Gender Perspective in Drug Addiction Programs and Services

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The current article opens with a brief introduction that makes reference to the concept of gender perspective, specifically in the field of drugs and addictions. Besides that, it also explains how the phenomena of multi causal consumption and gender violence correlate, and the prevalent difficulties associated with the users who resort to the means of drug addiction. Finally, it details some questions to take into account when addressing the subject of gender perspective in the area of drugs and addictions of a transverse manner in residential treatment, and contents to take into account in the therapeutic process.

Keywords: gender, drugs, gender perspective, gender violence, residential treatment, reintegration, therapy.

What do we mean when we talk about gender perspective?

In general, just like in other areas of a person's life, it is a determinant for health. It is a complex category that makes reference to a system of social organisation, which establishes the female and the male based on male-female dichotomy, which connect in a system of power

Even so, the changeable gender has been taken into account in a small way in epidemiology investigations and clinics, in actions carried out in the area of health, which has led to simplified interpretations of the results and observations of the field, which on occasion has helped to perpetuate ideas and gender stereotypes. On the other hand, in the field of drug addiction, the phenomenon of under-representation of women consumers and their circumstances has been generated, taking an androcentric view that considers the man as a neutral subject, and therefore reducing the approach of the phenomenon.

The gender perspective is an analytical and comprehensive framework that permits an analysis of the actual situation, analyses cultural and social structures attributed historically to the make up of men and women, ruling what is identifiable as female and male. This perspective hopes to distinguish and make visible the cultural and social determinants that weigh on the inequalities and generate identity, and also to promote initiatives (political events, the rethinking of programs and actions) in order to eradicate and correct the factors that generate inequalities (Catalan Federation of Drug Addiction, 2018).

The gender perspective, in reference to the theoretical frameworks adopted for an investigation, training or political development or programmes, involves (Gamba, 2008):

- To recognise the relations of power that exist between the genders, in general in favour to the men as a social group and discriminatory to women.
- To identify that the aforementioned relations have been made socially and historically and they are constitutive of people and an interpretation of reality.

- These constitutive relations cross the entire social framework and collaborate with other social relations or other areas of violation, like class, ethnicity, sexual orientation, and religion (intersectionality).

This idea makes reference to the gender perspective as a critical interpretation which in itself must question reality, with the purpose of transforming people's situations and adapting the initiatives and projects to generate changes in the interest of equality. On the other hand, it underlines the importance of authenticating the differences (Crenshaw, 2002) in order to obtain the greatest inclusion of the entire population and taking the opportunity to generate efforts that improve and decrease inequalities (Martín, 2008).

To think in terms of gender consists of covering the specific necessities of women and men, identifying inequalities and gender bias, reducing discrimination, influencing change in determinants of psychosocial genders, boosting favourable changes in the gender social structure, and boosting the participation of the population, looking for autonomy and empowerment. In order to promote equality in health programs, it is fundamental to analyse the determinants and the inequalities of gender (Velasco, 2008; OMS, 2018; Ariño, 2011).

In the scope of additions, it is fundamental to introduce the gender perspective given that it permits understanding of specific relationships that men and women maintain with substances. Although nowadays there are talks based on biased perceptions, that support the idea that no differences exist with regards to the consumption by men and women, it is well known that each respond differently to social determinants and cultures, therefore whichever analysis, strategy, or action that they want to commence has to be thought of in terms of gender. To have a rigid view of the consumption and to perceive as a whole the homogeneous and static population, brings an androcentric perception to the situation that doesn't allow a meticulous and specific intervention based on the realities of diverse and heterogeneous men and women.

This distorted vision of reality is the most favoured method of validity that we still have in our society of the traditional model of male and female roles, which perceives the consumption of drugs by women as an odd behaviour and of a violation of the assigned role, exerting a large social penalty.

