Welens

EDUCATIONAL PRACTICES THROUGH A GENDER LENS

SEXUAL EXPLOITATION & VIOLENCE TOOLKIT

MODULE 3

Addiction, Health and Care

Co-funded by the European Union

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While the terminology used in the English, Spanish, Estonian, Russian and French version of this toolkit refer to Prostitution as lacking of agency and harmful in any of its forms, this Toolkit in its Italian and Greek versions have been developed in the recognition of an ongoing debate about prostitution, sex work and sexual exploitation which better reflect the official position of CESIE ETS and that of Greece's legal framework and of the Center for security Studies' researchers.

Specifically, in the Italian and Greek toolkit, the term "sexual exploitation in prostitution" is used, which refers to a form of sexual violence that involves a person profiting from the use of another person's body in a sexual manner, whether financially or through other means and which is nonconsensual and harmful.

Both CESIE ETS and researchers from the Center for Security Studies recognise the importance of distinguishing what is mentioned above from sex work, which is understood as the consensual provision of sexual services between adults. This takes many forms, varies between and within countries and communities, and is undertaken for money, goods, or rewards, recognising the agency of individuals engaged.

As a result, "prostitution", even if valid in legal frameworks, will not be used as it is an umbrella term which does not take into consideration the above-mentioned nuances.

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GLOSSARY

0.GLOSSARY

Fight-Flight-Freeze Response

An automatic survival reaction triggered by danger. The body floods with stress hormones (e.g., adrenaline, cortisol), which speed up the heart rate, sharpen focus, and prepare muscles to fight, run, or remain still.

Cognitive Load

The amount of working memory used when we learn, think or solve problems. High load (when tasks are too complex) can reduce our ability to process information effectively.

Post-Traumatic Stress Disorder (PTSD)

A mental health condition that can develop after exposure to a traumatic event. Symptoms include flashbacks, nightmares, avoiding reminders of the trauma, hypervigilance, and mood changes.

Complex Trauma

Trauma from repeated or prolonged events, usually during childhood or in close relationships. It often leads to difficulties with self-regulation, identity, and relationships and may include symptoms beyond typical PTSD.

Dissociation

A mental process where someone disconnects from reality: feelings, memories, identity or awareness. It ranges from mild daydreaming to severe detachment in dissociative disorders linked to trauma.

Burnout

A work-related state of emotional and physical exhaustion caused by prolonged stress. It includes feelings of cynicism, reduced effectiveness, and fatigue. It is not classified as a medical disorder but as an occupational phenomenon.

Coping Mechanisms

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The methods people use, consciously or unconsciously, to handle stress or trauma. They can be positive (such as talking or exercising) or negative (like avoidance or substance use).

Trauma-Informed Care

An approach in services and organisations that starts with the question, "What happened to you?" rather than "What's wrong with you?" It recognises trauma's impact and aims to avoid re-traumatisation.

Adverse Childhood Experiences (ACEs)

Potentially traumatic events in childhood, such as abuse, neglect or household dysfunction. High ACEs are linked to poor mental and physical health throughout life.

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INTRODUCTION

1. INTRODUCTION

Following the previous modules, which focused on gender-based violence and sexual exploitation, this third module addresses a deeply interconnected area: health, care, and addiction. Traumatic experiences—often rooted in systemic violence and marginalisation—leave lasting impacts on both mind and body, shaping life paths and access to care services.

The module begins with a neurological perspective to better understand the brain mechanisms involved in stress, memory, and addiction, providing a scientific foundation for care and support work. It then explores the concept of trauma and its effects on the brain, emotions, and behaviour, with particular focus on the link between trauma, violence, and substance use.

Considerable attention is given to risk and protective factors, analysed across multiple levels—individual, family, community, and systemic—along with the influence of media, intersectional dynamics, and barriers to accessing care.

A core section is dedicated to practical tools and techniques to support victims of trauma, as well as to the well-being of the professionals involved. The emotional burden, risk of burnout, and the need for self-care among frontline workers are addressed with clarity and depth.

The module concludes with an overview of the relevant legal frameworks, offering guidance on international and regional standards, and outlining the legal pathways for supporting women who are victims of gender-based violence and also face mental health issues and/or addiction.

The overall goal is to provide integrated knowledge and practical tools

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that foster effective, compassionate, and informed care pathways—ones that respect the complexity of lives marked by suffering and exclusion.

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BRAIN FUNCTIONS: A NEUROLOGICAL PERSPECTIVE

2. BRAIN FUNCTIONS: A NEUROLOGICAL PERSPECTIVE

2.1. **The glove-hand model**

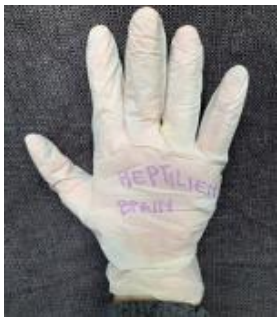
To support a better understanding of how the brain responds to trauma, stress, and addiction, we introduce here the "Hand Model of the Brain," developed by Dr. Daniel Siegel. This simple yet powerful visual tool helps explain the functions of the brain's main regions, including how they interact during moments of emotional regulation or dysregulation.

Using the hand as a metaphor, the model illustrates how the brain processes stressful or overwhelming experiences, and what happens when we "flip our lid" — that is, when the thinking and self-regulating parts of the brain temporarily disconnect in the face of threat or trauma.

2.2. **Brain map**

We invite you to put on a glove on your non-dominant hand and use it as a symbolic map of the brain.

In the centre of your palm, write: **"reptilian brain".**



This area is located at the base of your skull, right where your brain connects to your spinal cord. It is responsible for automatic survival

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functions, including: heart rate, breathing, and body temperature, your sense of balance and orientation in space, and regulation of basic biological needs, such as hunger, sexual drive, sleep, and wakefulness.

Fold your thumb across your palm, and write on it: **“limbic area”**.

You can think of the limbic area as a kind of **“**emotional headquarters”. It includes:

- The **amygdala**, which rapidly scans your environment for danger or safety, asks: *“Is this good or is this bad?”*
- The **hippocampus**, which helps you encode and retrieve **memories**, especially those linked to emotionally significant events.

This system helps you move toward what feels safe or rewarding and withdraw from what feels threatening or painful. When a situation is perceived as dangerous or overwhelming, your amygdala activates the body’s stress response—a chain reaction that can result in fight, flight, or freeze behaviours.

Importantly, the connection between the brainstem (reptilian brain) and the limbic system means that emotional experiences can quickly trigger instinctive survival responses—even before your thinking brain has time to process them.

To complete your glove-hand brain model, we now invite you to fold your four fingers over your thumb, forming a gentle fist. On the back of your fingers, write: **“cortex”**.

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It allows us to recognise our physical experience, generate our perceptions of the outer world through the five senses, and keep track of the location and movement of our physical body through touch and motion perception. From the neocortex, we will also plan our motor actions and control our voluntary muscles.

Now, to complete your brain-in-hand model, look at your fingertips—specifically the tips of your **middle and index fingers.** These represent your **prefrontal cortex**, often abbreviated as **PFC**. To mark this final area, you can write "PFC" on your fingernails.

The **prefrontal cortex** is one of the most recently evolved parts of the brain and is considered **uniquely human** in its level of development. It plays a crucial role in your ability to set goals, focus attention, manage impulses, and make thoughtful decisions. This region receives input from many other parts of the brain, processes that information, and helps you adapt your behaviour to changing situations.

Your PFC is responsible for a wide range of **executive functions**, including: maintaining focus and motivation, anticipating consequences and

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planning accordingly, practising impulse control, managing emotional reactions, adjusting behaviour based on changing conditions, and—perhaps most importantly—pausing before you act, allowing space for insight, empathy, and conscious choice.

Now, take a moment to notice something powerful: when your hand is in a fist, the middle fingertips (PFC) are resting directly on your thumb (limbic system) and touching your palm (brainstem), while also being a part of the larger cortex. This physical contact is more than symbolic—your Prefrontal Cortex is a deeply integrative structure. It brings together signals from:

- Your **reptilian brain** (automatic survival responses)
- Your **limbic system** (emotional evaluation and memory)
- And your **cortex** (sensory processing and voluntary actions)

2.3. Brain and stress

What happens when we are stressed?

That means we have perceived a sound, image, or body sensation as a threat to our identity (physical, professional, personal, or cultural) and our brain has activated the body's stress response in order to prepare us for fight, flight, or freeze. The prefrontal cortex shuts down and no longer works with the rest of our brain: lift your four fingers—extend them straight up.

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Keep your thumb folded across your palm. This physical movement represents a powerful neural shift: in that moment, you no longer have access to all of your high competencies.

We can call these physiological reactions **flipping our lid.** The reptilian brain and limbic area take over our analytical and empathetic thinking.

WARNING!
At that time, you are not in a physiological condition to make any kind of decision or to connect with another person. So avoid saying or doing something you'll regret. Instead, focus on calming the nervous system. Ground yourself. Use techniques such as slow breathing, sensory awareness, or connecting with a trusted person. The goal is to bring the **prefrontal cortex** back online, folding your fingers gently over your thumb again—to restore integration. Only then can you return to a place where you can think clearly, empathise deeply, and respond wisely.

2.4. **Brain and memories**

Memory is not a single entity. It is a dynamic set of systems that work together to enable us to retain information, make choices, feel, imagine and even know who we are.

Using the **hand model**, we will explore how these systems are distributed throughout the brain.

