MARISSA

Multi-agency approach to support victims of intimate partner violence with substance abuse issues.

Policy Recommendations

March 2022

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MARISSA – Multi-agency approach to support victims of intimate partner violence with substance abuse issues

Project Number: 881577 — MARISSA — REC-AG-2019 / REC-RDAP-GBV-AG-2019

WP2 – Policy Recommendations

University of Crete

Authors: Sofia Thanasoula (UoC), Stavroti Karpetaki (UWAH)

Co-authors: Akis Giovazolias (UoC), Nicholas Spetsidis (UWAH)

Initial version: March 2022

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Introduction

According to professionals from both the Intimate Partner Violence (IPV) and the Problematic Substance Use (PSU) field, the phenomenon of co-occurring IPV and PSU is considered immensely challenging due to the overlap and complex interplay between IPV and PSU. Furthermore, the lack of policies and protocols explicitly addressed to this issue invokes multiple unmet needs; hindering professionals from treating survivors of IPV with PSU issues effectively.

Based on the aforementioned finding, MARISSA Project stipulates that partners should develop policy recommendations for the European level on advancing policies related to co-occurring IPV and PSU. The aim of these policy recommendations would be, on the one hand, to ameliorate the support for women survivors of IPV with PSU issues and on the other hand, to facilitate multi-agency cooperation between IPV and PSU services, and with other services as well (e.g. the Criminal Justice System, Child Welfare Services etc.), laying special emphasis to the participating countries.

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1. Available Data & Theory

1.1 Correlation between IPV & PSU

The existing literature suggests that most women converting to problematic substance use (PSU) share a history of victimization (La Flair et al., 2012); while such violent and abusive experiences seem to significantly increase the likelihood of PSU (Covington, 2008). Furthermore, it is quite evident –through the relevant research- that there is a strong correlation between intimate partner violence (IPV), trauma, and PSU, since women survivors attending IPV treatment often report dealing with PSU issues (Devries et al., 2014; Sullivan et al., 2016; World Health Organization/ WHO, 2013). At the same time, women survivors attending PSU treatment, report high rates of experiences of abuse, IPV and Post Traumatic Stress Disorder (PTSD) (de Bruijn & de Graaf, 2016; Low et al., 2017; Mason et al., 2017; Schumm et al., 2018; Weaver et al., 2015).

In these cases, it seems that alcohol and/or drugs are used to manage symptoms of trauma, in terms of self-medication. Acting as a coping mechanism and in particular as an avoidance coping strategy, PSU is perceived as a means to numb emotional pain (Gezinski et al., 2021). In this way, substance use assists survivors in enduring and handling all the hardship resulting from violence, as well as many other stressors, including those deriving from social conditions (Gezinski et al., 2021; Sullivan & Cavanaugh, 2009; Sullivan & Holt, 2008). Overall, the co-occurrence of IPV and/or PTSD and PSU creates a vicious cycle according to which: the negative consequences of IPV trigger behaviours related to PSU. In turn, IPV and/or PTSD and PSU are often intensified through the effects on user's body, brain and mental state; exaggerating several times in this way both IPV and/ or PSU (Abasi & Mohammadkhani, 2016; Simonelli et al., 2014; van Dam et al., 2013). However, the relationship between IPV and/or PTSD and PSU should not be seen as a direct causal relationship, but rather as an intricate, multi-layered and bidirectional one (Mason & O'Rinn, 2014); which is part of a multi-factorial phenomenon, mediated by multiple factors, such as personality (Afifi et al., 2012; Kraanen et al., 2014).

1.2 Prevalence of IPV & PSU

Given the fact that 30% of ever-partnered women have experienced physical and/or sexual violence from their partners during their lifespan, IPV is rationally considered as the most common form of violence against women (Devries et al, 2013; WHO, 2021).