To tackle drug addiction from a gender perspective involves keeping in mind the differences and the specificity of gender with regards to the factors that determine the motivation to consume, the different patterns, effects and consequences to both the social and personal level of health. On the other hand, it involves eliminating the disadvantages and the inequalities at the time of agreeing to or remaining in the preventative or assisted programmes.

Gender and addictions

An important idea that is possible to highlight from the beginning of this interpretation is that the gender category is becoming devoid of purpose, given that "gender" is identified with "women" or "women's matters". In the area of drug addiction and mental health on occasions

a synonymous view can be established between gender and women. As Patricia Martínez points out: "we are experiencing the most absolute invisibility about female drug addiction and its essential form of visibility". The "gender" category makes reference to both sexes, and can and must be able to work with men and women from a gender perspective. However, it is necessary to work specifically with women and the interpretation of other types of explanatory theories of reality and the fact of being an active woman in consumption and addiction. To work from a gender perspective in addiction includes men and women drug addicts, but we ask ourselves to invest time and work to understand the reality of the women who have been invisible, given that the cultural rule and statistic of drug addiction is male, and therefore, they continue to be a neutral subject.

As has been previously mentioned, the idea continues to exist to deal with the risks and the problems that derive from the problematic use of drugs, consisting of the population as a homogeneous whole in which the masculine perspective as a neutral element takes precedence. Besides that, because of the initiatives in recent years of laying out the gender perspective as an analytic tool in the field of addictions, documents and declarations are frequently found with the error that women are*a "collective" with special needs.* This idea is erroneous, given that women are half of the population, so reflecting on how to have effective interventions and correcting the inequality that has generated the invisibility of half of the people is a matter of public health and social justice, not special attention to a vulnerable group.

Even today we tend to think that female drug use lacks unique elements, offering the same interpretations and intervention responses for men and for women. Despite this, there are shared but also distinctive factors that lead men and women to start using or abusing drugs or develop a dependency.

Biological differences, like social and cultural differences derived from gender socialization [1] demand the adaptation of strategies and activities meant to intervene in the problem, given that addictions in men and women have different characteristics, among them that the social and even judicial punishments are harder on women, such as added difficulty to access services and stay in them. According to the data, women make less favourable progress than men in treatment, largely because the design of these programs and services doesn't take into account women's specific needs, and at the same time, women are under greater pressure in their familial and social environments to leave the programs prematurely in order to resume the family responsibilities assigned to their role.

The absence of a gender perspective in treatment and services for drug dependence (and personnel) has two clear consequences:

- The invisibilization of women, which leads to not taking into account their specificities and particular needs.
- The gender determinants linked to masculinity that may be influencing problematic drug use are not being analysed.

Regarding data, we lack studies that explain the factors that influence men and women when it comes to starting and maintaining consumption, consuming one type of substance or another, whether or not to access resources and therapy adherence. For example, data are currently available such as prevalence rates of psychoactive substances based on sex. It is known that women only exceed men's' consumption in the case of hypnotic medicines, specifically tranquilizers, where female prevalence is almost twice as high as male. However, it is unknown what factors influence men and women to continue that pattern of consumption, or it is necessary to carry out studies with more in-depth reflections that take into account the data specifically on gender prevalence, questioning the psychosocial variables that contribute to the phenomenon.

With regard to social consequences, women consumers face more social penalties than men. This results in the presence of less family or social support, in addition to more precarious work or economical situations such as greater social isolation, which favours the invisibility of the problem, and the absence of help or delay in receiving care.

Thanks to the self-concept generated by gender socialization, women with problematic drug use perceive more frequently and intensely than men that they have failed on a personal, family, and social level, and that they have been incapable of playing the role that they "should" be playing. Guilt is a constant in them, and self-punishment for their "disruptive" behaviour is present in discussions with them from the beginning of treatment. This particularly shows that the content of the intervention must be carefully thought out, and that a confrontational style with them tends to be counterproductive in terms of personal recovery and adherence to treatment. The social environment responds differently to the processes of drug addiction in men and women. This explains why many women choose to hide the problem due to the great social penalty, and suffering exclusion or rejection in their surroundings, like the judicial consequences of losing custody of children in their care.

