugs are used and trafficked.

Table 3 | Most common profiles of aggressors attacking WWUD

	Man drug or alcohol user	Man NOT drug or alcohol user	Woman drug or alcohol user	Woman NOT a drug or alcohol user
Never	13.78% (n = 35)	48.03 (n = 122)	66.54% (n = 169)	78.35% (n = 199)
Sometimes	35.83% (n = 91)	36.22% (n = 92)	28.35% (n = 72)	17.32% (n = 44)
Frequently	50.39% (n = 128)	15.75% (n = 40)	5.12% (n = 13)	4.33% (n = 11)

N= 254

Note: More than one profile of aggressor may exist for every respondent

Table 4a | Early detection systems and protocols for GBV by the type of service. STAFF

		Outpatient care/ day centre for drug dependence treatment	Therapeutic community/ residential centre for drug treatment	Harm reduction centres or services for people who use drugs	Psychological -psychiatric care or mental health services	Integrated service for women who use drugs facing GBV
Early detection systems and protocols for GBV*	STAFF (N = 491)	22% (n = 22)	24% (n = 41)	25% (n = 11)	8% (n = 3)	61% (n = 11)
	Service sample	98	174	44	40	18

* Staff that "Agreed" or "Strongly agreed" that "Early detection systems and protocols for GBV are in place" in their service.

Table 4b | Early detection systems and protocols for GBV by the type of service. WWUD

		Outpatient care/ day centre for drug dependence treatment	Therapeutic community/ residential centre for drug treatment	Harm reduction centres or services for people who use drugs	Psychological -psychiatric care or mental health services	Integrated service for women who use drugs facing GBV
Early detection systems and protocols for GBV*	WWUD (N = 250)	13% (n = 12)	18% (n = 26)	25% (n = 5)	14% (n = 7)	68% (n = 13)
	Service sample	89	145	20	50	19

* "Early detection systems and protocols for GBV are in place" selected as a definitory trend of the service caring after them by WWUD (among 25 options, multiple answers possible)

3. 4 Existence of available tools for addressing GBV in drug services

Despite the high percentages of GBV observed, only 18.4% (n = 46) of WWUD and 25.73% (n = 124) of the staff highlighted that the "early detection systems and protocols for GBV" are not being effectively utilized. Qualitative information provided by staff revealed that, in general, the connection between drug use and experienced GBV is not sufficiently considered (Plaza-Hernández et al., 2022):

[About the connection between GBV and drug use] They are two concepts that are often conceived as unrelated... and all women I have worked with have survived GBV... (Woman/Social Educator/Inpatient drug treatment centre-reinsertion apartments).

The state and the system do not recognise the connection between drug use and GBV; there is insufficient education and knowledge... (Woman/Peer worker/ Outpatient care for people with drug-use-related problems)

The cross-reference between aspects that define the current service and the types of services, either reported by WWUD or by staff, revealed that drugs-GBV integrated services incorporate "Early detection systems and protocols for GBV" to a greater extent than other types of services *(Tables 4a and 4b).*

Additionally, the greatest consensus among the professional staff (54.39%, n = 267) was to recognise the need to improve their knowledge about the intersection between drug use and GBV; 40% (n = 100) of WWUD reported the same in relation

to staff. Only 24.49% (n = 120) of the professional staff surveyed (27.63% women and 11.7% men) reported working from a gender perspective. The qualitative information provided by the staff was consistent with this data:

The gender perspective is not mainstream in drug services ... (Woman/Social Educator/Drugs-GBV Integrated Service).

They are two concepts [drugs and GBV] that are often conceived as unrelated [by the staff] when they are very closely linked, and all the women I have worked with who use drugs have survived violence (Women-Social Educator- Inpatient drug treatment centre-reinsertion apartments).

The implementation of the gender perspective falls on one or two professionals, it is always one person in a team who takes the lead and wears the purple glasses, but the approach is not cross-cutting in most services... (Woman-Social worker/Director in a shelter against domestic violence).