- In the **reptilian brain**, the palm of the hand: we find the **procedural memory** and bodily reflexes. This is where motor, procedural, and bodily memory reside. It is the memory of the body (how to ride a bike, how to catch a ball, how to keep your balance). These memories are not conscious. They are automated, deeply ingrained, and resistant to forgetting. This memory does not come through

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language; it comes through action.

- In the **emotional brain**, the thumb bends toward the palm: we find the **emotional memory.** This is the emotional core of memory, where the amygdala evaluates: *Is this dangerous? Is this pleasant?* The hippocampus records memories with a time stamp: where? When? With whom? These structures create powerful emotional memories: the smell of the sea on a summer day as a child, the fear felt during an accident, or the joy of a surprise birthday party.

- In the **cortex**, four fingers folded: we find the **declarative (explicit) memory**. This is the memory we can verbalise. It is divided into two main categories:

    - Episodic memory: It records **personally experienced events** (e.g., *"I remember my first day of school."*)

    - Semantic memory: This contains **general knowledge**: facts, concepts, and vocabulary. *(e.g., "Paris is the capital of France.")*

These two types of memory are constantly interacting. Your episodic memory can enrich your semantic memory—and vice versa.

In the **prefrontal cortex (PFC)**, the fingernails: we find the **working memory**, which is often compared to a temporary whiteboard. It allows us to keep information in our mind for a short period of time and manipulate it (e.g., do mental calculations). Without it, we wouldn't be able to follow a conversation, make a shopping list, or think out loud. This memory is **very fragile**: stress, fatigue, or distractions are enough to overload it.

2.5. Brain and compensation circuit

To better understand the mechanisms of motivation and addiction, it is essential to examine the brain's reward system, particularly the **dopamine** reward circuit. Dopamine is often referred to as the "pleasure molecule." It

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is linked to anticipation, motivation, reward seeking, and the desire to repeat an action that stimulated us. In other words, it is the inner voice of the brain that says: *"Oh yes, do that again, it's important!"*

At the centre of the brain, a small area called the ventral tegmental area (VTA) releases dopamine whenever a stimulus is perceived as pleasant or promising (eating chocolate, watching a video, receiving a notification, winning something, accomplishing a task). This system is a survival engine: it pushes us to repeat what we found good, useful, or reassuring. But there's a catch. When this circuit is overloaded with dopamine, due to frequent or intense stimulation (substances, screens, social media, hyperperformance, pornography, etc.), the brain adapts.

It goes into energy-saving mode: *"Too much dopamine. Let's reduce the sensitivity of the receptors to avoid saturation."* This is known as the compensation circuit. The outcome: pleasure becomes less intense, it requires more stimulation to achieve the same effect, simple things become dull, and the need or compulsive desire increases. This can lead to an addictive spiral.

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TRAUMA

3. TRAUMA

Psychological trauma occurs when an individual is exposed to an event—or a series of events—that overwhelms their capacity to cope and integrate the experience. Judith Herman (1992) defines trauma as "a breach in the fundamental relationships between the self and the world," which may result from physical, sexual, or emotional violence, but also from chronic and structural experiences of oppression. Trauma can be:

- Acute: related to a single event
- Chronic: prolonged and repeated over time
- Complex: often linked to interpersonal relationships and violent or abusive environments, such as familial or institutional settings

Trauma symptoms may vary, but frequently include:

- Intrusive symptoms: flashbacks, nightmares, intrusive thoughts
- Avoidance: refusal to talk about the event or avoidance of places and people associated with it
- Cognitive and mood alterations: guilt, shame, emotional numbness, anhedonia
- Hyperarousal: hypervigilance, irritability, sleep disturbances, exaggerated startle responses (American Psychiatric Association, 2013)

These manifestations are directly linked to the neurobiological functioning of the body in response to threat.

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3.1. The brain's response to stress and trauma: the window of tolerance

The Window of Tolerance, a concept developed by Daniel Siegel (1999), is a key framework to understand how people respond to trauma. It refers to the optimal range of arousal in which a person can experience, process, and regulate emotions without being overwhelmed. Within this window, a person can remain present, reflect, and maintain emotional regulation. When someone has experienced trauma—especially chronic or interpersonal trauma—this window narrows. The body begins to perceive even ordinary stimuli as threatening, triggering automatic, non-rational survival responses. These reactions can be:

- Hyperarousal (above the window): The person enters a constant state of alert (e.g., anxiety, panic, explosive anger), dominated by the sympathetic nervous system. It's like having a "black fog" in the mind where every stimulus is perceived as dangerous.

- Hypoarousal (below the window): The parasympathetic system takes over, leading to symptoms such as freezing, numbness, dissociation, feelings of emptiness, depression, or disconnection from the body.

Practical examples:

- A survivor of domestic violence may have a panic attack simply from the sound of a slamming door—this is hyperarousal.

- A survivor of sexual assault might emotionally "shut down" during a routine medical examination or non-sexual physical contact—this is hypoarousal.

These reactions are not "exaggerated" or "irrational"; they are biologically learned survival responses. Unfortunately, in social and institutional settings, they are often misunderstood and punished: individuals are labelled aggressive, unstable, or apathetic rather than being recognised as existing outside of their window of tolerance. To widen and stabilise this window, trauma-informed care is essential—care that centres safety, emotional regulation, and personal agency.

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3.2. Impact of trauma and vulnerabilities

Trauma does not affect everyone equally; its incidence and impact are amplified by social, cultural, economic, and political factors. Individuals already living in conditions of marginalisation (e.g., women, LGBTQIA+ people, migrants, people with disabilities, racialised communities, and people living in poverty) are more exposed to repeated trauma and often lack access to effective support systems.

In this sense, trauma is intersectional (Crenshaw, 1991): it is not only generated by individual events but also embedded in systems of power and discrimination. The Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) found a strong correlation between early traumatic experiences—such as abuse, neglect, domestic violence, and poverty—and a wide range of adult health issues, including depression, anxiety disorders, addictions, cardiovascular problems, obesity, and risk behaviours. The study also showed a dose-response effect: the more traumatic experiences a person has, the higher the risk of illness and psychological distress. Trauma, therefore, has a systemic and long-lasting impact, which can be passed on intergenerationally and requires integrated, culturally sensitive, and non-pathologising approaches to care.

3.3. Trauma, violence and addiction

The link between trauma and addiction is deep, circular, and often overlooked. Survivors of complex trauma—particularly repeated and relational violence—may develop survival strategies involving substance use or compulsive behaviours (e.g., alcohol, drugs, self-harm, food, gambling, and sex). These strategies should not be viewed as “bad choices” but rather as attempts to self-manage physical and psychological pain (Najavits, 2002).

Examples:

- A woman who experienced childhood sexual abuse may develop alcohol dependence to silence flashbacks or numb unbearable emotions.

- An LGBTQIA+ person who has suffered family rejection, discrimination, and violence may use substances as the only way to feel “safe” or “connected” in certain social environments.

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These experiences are often compounded by stigma and social isolation, particularly when the individual belongs to already marginalised communities (e.g., migrants, racialised people, unhoused individuals). Unfortunately, health and social services often treat addiction as an individual issue, without addressing its traumatic and structural roots.

Moreover, many survivors of violence avoid accessing support services due to fear of being judged, punished, or losing custody of their children, especially in contexts where addiction is criminalised. This is particularly true for women: services are often not equipped to work in a gender-sensitive and violence-informed way.

The trauma-informed approach, particularly in the Seeking Safety model developed by Lisa Najavits, proposes addressing trauma and addiction simultaneously by building safety, emotional stability, and therapeutic alliances rooted in respect and self-determination. It is not just about “treatment” but about rebuilding trust, empowerment, and connection in full recognition of lived experiences.

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RISK FACTORS

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Over the last few decades, gender based violence has been increasingly recognised as a significant social and public health concern (Mercera et al., 2024; Franchino-Olsen, 2019). This phenomenon is associated with a range of serious mental and physical health consequences. In tackling the phenomenon, taking into account both risk and protective factors in its exposure is of utmost importance. The former are the elements that might enhance the exposure to negative experiences, while the latter are the conditions or experiences that reduce the likelihood of harmful and dangerous outcomes. In this section, they will be presented.

These factors can increase an individual's likelihood of becoming exposed to sexual exploitation in prostitution. They are characteristics at the biological, psychological, familial, community, or cultural levels that are associated with an increased risk of negative outcomes (SAMHSA, n.d.).

4.1. Individual Level

At the individual level, personal and psychological experiences, especially in early life, play a key role. Adverse Childhood Experiences (ACEs) can profoundly shape emotional development and long-term well-being (Mercera et al., 2024). Risk factors at the individual level include:

- Physical and emotional neglect (Franchino-Olsen, 2019; Mercera et al., 2024; Project Starfish, n.d.): Experiences of neglect can lead to a diminished sense of self-worth and an unmet need for affection, potentially contributing to a desire to leave the home and seek connection or shelter in unsafe contexts, such as criminal networks or gang involvement (Mercera et al., 2024; Project Starfish, n.d.).

- Prior experience of sexual abuse or early sexual initiation: Trauma resulting from abuse can impair the ability to develop healthy

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relationships with sexuality and consent (Mercera et al., 2024). Early sexual initiation may also increase vulnerability to further exploitation (Franchino-Olsen, 2019).

- Substance use (Benavente et al., 2021; Mercera et al., 2024; Project Starfish, n.d.): The cycle of addiction, financial need, and withdrawal may lead individuals to engage in survival strategies, including sexual exploitation (Mercera et al., 2024).