Addiction programs and services: The challenge of barriers

We have previously pointed out that despite the existence of combination and public resources, female users do not attain services to the same extent as male users, with the added difficulty that the few women who do manage to access and overcome the barriers to access spend less time in the programs and have less therapeutic success.

It is estimated that around 20% of treatment requests for drug addiction are made by women (PNSD, 2002) and therefore, substance rehabilitation treatments are mainly designed for a male population, without taking into account gender differentials (Institute for Addictions of the Community of Madrid 2005). Due to the complexity of quantifying female drug addicts, because it is a problem that they try to hide (Cantos, 2016), few statistics are available. In Spain, around 15% of women and 84% of men enter treatment for addiction (National Drug Observatory, 1998, 2010, 2013 in Márquez and Lorenzo, 2016). However, the proportion of women who visit hospital emergency departments for drug consumption is 26%, with the proportion of women

admitted for treatment corresponding to 19% (Cantos, 2016), with 7% not included in treatment.

At the time of the social emergence of drug dependence in Spain in the 1980s and 1990s, the neutral subject was associated with a young man with intravenous substance use. Epidemiological data indicate that women with drug addiction problems seek treatment to overcome them to a lesser extent than men and, in addition, show less favourable progress in treatment. This is because women face more barriers than men in starting treatment for addictions: they have less family and social support, starting treatment often means abandoning their responsibilities in caring for the home and minor children, and they fear that making their addictions public will mean losing custody.

At the national level, there is low demand among women for treatment for drug dependence compared to men; of those using resources, approximately 85% are men and 15% are women (National Drug Observatory, 1998, 2010, 2013). Over the years, women have not only had less access to resources compared to men, but also have lower treatment adherence and more difficulties with social and labour reintegration. It is worth highlighting the confluence of the problem of addiction and violence received, since female users who access a resource for drug dependency who have both problems need a comprehensive and planned approach to enhance their therapeutic success. It is essential to identify the presence of this phenomenon given that this circumstance will decisively influence the need to design the intervention, taking into account the characteristics of each case (Castaño, M., 2007). The vast majority of work on drug dependence treatment has highlighted that services adapted to the needs of women and other gender expressions were not being offered (Hser et al. 2003), which has led to the preparation of international monographic reports on the treatment of drug problems to suggest and guide differential interventions that are necessary to have more effective interventions. The difficulties women encounter in recovering from dependence lie in two types of factors (UN, 2005): a) Those that are related to the treatment program. b) Those that have to do with the social, personal, and cultural constraints of the users.

In line with the barriers indicated by the UN, the specific report on the treatment of substance abuse and assistance to drug-dependent women by the United Nations Office on Drugs and Crime (UNODC, 2004) indicates the presence of the following obstacles or barriers to women's access to treatment:

Barriers of the system: these are the factors that prevent the establishment of services adapted to the needs of different gender identities such as the low presence of women in political decision-making positions, the low awareness of different gender needs as a variable determinant in health, the poor knowledge of the characteristics of drug addiction in women and the lack of treatments sensitive to these characteristics, such as the lack of perspective of gender and the sexist attitudes of professionals who take part in the intervention.

Structural barriers: This is the case of having direct responsibility for childcare and lacking an alternative caregiver, absence of specific services for pregnant women, the variable of risking losing custody of their children due to drug use, rigid schedules and norms in the programmes and the deficient detection and referral of the problem from Primary Care associated with the over prescription of sedatives and hypnotics to the female population, the disconnect in networks that work on problems that coexist in an individual (Primary Mental Health Care, Violence, etc.).

