MARISSA

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

Analysis of Local Substance Abuse and Intimate Partner Violence Professionals' perspective in Greece, Estonia and Iceland

Training & Multi-agency needs on IPV & PSU co-occurrence

Tartu,
January 2021

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

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Introduction

MARISSA partners conducted focus groups with professionals in Intimate Partner Violence (IPV) and Substance Abuse (SA) centres during October 2020 – January 2021 in MARISSA project countries: Greece by UWAH, Estonia by WSIC, and Iceland by ROOT.

MARISSA Focus groups had three main goals:

- Identify the knowledge, needs & challenges of professionals who are working with co-occurring IPV & Problematic Substance Use (PSU)
- Identify professional experiences and institutional practices and protocols/tools used to treat the client with co-occurring PSU and IPV in IPV and SA centres.
- Assess the level of an existing collaboration between IPV and SA professionals and gaps in referrals.

In addition, UoC organized 2 focus groups with students in the Master Programme "Clinical Interventions in Addictions" to investigate students/new professionals' attitudes and perceptions on PSU and IPV co-occurrence and cooperation between agencies.

Focus groups had a semi structured format. During the focus groups, professionals were asked to discuss the organizational policies for clients with drug use and intimate partner violence; cooperation between IPV and SA centres and coordination of individual cases.

The feedback collected from the focus groups was integrated into the analytical report on professional training needs, and the educational materials developed in MARISSA Project.

Implementing partners carried out 8 meetings, in total, in GR, EE & IC. There were 72 participants in total. In Greece, there were 41 participants involved in 1 Physical meeting and 3 online meetings in total; 15 participants in 2 online meetings in Estonia; and 16 participants in 2 online meetings in Iceland.

The table below shows the implemented focus groups.

Country	Partner	N of focus groups	Date of focus group	Participants in total
Greece	UWAH	2	30.11.2020 3.12.2020	19
Greece	UoC	2	06.10.2020 20.10.2020	22
Estonia	WSIC	2	9.12.2020 10.12.2020	15
Iceland	ROOT	2	18.12.2020 22.02.2021	16
Total		8 meetings		72 Part.

Table 1. Implemented Focus groups

Professionals Involved in the Focus Groups

In total, partners involved 39 IPV and SA organizations. The analysis showed that an equal number of service providers was engaged in the focus groups (See Figure 1).

Gender profile 63 participants showed that 92% of participants were female (57), and only 6 were male (8%).

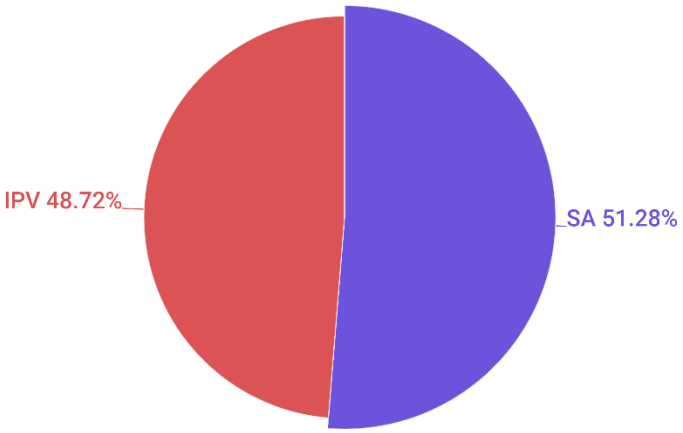

Figure 1. Involved Organizations in Focus Groups

The profession of Participants was diverse, but the majority was psychologists. Based on the collected data, we saw that only 63 participants responded to this question. Participant organizations deemed that the most appropriate professionals to participate to the focus groups were the Psychologists and Shelter Workers (front line workers) who are confronted with the issue of IPV and PSU.

Occupation of focus groups participants	N of participants	
Psychologist	31	49.2 %
Legal Counsellor	0	0
Counsellor	7	11.1 %
Social Worker	6	9.5 %
Shelter Worker/ Manager	10	15.8 %
Administration	1	1.5 %
Other	8	12.7%

Table 1. Professional Profile of FGs' Participants.

Dynamics in the focus group

In general, the dynamics in the focus groups were smooth and easy to follow. Semi-structured format of focus groups allowed higher input from professionals.