4.2. **Familial Level**

Family dynamics are a powerful influence on development. Dysfunctional or violent environments can increase the risk of involvement in sexual exploitation (Mercera et al., 2024). Key familial risk factors include:

- Household dysfunction and compromised parenting (Franchino-Olsen, 2019; Mercera et al., 2024): This may include exposure to domestic violence, normalisation of transactional or exploitative sexual behaviour within the household, or a family history of exploitation (Benavente et al., 2021).
- Family estrangement (Benavente et al., 2021): A lack of stable family support may drive individuals across all ages to seek safety or belonging elsewhere, sometimes in unsafe or exploitative environments.

4.3. **Societal/Community Level**

Social and community environments significantly influence the trajectories of individuals experiencing trauma, addiction, and exploitation. Community-level conditions often serve as a bridge between structural inequalities and individual vulnerabilities, either mitigating or amplifying harm. When social cohesion breaks down, support networks weaken.

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Services become inaccessible or unwelcoming, the risk of marginalisation, abuse, and exploitation increases—especially for women who use drugs, survivors of violence, undocumented or internally displaced migrants, and those in precarious housing or employment (EMCDDA, 2022; Mercera et al., 2024).

Community cohesion—defined as the degree of trust, mutual support, and shared values among members of a local area—is a critical protective factor. It includes access to both formal and informal support structures, such as neighbours, cultural or faith-based groups, and local associations. Where this cohesion is absent, individuals are more likely to experience isolation, lack of protection, and diminished access to services. Marginalised individuals, including migrants and people experiencing substance dependency, often remain disconnected from these protective systems, increasing their vulnerability to exploitation and repeated trauma (Franchino-Olsen, 2019; Buller et al., 2020).

Several community-level risk factors exacerbate this exclusion. These include residential instability, such as homelessness or displacement; barriers to education, particularly in rural or underserved areas; and economic hardship, including unemployment, debt, or material deprivation—all of which increase exposure to sexual and gender-based violence (Mercera et al., 2024; Franchino-Olsen, 2019). The normalisation of violence within certain media narratives and cultural environments also contributes to desensitisation and misunderstanding, reinforcing harmful stereotypes around addiction and mental health, while eroding empathy at the community level (Brown, 2019).

Additionally, stigma remains a powerful force of exclusion. People struggling with addiction or mental health challenges are frequently perceived through moralising or individualistic lenses, rather than being recognised as individuals coping with trauma and structural adversity. Women who use drugs and have experienced violence are particularly stigmatised, often facing disbelief or dismissal when reporting abuse (Jiménez et al., 2014).

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Gendered stigma is not rooted in substance use per se, but in broader societal expectations and discrimination toward women who deviate from traditional roles.

Cultural narratives that emphasise individual responsibility—such as the idea that healing from addiction or trauma depends solely on personal strength—tend to obscure systemic causes like poverty, gender-based violence, and exclusion. As feminist thinkers like bell hooks have noted, such framings depoliticise suffering and displace collective accountability, encouraging communities to focus on resilience rather than justice.

Yet, communities also have the potential to serve as spaces of resistance and healing. Grassroots responses, mutual aid initiatives, and trauma-informed outreach efforts often provide essential care and solidarity where formal systems fall short. Adopting an intersectional and trauma-informed lens allows practitioners to recognise not only the risks, but also the resources and forms of resilience that emerge within communities—even in the face of adversity.

4.4. **Systemic violence**

Systemic violence refers to the set of practices, norms, and institutional arrangements that reproduce structural inequalities and effectively deny fundamental rights to entire social groups. For women experiencing addiction and mental health issues, systemic violence often manifests as stigmatisation, social exclusion, and barriers to accessing services. These women are frequently subjected to moral judgment, secondary victimisation, or a lack of credibility—both within healthcare systems and the judicial system (Bartlett et al., 2022).

Systemic violence goes beyond individual acts; it is rooted in the very systems that are supposed to protect the most vulnerable. For instance, many addiction and mental health treatment facilities are not designed to take into account gender-specific needs or trauma histories. This can

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amount to a form of institutional violence that discourages women from seeking help and exposes them to further control or medicalisation (Covington, 2008). Moreover, conditional welfare policies—those that make access to housing or income contingent on participation in certain programs or demonstrations of "appropriate behaviour"—can have a punitive effect on women facing complex life situations, contributing to the chronicity of marginalisation (Pittaway et al., 2009).

Several studies have highlighted the correlation between exposure to systemic violence and the increased risk of developing substance use disorders or mental health conditions, as well as the difficulty in accessing pathways out of interpersonal violence (Mills et al., 2020). This is because institutional responses—often fragmented and poorly coordinated between justice, health, social, and gender-based violence services—tend to ignore the interconnections between trauma, addiction, and mental health, thus perpetuating exclusion or retraumatization.

Recognising systemic violence as a risk factor requires a shift in perspective from individual pathology to institutional and collective responsibility. This means seeing substance use not as a personal failure, but as a survival strategy developed in response to environments that have failed to offer protection, safety, and self-determination.

4.5. **Media influence and normalisation of trauma**

The role of media is crucial in shaping how society perceives issues like sexual exploitation and gender-based violence. One of the most worrying trends is how violence and harmful stereotypes are often romanticised or normalised through films, TV shows, and online platforms. Repeated exposure to portrayals of women as submissive or degraded can lead to desensitisation, diminishing the urgency with which society responds to these crimes (Coy & Bragg, 2020). Moreover, sensationalist media coverage can sometimes reinforce blame on victims, perpetuating damaging

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narratives that make survivors hesitant to seek help or justice (Loney-Howes, 2021). To that end, the widespread use of hypersexualised images and the glamorisation of abusive relationships in media content contribute to the dangerous idea that violence is an acceptable or normal part of relationships, which can increase the risk of exploitation (García-Moreno et al., 2015).

However, the media also has the potential to be a powerful tool for positive change when it is used thoughtfully. Campaigns, documentaries, and survivor-led stories have demonstrated that strategic media approaches can gradually shift societal attitudes and foster advocacy. When platforms focus on honest and compassionate representations of those affected by gender-based violence, they help break down silence and stigma, encouraging victims to come forward and seek support (Kitzinger, 2004). The rise of social media movements, such as #MeToo, has created a global platform for survivors to share their experiences, building solidarity and pressuring governments and institutions to implement meaningful reforms (Fileborn & Loney-Howes, 2019).

To counteract the normalisation of trauma in media, incorporating media literacy education into schools can equip students with the critical skills needed to recognise and challenge harmful portrayals (Brown, 2018). Regulations that hold media outlets accountable for spreading stereotypes and sensationalism can also help curb the cycle of misinformation and harm. Promoting survivor-centred storytelling and trauma-informed journalism practices can ensure that stories are respectful and validating, rather than exploiting them for sensational impact (Stanko, 2017). Ultimately, by reshaping the media landscape into an educational and advocacy tool, societies can break down cycles of exploitation and support survivors' paths to healing.

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4.6. Intersectionality and Compounded Risk

Intersectionality reveals how overlapping identities—such as race, gender, class, and disability—can intensify vulnerability to trauma and structural disadvantage. When these identities intersect, they often amplify risk and reduce access to support. Recognising these dynamics is crucial for addressing compounded harm and systemic inequality.

4.6.1. The role of intersecting identities (e.g., gender, race, class, disability)

Intersecting identities (such as gender, race, class, disability, sexual orientation, and immigration status) significantly influence a person's vulnerability to trauma, addiction, and exploitation. These overlapping social identities shape individuals' life experiences, access to resources, and exposure to systemic inequalities. Vulnerable individuals often experience higher rates of trauma due to systemic oppression and discrimination, and the more a person “accumulates” marginalised identities, the higher the risk is. For example, a low-income Black woman with a disability may face compounded risk from both community violence and medical neglect. Intersecting identities amplify risk factors because they interact with structural power imbalances. The intersectional approach, first introduced by legal scholar Kimberlé Crenshaw, helps to understand where and how power and exploitation collide, intersect, and interlock.

4.6.2. How overlapping factors can increase exposure to trauma or reduce access to care

Marginalised individuals often experience higher rates of trauma due to systemic oppression and discrimination. For example, people of colour in many societies may face racial profiling and police violence, in addition to experiencing generational trauma due to colonialism or the history of

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slavery. Systemic discrimination and violence against racialised individuals, LGBTQ+ people and people with disabilities increase exposure to trauma. They often face workplace discrimination, hate crimes, assault, family neglect or abuse; all traumatising experiences. Other groups of people facing more exposure to trauma include low-income individuals, women and non-binary people, especially immigrant women. These persons face structural barriers to accessing care, such as a lack of transportation or childcare. Migrant women also may not have access to the healthcare system due to not being documented, and they also face language and cultural barriers in accessing care. Mental health and trauma recovery services are often underfunded, waitlisted, or only available privately, excluding people without financial resources. Rural communities and marginalised urban neighbourhoods often lack nearby clinics or specialised care.

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PROTECTIVE FACTORS

5. Protective Factors

When trauma occurs—whether it is a single event or a series of chronic experiences—the nervous system is put under severe stress. It reacts, defends itself, and sometimes freezes. But not everyone experiences the aftermath of trauma in the same way. Why do some people develop post-traumatic stress disorder (PTSD), while others seem to emerge with renewed strength, growth, and clarity? The answer often lies in an invisible but powerful safety net: protective factors.

These are our internal resources and external connections that enable the brain and body to remain intact despite injury, or to rebuild afterwards.

Personal protective factors (internal resources)

These resources are right at our fingertips: they are personal, often silent, but fundamental. They can be innate or acquired, conscious or implicit.