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Since IPV victimization is closely linked to the development of PTSD, and substantial evidence indicate the existence of an immediate relationship between IPV and PSU, high prevalence rates of IPV incidents are expected to be found among female PSU population, and vice versa (Afifi et al., 2012; Cafferky et al., 2016; Flanagan et al., 2020; Kraanen et al., 2014). Indeed, women with PSU issues, have three to five times higher odds to have experienced IPV, compared to nationally representative samples of the same sex (El-Bassel et al., 2011). The percentage of women survivors of IPV within the PSU population is estimated to range from 25% to 57% (El-Bassel et al., 2011) or even to 80% (Langenderfer, 2013); while the percentage of women with PSU issues within the IPV population is estimated to range from 7% to 25% (Weaver et al., 2015). Another study revealed that more than half of women survivors of IPV (57.4%) meet the criteria for PTSD; while 6.4% of them meet the criteria for drug addiction and 18.1% for alcohol addiction (Nathanson et al., 2012). Regarding women's abusive experiences the year prior to their PSU treatment, Schumm et al.'s (2018) study demonstrated that the most prevalent type of IPV was psychological aggression (96.7%), followed by physical assault (53.7%) and sexual coercion (49.2%). Recent research conducted in European (Austrian, Italian, Polish, Scottish and Spanish) drug-injecting women has showed that 70% of them have experienced IPV in the last 12 months, while the most common type of IPV was combined sexual and physical abuse (Tirado-Muñoz et al., 2018).

1.3 General Characteristics of co-occurring IPV & PSU

The relevant research indicates that women with co-occurring IPV and/or PTSD and PSU face more severe difficulties, which interfere with their functionality, affecting -as a result- all aspects of their lives (i.e. at physical, psychological and social level) (Lipsky et al., 2010; Mason & O'Rinn, 2014; Mcgovern, et al. 2009). Co-existence of IPV and PSU also induces negative impact on both IPV and PSU treatment, since it burdens help seeking behaviours, therapeutic commitment, and outcome, thus resulting into higher rates of drop-out and lower rates of treatment completeness for both issues (Berenz & Coffey, 2012; Davis, 2006; Lipsky et al., 2010; Mason & O'Rinn, 2014; Mcgovern, et al. 2009; van Dam et al., 2012). Moreover, women survivors of IPV with PSU issues are more likely to get stigmatised, surcharged with shame, and provided less social support compared to men (Arpa, 2017).

2. Defining the Problem/ Identifying the Needs

Research data and scientific knowledge gained so far, demonstrate that the interplay between IPV and PSU seems to be indisputable and apparent, while it could be characterized as potent and influential. Notwithstanding the robust evidence though, and despite the well-established corresponding theory, the treatment of co-occurring IPV and PSU proves to be inadequate and often problematic (Benoit & Jauffret-Roustide, 2015; Schäfer & Lotzin, 2018; NICE, 2014). This is the case especially when referring to women suffering from both IPV and PSU (AVA, 2013; Covington, 2019; Manandhar et al., 2018; Schamp, 2019; Stella Project, 2007; UNODC, 2016).

2.1 Literature Review

Review of relevant literature brings to light research and clinical experience's pivotal findings, which indicate the existing gaps and barriers regarding dealing with co-occurring IPV and PSU. The identified gaps are mainly attributed to insufficient ways of operating and intervening; highlighting, at the same time, the necessity and urgent need for developing and implementing corresponding policies.

As part of the health system domain, IPV and PSU services are influenced by the dominant way of responding. More specifically, they are saturated with gender-related norms, stereotyping, and patterns of employment and work (that are being manifested by health-care providers); whereas they tend to ignore the ways according to which these unequal gender norms, roles and relations affect health and establish discriminations against women, even within health-care settings (Manandhar et al., 2018). Such discriminative norms, seem to negatively affect the diagnostic and treatment pathways addressed to women, and burden their access and uptake to services; leading, as a result, in gaps in coverage and finally, in failure of therapy provision (Manandhar et al., 2018). Gender-related issues and barriers (i.e. social stigma, gender-based stereotypes, shame, guilt, poverty, accessibility and affordability of services, absence of child care services and the fear of losing custody of their children), pose to women survivors of IPV with PSU additional difficulties regarding entering and assessing treatment programmes; put them in greater danger and risk, and place them at a straitened position (Arpa, 2017; Covington, 2019; Schamp, 2019).

In addition to the dominance of gender-related stereotypes, prejudices and discriminations, there is a lack of treatment specifically tailored to women, due to the

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fact that most services are designed by men for men (Covington, 2019). Especially PSU services lack approaches that acknowledge and treat women's gender-related issues and trauma/ IPV, such as gender-sensitive and trauma-informed approaches (UNODC, 2016). Indicative is the fact that only 38.4% of the PSU facilities in the U.S.A. offer specialized IPV services to women (Capezza et al., 2015). This gap in the current drug policies leads in worsening, through structural violence, the already existing stigmatisation, victimization, marginalisation and disempowerment of women (UNODC, 2016).