In **Greece**, the focus groups' dynamics were compelling, as many knowledgeable and very experienced professionals participated. Each one of them was an expert in their field, conveying significant views and experiences to share with the group. There was mutual respect throughout the process; all thoughts were heard and equally respected by everyone. In the second MARISSA Focus Group conducted by UWAH, most of participating organizations were based in Heraklion, Crete. The participants representing them were reached in the context of continuous collaboration and joined endeavours. Except for the participant that was an IPV counsellor in immigrant camps based in Ioannina (North of Greece), the remaining participants were all coming from Heraklion based organizations.

UOC conducted the focus groups with students and alumni of the Department of Psychology (University of Crete) Master Programme *"Clinical Interventions to Addictions"*. Some of the participants had voluntarily worked in rehab programmes such as KETHEA, while others have devised relevant tasks and assignments (e.g. Bachelor and Master Thesis). Regarding the alumni of the Master Programme, all participants have conducted a 1200-hour supervised traineeship at Greek rehab programmes (KETHEA and OKANA). At the time of the focus group, many of them were working at KETHEA and OKANA as addiction counsellors, while others were working at International Organisation for Migration (IOM) treating refugees/ migrants with mental health issues, including PSU and/or addiction and IPV or other forms of abuse and/ or PTSD. A friendly, safe, and trustful environment was established, in which participants could freely express their opinions and share their experiences. Due to this fact, a very productive discussion took place. Participants were filling out each other's opinions and experiences, while conflicted opinions were welcomed and treated with respect. It is worth to note that their academic orientation and practical experience in PSU field led to a focused discussion on this specific population in contrast with IPV population.

In **Estonia**, all participants were able to enrol via Zoom. Introduction to MARISSA project was given, and the main aim of the focus groups was explained. All participants introduced themselves, gave a short insight into their work. Participants were active, curious, and cooperative and wanted to contribute. The focus groups conversations were inspiring for **participants to learn about services and activities provided by participants' organizations.**

In **Iceland**, the groups were very dynamic and interested in the subject. The discussion was open and sincere. There was eagerness for more collaboration, and **two connections were made during the group with interest in cooperation**. Most participating organizations do not have written policy on this. People with IPV experiences are generally sent to specialist services, although work with IPV and trauma is a growing part of the services. All participants talked about the increased focus on trauma, and trauma-informed paradigms.

Existing Policies in the Organizations on tackling the co-occurrence of IPV and PSU

Policies in Greece

In the first focus group run by UWAH, participating IPV centres and Women shelters claimed to follow the same approach, namely to refer the IPV victim to the nearest SA centre, and in the most severe cases, insist on receiving some proof that they committed to the SA programme, as a prerequisite for following the IPV therapy. The SA centres follow the policy of incorporating IPV therapy as part of their holistic therapeutic approach. However, they treat IPV as a consequence or reason of the SA, supporting problematic behaviour's vicious circle. As opposed to the IPV shelters, where they follow the strict protocol of not admitting women with PSU; the participating SA centres claimed that they accept women with IPV co-occurrence to their shelters, as long as they follow their obligations. For example in one of the participating SA centres the rules are "no drugs, no violence and no sex" while beneficiaries use the sheltering services. SA centres have noticed that women follow those restrictions in most cases, especially if the clients are women who wish to keep their children and not have them taken away by the authorities due to their addiction problem. However, there was one case discussed when they had to release client from the programme because of her violent behaviour and not due to her PSU. The rest of the participating SA organizations agreed that violence is a vital factor in their clients' outcome.

The IPV centres reported that they refer the IPV victim to an SA centre, and may request proof that they committed to the SA therapy. IPV therapy helps the victim realize that SA is part of the problem and that it needs to be equally treated. SA centres do not follow the same procedure, as it was mentioned before, but they include the IPV treatment into the psychotherapy to all PSU clients.

The SA organizations did not report any incidents or cases where they did not admit any PSU beneficiary who wished to commit to the programme. There were two different approaches discussed.