Social / cultural and personal barriers: The stigmatization associated with the feeling of shame and guilt due to the transgression of gender roles, motivation / will, concern about the confidentiality of the treatment, low perception or acceptance of the problem, exposure to trauma such as violence and abuse, poor social networks and "invisible" use that is relegated to the domestic sphere, greater social deterioration, lack of support from family and friends, less economic independence. The fear of losing custody of children or distrust in the effectiveness of treatments and their ability to understand the unique problems of women.

Below are some fundamental contents that should be part of the individual and group intervention with users in the services and gender-based programs:

Some fundamental contents for the intervention with women in treatment in drug addiction resources **(Adapted from Cantos, R. (2017))**
Guilt due to breaching gender mandates
The family as a pressure agent for treatment abandonment
The use of the body and sexuality as a response of self-affirmation and recognition, the consequence of a socialization process. To not judge behaviours and attitudes but rather analyse them in terms of gender.
The search for emotional relationships and emotional ties in women due to the mandate to love and connect with other people. To abandon the model of emotional dependence and talk about gender socialization in women and the mandate of romantic love or completeness with the couple.
Special attention to resources where affective / sexual relationships are prohibited as they will be left out of the process and will not be addressed if they are kept hidden.
Promote support networks among women and work on the competitiveness that usually exists among them due to gender issues. Promote sisterly attitudes.
Work deeply on gender mandates and how they relate to consumption: The role of the caregiver, the couple and the family as the axis of fundamental self-realization, the need to like others and be

through this look or evaluation from third parties. Social skills. Knowing how to say no, ability to think of oneself, expressing demands and needs...
Self-esteem and self-care (analyse the subversive component that female self-care can have in a patriarchal society).

As for the contents to take into account in regards to working with men, it is important not to fall into the simplicity of only talking about risk factors associated with hegemonic masculinity, since this can reinforce victimist positions and lack of self-criticism. As Patricia Martínez points out*"… a gender perspective approach analyses the consequences of gender on male identity, of course, but works at the same time on how that puts men in a symbolic status of overvaluation. And from that ambivalence deeply transforming work horizons open up."*

Some fundamental contents for the intervention with men in treatment in drug addiction resources **(Adapted from Cantos, R. (2017) and SENDA (2016))**
Work on shame felt due to not fulfilling gender mandates
How the continuing need for demonstrations of masculinity influences risk taking in general and drug use in particular.
The importance of achievement for their self-esteem (winner's myth)
Stop reinforcing the roles of care and responsibility for their well-being in women around them and take the reins of their self-care and the consequences that consumption and other aspects of their lives have had.
Control over others and oneself as a reaffirmation mechanism.
Importance of drug use associated with the mandates of masculinity: risk, transgression, etc. Make visible the connection between consumption behaviours and the discourses of hegemonic masculinity as maintainers and reinforcers of said behaviours
Violence as an instrument for conflict regulation and reaffirmation of masculinity. Work on gender assertiveness so that it is not lived as a loss of privileges / status. Make violence known as a behaviour learned for the resolution and confrontation of conflicts from socialization within the framework of a hegemonic masculinity. Elaboration of traumatic experiences (victims or witnesses of violence) caused by exposure to violence.

Violence against others (justification for drugs) and relationship with the hegemonic model of masculinity.
Enhance the emotional side. Strengthen emotional management and dig deeper into the consequences of their absence in men's lives (emotional deprivation, emotional-sexual disconnection, relationship difficulties, emotional management difficulties
Social skills. Empathy, expression and reception of emotions and opinions, assertiveness.
The responsibility in the care of dependents: of parenthood and the role that they play in their family nucleus as parents and children among others. Individual or group interventions oriented towards the exploration of feelings arising from the effective exercise or the role attributed by parenthood.
Sexuality: the construction of sexual identity (conceptual difference: sex, gender, sexual identity, and sexual orientation). Self-care and sexual health of men.
Alternative masculinities: visibility of the process of identity construction.