- Emotional regulation: the ability to recognise, contain, and express emotions without being overwhelmed. *"I can feel it rising, but I know how to breathe through it."*

- Preserved executive functioning: thanks to a robust prefrontal cortex (the fingers), we can maintain inhibition, cognitive flexibility, and working memory. *"I take a step back; I don't react right away."*

- Self-esteem and sense of competence; the inner conviction: I am worth something, I can cope. *"I have survived other storms; I will find a way forward."*

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- Sense of meaning/spirituality/worldview: a framework of meaning, a belief, a practice, a philosophy… *"Even if I don't control everything, there is a thread I can follow."*

Relational protective factors (interpersonal resources)

These factors come from others, but are just as vital. They activate the attachment system, regulate the nervous system, and allow us to come back to ourselves after chaos.

- Presence of a secure adult / secure attachment: a non-judgmental gaze. A calm voice. A reassuring body. *"When I'm with you, my nervous system feels safe."*

- Supportive social network: people who listen to us, validate us, and offer us guidance. "I am not alone in my journey."

- Positive role models, figures of hope; people we admire, who inspire us, who show us that it is possible. "If they can do it, maybe I can too".

These factors do not eliminate the trauma, but they modulate its impact, reduce its toxic footprint, and above all, reactivate resilience circuits. When activated, the hand can close more quickly, recreate connections, and restore integration.

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HELPING THE VICTIMS AND THE PROFESSIONALS

6. HELPING THE VICTIMS AND THE PROFESSIONALS

6.1. For the victims- practical tools and techniques to work with victims of trauma

There are several simple, body-based, and trauma-informed techniques that practitioners can use to help individuals cope with trauma and regulate their nervous systems—especially when words may not be enough. These tools can be helpful in clinical or community settings and are often grounded in somatic (body-based) approaches and polyvagal theory.

Important Notes for Practitioners

- Always ask for consent before introducing body-based techniques.
- Let the person opt-in and adapt any technique to fit their needs.
- Offer choice and agency—this helps restore control, often lost in traumatic experiences.
- Be trauma-informed: do not force eye contact, silence, or stillness, as these may feel unsafe.

Some techniques can be used only by psychologists and healthcare providers:

- Use of trauma-informed **CBT (Cognitive Behaviour Therapy)**: this is a structured, evidence-based approach used to help individuals reframe harmful thought patterns, manage emotional responses, and

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reduce symptoms of PTSD.

- **EMDR (Eye Movement Desensitisation and Reprocessing)**: is a specialised psychotherapy technique used to help individuals process and heal from traumatic memories. It involves guided eye movements or other forms of bilateral stimulation while recalling distressing events, helping to reduce the emotional intensity associated with those memories. Due to its complexity and the potential to trigger intense emotional responses, EMDR must be administered exclusively by trained and certified mental health professionals.

- **Screening for Adverse Childhood Experiences (ACEs)** during routine checkups can help identify individuals at risk of trauma-related health issues. Using standardised tools like the **ACE Questionnaire**, healthcare providers can detect early signs of trauma and provide timely support. When needed, practitioners should offer appropriate referrals to mental health services, ensuring access to specialised care for healing and recovery.

Others are easier to learn and teach, non-invasive, and grounded in evidence-based practices, and can be used by all professionals who work with women.

4-7-8 Breathing

- Inhale for 4 seconds
- Hold for 7 seconds
- Exhale for 8 seconds

This slows the heart rate, calms the body, and reduces anxiety.

Box Breathing

- Inhale 4 seconds → hold 4 → exhale 4 → hold 4

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This helps with emotional regulation and grounding.

Hand on Heart or Belly Breathing

- Place one hand on the heart or stomach and breathe slowly

This activates the parasympathetic (rest and digest) system.

Tapping (EFT – Emotional Freedom Technique)

- Tap on specific acupressure points (e.g., forehead, under eyes, collarbone) while speaking calming affirmations or acknowledging distress.

This helps release stress and reduce emotional intensity, and it is easy to teach and self-administer.

Pushing the Wall (Grounding Through Resistance)

- Stand facing a wall, push firmly against it with palms for 10–20 seconds

This engages large muscle groups and redirects awareness to the body. It is effective for dissociation or freeze responses.

Orienting Technique (Visual Grounding)

- Gently look around the space and name 5 things you see, 4 you can touch, 3 you hear, 2 you smell, 1 you taste.

This reorients the person to the present moment, and it is useful during flashbacks or panic.

Sensory Reset Tools

- Hold a cold object (ice cube, cold water bottle)
- Use textured items (stress balls, fidget toys, fabric swatches)

This stimulates sensory awareness and brings focus to the “here and now”.

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Chair Push or Chair Grip

- Sit and press down into the seat or grip the chair's arms or legs

This grounds the individual through physical contact and the release of tension. It is beneficial for survivors with mobility difficulties.

Butterfly Hug (Bilateral Stimulation)

- Cross arms over the chest, lightly tap shoulders alternately

This engages both hemispheres of the brain and encourages calming feelings and thoughts. It is used in EMDR and self-soothing exercises.

Feet on the Floor – "Anchor the Body"

- Guide the person to notice their feet touching the floor, weight distribution, and stability

It is simple but powerful for grounding and restoring safety.

Drawing or Scribbling

- Use paper and crayons/markers to scribble freely or draw emotions

It offers non-verbal communication and alleviates stress, particularly beneficial for children or individuals with language barriers.

6.2. For the professionals

6.2.1. The emotions of the professionals

Encountering a woman who has experienced violence is a delicate, intense, and deeply human experience. In this space of care, each professional brings not only their knowledge and technical skills (*knowing how to do*), but also their personal qualities, sensitivity, and emotional presence (*knowing how to be*).

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The relationship established with the woman is never neutral: it is a complex interweaving of emotions and feelings involving both parties. Alongside the pain of the victim, professionals may find themselves experiencing strong emotional reactions of their own. Fear, anger, and sorrow are just some of the emotions that may emerge in the course of this work.

In working with women who have suffered violence, the emotions experienced by professionals are not obstacles—they are an integral part of the helping relationship. However, because of their intensity, they require awareness and appropriate tools for recognition and management. The most common emotions include:

- Fear: arising from the severity of the situations described, concern for the woman's safety, or even one's own.

- Anger: towards the perpetrator, and sometimes towards a system perceived as slow or inadequate.

- Sorrow: in response to hearing stories that touch deeply or awaken personal or collective wounds.

When emotions become overwhelming, it is natural to activate psychological defences—often unconsciously. Some of the most frequent include:

- Sense of helplessness: feeling paralysed, as though nothing one does is sufficient.

- Sense of omnipotence: the need to "rescue" at all costs, risking emotional burnout.

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- Identification: over-identifying with the victim, blurring the boundary between self and other.

- Idealisation: perceiving the victim as entirely good or the context as wholly negative.

- Projection: attributing one's own feelings or assumptions to others.

Vicarious Trauma and Compassion Fatigue:

Repeated exposure to traumatic stories and constant proximity to the suffering of others can lead to vicarious trauma (McCann et al., 1990; Pearlman, 1995)—a secondary trauma that manifests through symptoms similar to post-traumatic stress. When prolonged, this may develop into compassion fatigue (Figley, 1995), a condition characterised by emotional and physical exhaustion associated with deep empathic engagement.

Compassion fatigue may present through:

- Feelings of ineffectiveness and frustration;
- Emotional withdrawal or disengagement from work;
- Sleep disturbances, irritability, difficulty concentrating;
- Relational isolation or withdrawal.

6.2.2. Caring for Those Who Care

As Quino aptly wrote: *"Too often, the urgent leaves no room for the important."* Self-care—and care of the team—is essential to sustaining the quality of care and the well-being of those providing it. According to Judith Herman, the work team is a vital protective resource: it

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nourishes, supports, and amplifies the strengths of each of its members. Protective factors include:

- Plural thinking: addressing cases collectively, building shared interpretations;
- Sharing resources and power: mitigating isolation in decision-making;
- Learning from experience: transforming daily practice into ongoing professional development.

To ensure these protective factors remain active, they must be intentionally nurtured over time, through:

- Regular spaces for reflection and dialogue;
- Continuing professional development;
- Structured and consistent supervision, both clinical and emotional.

Supervision is one of the most important tools for support and growth available to professionals. It provides an opportunity to pause and reflect, offering a different perspective on experience and enabling practitioners to become more aware of their own "being in action". The case brought to supervision becomes a *pretext*: the real "text" is the narrative process activated within the group. The emphasis is placed on *how* the case is approached, rather than on *what* to do or not to do.

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LEGAL FRAMEWORK

7. LEGAL FRAMEWORK

7.1. Legal pathway for taking care of women victims of GBV with mental health issues and/or addiction

Estonia

Legal Framework

Estonia's Victim Support Act (in force since April 2023) establishes a comprehensive support system for survivors of gender-based violence (GBV), coordinated by the **Social Insurance Board**. Victims can access support services regardless of whether they report the violence to the police or initiate criminal proceedings. The system aims to provide trauma-informed care, psychological assistance, and pathways to recovery.

Entry Points / First Contact

- 116 006: 24/7 national victim support hotline.
- Women's Support Centres: Accessible via self-referral, police, healthcare providers, or NGOs.
- Hospitals / Social Services: Can initiate referrals without police involvement.

Support Services

- Women's Support Centres: Safe accommodation, legal counselling, psychosocial crisis support, and reintegration assistance.
- Psychological and Psychotherapeutic Services: Trauma recovery support is offered even without legal proceedings.

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- Addiction Treatment Services: Available via the national healthcare system, though access is limited and not fully integrated with GBV support.