On the other side, survivors of IPV with PSU issues may be evicted from shelters for safety reasons; since service providers express concerns regarding the safety and well-being of the other survivors and their children (Gezinski et al., 2021). However, these professionals have expressed conflicting feelings on "*if/how to balance the immediate demands of substance users with the safety needs of others*", especially due to the lack of health-related infrastructure to address detoxing clients and active substance users by their organisations (Gezinski et al., 2021).

2.2 MARISSA Project's Research

2.2.1 Methodology

In terms of the MARISSA Project's research, partners from the three participating countries (Estonia, Iceland, and Greece) assessed IPV and PSU professionals' needs regarding the treatment of co-occurring IPV and PSU. This research included reviewing the existing literature about the available data, interventions, tools, methods, material, and practice in reference to the multi-agency co-operation between IPV and PSU services, in Europe and beyond. Additionally, partners composed a report, that demonstrated each country's national context and relevant information about the topic of co-occurring IPV and PSU (i.e. existing policies, legislation, services etc.). Moreover, focus groups with IPV and PSU professionals were conducted in all participating countries, to identify professionals' knowledge, needs, challenges, experiences, institutional practices, protocols/tools and level of existing collaboration. The findings that derived from the National Reports and the Focus Groups were integrated into an analytical "Needs Assessment Report" on professional needs. Finally, during the development of all deliverables, special attention was paid to the existing as well as to the required policies, as they emerge from relevant literature, research and

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professionals' inputs. Based on this material, Recommendations on advancing policies related to IPV and PSU for the European level will be developed aiming at ameliorating the support for women victims of IPV with co-occurring PSU issues and at facilitating multi-agency cooperation in the field. Finally, these "Policy Recommendations" will be discussed and promoted to local/regional/national policy makers, in terms of the "Advocacy Meetings" that will be conducted in Greece, Estonia and Iceland.

2.2.2 Findings

Consistent to relevant literature, –both field and desk- research conducted for the MARISSA Project highlighted the multiple challenges and various needs of IPV and PSU professionals regarding working with women survivors of IPV with PSU issues.

A key challenge that emerged from MARISSA Project's research ***was the fragmentation of data collection regarding co-occurring IPV and PSU,*** and particularly regarding women suffering from these two issues simultaneously. This gap, in turn –accompanied by the lack of relevant knowledge and training- seem to deprive professionals from an accurate picture of this phenomenon's totality. As a result, ***professionals have difficulty –or are even completely incapable- of perceiving and/or understanding the importance, expansiveness and significance that surround the co-occurrence of IPV and PSU, as well as the necessity for implementing relevant policies and approaches.***

Another challenge identified pertains to the existing legislation and policies. Notwithstanding that ***legislation and policies about IPV and PSU (separately) are quite widespread almost all over the world, specific legislation, and policies about co-occurring IPV and PSU in the three participating countries (Greece, Iceland and Estonia), as well as in most countries worldwide, do not exist***.

The results of the MARISSA Project's research also revealed that, ***in contrast with IPV services, there is severe lack of PSU services for women only, whether they have experiences of IPV or not***. Typically, PSU services lack sensitivity towards gender-related issues and trauma; forsaking -as a consequence- approaches, such as gender-sensitive, feminist, and trauma-informed approaches. At the other end of the spectrum, generally, IPV services do not take into consideration clients' PSU issues. Even in cases where PSU services deal with survivors of IPV and/or in cases where IPV services deal with women with PSU issues, MARISSA findings featured the almost absolute absence of

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clear and all-embracing policies, protocols, and guidelines for cases of co-occurring IPV and PSU, in the vast majority of both IPV and PSU services.

In addition to the absence of specific policies for co-occurring IPV and PSU in IPV as well as PSU services, ***there is a lack of services exclusively addressed to survivors of IPV with PSU issues, and especially to women survivors of IPV with PSU issues.*** According to MARISSA Project's results, such specialised services are highly scarce -if not completely non-existent- in most countries.