The participants in the second MARISSA focus group, run by UWAH, were very clear about their organizations' policies and strategies. The Heraklion IPV shelter and IPV counselling centre clearly stated that they had admitted only a small number of cases, where there is a co-occurrence of PSU and IPV, in the last 8 years of their operation. However, in those cases, they informed the victim of the procedures and the prerequisites and referred them to the nearest SA centre. The counselling and the provision of shelter for women victims of IPV can only proceed with a certification of commitment and admission to the SA centre. An incident was mentioned from the shelter's psychologist about a woman who had to be discharged due to her continuous alcohol problematic use; even though she has been informed of the regulations. In Heraklion, the Counselling Centre follows the policy of referring any woman with IPV and PSU to the nearest SA centre, but continues to provide IPV counselling independently. If the PSU is severe and interferes with the IPV counselling, a certificate of attendance from the SA centre is required.

In the extreme cases of not being delivered upon request, most of the women drop out of the IPV counselling by themselves, since they are aware of the protocol.

The participating SA centres mentioned that most of the women admitted to their centres have been abused; mostly by physical violence, followed by sexual and psychological violence. In the most severe abuse cases, they refer the women to an IPV centre, and the woman victim has sessions with an IPV counsellor and the SA therapist separately.

The SA organizations mentioned no restrictions at all in admitting beneficiaries, since most women with PSU are also victims of IPV and cannot refuse their services. They fully recognize the interdependent relationship between IPV and PSU, taking all the factors under consideration. In their opinion, women with PSU and with IPV experiences are the most vulnerable group of victims, since their problematic behaviour is strained from both ends. Psychotherapy for the SA and counselling for IPV, either as part of their SA treatment or separately in an IPV centre, is the only way to keep a woman safe and away from those problems.

Policies in Estonia

In the Estonian focus groups, participants discussed that long-term inpatient rehabilitation services are provided for Viljandi Hospital adults in two departments, located in Viljandi and Sillamäe. Patients from all areas of Estonia are treated. The service is not substance-specific, and it is provided to both men and women. On average, the rehabilitation lasts nine months, depending on the state of the patient's health. Follow-up services are also provided to people who have completed inpatient rehabilitation, the goal of which is to prevent relapse and support the client's social adaptation. The service is provided on a case-by-case basis and this includes outpatient social counselling, psychological counselling and peer counselling. The service is intended for both recovering drug users as well as their families. The counselling is conducted individually and in groups. The service is available in various parts of Estonia (Tallinn, Jõhvi, Narva and Viljandi). NGO Peaasjad was established in 2009 by mental health specialists working for the Psychiatry Clinic of North Estonia Medical Centre and the team now consists of qualified mental health specialists, youth workers, ICT specialists etc. The National Institute of Health Development funds provision of low-threshold harm reduction services to drug users by several non-governmental organizations.

NGO Peaasjad is involved with a project VALIK (Choice) for young people with light cannabis use (low dose, beginners) and targeting behavioural change. The website peaasi.ee provides information and online consultations. Corrigo offers outpatient rehabilitation services for 14- to 18-year-olds with drug addiction. The primary treatment for opioid addiction is psychosocial help, which is based on medication's daily administration (methadone). Based on individual needs, the service can last from 9 to 12 months.

The rehabilitation process focuses on restoring the healthy state, physical condition, and social coping skills of the youths.

Women with PSU are not allowed to stay in women's shelters. **Employees of the women's support service and shelter providers have problems with recognition of drug users and SA service providers are not trained to notice signs of IPV but are eager to know more about how to recognize problems with IPV.**

Integrated programmes for women and men with a co-occurring IPV and PSU do not exist in Estonia. National coordination is fragmented. Intervention for women and men with a co-occurring IPV and SA is now based on voluntary cooperation through personal network and enthusiasm. Women's shelter service professionals give advice to victims and share information on PSU intervention centres; they try to refer beneficiaries to PSU treatment centres directly through their network. There is no obligation to do so, and there are no guidelines prepared for support chain on a national level. The leading organizations carrying out prevention activities fall under the Ministry of Social Affairs, Interior, and Education and Research control. Coordinating body for the Istanbul Convention is the Ministry of Justice. People with PSU need comprehensive, complex and long-term treatment, as PSU is caused by emotional instability and users have childhood trauma. There exist both scenarios where PSU precedes the IPV incident, and vice versa. Even when there are persons healed from PSU, physical violence is decreasing, and psychological violence remains.