Only one or two people are the "gender specialists" in the service, so, in addition to the overload that this entails for them, it is not possible to mainstream the gender perspective... (Woman/Director/Therapeutic Community).

In the same vein, only 30.5% of staff and 20% of WWUD indicated that „the design of facilities considers the specific needs of women and their children"; and only 42.12% of staff and 34% of WWUD indicated the „existence of women-only spaces".

4 DISCUSSION

The results highlight the *high prevalence of diverse types of GBV among WWUD in different contexts* (see Table 1a). This is consistent with findings from previous research on GBV among WWUD that points to a significant overall prevalence (14.90%–88.55%) (Malinowska-Sempruch et al., 2015; Gilbert et al., 2016, 2017; Caldentey et al., 2017; Tirado -Muñoz et al., 2017; Collazo-Vargas et al., 2018; Boyd et al., 2018; Balasch et al., 2018; Stoicescu et al., 2020; El-Bassel et al., 2020; Valencia et al., 2020; Palamar & Griffin, 2020; Morton et al., 2022). An EU survey of nearly 5,000 participants on sexualised violence in nightlife and drug and alcohol use environments found that 32% of women had experienced some form of sexual violence in their lifetime in these settings (Plaza-Hernández et al., 2022). According to Walsh et al. (2015), a study in the United States with 20.089 women in the National Epidemiologic Survey of Alcohol and Related Conditions examined how lifetime exposure to gender-based violence (GBV) is related to a broad range of substance use disorders. Women reporting lifetime GBV (25%; n = 5284) had 2.5 times the odds of meeting lifetime substance use disorder criteria.

WWUD reported the highest prevalence of GBV in the context of sex-affective relationships[8] (see Table 1a); In the same table, other contexts where GBV occurs with top frequency are the family of origin and the use of alcohol/drugs contexts (as in the private or public spaces where people who use drugs consume together). The next most common contexts for violence are the drug traffic scenes and the party environments, as also pointed out by previous research (Plaza et al., 2022). Table 1b showed a prevalence comparison of diverse types and contexts of GBV experienced by WWUD in relation to the data from our study, from which the following main ideas arise:

GBV towards WWUD appears significantly higher than that found in women among the general population (European Union Agency for Fundamental Rights, 2015), in line with what was previously noted by the UNODC (2018). Therefore, it is confirmed that WWUD experience more GBV, given that they are impacted by drug use and other overlapping risk factors. In this line, migrant background and low-income level constitute relevant axes of discrimination for WWUD compared to women in the general population affected by the same factors (European Union Agency for Fundamental Rights, 2015) (see Table 2).

While previous research has focused on intimate partner violence (Gilbert et al., 2016, 2017; Caldentey et al., 2017; Stoicescu et al., 2020; Valencia et al., 2020), other contexts, such as drug use contexts, the family of origin or institutional settings are not generally considered. The highest prevalence of intimate partner violence (71.20%–88.55%) was found among WWUD linked to harm reduction services (Malinowska-Sempruch et al., 2015; Gilbert et al., 2017; Stoicescu et al., 2020; Valencia et al., 2020) possibly because they are women who are in an even more vulnerable situation. Our results on intimate partner violence are consistent with previous research.

Several authors have noted the high prevalence of sexual violence experienced by WWUD in adulthood (Malinowska-Sempruch et al., 2015; Gilbert et al., 2016, 2017; Caldentey et al., 2017; Collazo-Vargas et al., 2018; Tirado-Muñoz et al., 2018; Boyd et al., 2018; Stoicescu et al., 2020; Valencia et al., 2020). However, childhood sexual violence is not generally considered with exceptions (Najavitis et al., 1997), which may indicate a lack of a trauma-informed approach. The childhood sexual violence obtained within our survey (24.62%) is estimated as under-reported given that, according to previous research (Herman, 2015; Van Der Kolk, 2014; Bass & Davis, 1992), memories related to childhood sexual violence may be blocked; furthermore, the context of data collection, through the interview format, might have biased the outcome of this sensitive question. Focus groups with WWUD and professional staff have pointed to the need for further exploration of childhood sexual violence and its relationship to later drug and/or alcohol use as a coping mechanism (Plaza-Hernández et al., 2022).