Drugs and violence

Gender violence is any act of violence or aggression stemming from a situation of inequality generated by a relational system in which men dominate women, and that has or may have physical, sexual or psychological damage as a consequence, including threatening such acts and coercion or arbitrary deprivation of liberty, whether these acts occur publicly or in the family or personal life. (Law 11/2007, July 27, for the prevention and comprehensive treatment of sexual violence).

Although different theories exist to explain gender violence, each one bestowing heavier weight to a certain type of factors, there is a basic consensus of considering it as a phenomenon with several determining factors.

Women who request help getting treatment for a substance abuse problem are more likely to suffer abuse than women in general. (PNSD, 2001), (Kokkevi, A., 1995). Research and field observation show that abuse and drug dependence are multicausal syndromes (social, genetic, family, educational, emotional factors, etc.), which in turn have interactions with each other: Addiction makes women more vulnerable to being a victim of abuse, and in turn the abuse predisposes to substance addiction (Centre for Health and Gender Equity, 1998). In the United Kingdom drug dependence care network, 60% of women have been found to suffer detected violence (Easton et al, 2000). In the domestic violence network at the Spanish State level we still do not have clear data on the prevalence of women who abuse drugs, but from previous research it is known that a woman who suffers violence is 15 times more likely to abuse legal or illegal psychoactive substances (Shipway, 2004). Drug users who are victims of violence tend

to hide consumption due to fear of losing custody of their children, family rejection and other associated situations. Most studies indicate that 10% of abused women abuse some substance as a coping mechanism (Villavicencio, C. and Herranz, S., 2015). The coexistence of both problems usually results in greater medical problems, greater social and family isolation, economic dependence and, above all, greater family responsibilities that imply a serious barrier to access and permanence in certain treatments (Altell G., 2011). Regarding the heterogeneity of situations, it is observed that women can use substance abuse as a strategy to cope with violence experienced in the domestic environment. Another variant would be if the consumption is prior to the beginning of the violent relationship, which places her in a position of greater vulnerability to the aggressor, as the woman's addiction is often used to justify the aggression. There are also cases in which women are initiated into substance use/abuse by their aggressor/consumer partners.

It is necessary to point out the complexities involved in working with drug-dependent women and to not pigeonhole them in a single profile. Evaluating each case will determine the priorities and possibilities of action such as multidisciplinary and coordinated lines of intervention. As for the team, drug addiction care resources have multidisciplinary teams, which is a great advantage when it comes to providing a comprehensive recovery service, but for this it is necessary that the people who intervene with the users who present consumption problems and survive violence have gender training, which would help to better detect the problem and design more effective and fair interventions. Ruiz-Jarabo and Blanco (2004), point out that professionals who work with users in these situations should reflect on the following aspects to give better attention based on an experiential process: Reflect on what it means to be a man and be a woman; on our own prejudices; on differences, inequalities and what they imply. Also reflect on violence as an experience in our own lives. Keep in mind in the therapeutic process that the separation of an abusive partner and the personal recovery of the woman constitute a very long and difficult process. On the other hand, as in any therapeutic process, but especially in this context, pay maximum attention to listening skills, empathy and the attitude of respect and credibility towards the woman who comes for help, whether due to drug addiction problems, because of her abusive situation or due to the consequences that both situations entail for her. We would also add the need to know the protocols, resources and network with other devices to offer effective comprehensive care.

Regarding the contents to work with in individual intervention, it is necessary to take into account different aspects or practical issues in treatment with the users:

Some aspects to take into account in individual intervention with women in treatment in drug dependence and who suffer violence(**Castaño, M. 2017**):
Identify the different forms of abuse, so that the woman learns to recognize what she has normalized, and what therefore remains hidden, as abuse.