- Mental Health Services: Survivors can receive psychiatric care via public or private providers, though availability is uneven.

Key Actors and Responsibilities

Actor	Role
Social Insurance Board	Coordinates victim support services, including the national helpline.
Women's Support Centres	Deliver trauma-informed support, shelter, and legal assistance.
Health Insurance Fund	Covers eligible mental health and addiction services.
NGOs / Local Authorities	May support rural access or specialised care, especially for addiction.

Challenges in Practice

- Specialist Shortages: Insufficient clinical psychologists, psychiatrists, and trauma experts; waiting times can extend for months.

- Geographic Disparities: Services are concentrated in urban centres; rural women face serious access barriers.

- High Cost of Private Care: Sessions range from €50 to €100, limiting access despite partial reimbursement.

- Fragmented Pathways: Lack of coordination between addiction treatment, GBV response, and mental health care.

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- Stigma and Distrust: Women with mental health or substance use issues may be seen as unreliable by service providers or police, reducing their likelihood of seeking help.

- Shelter Access Limitations: Some shelters may be reluctant to accept women with active addiction or psychiatric symptoms.

In conclusion, while Estonia's legal framework allows for unconditional access to support for GBV survivors with mental health or addiction challenges, systemic barriers—such as workforce shortages, service fragmentation, and stigma—continue to undermine effective healing pathways.

Greece

Healthcare Access Pathway

Initial Contact & Referral

- Victims may contact the SOS 15900 helpline or be referred by police, social services, or NGOs.

- Counseling Centers (twenty-eight nationwide) assess needs and refer to shelters or healthcare providers.

Shelter & Support Services

- Eighteen (18) Shelters offer safe accommodation, staffed by psychologists and social workers.
- Victims receive psychosocial support, legal aid, and referrals to public hospitals or addiction treatment centres.

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Medical & Psychiatric Care

- Public hospitals provide mental health evaluations, psychiatric treatment, and addiction services.
- The National Public Health Organisation (KEELPNO) coordinates medical case management, especially for refugee or undocumented women.

Legal and Social Reintegration

- Victims may access free legal aid (Law 3226/2004) and compensation.
- NGOs and municipal services support rehabilitation, including therapy, vocational training, and housing assistance.

Challenges

- Limited Shelter Capacity
- Fragmented Services: Lack of sufficient coordination between health, legal, and social sectors.
- Undertrained Professionals: Insufficient gender-sensitive training for police, healthcare workers, and the judiciary.
- Barriers for Migrants: Language, documentation, and stigma hinder access to care.

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Key Actors

- GSDFPGE is the General Secretariat for Demographic and Family Policy and Gender Equality
- KETHI is a Research Centre for Gender Equality
- EKKA is the National Centre for Social Solidarity

Actor	Role
GSDFPGE	Designs and monitors gender equality policies
KETHI	Coordinates shelters and counselling centres
EKKA	Operates emergency shelters and helpline 197
NGOs	Provide specialised support, legal aid, and addiction services
Public Hospitals	Deliver psychiatric and addiction treatment

In more detail:

Greece has established a pertinent legal framework addressing access to healthcare, particularly in the areas of mental health and gender-based violence (GBV).

Access to Mental Healthcare in Greece

- Law 2716/1999 regulates mental health services and promotes community-based care. It ensures equal access to mental health services, including for vulnerable populations. Challenges in its implementation revolve around the limited number of mental health professionals, particularly in rural areas. There are continuous efforts to integrate mental health services into primary healthcare.

Gender-Based Violence & Mental Health

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- Legal Definitions & Recognition of GBV as a Public Health Issue: Greece ratified the Istanbul Convention in 2018, recognising GBV as a human rights violation. Further, GBV is addressed under Law 4531/2018, which aligns national legislation with international standards. As per protecting survivors, Law 3500/2006 criminalises domestic violence and provides legal assistance for victims. Towards that end, Law 4324/2015 strengthens support services for victims of sexual violence.

Integration Between the Justice System & Psychological Care

Survivors have access to state-funded psychological support through counselling centres and hotlines. Nevertheless, challenges remain in coordinating legal and mental health services effectively.

Institutional Obligations and Protective Measures

- Obligations of Institutions (Police, Hospitals, Social Services): Police are required to refer victims to support services. Hospitals must provide free medical and psychological care for survivors, and doctors have to call the Police in cases where they recognise signs of domestic violence in women seeking medical care.

Protective Measures

- Restraining orders and shelters are available under Law 3500/2006. Other than that, victim protection programs are supported by EU funding and national initiatives.

France + Martinique

Mental Health and Psychiatric Care Pathway

Women exposed to prolonged violence often suffer from complex trauma, which can manifest as PTSD, depression, anxiety, dissociative disorders, or psychosis. These symptoms are frequently exacerbated by or co-occur with

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addiction, such as alcohol or drug abuse (e.g., polydrug use, benzodiazepines, etc.).

The main point of entry into psychiatric care in France is the Centre Médico-Psychologique (CMP) (Medico-Psychological Centre), a free, sectorised public mental health facility. Victims may be referred by general practitioners (médecins généralistes), hospitals, and associations, or present themselves voluntarily. The CMP provides psychiatric evaluation, psychotherapy, social support, and, where needed, medication.

In complex cases, victims may be referred to specialised trauma units, but access is limited and geographically unequal. This is compounded by the fact that many psychiatric services are not systematically trained in trauma-informed care.

Psychiatric hospitalisation (voluntary or involuntary) may be needed in cases of psychotic episodes, severe depressive states, or suicidality. Involuntary hospitalisation follows Article L3213-1 and Article L3212-1 of the Code de la santé publique, depending on whether a third party requests it or it is ordered by a local authority.

Addiction Services and Specialised Support

Addiction services are mainly provided by CSAPA (Centres de Soins, d'Accompagnement et de Prévention en Addictologie – Care, Support and Prevention Centres for Addiction). These centres offer comprehensive care for people struggling with addiction, including:

- Psychosocial support (accompagnement psychosocial)
- Substitution therapy (traitements de substitution)
- Harm reduction (réduction des risques)

Some CSAPAs are equipped to work with women who are victims of violence, but most lack trauma-informed frameworks. There is an urgent need for

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integrated services that recognise the link between GBV and addiction as a coping mechanism.

When necessary, detoxification and stabilisation can occur in hospital settings, often under ELSA units (Équipes de Liaison et de Soins en Addictologie, Liaison and Addiction Care Teams). In rare but promising cases, residential therapeutic settings (structures de postcure) may accept women with co-occurring trauma and addiction, but this offer remains limited.

Women who are homeless or in very precarious conditions may also access CAARUD (Centres d'Accueil et d'Accompagnement à la Réduction des risques pour Usagers de Drogues, Reception and Support Centres for Drug Users), though these structures are not designed for therapeutic follow-up.

Departmental coordination is ensured by the CDPEF (Commission Départementale de Prévention et de Lutte contre les Violences Faites aux Femmes – Departmental Commission for the Prevention and Fight against Violence Against Women), chaired by the Prefect (Préfet) and involving all relevant actors.

A Projet d'Accompagnement Personnalisé (PAP) (Personalised Support Plan) is often built for the woman, integrating:

- Legal support: Filing complaints, court accompaniment, child custody (garde d'enfant)
- Health pathway: Psychiatric treatment, detox care
- Social integration: Income stabilisation, housing, work reintegration
- Parental support: Especially when the woman has children, with possible involvement of Child Protection Services (Protection de l'Enfance)

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Challenges and Structural Barriers

Despite the robust legal and medical frameworks, several structural challenges persist:

- Siloed services: Mental health, addiction, and GBV support are often poorly coordinated
- Service exclusion: Shelters may reject women with psychotic symptoms or active addictions
- Stigma: Victims with psychiatric diagnoses may be perceived as unreliable by judicial and medical professionals
- Territorial inequality: The availability of trauma-specific services varies drastically by department (département)

Martinique: The Same Rights, But Uneven Access

Specificity in Martinique: Although victims in Martinique have the same rights as in mainland France, access to the judicial system may be slower or more complex due to:

- Limited number of Family Court Judges (Juges aux affaires familiales – JAF)
- Overloaded Tribunal Judiciaire de Fort-de-France (main court)
- Structural delays in issuing Protection Orders (Ordonnances de protection)

Victims often rely on local associations like the Mouvement du Nid Martinique, the CIDFF Martinique (Centre d'Information sur les Droits des Femmes et des Familles), which is the information centre for families and

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women's rights, or Maison de Justice et du Droit (Law and Justice House) to navigate the legal system.

Protection and Emergency Housing: A Limited and Fragile Network

In Martinique, first responders include the police, the CHU (public hospital) de Martinique, and the "3919" helpline (operated locally in partnership with associations). The Préfecture can activate emergency protection, in connection with the Procureur de la République. (Public Prosecutor)

Local limitations:

- A very limited number of shelter beds, especially for women with mental health or addiction issues
- Most emergency shelters are not adapted for dual-diagnosis victims
- Shelters and hostels may refuse women in psychological crisis or with active substance use

This forces many victims to return to unsafe homes, rely on informal networks, or remain homeless.

Psychiatric and Mental Health Services: Chronic Under-Resourcing

Psychiatric care is officially provided by sectorized public services (sectorisation psychiatrique) through the Centre Médico-Psychologique (CMP) system (Medico-Psychological Centre).