Apart from IPV and/or PSU services' existence, regulation, operation and philosophy, the current research also illustrated ***that the majority of IPV professionals have little to no knowledge, skills and capacity to adequately address PSU; while, by the same token, the majority of PSU professionals have little to no knowledge, skills and capacity to adequately address IPV.*** In particular, all professionals referred to the existence of major inefficiencies in screening and dealing with PSU and IPV. On top of that, professionals from both fields lack knowledge, skills, and capacity to treat women survivors of IPV with PSU issues efficiently and effectively, including of course screening and dealing with co-occurring IPV and PSU. These deficits, appeared to be related to various aspects of the co-occurrence of IPV and PSU; such as its high prevalence, the overlap and complex interplay between IPV and PSU, as well as the available interventions, tools, methods, material, and models, oriented to provide adequate support to women IPV survivors with PSU issues.

Being consistent with corresponding literature, MARISSA Project's research indicates that the deficits observed in professionals' competence are inextricably linked to the lack of relevant training. According to literature review and professionals' statements, the provision of formal training on co-occurring IPV and PSU is highly scarce, severely limited, and quite fragmented; while it mainly relies on their personal interests, ethic, and quest for development.

In a similar vein, in most cases, formal collaboration between IPV and PSU services is absent. Similarly, to training, co-operation among involved services appears to be based primarily on professionals' personal enthusiasm, resources, networks, acquaintances and relations formed in work-related events. The most common challenges for professionals working in the IPV and/or PSU field are fragmented or absent policies; different angles of approaching this phenomenon; different philosophies; trust issues;

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isolation and introversion of services; lack of effective communication and problem-solving skills and lack of both general and specific training on IPV issues.

Last but not least, relevant literature and research conducted within the MARISSA Project, indicated that the existing policies about co-occurring IPV and PSU are fragmented. The identified lack of inclusive policies seems to pose additional challenges to all professionals working in the field; resulting in the obstruction of providing qualitative and effective treatment to women survivors of IPV with PSU issues.

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3. Policy Options & Recommendations at European level

According to the MARISSA project's literature review and research, professionals working with IPV survivors with PSU issues have various needs. More precisely, this survey indicated that the vast majority of IPV and PSU professionals' needs are common among the three participating countries, namely among Estonia, Greece and Iceland.

Confirming the above-mentioned statement, Estonian, Icelandic, and Greek country reports and focus groups' results showed that treating women survivors of IPV with PSU issues constitutes a great challenge for both IPV and PSU professionals, mainly due to the lack of corresponding, inclusive policies. Since different public sectors and agencies deal with different issues and approach the phenomenon from different angles, policies and activities aiming to manage co-occurring IPV and PSU are fragmented. In all these countries (Greece, Estonia, Iceland), IPV and PSU services do not often allocate specific protocols, guidelines, tools, and approaches regarding screening, dealing, and treating survivors -and especially women survivors- of IPV with PSU issues. Furthermore, in broad terms, due to the absence of such policies, there is no formal collaboration between corresponding services in co-occurring IPV and PSU cases. Even in the few occasions that these policies exist, they seem to vary between not only these three countries but also both between and within IPV and PSU services of the same country. According to the MARISSA project's research, **new policies should be developed according to professionals' needs, extended in local and national level.** These policies should be explicitly targeted to the needs and challenges of professionals who work with women survivors of IPV with PSU issues, addressing and respecting at the same time the needs and challenges of women as well.

Therefore, the National and Regional authorities should develop a comprehensive training curriculum for front line professionals dealing with IPV about PSU addressing key issues of the phenomenon of co-occurring IPV and PSU, taking into consideration the treatment of both trauma and substance abuse and act in coherence with PSU professionals. The same goes for the development of comprehensive training curriculum for front line professionals dealing with PSU about IPV.

The MARISSA training material could be a baseline of added value so to develop and tailor further the training curriculum for the professionals (IPV) at national level.

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3.1 Legislation and Policies about co-occurring IPV & PSU

To effectively address the rights, interests and needs of women survivors of IPV with PSU issues, the existing legislation and policies about IPV and PSU need to change; while new ones about co-occurring IPV and PSU should be implemented. This need stems from the fact that the current legislation neither refers nor accommodates for the phenomenon of co-occurring IPV and PSU.