Help the woman understand that it is not her fault; she neither deserves nor is to blame for the abuse she is suffering.
Discover the purpose of her consumption and especially the way it correlates with the violence experienced.
Help her identify and develop her own goals and reflect on their compatibility with drug use and with the couple's relationship.
Explain, if appropriate, the cycle of violence, to anticipate and differentiate expected changes from the real (or definitive) ones.
Question the abuser's messages. Act as facilitators of an alternative point of view, being respectful and accompanying her reflection.
Argue from the personal and from the collective point of view; not everything should be reduced to the individual level.
Facilitate the expression and elaboration of her emotions, sometimes contradictory, in relation to herself and her partner. Normalize the reactions that are part of this process.
Take into account the fears expressed; value them, weigh them and look for elements that can provide certain levels of security.
Constantly work on relationships with family, children, motherhood and consumption, non-motherhood, sexuality.
Recognize the resources she has put in place over time to defend herself, avoid and face the abuse. This implies that she does not want or look for him and that she has taken an active attitude towards that situation.
Recognize and reinforce any changes she makes, as well as the effort involved.
Anticipate difficulties that may hamper the process of change.
Help her to recognize the achievements that imply more autonomy and independence (for example, decreasing or ceasing consumption, or foregoing it in specific situations), while respecting the expression of discomfort that accompanies the process of change and grieving for loss (feelings of loneliness, sadness...).
Seek external support: return to relationships, go to specialized professionals, participate in women's groups...

In the case of physical abuse, facilitate the perception of the danger with which she lives and develop strategies to increase her safety, whether she continues with her partner or if she decides to separate.
Work on feelings of guilt and shame: provide information on the causes, frequency and forms of violence suffered by women, as well as the consequences of such violence, with special emphasis on the feelings and emotions it can generate.
Unveil and question gender stereotypes and roles, especially as regards to discourse that justifies the aggressor and/or victimizes the woman.

GENDER PERSPECTIVE IN SERVICES

In order to introduce a gender perspective in drug dependence care services in the short and medium term, it is necessary **to adopt positive measures**[1] around the starting points of the social disadvantages of women and to carry out specific **actions for specific needs** with both men and women. These actions should arise from a process of reflection based on the knowledge and training of the professionals involved in a gender-sensitive perspective, and should be promoted and protected by a fair program design for all the people who receive attention.

Programs must have data segregated by sex (socioeconomic situation, training and work, time in the program, therapeutic successes, etc.) and generate evidence for the design of egalitarian public policies, as well as gender indicators that make it possible to evaluate the complexity of situations and not fall into the reductionism of interpreting reality only with quantitative data.

Gender perspective in residential treatment

In treatment programmes, women who are drug addicts are at a clear disadvantage compared to men when it comes to accessing them because of the additional risk they feel of failure in the exercise of their role and of social isolation and rejection.

The evidence provided by studies that collect the difficulties of access for drug-dependent women to treatments indicate as determinants (SÁNCHEZ, L. 2010): The added social penalization suffered by women, the fear of losing custody of minors for whom they are responsible and the transgression that is implied by the abandonment of the role of caregiver of their family/partner, the presence of a drug-dependent partner (does not usually occur the other way around with the same frequency), the long waiting lists for access to services due to the lower number of places for women or the impossibility of doing residential treatment while

[1] A strategy aimed at establishing equal opportunities by means of (temporary) measures that make it possible to contrast or correct those discriminations that are the result of practices or social systems; in other words, it is an instrument that develops the principle of equal opportunities and tends to correct inequalities.

with their children, the absence of specific services for women drug addicts who suffer violence (hosting services in the violence network cannot be accessed while using drugs).

It is often said that the number of male drug addicts is much higher than the number of women, but the problem is that many of the problematic consumptions by the female population remain invisible (alcohol in solitude, psychotropic drugs, etc.) which goes undetected or that they are attended to in the primary care network with the risk of over-prescription of psychotropic drugs.

It is also common to find that there are few specific resources for women, or that the number of places for women in mixed centres is limited and does not depend on possible demand. We must search for strategies that will facilitate entry into treatment for those who request it.