In Martinique, these include:

- CMP for adults (Fort-de-France, Trinité, Rivière-Salée)
- Specialised services within the CHU (hospital) of Martinique

Critical barriers:

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- Staffing shortages and a lack of trauma-specialised professionals
- Long delays for appointments (up to several months)
- Emergency psychiatric units are often overwhelmed and underfunded
- Lack of crisis shelters with on-site psychiatric support

For victims suffering from complex trauma (PTSD, dissociation), Martinique lacks specialised trauma care pathways, particularly in outpatient settings.

Addiction Support: Scarce and Fragmented Services
Addiction care is provided through:

- CSAPA Martinique (Centre de Soins d'Accompagnement et de Prévention en Addictologie), a centre specialized in various forms of addiction
- CAARUD (for users in highly precarious situations)
- ELSA team at CHU (hospital-based liaison and care team)

Local gaps:

- No residential therapeutic care (postcure) facilities on the island
- Addiction services are not integrated with trauma or GBV support
- Many women with addiction issues avoid care due to stigma, shame, or lack of women-specific programs

There is also a cultural and societal taboo around female substance use, which adds layers of invisibility to these women's situations.

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Structural Challenges Specific to Martinique

- Insular geography makes access to services difficult for women in rural or remote areas
- High poverty rates and youth unemployment exacerbate social vulnerability
- Medical desertification affects both general and mental health care availability
- Colonial legacies and cultural silence around GBV can lead to institutional minimisation of women's suffering
- Underreporting and revictimization are major concerns: women may be dismissed by police or medical staff when they disclose mental health or addiction issues

Guyana:

Guyana has a healthcare system and legal framework that reflect its unique historical, social, and economic context.

Health Legislation and Policy in Guyana

Guyana's Constitution, the supreme law of the land, guarantees certain rights related to health and well-being. While the Constitution does not explicitly enshrine a right to healthcare, it directs the state to improve public health, ensure access to medical services, and promote the well-being of all citizens. The country's governance structure places the responsibility for health primarily with the Ministry of Health, though regional administrations also play a significant role in service delivery.

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Primary Health Legislation

A series of acts and regulations form the backbone of Guyana's legal health framework. Some of the most notable include:

- Public Health Ordinance (1934, as amended): This historic legislation remains a central pillar in Guyana's public health system. It governs the prevention and control of infectious diseases, sanitation, vaccination, reporting of notifiable diseases, and the powers of health officials.
- Food and Drugs Act (1971): This act regulates the importation, sale, and distribution of food, drugs, cosmetics, and medical devices, ensuring safety and quality for consumers.
- Mental Health Ordinance (1930, with subsequent amendments): This piece of legislation governs the treatment and institutionalisation of people with mental health conditions. There is ongoing advocacy to modernise this law to better reflect human rights principles and community-based care.

Healthcare System Structure

Guyana operates a mixed public-private healthcare system. The public system is organised into primary, secondary, and tertiary levels, with the majority of facilities, services, and oversight under the Ministry of Health. Regional Health Authorities administer services across the country's 10 administrative regions, aiming to ensure that even rural and hinterland communities have access to basic healthcare.

Legal Approaches to Addiction: Drugs, Alcohol, and Tobacco

Drug Control and Rehabilitation Laws

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Guyana's legal approach to drug use and addiction is primarily punitive but includes some provisions for treatment and rehabilitation. Key laws include:

- Narcotic Drugs and Psychotropic Substances (Control) Act (1988, as amended): This act criminalises the possession, trafficking, manufacture, and use of controlled substances, in line with international treaties. Sentences for drug offences can be severe, though the law also allows for the establishment of rehabilitation centres for those addicted to narcotics.
- Drug Abuse Resistance Education (DARE) and National Anti-Narcotics Strategies: These are policy initiatives rather than formal legislation, focusing on public education, prevention, and demand reduction, especially among youth.

Despite the legal focus on criminalisation, there is growing recognition of the need for harm reduction and treatment-based approaches, particularly for vulnerable populations.

Alcohol and Tobacco Control

Guyana has enacted specific laws and regulations to control the sale, advertising, and consumption of alcohol and tobacco:

- Intoxicating Liquor Licensing Act: This law regulates the sale and distribution of alcoholic beverages, with licensing requirements, age restrictions, and limits on hours of sale.
- Tobacco Control Act (2017): This modern legislation aligns with the Framework Convention on Tobacco Control (FCTC). It prohibits smoking in enclosed public spaces, restricts advertising, mandates warning labels on packaging, and bans sales to minors.

Treatment and Rehabilitation Services

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The government and several NGOs operate drug and alcohol rehabilitation programs. The legal framework allows for voluntary and, in some cases, court-mandated treatment. However, resources are limited, and access, especially outside Georgetown, remains a challenge. There is increasing advocacy for a more health-centred, rather than punitive, response to addiction.

Mental Health and Disability Law

Mental Health Legislation

The mental health legal framework in Guyana is in transition. The Mental Health Ordinance, dating back to colonial times, is widely regarded as outdated, with limited protections for the rights and dignity of people with mental health conditions. Efforts are underway to reform these laws, emphasising de-institutionalisation, community-based care, and alignment with international human rights standards.

Public Health Emergency Framework

Disease Control and Emergency Response

The Public Health Ordinance and related regulations grant broad powers to health authorities during disease outbreaks and emergencies. These include quarantine, compulsory vaccination, contact tracing, and closure of premises. Guyana's experience with COVID-19 highlighted the strengths and limitations of this framework, including the need for transparency, proportionality, and protection of civil liberties.

International Commitments and Human Rights

International Health Regulations

Guyana is a party to the International Health Regulations (IHR, 2005), which establish global standards for disease monitoring, reporting, and response. The country collaborates with the WHO, PAHO, and CARICOM on cross-

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border health threats and regional health initiatives.

Human Rights and Health

While Guyana's Constitution and laws provide for equality and non-discrimination, gaps remain in the realisation of the right to health, especially for Indigenous peoples, LGBTQ+ communities, and people with HIV/AIDS. Civil society organisations and international partners continue to advocate for stronger anti-discrimination measures and greater inclusion in health policy.

Challenges and Ongoing Reforms

Guyana's legal framework for health, addiction, and care faces several key challenges:

- Resource Limitations: Funding, staffing, and infrastructure shortages, particularly in remote regions.
- Outdated Legislation: Several laws, especially on mental health and disability, need modernisation to reflect current best practices and human rights standards.
- Stigma and Discrimination: People with addiction or mental health conditions often face social and institutional stigma, limiting access to care.
- Enforcement and Oversight: Weak implementation and monitoring of existing regulations undermine their effectiveness.
- Policy Gaps: Areas such as harm reduction, reproductive health, and community-based services require further legal and policy attention.

The legal framework on health, addiction, and care in Guyana is multifaceted, blending historic laws with ongoing reforms, and is shaped by domestic priorities and international influences. While significant

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achievements have been made, especially in controlling infectious diseases and regulating key sectors, substantial work remains to create a rights-based, inclusive, and resilient health system that serves all Guyanese. The coming years will likely see further legal and policy evolution, particularly in mental health, addiction, and disability rights, as Guyana strives to uphold health as a fundamental pillar of national development.

Italy

Women who experience gender-based violence and who also suffer from mental health disorders and/or substance use issues often find themselves on the margins of institutional responses, caught in a **fragmented system** that hinders access to integrated and appropriate support. In Italy, the main legal framework consists of the **Istanbul Convention** (Law No. 77/2013) and the **"Codice Rosso"** (Law No. 69/2019), which strengthen protection measures for victims of violence. However, **neither law provides specific or coordinated interventions** for women with psychiatric disorders or those undergoing addiction treatment, resulting in significant protection gaps.

According to ISTAT (2015), **31.5% of women** aged 16 to 70 have experienced some form of physical or sexual violence during their lifetime. In nearly **65% of intimate partner violence cases**, the victims reported **psychological or physical consequences**. Additional data (2022 Parliamentary Report on the implementation of Law 119/2013, Department for Equal Opportunities – Presidency of the Council of Ministers) indicate that a significant number of women accessing anti-violence centres also present **mental health issues or substance abuse**. Still, these conditions often **impede access to or continuation of support pathways**.

One of the primary critical issues is the **lack of real integration between social health services and anti-violence services**. Anti-violence centres, often run by third-sector organisations, do not always have the necessary expertise to address cases of **dual diagnosis**, nor do they have structured

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collaboration with **Mental Health Departments** or **Addiction Services (Ser.D)**. At the same time, health services often fail to recognise **violence as a key clinical factor** in psychological distress, treating symptoms in isolation rather than within a relational and traumatic context.

Women with psychiatric disorders or addiction problems also face **severe stigma** in legal and institutional settings, which negatively impacts their **credibility as witnesses** in legal proceedings and their ability to access protective measures such as restraining orders or child custody rights. In some documented cases (D.i.Re, 2021), these women **choose not to report violence** or pursue legal action out of fear of being deemed unreliable or unfit as mothers.

Finally, the **absence of shared protocols** and a lack of a **trauma-informed and intersectional approach** prevent effective and holistic care. Public policy must promote **integrated, multidisciplinary care pathways**, where anti-violence centres, healthcare services, and the justice system work together to recognise and address the complexity of these women's experiences, ensuring non-discriminatory access to care and justice.

Argentina

- Argentine Constitution: Incorporates international human rights treaties with constitutional rank (Art. 75 inc. 22), which include protections against violence and abuse.
- **CEDAW** (Convention on the Elimination of All Forms of Discrimination Against Women) and the **Belém do Pará Convention** (Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women) are binding in Argentina.
- **Law 26.485 – Integral Protection Law for Women (2009):** Law on Integral Protection to Prevent, Punish, and Eradicate Violence Against

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Women in the Areas Where They Develop Interpersonal Relationships.