Moreover, both legislation and policies should empower and validate the role of IPV and PSU professionals and services, while providing them the essential safety and security for working uneventfully.

As a result, there is a need for corresponding laws and comprehensive, all-embracing policies specifically addressed to women survivors of IPV with PSU issues.

The three participating countries suggested the following policy recommendations:

- Development of integrated service provision programmes, as well as service description and support to local municipalities where service provision takes place.
- Development of training programmes for supporting professionals.
- Development of integrated services.
- Development of training programmes for people who can provide foster care.
- Multi-agency cooperation between professionals and services addressed to survivors of IPV with PSU issues, including and assorting low, medium, and high-risk cases.
- Shelters or supported housing system for survivors of IPV with PSU issues should be established.
- A closer collaboration or fusion of services, recognizing the diverse challenges of people with substance use issues.

3.2 Services for co-occurring IPV & PSU

Although there are many IPV services available in all three participating countries, when focusing on women, the **lack of specialised PSU services for women is evident.** Consequently, and in compliance with the existing literature, focus groups' results

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highlighted that PSU services explicitly referring to women, either with or without IPV experiences, constitute a basic and essential need for both clients and professionals.

3.3 Approaches to co-occurring IPV & PSU

Both relevant literature and the MARISSA project's research results, underlined an urgent existing need for gender-sensitive, feminist, and trauma-informed approaches; as IPV services usually do not take into consideration PSU issues, whereas PSU services lack sensitivity towards gender-related issues and trauma. This need is more intense among PSU services, since they are characterised by gender-blindness. Of all three participating countries, it is documented that over the last years, there has been some work done to address this problem in Iceland.

All the above needs led to the following policy recommendations:

- Increased access to services for women suffering from co-occurring IPV and PSU.
- Social stigma and gender-based stereotypes should be appointed as a priority and targeted as a primary goal to be eliminated.
- Shame and guilt should also be appointed as a priority and targeted as a primary goal to be eliminated.
- Poverty, accessibility, and affordability of services, as well as the absence of childcare and the fear of losing custody of their children should be addressed.
- Gender parity in decision-making positions and leadership should be ensured and fostered.
- Gender should be perceived as a social and relational construct of power that amplifies inequities in health due to the different levels of power that influence the roles, behaviours, activities and attributes; thus, creating the need to move forward and be more informed and inclusive.
- Social determinants and health-seeking behaviour, service provision and professionals and/or services' responses to co-occurring IPV and PSU should be simultaneously addressed through holistic approaches fostered by corresponding policies.
- Effective, evidence-based approaches, models, and good practices for the prevention and treatment of co-occurring IPV and PSU should be adopted.

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Focus should be given to **gender-sensitive and feminist approaches**, eliminating in this way gender blindness and tackling discriminations against women, as well as to **trauma-informed approaches** that enable:

- women's emotional safety;
- need of self-determination, making their own choices, and having the control of their lives;
- health and social priorities;
- empowerment;
- strengths and sense of value;
- trustworthiness;
- confidence;
- self-efficacy,
- thus preventing re-traumatisation.

Apart from clients, through trauma-informed approaches, professionals would also benefit. In particular, trauma-informed approaches could:

- improve staff retention;
- increase professionals' satisfaction with employment (e.g., less burnout or compassion fatigue, less vicarious or secondary trauma),
- and improve the system and program planning (e.g., ability to respond to trends in substance use such as young women's high rates of heavy drinking) (Anyikwa, 2016; Covington; 2019; Manandhar et al., 2018; Schamp, 2019; Schmidt et al., 2018; Poole, 2019).

3.4 Models for Treating co-occurring IPV & PSU

Apart from gender-sensitive and trauma-informed approaches, the high prevalence of co-occurring IPV and PSU, as well as the overlap and the complex interplay between these two phenomena pose additional challenges to the effective treatment of women survivors of IPV with PSU issues (Afifi et al., 2012). In these terms, and according to IPV and PSU professionals, from Estonia, Greece and Iceland***, a holistic, comprehensive,***

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and integrated model for co-occurring IPV and PSU is required (Afifi et al., 2012; Cohen et al., 2013; Crane et al., 2014; Engstrom et al., 2012; Fals-Stewart & Kennedy, 2005; Fowler & Faulkner, 2011; Gilchrist & Hegarty, 2017; Macy & Goodbourn, 2012; Schumacher & Holt, 2012). This integrated model would give professionals the opportunity to consider and tailor different types of IPV (e.g., physical, emotional/ psychological and sexual IPV) among women with PSU issues (Benoit & Jauffret-Roustide, 2015; Morton, 2019), as well as the problematic use of different and various substances among women survivors of IPV (Afifi et al., 2012; Crane et al., 2014).