The results for GBV in party environments are consistent with previous research (Plaza et al., 2022), except in the case of Palamar and Griffin (2020) and Balasch et al. (2018), where the definitions of GBV or Sexualised Violence were narrower and of higher intensity, so it was expected to obtain lower prevalence.

8 | By GBV in the context of sex-affective relationships we refer to interpersonal violence (IPV) or domestic violence (DV), terms commonly used in the scientific literature.

In any case, this highlights the structural nature of GBV, which mainly affects women (and gender-diverse people) even in the absence of problematic drug or alcohol use.

This research found a high prevalence of institutional violence, mainly psychological, perpetrated at different care services, including drug services. El-Bassel (2020) and Gilbert et al. (2017) reported institutional violence only in reference to the police (without specifying the types of GBV and how it was perpetrated) and without considering other settings such as health centres, social services or drug services. As shown in the results, focus groups (Plaza-Hernández et al., 2022) with WWUD have made institutional violence against WWUD visible, according to previous qualitative research (Benoît & Jauffret-Roustide, 2015). Our research found a high prevalence of police violence, mainly psychological and physical, in line with what has been reported in other studies (El-Bassel, 2020; Gilbert et al., 2017), which reported an even higher prevalence. This could be related to other axes of discrimination, such as the number of ethnic minorities in the sample, as well as to the conflict arising from the illegal character of the trade and even of the use of substances in different contexts, the role of the police in law enforcement and the ways to exercise it.

This research, therefore, makes visible and quantifiable the GBV experienced by a broader range of WWUD than previous research.

In addition, the results on *intersectionality* suggest that migrant, ethnic minorities, and low-income women experience more gender-based violence, especially sexual violence in adulthood and economic violence. Therefore, this research also allows us to examine how specific axes of discrimination intersect among WWUD in line with previous research (Collins, 2019).

The *perpetrator's profile* was mainly a man, as previous research has also shown (Collazo-Vargas et al., 2018). Analysing the relationship between the most common profiles of aggressors and the typology and frequency of the violence suffered is difficult because most WWUD reported multiple types of aggressors and types of aggressions. An attempt has been made to identify those reporting a single category of perpetrators, and consequently, 72 women report only male perpetrators who were using psychoactive substances, 12 from men not using these substances, and a small number (two and two) of female perpetrators, either women who use or do not use drugs. From our data, it stands out that most of the aggression is related to the gender of the perpetrator, and therefore the probability of being attacked by a man (whether or not he used drugs) was 7 times higher than being attacked by a woman, a ratio which increases if we take only into account the frequency of aggressions (see Table 3). In contrast, the probability of being attacked by a man who used drugs/alcohol was 10 times higher than by a man who was not using drugs[9]. Thus, gender seems to be the most relevant factor in this synergy, whereas drug use plays a relevant facilitating role. However, beyond the profile of the cisgender male, some authors have pointed out that there is no "general" profile of the perpetrator (Bagshaw & Chung, 2000); research on the perpetrators' profile does not allow generalisations about mental health (Ferrer et al., 2004; Echeburúa & Corral, 2004) or drug use (Ponce et al., 2013), although statistically significant correlations have been found (Capaldi et al., 2012; Cafferky et al., 2018). Rather, the offender profile has been found to be associated with specific characteristics, behaviours, and environmental and relational factors (Finkelhor et al., 1984; Holtzworth-Munroe et al., 1994 and 2004; Zatkin et al., 2022).

The existence of significant differences between men and women perpetrators, whether they were using drugs or not (see Table 3), points to the structural nature of GBV as a power issue mainly crossed by the category of gender identity, as also suggested by the Council of Europe Convention (2011)[10]. In this sense, the majority of both sexual (men 97%; women 2%) and physical violence (men 67%; women 26%) against women in the general population is also gender-based (European Union Agency for Fundamental Rights, 2015).