A shelter worker is available in usual working hours, but emergency specialists come to solve the case in cases of emergency. Every shelter has “home rules”, where is stated that alcohol and substance use is prohibited. On a national level, there is a regulation on the Women's shelter service description that underlines that "Weapons, alcohol, drugs and other things dangerous to life and health may not be brought into the premises used for the provision of the service (shelter and counselling office), and should not behave in a way that disturbs or endangers other persons”. The service provider shall set out more specific security requirements in their house/internal rules.

Policies in Iceland

In Iceland, focus groups participants discussed their policies and work procedures. Most participating organizations do not have written policies on treating co-occurring IPV and PSU.

There were several organizations involved in the focus groups. They briefly described the services they provide to the clients. Foreldrahús, organisation engaged with PSU, is mainly servicing children and families, and everybody is welcome. Foreldrahús is a Family Centre and refers to work with violence which provides counselling and motivational interviewing for both adolescents and parents for up to a year in outpatient services. Kvennaathvarfið, the Women's shelter does not provide service to women with active PSU but is planning for new services for a broader group of women.

Bjarkarhlíð and Bjarmahlíð are sister organizations that act as one-stop shops for victims, with the same policy; women with IPV and PSU are welcome and get benefits.

In Bjarmahlíð, there are no specialized services for PSU. The women are referred to SA services, and more specifically Bjarmahlíð has an active cooperation with Root where women with PSU are treated. Konukot is an emergency shelter for women, and all homeless women are welcome; while referrals to emergency rooms, police, IPV services are undertaken. Konukot admits all homeless women but does not offer treatment of any kind. Hringbraut 79, Reykavíkurborg, admits women with complex needs, PSU and IPV. No treatment is offered.

One participant mentioned that **sometimes there is a need to explain to clients what violence is since there is often a lack of acknowledgement.** The methods used are to build trust and listen, create a secure environment, make a plan with the client, and motivate women to talk about the problem. It was also underlined that it is important to refer or provide information about special services for IPV/PSU. Last but not least, the danger the women is in should be estimated and the police should be called if necessary.

Cooperation Between SA and IPV agencies

Cooperation Status in Greece

The first focus group revealed that the level of cooperation among IPV centres and SA organizations in Greece is mostly one-sided, as IPV centres refer their victims with PSU to an SA programme. They even have to request a certification from that SA programme, for the IPV therapy. However, SA organisations do not refer their clients with IPV co-occurrence, but rather cope with IPV as a consequence of the PSU.

The SA centres reported being satisfied with their protocols, their statistics, and their outcomes. Addicted men and women realize that their PSU and the IPV in their lives are interdependent and commit to holistic therapy. Especially addicted women are more consciously aware of IPV and PSU's vicious circle, making them more willing to work on their progress.

In the second focus group that mainly included participants from Heraklion, Crete; the participants from both fields reported an excellent cooperation level since they both refer women to the other when necessary. The main difference that can be spotted is that participants in the second focus group were all officers in public organizations; whereas in the previous focus group, NGOs representatives also participated.

Both the Heraklion Shelter and Counselling centre for women reported that only a small number of women with co-occurring IPV and PSU were admitted and referred to the SA centre. However, in those few cases, they reported a positive outcome, since both problematic aspects of their lives were managed and treated by specialized counsellors. The SA centres also mentioned positive results from the women who had to be referred for their IPV to the Counselling centre for women, maintaining a rather conservative look, due to the unpredictability of substances use.

The main area that needs to be looked into, according to their reports, is the fact that **women with PSU and IPV cannot be admitted to the Shelters for Abused women**. **This obstacle is leaving the most vulnerable women unsupported and abandoned.** Another area that needs improvement is the training required to manage cases of IPV and co-occurring PSU. The participants in the second focus group reported that they had not received any training in the last 5 years relevant or not to their field. Again, we note that the represented organizations are state-managed and the economic crisis of the previous 10 years in Greece has minimized all costs, including extra training and seminars.

Cooperation Status in Estonia

Drug treatment in Estonia is provided through hospitals, which need to obtain a licence for mental health services to provide inpatient and outpatient treatment for dependency. According to the Mental Health Act, only psychiatrists can provide drug treatment. In general, drug treatment is primarily offered in outpatient treatment units, and inpatient treatment services remain limited.