Recognises multiple forms of violence:

- Physical
- Psychological
- Sexual
- Economic and patrimonial
- Symbolic violence
- Promotes prevention, victim assistance, education, and access to justice.

- **Law 27.210 – Comprehensive Sexual Education (ESI)**
  - Mandates comprehensive sexual education in all schools
  - Aims to prevent abuse, promote consent culture, and provide children and adolescents with tools to detect abuse.

- **Criminal Code (Código Penal Argentino) Contains specific articles criminalising sexual abuse and violence:**
  - Art. 119: Sexual abuse (includes rape, aggravated sexual abuse, abuse of minors, and abuse with penetration).
  - Art. 130: Grooming (online sexual predation).
  - Art. 145 bis & ter: Trafficking in persons for sexual or labour exploitation.
  - Art. 80: Aggravated homicide (includes *femicidio* as an aggravating factor).

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- Penalties vary based on the severity and circumstances (e.g., abuse by a person in a position of authority, repeated abuse, or abuse resulting in death).
    - Femicide classification: Argentina formally recognises femicide (gender-based murder of a woman) as a distinct aggravating factor in homicide cases.
- Sexual abuse statute of limitations: Extended or removed in cases involving minors.
- Micaela Law (Law 27.499): Mandatory gender perspective training for all public officials.
- Ni Una Menos movement: Strong civil society push against femicide and gender violence.

Extra considerations in Argentina

- Children with ACEs are entitled to free psychological support through the National Health Service. Despite this regulation, it is often challenging to find a place.
- Mandatory reporting for educators and health professionals under the Argentinian legal Code of Procedure is an obligatory regulation that makes an alert for most cases.
- Local child protection services coordinate with schools and hospitals.

Although emergency access to mental health care must be guaranteed for abuse victims, in many cases, this is not possible. Health professionals are not always prepared for such cases.

Key Actors

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Actor	Role
Armed national forces	Identification, protection, referral
Health in hospitals	Psychiatric and psychological care
NGOs (Madres Victimas de Trata and many others)	Shelter, social, psychological and legal assistance
Social Services (local and departmental)	Evaluate and follow up on cases
Justice System (courts, prosecutors)	Legal protection and restraining orders

7.2. International and Regional Legal Frameworks for mental health and care

United Nations Conventions and Treaties

- Convention on the Rights of Persons with Disabilities (CRPD), 2006

The CRPD recognises the right to equal access to healthcare, including mental health services, for persons with disabilities. It emphasises non-discrimination and the need for reasonable accommodations in healthcare settings while also requiring state parties to ensure that mental health services are accessible, affordable, and culturally appropriate. One key point is that it encourages community-based mental health support rather than institutionalisation.

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979

The CEDAW defines GBV as a form of discrimination against women. It mandates state obligations to protect survivors through legal, social, and healthcare measures. It highlights the importance of specialised mental

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health services for survivors of domestic violence, sexual violence, and trafficking. It further encourages training for healthcare professionals to recognise and respond to GBV-related trauma.

- Universal Declaration of Human Rights (UDHR), 1948

The UDHR is a landmark document that establishes fundamental human rights for all individuals, regardless of their nationality, race, gender, or social status. It laid the groundwork for modern human rights treaties, influencing over seventy (70) international agreements. Although it is not legally binding, its principles have been incorporated into national constitutions and legal codes worldwide.

Some of its core principles include:

- Universality: Human rights apply to everyone, everywhere.
- Indivisibility: Economic, social, cultural, civil, and political rights are interconnected.
- Non-discrimination: Rights must be upheld without distinction based on race, gender, religion, or status.

Its thirty articles cover freedom of speech, equality, education, and protection from torture. It inspired the creation of regional human rights instruments, such as the European Convention on Human Rights (ECHR). It also led to the development of binding treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).

- International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966

The UN General Assembly adopted the ICESCR on 16 December 1966 and came into effect on 3 January 1976. It is a legally binding treaty that obliges states to protect and promote economic, social, and cultural rights. Unlike

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the UDHR, the ICESCR requires governments to take action to realise these rights progressively.

Core rights include:

- The Right to Work: Fair wages, safe working conditions, and protection against unemployment.
- The Right to Education: Free primary education and equal access to higher education.
- The Right to Health: Access to medical care, sanitation, and environmental health protections.
- The Right to Social Security: Safeguarding vulnerable populations, including children, the elderly, and persons with disabilities. It affirms the right to health, including mental healthcare, as a fundamental human right. Furthermore, it requires state parties to ensure equitable access to healthcare services, including psychological support for vulnerable groups. This highlights the recognition of mental health as a vital component of overall well-being.

- WHO Guidelines on Mental Health

The World Health Organization (WHO) has created several guidelines to improve mental health policies, services, and interventions worldwide. These guidelines emphasise accessibility, affordability, and the integration of mental health care into primary healthcare systems. WHO's Mental Health Action Plan (2013-2020) aimed to strengthen mental health systems globally and increase access to mental health care. It strongly urged governments to prioritise mental health in national health policies, supported funding for mental health programmes, and promoted the enhancement of mental health services within primary healthcare settings.

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The Mental Health Action Plan was later extended to 2030 to align with the UN Sustainable Development Goals (SDGs).

- WHO Guidelines on GBV Survivor Support (2021)

The guidelines on GBV Survivor support outlined best practices for integrating mental health services into GBV response frameworks. They recommended trauma-informed care for survivors of domestic violence, sexual assault, and trafficking. It further emphasised the importance of confidentiality and survivor-centred approaches in mental health interventions.

Regional Legal Frameworks

- The European Convention on Human Rights (ECHR), 1950

Among its other crucial guidelines, the ECHR protects individuals from discrimination in mental health care and ensures legal safeguards for people with mental health conditions.

- Istanbul Convention (Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence), 2011

The Istanbul Convention recognises GBV as a public health issue and mandates state obligations to provide mental health support for survivors. It requires healthcare institutions to integrate psychological care into GBV response mechanisms and establishes institutional obligations for police, hospitals, and social services to refer survivors to mental health professionals. In addition, it mandates protective measures, including restraining orders, shelters, and victim protection programs.

- EU Mental Health Strategies and Frameworks

The European Commission (EC) has devised a comprehensive approach to mental health (2023), recognising its importance alongside physical health. Within this framework, it has established the EU Mental Health Action Plan,

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which introduces twenty initiatives aimed at enhancing mental health services, along with over one billion euros in funding dedicated to prevention, early intervention, and reintegration into society.

The EU has further established legal protections and programs to ensure mental health care is accessible and non-discriminatory:

- European Pillar of Social Rights (2017): The Pillar recognises mental health as a fundamental right and calls for equal access to healthcare for all EU citizens.

- EU4Health Program (2021): This program provides funding for mental health research and digital tools, as well as supporting cross-border cooperation in mental health policy.

- Maputo Protocol (2003)

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol, recognises women's rights as human rights and calls for gender equality in all aspects of life. It covers economic, social, political, and reproductive rights, as well as GBV and legal protections; it criminalises all forms of violence against women, including domestic violence, sexual violence, and harmful practices, and calls for legal frameworks to protect survivors and ensure access to justice. It is ratified by forty-four (44) African countries, but implementation varies across nations.

- Convention of Belém do Pará (1994)

The Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women, known as the Convention of Belém do Pará, was adopted by the Organisation of American States (OAS). It also recognises GBV as a Human Rights violation and establishes state obligations to prevent, investigate, and punish GBV, as well as support victims. Ratified by thirty-two States, enforcement also varies.

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BIBLIOGRAPHY

References:

Estonia's Draconian Drug Policy Violates The. (n.d.). Docslib. https://docslib.org/doc/3012522/1-estonias-draconian-drug-policy-violates-the

About the Protocol | Maputo Protocol. (2003). https://maputoprotocol.com/about-the-protocol

Accueil - AUDe — CIDFF. (2024, September 19). Aude — CIDFF. https://www.cidff.fr/

Accueil - France Victimes. (n.d.). https://www.france-victimes.fr/

Andmevara, A. (n.d.). *Victim Support Act–Riigi teataja*. https://www.riigiteataja.ee/en/eli/509012018004/consolide

Baddeley, A. D., Eysenck, M. W., & Anderson, M. C. (2020). *Memory* (2nd ed.). Psychology Press.

Belong. (2025a, March 7). Access to mental health services in Estonia: challenges and solutions - Belong. *Belong - Elu terviklikkuse hüvanguks*. https://belong-events.com/en/study/access-to-mental-health-services-in-estonia-challenges-and-solutions/

Belong. (2025b, March 11). Mental health services in the Estonian Human Development Report 2023 - Belong. *Belong - Elu terviklikkuse hüvanguks*. https://belong-events.com/en/study/mental-health-services-in-the-estonian-human-development-report-2023/

Benavente, B., Brage, L. B., Solé, J. P., & Beltrán, N. P. (2021). Risk factors for commercial sexual exploitation of children and adolescents: results of an International Delphi panel. *Psicothema*, *3*(33), 449–455. https://doi.org/10.7334/psicothema2020.480

Biarella, L. (2019, July 26). Codice Rosso: definizione, procedura, nuovi reati e aggravanti. *Altalex*. https://www.altalex.com/documents/news/2019/07/26/codice-rosso

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Biroli, F. (2018). Violence against Women and Reactions to Gender Equality in Politics. *Politics & Gender*, *14*(4), 681–685. https://doi.org/10.1017/s1743923x18000600

Bloom, S., & Farragher, B. (2013).). Restoring Sanctuary: a new operating system for trauma-informed systems of care. *Oxford University Press*.