In our research, the use of drugs by either the perpetrator (66.76%) or the victim (57.15%) seems to facilitate further violence towards WWUD (see point 2.2 of the results). Drugs and GBV are related differently in women and men (Arpa, 2017; Martínez-Redondo & Arostegui Santamaría, 2021; Morton et al., 2022). For women, drugs, often legal drugs such as alcohol or prescribed or non-prescribed benzodiazepines, are a way of coping with GBV experienced throughout life; also, contexts of drug use expose women to more economic deprivation, social exclusion and homelessness and GBV. For men, drug use is part of the male "norm" and male gender mandates associated with the culture of intoxication, disinhibition, power, risk-taking, poor emotional management and violence as a conflict resolution strategy in the context of our patriarchal societies. Previous research (Collazo-Vargas et al., 2018) has shown similar results regarding the use of drugs by perpetrators (50%; n = 26) and survivors (55%; n = 29). Other studies (Caldentey et al., 2017; Stoicescu et al., 2020; Moore et al., 2020, 2021, 2022) have revealed how contexts of drug and alcohol use with the intimate partner are intersected by gendered power relations beyond the use and effects of specific drugs by either the perpetrator (alcohol or cocaine) or the victim (cannabis); the focus groups in the context of this research have also shown how drugs and alcohol are intersected by gender.

Despite the high prevalence of GBV reported by WWUD, quantitative and qualitative results show that *most professional staff do not focus sufficiently on the GBV experienced by WWUD.* Thus, a low percentage of women and staff (see point 3.4 of the results) reported that „systems and protocols for early detection of gender-based violence" defined the current service in which they worked. This is consistent with previous research (Najavits et al., 1997, 2015, 2020, 2021; Tomkins et al., 2016; Stoicescu et al., 2020; Irfan et al., 2021; Arostegui Santamaría

9 | We focus on drug use to address the debate about what influences violence more: gender as a social structure that oppresses women and non-diverse people or drugs/the effects of certain drugs on people's behaviour.

10 | https://rm.coe.int/168008482e

& Martinez-Redondo, 2018; Martinez-Redondo & Arostegui Santamaría, 2021) that points to gender-blind interventions in drug services and the need to consider trauma and violence from a gendered perspective in addiction recovery. The fact that drugs-GBV integrated services aimed at WWUD surviving GBV incorporate „Early detection systems and protocols for GBV" more than other types of services ($p < .001$) shows that this specific type of service may be considering better gender and trauma-informed approach. Anyway, these results should be confirmed with a larger sample of WWUD in drug use-GBV integrated services.

Results are also consistent with the most often stressed improvement wished by the staff respondents, the knowledge about the intersection between drug use and GBV; also, with the fact that less than 25% of the professional staff surveyed (especially staff men) reported working from a gender perspective[11] (see point 3.4 of the results), which is directly related to the design of facilities poorly adapted to the needs of WWUD or the lack of women-only spaces. As stated in research by Tomkins et al. (2016), the complex needs of WWUD and the programme's intensity made trauma-informed services demanding for staff and clients. Staff working in the residential service needed sufficient training on the intersection of drug use and GBV (and among diverse GBV in their lifetime), support and supervision to work with clients and keep them safe. Clients required safety and stability to establish trusting relationships with staff and to engage with treatment. As a result, this lack of gender-based and trauma-informed approach creates barriers to access and adherence to treatment (Zerminai et al., 2013), increasing the risk of overdose (Goldenberg et al., 2020; El-Bassel et al., 2020; Shirley-Beavan et al., 2020) associated to risk factors specifically related to women (Lynn et al., 2020) and re-victimising WWUD (Martínez Redondo & Arostegui Santamaria, 2021). However, previous research (Morton et al., 2022) has suggested the advantages of the trauma-oriented model for WWUD surviving GBV. For instance, Adverse Childhood Experiences (ACE) routine enquiry was a useful tool to engage women in conversations about trauma and intergenerational patterns and a basis for developing trauma-informed interventions. Our findings suggest the need for the establishment of protocols for systematic screening for GBV among WWUD, as also noted in previous research (Stoicescu et al., 2020); the training and supervision of professionals on drug use and gender-based violence from a gender perspective, as also stated by Tomkins et al. (2016); and the mainstreaming of gender and intersectional perspective in drug services (Collins et al., 2019; Simonelli et al., 2014; Goldenberg et al., 2020; El-Bassel et al., 2020; Shirley-Beavan et al., 2020; Martínez Redondo & Arostegui Santamaria, 2021) to promote structural interventions in public health services that address the severe burden of violence and criminalisation faced by WWUD (El-Bassel et al., 2020; Shirley-Beavan et al., 2020).