SA centres working within harm reduction programmes cooperate with probation service, rehabilitation centres and local governments. The Estonian Unemployment Insurance Fund is also an important partner, where Work rehabilitation services are provided. Work rehabilitation prepares beneficiaries for working life and supports persons, even people with PSU, in starting work or maintaining employment, peer support is also provided. Work rehabilitation activities occur individually or in a group, depending on the needs of people with PSU. A case manager from the Unemployment Insurance Fund assesses the service needs. From the other side, the Estonian Unemployment Insurance Fund provides various services for employers of people with decreased work capability. The labour market service offered to individuals with reduced working ability is co-financed by the European Social Fund. Social rehabilitation programme is available through the Social Insurance Board. The Board runs procurement for getting services and has many partners. Women's support and intervention centres deal with social rehabilitation and cooperate with the Social Insurance Board and are involved in MARACs held on a national level, but cooperation with the Unemployment Insurance Fund is missing.

Smooth cooperation between IPV support centres and SA service providers does not exist. **Cases are solved case by case and depend on personal enthusiasm and resources of the service provider.** SA centres are satisfied with the cooperation with the Estonian Unemployment Insurance Fund. For the Social Insurance Board, sometimes collaboration with local government specialists is not so good due to the specialists' little interest or willingness.

During the focus groups, a case was used as an example to explain the deficiencies of the existing system. There was a woman, victim of IPV with a baby. The psychologist has discovered that the woman also has PSU issues. A shelter is not a place for her due to PSU, as the shelter has no 24/7 employee in place, and PSU could cause harm to herself, the baby, and other shelter clients. There is no place to send her further. The local government's child protection specialist can take a baby and look for a place for a child; but there are no procedures for a woman who suffers IPV at home and a co-occurring PSU. There should be integrated services and also 24/7 emergency care available in these cases. The SA centres face the same problem, there are no centres and intervention with 24/7 integrated services.

Cooperation Status in Iceland

During focus groups in Iceland, MARISSA team observed that Landspítali cooperates with the VoR-team, Frú Ragnheiður (mobile harm reduction and needle changing unit), Bjarkarhlíð, the National Center of Addiction Medicine, and the Addiction Psychiatry Clinic at the Landspítali. Foreldrahús has good cooperation with children's services, both health and welfare and childcare services. For Bjarkarhlíð, Rótin and the VoR-team have been of great help. Landspítali stated that more cooperation with SA services and Foreldrahús is necessary, while according to Bjarkarhlíð, more collaboration is needed with the Addiction Psychiatry Clinic and the Mental Health Clinic at Landspítali.

Konukot finds it challenging to encourage clients to take responsibility for themselves when they face “closed doors” everywhere.

There is no formal cooperation between the services providers. The harm reduction service does not want to jeopardize clients' trust to close collaboration with other organizations and emphasize user focus and trust. Some have an informal relationship with other service providers and referrals to other organizations. Most participants talk about the lack of cooperation and consultation.

Everybody in the focus group agreed that the healthcare system's prejudices are a significant obstacle, and education on IPV is desperately needed. Although there is more awareness of violence's consequences, more education on IPV and PSU is needed. Information sharing and lack of funding are the main issues.

The participating nurse underlined that there is a significant improvement in the way nurses treat their clients and support them according to their code of ethics. There have also been improvements regarding recognition of trauma in the lives of substance users and harm reduction. A main challenge is to trust other professionals; and professionals' ego is sometimes a problem in this field. The most significant challenges include limited funding of services, lack of follow up by gender-specific services and support, information on what services are available, and tools to assist clients when they disclose violence.

Coordination of Cases between SA & IPV Agencies

Coordination of Cases in Greece

In the first focus group, participants discussed that the referrals could occur twice a month or twice a year, depending on the IPV centre. For example, the National Centre for Social Solidarity refers more often as their services expand to a larger group of people and their offices being based in Athens, which populates around 5 million people.

Some of the participants expressed that they request their IPV clients to prove that they are still committed to the SA programme. If needed, they ask the client's permission to communicate with their SA counsellor, for further information, and possible alterations to the therapy followed so far.

All of them mentioned that many things need to change, for better services to be provided in IPV and PSU clients. They all agreed on the need for cooperation between IPV and SA services. There are many gaps in the management of co-occurrence of IPV and PSU, related to further practical training and to frequent exchanges of knowledge, experiences and suggestions with experts from the other field. Finally, all participants were eager to engage with activities and suggestions to further improve their skills, in order to provide more effective and better services.