Brewer, J. (2017). *The Craving Mind*. Yale University Press. https://books.google.it/books?hl=it&lr=&id=Lyc2DgAAQBAJ&oi=fnd&pg=PR9&dq=Brewer,+J.+(2017).+The+craving+mind:+From+cigarettes+to+smartphones+to+love%E2%80%94Why+we+get+hooked+and+how+we+can+break+bad+habits.+Yale+University+Press.&ots=qq5su1k-9r&sig=I-Ab0ALjdgMBka3XZdRR9hT0kIc&redir_esc=y#v=onepage&q&f=false

Brown, J. D. (2018). Media literacy and gender-based violence: Challenging harmful portrayals in digital spaces. *Journal of Media Ethics*, *33*(2), 102–117.

Brown, K. (2019). Vulnerability and child sexual exploitation: Towards an approach grounded in life experiences. *Critical Social Policy*, *39*(4), 622–642. https://doi.org/10.1177/0261018318824480

Buller, A. M., Pichon, M., McAlpine, A., Cislaghi, B., Heise, L., & Meiksin, R. (2020). Systematic review of social norms, attitudes, and factual beliefs linked to the sexual exploitation of children and adolescents. *Child Abuse & Neglect*, *104*, 104471. https://doi.org/10.1016/j.chiabu.2020.104471

Coy, M., & Bragg, J. (n.d.). Desensitization to gender-based violence in media: Implications for societal attitudes and intervention policies. *Feminist Media Studies*, *20*(5), 712–730.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241. https://doi.org/10.2307/1229039

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Customs Anti Narcotic Unit. (2024, July 3). *GUYANA DRUG/ NARCOTICS LAWS - Customs Anti Narcotic Unit*. Customs Anti Narcotic Unit - Integrity and Professionalism. https://canu.gov.gy/guyana-drug-laws/

Dégelih, F., Eustache, F., & Guillery-Girard, B. (2015). Le développement cognitif et cérébral de la mémoire : de l'enfance à l'âge adulte. *Biologie Aujourd'hui*, *209*(3), 249–260.

Eesti inimarengu aruanne 2023. (2023, September 26). *Activities and services supporting mental health in Estonia: the current situation and development needs - Estonian Human Development Report 2023*. Estonian Human Development Report 2023 - Mental Health and Well-Being. https://inimareng.ee/en/activities-and-services-supporting-mental-health-in-estonia-the-current-situation-and-development-needs/

Essue, B. M., Chadambuka, C., Perez-Brumer, A., Arruda-Caycho, I., Tocallino, D., Balasa, R., Namyalo, P. K., Ravanera, C., & Kaplan, S. (2025). Women's experiences of gender-based violence supports through an intersectional lens: a global scoping review. *BMJ Public Health*, *3*(1), e001405. https://doi.org/10.1136/bmjph-2024-001405

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

Fileborn, B., & Loney-Howes, R. (n.d.). Navigating digital spaces: The role of social media activism in countering gender-based violence. *Social Movements & Media*, *15*(3), 215–234.

Franchino-Olsen, H. (2019). Vulnerabilities Relevant for Commercial Sexual exploitation of Children/Domestic Minor Sex Trafficking: A Systematic Review of Risk Factors.

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Funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Education and Culture Executive Agency (EACEA). Neither the European Union nor EACEA can be held responsible for them.

Trauma Violence & Abuse, *22*(1), 99–111. https://doi.org/10.1177/1524838018821956

García-Moreno, C., Stöckl, H., & Watts, C. (n.d.). The impact of media narratives on the normalization of gender-based violence. *The Lancet Global Health*, *3*(5), 254–259.

Gazzaniga, M. S., Ovry, R., & Mangun, G. R. (2019). *Cognitive neuroscience: The biology of the mind* (5th ed.). W. W. Norton & Company.

Gill, R. (2007). Gender and the media: A critical analysis of power and representation. *Oxford University Press.*

Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO). (2025). *Report submitted by Estonia pursuant to Article 68, paragraph 1 of the Council of Europe Convention on preventing and combating violence against women and domestic violence (First thematic evaluation round)*. https://rm.coe.int/report-submitted-by-estonia-pursuant-to-article-68-paragraph-1-of-the-/1680b5db9e

HAS - professional. (n.d.). Haute Autorité De Santé. https://www.has-sante.fr/

Herman, J. L. (1992). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. *Basic Books*.

ISTAT. (2014). LA VIOLENZA CONTRO LE DONNE DENTRO E FUORI LA FAMIGLIA. In *ISTAT*. https://www.istat.it/it/files/2015/06/Violenze_contro_le_donne.pdf

Jiménez, A. M., Molina, M. I. S., & García-Palma, M. B. (2014). Gender Bias in Addictions and their Treatment. An Overview from the Social Perspective. *Procedia - Social and Behavioral Sciences*, *132*, 92–99. https://doi.org/10.1016/j.sbspro.2014.04.283

Kitzinger, J. (2002). Framing gender violence in media discourse: Challenges and opportunities for advocacy. *Journal of Social Policy*, *28*(4), 535–557.

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Koob, G. F., & Le Moal, M. (2006). Neurobiology of addiction. *Academic Press.*

Le village des addictions - Addict Aide - Le village des addictions. (2025, July 30). Addict Aide - Le Village Des Addictions. https://www.addictaide.fr/

Lembke, A. (2021). *Dopamine nation: Finding balance in the age of indulgence*. Dutton.

Lolk, A. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. https://doi.org/10.1176/appi.books.9780890425596

Loney-Howes, R. (2021). Victim-blaming narratives in mass media: barriers to justice and survivor empowerment. *Violence Against Women*, *27*(9), 1342–1362.

Mental health problems among Estonia's adult population. (n.d.). INIMARENG. https://inimareng.ee/en/1-4-mental-health-problems-among-estonias-adult-population/

Mercera, G., Kooijmans, R., Leijdesdorff, S., Heynen, E., & Van Amelsvoort, T. (2023). Risk and Protective Factors for Sexual exploitation in Male and Female Youth From a Cross-Cultural Perspective: A Systematic review. *Trauma Violence & Abuse*, *25*(3), 1966–1984. https://doi.org/10.1177/15248380231201815

Ministry of Health Guyana. (n.d.). National Mental Health Action Plan and National Suicide Prevention Plan for Guyana 2024-2030. In *Ministry of Health Guyana.* https://health.gov.gy/wp-content/uploads/2024/04/Guyana-National-Mental-Health-and-Suicide-Plan-Final.pdf

Ministry of Health, Guyana. (2003). *National Health Plan 2003-2007.* https://www3.paho.org/hq/dmdocuments/2010/National_Health_Policies-Guyana_2003-2007.pdf

Ministry of Health of Guyana. (n.d.). *HEALTH VISION 2020 - A National Health Strategy for Guyana 2013 - 2020*.

Najavits, L. M. (2002). Seeking safety: A treatment manual for PTSD and substance abuse. *Guilford Press*.

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OHCHR. (2003). *Convention on the Rights of Persons with Disabilities*. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

Organization of American States. (1994). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará*. https://www.oas.org/en/mesecvi/docs/belemdopara-english.pdf

Parcours Victimes. (n.d.). *accueil*. https://www.parcours-victimes.fr/

Powell, A., & Henry, N. (2017). Sexual violence in digital culture: The role of media in shaping narratives. *Routledge*.

Salihu, J. (2025). EXPLORING THE INTERSECTIONALITY OF GENDER-BASED VIOLENCE: UNDERSTANDING DIVERSE EXPERIENCES AND INFORMING INCLUSIVE POLICIES. *ResearchGate*. https://www.researchgate.net/publication/389072031_EXPLORING_THE_INTERSECTIONALITY_OF_GENDER-BASED_VIOLENCE_UNDERSTANDING_DIVERSE_EXPERIENCES_AND_INFORMING_INCLUSIVE_POLICIES

Siegel, D. J. (1999). The developing mind: How relationships and the brain interact to shape who we are. *Guilford Press*.

Solidarité femmes. (2024, March 7). Solidarité Femmes. https://www.solidaritefemmes.org/

Stanko, E. A. (2017). Trauma-informed journalism: Ethical reporting on gender-based violence and exploitation. *Journalism Studies, 21*(1), 85–102.

Ste_Ro. (n.d.). *Pubblicazioni*. D.i.Re - Donne in Rete Contro La Violenza. https://www.direcontrolaviolenza.it/pubblicazioni/

Strid, S., & Verloo, M. (2019). Intersectional complexities in gender-based violence politics. In *Routledge eBooks* (pp. 83–100). https://doi.org/10.4324/9780429289859-6

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The Council of Europe. (2011). *The Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention)*. https://www.coe.int/en/web/gender-matters/council-of-europe-convention-on-preventing-and-combating-violence-against-women-and-domestic-violence

United Nations. (1948). *Universal Declaration of Human Rights | United Nations*. https://www.un.org/en/about-us/universal-declaration-of-human-rights

United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

United Nations. (1979). *Convention on the Elimination of All Forms of Discrimination against Women*. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women#:~:text=On%2018%20December%201979%2C%20the%20Convention%20on%20the,1981%20after%20the%20twentieth%20country%20had%20ratified%20it.

Van Der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. *Viking*.

World Health Organization. Regional Office for Europe. (2015). *The European Mental Health Action Plan 2013–2020*. https://iris.who.int/handle/10665/175672

World Health Organization: WHO. (2019, June 19). *Gender*. https://www.who.int/health-topics/gender#tab=tab_1

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