However, *most professionals in the focus groups conducted within the MARISSA Project, admitted being unaware and lacking formal training on these models, expressing a need for increasing their awareness and knowledge, along with a need for developing through training their complementary skills and capacities*. Understanding integrated models' significance and benefits would promote their motivation and commitment to adopt these models while working with women survivors of IPV with PSU issues.

Therefore, policies should acknowledge the need to alter and improve the existing IPV and PSU interventions and services and create new services for the benefit of women survivors of IPV with PSU issues. In this context, policies should promote and assist the adoption of integrated models for treating co-occurring IPV and PSU and the establishment of PSU services explicitly referring to women. These services would address women's needs, including the need for 24/7 emergency care for IPV and PSU cases. Policies should also promote a family support person service, where better parenting skills and daily routine are supported, as well as bulk of foster families, who can take care of children of survivors temporarily while survivors are being treated as an alternative to institutional care of children.

3.5 Professionals' Knowledge, Skills & Capacity to Deal with Co-occurring IPV & PSU

The high prevalence and strong correlation between IPV and PSU highlights the professionals need of recognising the scope of the problem in order to be able to take the first steps towards providing support to women dealing with both IPV and PSU. To that end, professionals should be aware of the intricate and complex manner that IPV and PSU are being closely linked and realise that it is impossible to determine which one

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affects the other, since they both work towards exacerbating the other problem, producing in this way a vicious cycle.

According to the data, there is a lack of relevant knowledge and corresponding skills and capacities among IPV and PSU professionals regarding treating co-occurring IPV and PSU. In this line, professionals from the countries participating in this project expressed a need for further knowledge, training, and provision of tools that would assist them, especially in screening and dealing with women survivors of IPV with PSU issues. Moreover, given the fact that there is absence of clear protocols for cases of co-occurring IPV and PSU, the procedures, and interventions regarding dealing with this phenomenon vary not only between countries, but also between the same service providers; which points to the need for all-embracing protocols and guidelines.

3.6 Professionals' Training on Treating Co-occurring IPV & PSU

Regarding IPV and PSU professionals' training needs, the relevant literature review and research conducted within the MARISSA project revealed that official training on dealing and treating women survivors of IPV with PSU issues is severely limited and fragmented, and it mainly relies upon professionals' personal interests, ethic, and the quest for development. As a result, professionals express a need of, as well as their eagerness to be trained on specific aspects of co-occurring IPV and PSU, such as the characteristics and the efficacious treatment of women survivors of IPV with PSU issues.

It is worth mentioning though that, even in cases that such training is provided, findings indicate the presence of gaps and deficiencies. For instance, according to Estonian professionals, staff shortage has led to less skilled professionals who have completed some form of training but are incapable of working with IPV survivors with PSU issues. Policies should implement specific criteria for candidates for personal assistants and peer support individuals to be more efficient.

Effective training could take place in several ways. For instance, in the inial stage of knowledge and capacity building, displaying informative material regarding IPV and PSU to corresponding professionals seems to be a good practice. In particular, the availability and accessibility of such information to professionals as well as to beneficiaries increases professional confidence and makes them feel capable of making changes to and improving their work (Stella Project, 2007). At the following stages, it is important to include skills and capacity building in order to foster professionals'

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competency in practice. Moreover, IPV professionals could train PSU professionals on IPV issues and vice versa, fostering in this way exchanges of expertise, specialisation, experienced knowledge and practice (AVA, 2013; Benoit & Jauffret-Roustide, 2015; NICE, 2015). Another alternative would be experts on both IPV and PSU and ideally, experts on relevant integrated models to train IPV and PSU professionals that would participate in these partnerships on the treatment of trauma and substance abuse in a simultaneous and holistic way (NICE, 2015). Last but not least, partnerships should consider collocation of services, as well as aim to make changes in state-level policies in order to foster, facilitate and strengthen multi-agency cooperation at community and state level (Macy & Goodbourn, 2012). As a result, financial, moral, and training support to services, including NGOs, working with women survivors of IPV with PSU issues is proposed.