In the second focus group, for both fields' referral protocols were definable for all, even though no many cases are referred. Women with PSU are admitted to the Counselling Centre for support but have to provide a certification of attendance in severe addiction cases. If they do not comply with the Centre’s policy, they have to be excluded from their services. In the Women's shelter, women with PSU cannot be admitted, according to their protocol, as the consequences of PSU might endanger other cohabitants and their children's health and safety.

The Shelter for Abused Women and the Counselling Centre for Women have referred only a small number of women in the 8 years they have been operating in Heraklion, Crete, which is less than 1 incident per year. The SA therapeutic centre refers to a slightly larger number of incidents, continuing their intervention independently.

Participating officers in the second focus group also reported a clear need for extra training to their centres, relating to co-occurring IPV and PSU. The psychologist from the Women's shelter strongly noted that the training required should not expand to therapy methods for women with PSU and IPV. The current strategy and treatment method of referring those women to an SA centre works effectively, in her opinion, and this should be maintained. This way, each specialized officer is most productive, and the workload is equally shared. The rest of the participants agreed on that statement.

They all concluded that the training should entail more information about the different kinds of drugs used for the IPV centres; and the various forms of violence and victims' psychological profile for the SA centres.

Coordination of Cases in Estonia

MARISSA team observed that during the focus group, women's shelter service, victim support, and violence prevention are coordinated by the Social Insurance Board. The National Institute for Health Development (NIHD) monitors the quality of services and programmes for drug users (treatment, rehabilitation, counselling services) and prevention activities. No referral pathways between IPV and SA service providers. But IPV centres have their referrals and procedure within their service provision chain. And SA centres have their referrals and service provision chain.

Every organization has its 'own' partners. In emergency cases, an Ambulance can take a person with health problems to the Psychiatric Clinic. In milder cases, specialists of the local government are contacted. Women's support service providers do not offer services for people with PSU or psychological disorders.

After inpatient PSU treatment in the Viljandi Hospital, there is an outpatient follow-up rehabilitation programme in the capital area and eastern Estonia. Follow-up procedure is occasional, only probationers are followed, and guidelines exist. Other clients have voluntarily come to participate in some programme. If persons with PSU contact a harm reduction programme or programme dealing with light PSU although they are heavy drug users, then the SA centre tries to send them to the inpatient treatment. Long-term inpatient rehabilitation services are provided for adults by Viljandi Hospital in two departments.

All participants stressed that improvement and link between IPV and SA centres and services should be established. Participants from SA centres have mentioned that they intervene in PSU and provide advice, assistance and treatment by psychologists and psychotherapists, mostly outpatient and voluntary treatment for the client. More specialists are needed; more treatment sessions, meetings and group work is required.

The discussion was in-depth in the Estonian focus groups. Professionals discussed that people suffering from PSU could also seek help from the outpatient receptions of psychiatric clinics. For example, people with PSU can register at the Psychiatric Clinic of the Estonian Regional Hospital. SA centre Libertas has several cooperation partners. If social rehabilitation is needed, then the partner is the Social Insurance Fund. They have been successful to work together with the Unemployment Insurance Fund. SA centres working within harm reduction programmes cooperate with probation services, rehabilitation centres and local governments. The Estonian Unemployment Insurance Fund is also an important partner where work rehabilitation services are provided. Work rehabilitation prepares people for working life and supports persons and people with PSU. Still, IPV survivors could be a target group, in starting work or maintaining employment; while peer support is also provided.

IPV centres have good collaboration with the Social Insurance Board, and they are involved in MARACs. The Social Insurance Board has not yet taken action towards integrating IPV and SA services. IPV and SA centres both cooperate with specialists of the local governments (79 LGs in total in Estonia). SA centres and IPV centres have positive and negative experiences regarding cooperation with local governments.

The local authority should identify the need for a person who requests assistance and determine corresponding aid. According to the Social Welfare Act, a local government must provide 11 social services, case management and support with delivering personal assistant and shelter service. In 2018, a new pilot programme SÜTIK was initiated by the National Institute for Health Development (TAI) and the Police and Border Guard Board (PPA). The programme gives police officers the option to refer arrested addicts for the abuse or possession of small amounts of illegal narcotics to the support programme SÜTIK. The programme aims at fentanyl and amphetamine addicts, and participation is voluntary and free of charge. There is a support person assigned to each beneficiary. The support person has the task to help them deal with problems caused by PSU as well as find the necessary services for them, for example, a place to live, gainful employment, advice from a therapist, help with debt management, and medical care to back them up in their fight against drug addiction. A competent and skilful support person has a crucial role in this programme.