5 CONCLUSION

WWUD face a high prevalence of diverse types of GBV in various settings, including institutional violence (Which is mainly psychological.). In addition, and fully expected in our patriarchal societies[12], men have been identified as the main perpetrators of such violence. Thus pointing to the structural nature of violence as a gendered power issue; and drugs play a facilitating role in GBV, mostly when used by men. Despite the high prevalence of GBV among WWUD, WWUD and staff surveyed noted the lack of systematic screening for GBV in drug services, even if drugs-GBV integrated services seem to be doing better than other types of services. Furthermore, more than half of the staff outlined the need for improving their knowledge on the intersection between drug use and GBV. Similarly, only a quarter of staff acknowledged working from a gender perspective. According to previous research, this is a barrier to access and success in treatment, increasing the risk of overdose and re-victimising WWUD. In summary, given the high levels of GBV experienced by WWUD, including institutional violence perpetrated by care services, including drug services, this research points out the need for training professionals on drug use and GBV, establishing protocols for the systematic screening of WWUD for GBV, and mainstreaming a gender and intersectional perspective in drug services to promote structural interventions in public health services that address the severe burden of violence and criminalisation faced by WWUD.

This exploratory study has some limitations that must be considered when interpreting results. At the methodological level, the survey aimed at WWUD asked for very sensitive information in an interview/self-report format, which, at times, might not be ideal. Our results shed light on the situation and needs of drug centres and drugs-GBV integrated services, but the sample from gender violence services was insufficient for any purpose. The very different sample sizes in each country does not allow to reach representativeness for all the participating countries, nor does it allow for a comparison between countries. A more intersectional view is needed, as the sample of WWUD was not diverse enough in terms of gender identity, sexual orientation, country of birth, and type of service; this makes it difficult to generalise findings and apply them to populations that show other axes of discrimination. Causality cannot be inferred because this is a cross-sectional and correlational study.

11 | Perspective considering gender-based differences when looking at any social phenomenon, policy or process (EIGE 2021). Considering gender for different groups can be a tool that, used wisely, helps us broaden our horizons and develop better policies and measures (Morton et al., 2022).

12 | A patriarchal society consists of a male-dominated power structure throughout organized society and in individual relationships (Napikoski, 2021).

There is a need for future research on trauma-sensitive surveys and protocols from gender and intersectional perspective. Also, a need for research on WWUD facing GBV with a more intersectional design and analysis that considers sexual identity and orientation, class/poverty, migration/ refuge, and ethnicity. Drug-use-related problems and contexts must also be considered more in-depth, with a clearer differentiation of drugs involved. Data needs to be made visible, and research needs to be systematised to address all forms of institutional violence, which is also included in many international declarations and conventions[13] as a specific form of GBV.

13 | Convention on the Elimination of All Forms of Discrimination against Women (United Nations Treaty of 18 December 1979). Articles 2 and 3. Declaration on the Elimination of Violence Against Women (1993) of the General Assembly of the United Nations (which refers to physical, psychological and sexual violence perpetrated or tolerated by the State). Art 4: more than 17 State duties to protect against violence against women. Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (1996), (Organization of American States): violence perpetrated or tolerated by the State or its agents, wherever it occurs. Council of Europe Convention on preventing and combating violence against women and domestic violence (2011). Art 5. Obligations of the State and Art. 30 Compensation.

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