3.7 Protocols for Treating co-occurring IPV & PSU

It is essential even for small agencies with few resources to incorporate fundamentalpolicies and practices that provide inclusive services for women survivors of IPV with PSU issues. More precisely, protocols that contain diverse information on basic knowledge for treating co-occurring IPV and PSU and suggest practical techniques and helpful tools are required. For example, such a protocol can consist of information on practice issues, support services, screening, assessment, documentation for client files, risk, crisis intervention and emergency drug/ alcohol support, safety and additional factors to consider when safety planning such as HIV and Hepatitis issues.

With regard to services' operation, although in all three participating countries PSU services admit women survivors of IPV, in none of these countries women with PSU issues are being admitted in women's shelters; while their admittance at IPV counselling services varies among different services and countries. Due to the absence of policies regarding co-occurring IPV and PSU, there is no formal collaboration between corresponding services in such cases. Even in the few occasions that these policies exist, they seem to vary between, not only these three countries, but also both between and within IPV and PSU services of the same country. Thus, it is important to be suggested that local governments should provide shelter accommodation options for women survivors of IPV dealing with PSU.

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As a result, a key issue that needs to be addressed through policy making is the admittance of women with PSU issues to IPV services, and especially shelters. It is well acknowledged by participating professionals that excluding them from IPV services, the most vulnerable women are being left unsupported and abandoned. In a similar vein, policies for IPV and PSU co-occurrence should also include effective, evidence-based approaches, models, and good practices for the prevention and treatment of co-occurring IPV and PSU.

3.8 Services' Collaboration on Co-occurring IPV & PSU

In all three participating countries, and especially in Estonia and Greece, in most cases, there is an absence of formal collaboration between IPV and PSU services. Like training, co-operation among these services is mainly based on professionals' personal enthusiasm, resources, and networks; acquaintances, and relations formed in work-related events. Another similarity identified between Estonia, Iceland, and Greece, were the challenges of IPV and PSU services' collaboration. The most prevalent challenges were: fragmented or absent policies; different angles of approaching the phenomenon; different philosophies; trust issues; isolation and introversion of services; lack of effective communication and problem-solving skills, and lack of both general and specific training on IPV issues, mainly among PSU professionals. In agreement with the relevant literature, the MARISSA project's research results underlined an urgent need for formal cooperation, which could be defined by policies and institutionalised protocols. According to professionals, these protocols should include clear information regarding the required actions, existing focal points, referral pathways and follow up, implementing a shared understanding and standard procedures among IPV and PSU services.

Apart from implementing IPV and PSU integrated services, policies should also focus on multi-agency cooperation, including clear referral pathways. Such protocols and guidelines do not exist in any of the participating countries. Furthermore, another issue that arose from Greek and Icelandic focus groups was the limited funding of IPV and PSU services. According to professionals, sufficient funding should be anticipated by related policies in order to enable efficient co-operation among services, adequate training, staffing and infrastructure.

Finally, collaboration between corresponding services and education efforts are needed between the IPV and PSU fields, but also with other stakeholders including child welfare agencies, the criminal justice system, home visiting programs, housing programs, and trauma-informed mental health services.

3.9 National Strategies, Plans & Policies about Co-occurring IPV & PSU

According to the relevant literature, the management of co-occurring IPV and PSU should be incorporated in national strategies and plans, securing at the same time sustainable and sufficient funding (Benoit & Jauffret-Roustide, 2015). In accordance with this statement, Estonian, Icelandic, and Greek country reports and focus groups' results highlighted that the lack of corresponding, all-embracing policies pose additional challenges to IPV and PSU professionals regarding the effective treatment of women survivors of IPV with PSU issues. As a result, new policies extended at local and national level should be developed explicitly targeted to the needs and challenges of professionals, addressing, and respecting at the same time the needs and challenges of women survivors of IPV with PSU issues.