Coordination of Cases in Iceland

The focus groups in Iceland showed that, in general, there are not clear referral pathways. Most cases are referred to the Emergency rooms to get injury notes. In other cases, women are encouraged to seek other services. For most of the participants, there is not a formal procedure for the following up. Some call the clients and get permission to call when they come in for treatment. There are some incidents of inadequate services after referral, and this is not easy.

Professionals from Landspítali mentioned that clients can always contact them, psychologists provide services to victims if they are older than 18 years old, otherwise, they are directed to the Government Agency for Child Protection. If victims open up about IPV they get in house support and referral with their appropriate permission; Bjarkarhlíð, Emergency rooms, Stígamót and Drekaslóð (the last two are centres for victims of violence). The view that PSU is a hindrance for work with trauma is still prevalent. According to participants, this needs to change.

Training Needs of Professionals

Training Needs in Greece

Participants in the first focus group claimed that there has been some training within the last 5 years in all organizations regarding IPV or PSU. They all reported that the training they have received was very theoretical, and did not provide much further knowledge. What they suggest is **more practical training, combining IPV and PSU experiences.**

Participants from SA centres requested further training on gender-based stereotypes since many of their male colleagues are still influenced by gender stereotypes when dealing with women clients. The phenomenon of gender stereotypes is also a negative factor in IPV centres and points out the importance of such training. The participants also wished for further legal counselling, since many of their clients require such, which they cannot provide as they lack knowledge. Furthermore, **group therapy techniques for women were also mentioned as a need for training**. And finally, they all agreed on **the general distortion of family values**, which is quite evident in the increase and earlier start of both, IPV and PSU, according to the statistics.

According to the participants of the second focus group, since no official training has been provided to them in the last five years, each officer is independently looking, studying, or following professional improvement seminars. Their opinion on the training is that it should entail **more information about the different kinds of drugs used when targeting IPV centres**, and the **various forms of violence and the psychological profile of victims when targeting SA centres**.

Training Needs in Estonia

Training programme depend on projects and topic. Training is provided separately by the case, such as **alcohol abuse, drug abuse, HIV prevention, tackling VAW, IPV and related prevention and support services.** IPV centre specialists need much **better knowledge about PSU: drugs, influence, behaviour and habits, recognizing signs and tackling manipulation by persons with PSU.** SA centre professionals pointed their **need for more knowledge on IPV intervention programmes and support services and about the existing network**. **Risk assessment tools** are required for all people working with IPV and PSU clients.

Participants have felt that training material and **practical tips about working with clients with PSU** and additional programmes are needed to tackle cases where co-occurrence of IPV and PSU appears. SA centre professionals think they need adequate inventories and screening tools to discover co-occurring problems, including IPV-related issues, whether a victim or abuser or both. SA centres do not know their clients' background; questions may be found in the ongoing treatment and consultation process. Their training needs include effective communication and problem-solving skills in the work with clients with co-occurrence of IPV and PSU, skills about **how to engage the client to accept intervention, as well as how to avoid slips and relapses**.

Integrated service description and client management within the existing system and compulsory and optional referral schemes should be developed on national level and guidelines. Informing agencies and service providers about the integrated support service provider is essential.

The specificity of treatment, behaviour and habits of clients with PSU and IPV is needed to both professional groups – to the personnel of IPV centres and SA centres. It is good to have **centres of excellence** to get additional information, advice and support. Also, personal assistants and peer support persons should be more efficient, and there should be a selection criterion for candidates. Low threshold has led to numerous less skilled people who have passed some training but are incapable of working with IPV survivors with PSU. Prevention and early identification of problems for PSU and IPV are essential.

Training Needs in Iceland

Hringbraut mentioned that they have had training on harm reduction and violence against people with disabilities. Professionals attended 3 courses on harm reduction and two times the other activity. In Landspítali, they receive continuous training on IPV and PSU and a special information meeting held on SA. Foreldrahús underlined that there is higher availability of training on IPV but less on PSU. Konukot, mentioned that they recently received training on harm reduction.