We have previously commented that one of the barriers that form part of the permanency in treatments are some gender biased perceptions of the therapeutic teams that intervene. Women consumers are perceived as more complex and of worse prognosis in comparison to men. It is necessary to reflect on why users often present greater associated psychopathology and a high degree of chronicity; we must relate this to the invisibilization of consumption, and the delay in seeking care due to their role as caregivers and lack of social support, clinical overdiagnosis in women especially of personality and mood disorders, which influences the chronicity of drug dependence and the deterioration of multiple areas of their lives. In other words, there are gender-related variables that make working with our users seem more complex at first, but this is due to a lack of knowledge of the reality of female drug dependence and trying to make the methods we use with male drug users as effective as with them, and when this is not so, instead of questioning the lack of suitability of the professional intervention, we attribute it to the complexity of the cases or their lack of motivation to continue the program. Another perception of residential resources is that women's groups are problematic, compete with each other, and have many conflicts that generate disruptive behaviours. It is necessary to reflect on this from the perspective of gender socialisation; the system is organized so that women perceive ourselves as competitors in common elements (a partner, beauty, etc.). Due to this, deactivating these mechanisms requires a guided and constant work of reflection and planning. A good time to strengthen behaviours and thoughts of sorority are women's groups, in order to make visible the mechanisms of rivalry and what this entails, the benefits of intragender support and mutual help between users.

On the other hand, in mixed resources there is also "the problem of sexuality", that is to say, as Patricia Martínez explains, *"Sexuality defined as a problem associated with the presence of women is a recurrent theme in workshops and studies. The mere link between sexuality and the presence of women is an unjust act, full of prejudice and undervaluation of them, even if we don't realise it. In a heterosexual relationship are the women the only participants? However, the weight of our observation continues to fall on women... and also our assessments and judgements in this regard. It is only a matter of drawing attention to the perspective that leads us to affirm, as in fact is done, that problems come because "there are girls""*. (Martínez, P. ASECEDI) The emotional relationships between heterosexual people will affect men and women

in a differentiated way, but it is not viable to leave female user out of the treatments in order to avoid the problem of "relations," but rather what can be done is to train ourselves in issues in sexuality or to incorporate people trained in the matter to the therapeutic teams to accompany in the therapeutic process in an integral way without making moral judgments. In this vein, it should be noted that there is a trend in the resources in terms of the contents of the workshops that are taught on STD prevention--these are based on heterosexual practices, marginalising LGTB+ groups also present in treatment whose needs for information and specific care are not being considered with the same prominence.

With regard to working with users who have suffered gender-based violence, the Drug Addiction Care Network does not pay attention that should be paid to the violence received as a factor that interacts decisively with the problem of drug addiction: it is not part of the protocols nor is there usually present personnel specialized in gender-based violence. On the other hand, in mixed residential resources, these users live with men who have abused and live in situations of violence, experiencing the repetition of certain patterns that hinder recovery and place the users in unpleasant situations. Teams must be prepared to deal with these situations and act rigorously, with established consequences in the case of specific situations and limited lines of intervention, with the aim of creating safe treatment environments for all.

The presence of groups of men and women where gender as associated with consumption is worked on are necessary and fundamental for the program to have this sensitivity, but merely forming groups based sex is not working on gender, but rather behind this dynamic there must be a person trained in the matter carrying it out, and there must be a plan for the contents of the groups, such as a follow-up and an evaluation of the impact of the activity carried out. Spaces for reflection and team supervision are also considered necessary parts of experiential training, in order to identify prejudices and work on them. A professional title does not "waterproof" us from the patriarchal system and with greater or lesser awareness we repeat guidelines learned in our daily work, so that deep reflection and experiential training contributes to identifying our own barriers and biases. In residential resources it is important to have an equal degree of participation between men and women in tasks of responsibility without falling into assigning them activities traditionally associated with masculinity (masonry, maintenance) or femininity (cleaning, sewing), making sure that this assignment of women to tasks of masculine dominance in the resource does not become a space of contempt and that the mechanisms of social penalization are not activated by their male companions for occupying a space that "does not belong to them".