These policies should include:

- data collection;
- acceptance of women survivors of IPV with PSU issues at IPV and PSU services, and vice versa;
- Active and structured multi-agency collaboration of IPV front line professionals (Victim Support Services and counselling Centres) with PSU professionals in close collaboration with Law Enforce Agencies (Prosecutor's Office, Judges and Magistrates) so to correspond effectively to the complexity of the incident of co-occurrence of IPV and PSU of the women survivors of IPV (who might be a single mother as well);
- adequate and structured training of engaged organisations on multiagency collaboration – promotion of collaboration of different level organisations;
- altering and improving the already existing IPV and/or PSU interventions and services (e.g. through the adoption of gender-sensitive and trauma-informed approaches);

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- creating new services recognizing the interdependence of IPV and PSU for the maximization of therapeutic treatments (e.g. specialised PSU services for women, integrated services);
- day to day cooperation between IPV and PSU services upon cases (use of a reliable data base of incidents – cases protecting the personal data and security of women);
- provision of additional funding on research of grass roots organizations as well as on Civil Society Organizations on multiagency collaboration;
- promote multiagency and multilevel collaboration at national and European level, and
- adequate staffing and infrastructure for relevant entities.

In some countries, such as Estonia, the Ministry of Justice coordinates violence prevention in cooperation with the Ministry of Social Affairs. Victim support and prevention services developed and implemented by the Department of the Victim Support and Prevention Services of the Social Insurance Board also coordinate women's support services and work. Also, a National Action Plan for preventing intimate partner violence is developed. Harmonization of violence prevention action plan with national health and welfare plans as well as affordable access to psychologists and psychiatrists from less privileged people are some policy recommendations that are also suggested.

3.10 Data Collection for Co-occurring IPV & PSU

Firstly, data regarding IPV and PSU population and data regarding women survivors of IPV with PSU issues seem to be fragmented, leading to a need for systematic and official data collection process. First and foremost, it is essential to recognise the statistical correlation of the two phenomena. It is also suggested that data collection should include the prevalence of IPV and PSU co-occurrence in IPV and/or PSU and the general population and the special characteristics of women survivors of IPV with PSU issues, their challenges, needs, vulnerability and protective factors. In this way, professionals' need for an accurate picture of the totality of this specific phenomenon would be adequately met.

For example, in countries like Estonia, IPV and PSU data come from different ministries and agencies and are therefore very fragmented. Health and PSU data come from the

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National Institute for Health Development (NIHD), and IPV data come from law enforcement agencies. The Ministry of Justice prepares an annual crime report (incl. IPV prevalence).

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4. Concluding Remarks

Policies at European level need to provide guidance to member states of Europe and should aim at a number of areas in order to strengthen IPV and PSU service cooperation. First of all, the prevalence, relationship, correlation and interplay between IPV and PSU is far from being generally known and understood. Increased awareness and knowledge regarding the intricate, multilayered and bidirectional correlation, and the overlap and complex interplay between these two phenomena need to be available to professionals working on these fields in Europe, as well as to the policymakers themselves.

The EU needs to put a plan in place on gathering the research that has already been conducted, commission more in-depth research and disseminate this knowledge to professionals and policy makers within the EU. Secondly, trainings can form part of the dissemination of knowledge, and the EU should put a plan in place to offer short and to the point trainings for its policy makers so that they have the capacity to draft policies based on good understanding of both issues as well as their interlinkages, resulting in the co-occurrence of IPV and PSU. The EU should also put in place a policy on capacity building for professional working on both IPV and PSU services.

The Council of Europe Convention on preventing and combating violence against women and domestic violence, usually referred to as the Istanbul Convention, was a landmark treaty regarding the protection of women against all forms of violence. However, more work at the EU level is needed to combat intimate partner violence against women. Linking IPV and PSU is a necessary next step. The European Monitoring Centre for Drugs and Drug Addiction recognises that women dealing with problematic substance use face different challenges than men and that this requires amongst other things, specific services tailored to women; collaboration between drug treatment services and mental health services; and special services for pregnant women and women who have children (EMCDDA, 2019).

There is however no linking to IPV specifically. The European Institute for Gender Equality (EIGE) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) should join their forces and work together on a policy brief based on each of their expertise on IPV and PSU. This would be the first step to not only link IPV to PSU policy work and PSU to IPV policy work, but to draft a holistic policy on how to support women survivors of IPV who are also dealing with PSU.

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