According to participants, it would be good to have useful **information on where to refer the clients**. In general, there is a lack of training and education about **IPV, what it is**, **how to screen for IPV, and how to deal with it**. One participant talked about training on lobbyism and education for further understanding of the clients' needs. Other participant talked about learning about different approaches. The most challenging task is **how to help people that are stuck in a violent relationship**.

MARISSA Focus Groups with MCS students & alumni, University of Crete

According to participating students' experience and knowledge, there is no established protocol and policies about PSU and IPV, neither coherent guidelines in Greece's PSU programmes. The treatment of PSU client that are also victims of IPV is individualized and depends on the therapist, the therapeutic team, the framework, and their intentions. In practice, professionals in the PSU field discuss this matter. For instance, one participant mentioned that a few days ago, she and her colleagues addressed a case in which an addicted man was abusing his partner and their child. However, in most of the issues, according to participants, therapists do not directly ask about the possibility of IPV victimization, neither in the present nor the past. Especially in OKANA, this topic comes into therapy only if the beneficiary brings it and opens the discussion.

There are no available policies about gender discrimination and specific interventions about addicted women in Greek rehab programmes. The only exception is "18 Ano" Rehab Programme that offers a specific centre for addicted women and mothers, including a shelter. Some participants mentioned that this exception is correlated with the population addressed by "18 Ano", which is much more motivated. In substitution programmes such as OKANA's (public SA organisation), activating a process about IPV may lead even to death. Unfortunately, when the perpetrator of IPV is a rehab programme member, the only used policy is removing the programme as a penalty. However, this happens only in the case that IPV will be perpetrated in front of the professionals.

Due to the gap of relevant policies, in practice, lots of questions are raised. In the absence of a protocol, participants feel that this conversation does not lead anywhere.

As for referrals, participants mentioned that they do not know whether and how they are taking place; it was something that they didn't meet during their practice or work on the SA field. Moreover, participants believe that therapists do not have the knowledge and capacity needed to refer to beneficiaries. They questioned referrals between different agencies as, according to their experience, even referrals between SA services and inside the same organization fail to succeed. In cases where referrals between SA and IPV services are successfully made, participants believe that therapists' contact and knowing each other is a matter of therapists' contact. Moreover, in Greece, referrals have often the characteristic of a personal favour ("If I don't like you, I don't serve you").

Participants claimed that referral pathways, like those implemented at IOM, are beneficial as there are clear protocols regarding what to do; which are the focal points and how referral should be done. As a result, the correspondence is sufficient. They also think that for referrals to be effective, a specific, expertise team should be available to frame the incidence. SA therapists should be well trained on referral procedure as well.

Another issue that should be considered is a therapeutic relationship, as clients referred to other agencies will have two therapists. As a result, there are two therapeutic relationships, which may be very frustrating and challenging to handle.

Participants did not know how frequent the phenomenon of co-occurring PSU and IPV is. Many claimed that they have not met it in clients' narratives during their practice and work experience.

Little was their literature-based knowledge regarding this phenomenon. On the contrary, some other participants mentioned that in SA services, they immediately recognized it. The percentage of co-occurring PSU and IPV is even higher in services specialized in addicted women and mothers and addicted parents. According to them, many couples enter PSU therapy together or become couples during PSU therapy. In such cases, women often are coerced to prostitution to gain money for their dose, experiencing high rates of mainly sexual and economic IPV.

Moreover, especially in alcohol therapy, specifically in alcohol group therapy, it is usual for couples to attend meetings together. In contrast, many of these couples face IPV issues and mainly physical and psychological IPV. Moreover, in migrant and refugee population - according to participants' experience and opinion - in cases of physical and sexual IPV, the perpetrator had had PSU issues, as a matter of culture.

Students mentioned that as gender violence –including IPV- is a result of patriarchal- and power-relations within the community; this trend also intrudes in the world of PSU; there are hierarchical structures expressed in every field, including PSU.

Participants mentioned that screening IPV in SA services arises during social history while asking about significant others' relationships. However, this is not institutionalized and is not an obligation of the therapist. In most of the cases, IPV arises as a topic during therapy. There are many therapists that, although they suspect IPV, they do not "open" this topic, unless the client does. Many participants mentioned that therapists didn't make questions regarding IPV or violence in general during their practice.

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