Reintegration

The employment of drug-dependent persons is one of the fundamental steps towards achieving social integration and improving their psychological and physical health (Cantos, R. 2014). Employment favours not only a status and role in society, but also a positive self-perception, occupation of time and capacity for social participation.

In the case of women drug addicts, the search for employment entails a greater difficulty, since to the fact of being a consumer or a drug addict is added the structural gender gap that women already suffer for the mere fact of being a drug addict. Issues such as lower wages, more precarious and part-time contracts that directly affect women, must be added to the difficulty of drug dependence with the associated social stigma and the higher penalty for women consumers.

We have already commented that there is unequal access for men and women to residential resources, and that of the few women who reach these resources, the percentage that consolidates a high therapeutic level and goes on to a resource of socio-labour reinsertion is even more scarce. This numerical inferiority is compounded by the fact that, although social and labour insertion programmes normally respond to specific resources other than drug devices, they tend to be strongly linked to these devices to which women usually have less access. In the phase of socio-occupational integration, the job orientation will have to be adapted according to the specific needs of this specific population. In the document "Barriers to social inclusion of chronic drug-dependent population. Analysis from a gender perspective" the Athena Foundation proposes the following among many other interesting measures:

- Develop women's employment workshops in which women analyse and share their job expectations and desires.
- Seek out and learn about resources and services in the area or closer that can support the women's recovery process.
- Facilitation and use of standardized resources, motivating the woman to go to the services she needs.

CONCLUSIONS

The World Health Organization (2018) states that trying to incorporate the gender perspective in the field of public health consists of highlighting the different needs that women and men have in all phases of their lives. It seeks to transversally influence laws, institutions, and organizational systems towards generating equality between the genders, not only formally, but also materially. One way to incorporate the gender-sensitive perspective transversally ("gender mainstreaming"), that is, to make it a more global approach, could be to promote the *transformative approach*, seeking to truly modify policies (Fernández and Martínez, 2015).

It is essential that we promote the **incorporation of the gender-sensitive perspective at all levels**: research, training, prevention, care, awareness-raising, among others. If the gender-sensitive perspective is not incorporated, the conception of the population as a homogeneous whole with equal needs will be perpetuated, ignoring the fact that men and women require differentiated interventions that respond to their specificities.

To advance using these strategies it is necessary to train and sensitize people in the sector, thus ensuring our ability to serve all people and validate differences. It is necessary to

consider the gender perspective in each of the actions carried out, from interactions with users, the design of programs, to the training of professional teams (Tudela, 2016).

To move forward we need to know from where we start and where we can go, which is why initiatives such as the generation of a diagnostic instrument of the degree of implementation of a gender-sensitive perspective in entities of the third sector presented in 2018 are so necessary. The generation of an instrument in a project shared by CDF and the Subdirectorate General of Drug Dependencies (ASPC) with indicators that come from a focus group of experts in drugs and gender, allow each entity to know its starting point and mark the path to follow to improve the implementation of the gender-sensitive perspective at three levels: The direction of the entity, the direction of programs, and professional teams. The final report of this joint work will be published at the beginning of 2019 will shed light on the point at which the entities of the Catalan Federation of Drug Dependence are in terms of gender-sensitive perspective and will mark a roadmap with lines of action to continue growing in this direction.

With regard to the concurrence of different problems (gender violence, drug addiction, mental health, etc.) we must carry out joint and coordinated actions among the networks of attention, generating common and consensual strategists (protocols), ceasing to conceive of people in a sectorial and partial way, in order to be able to develop integral, effective, meaningful and global forms of work.

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