"Free from Addiction,
Safe from Abuse" project

Analytical report on women survivors of intimate partner violence and problematic substance use

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Women's Support and Information Center

There is a way out of violence!

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Introduction

Intimate partner violence (IPV) against women and problematic substance use (PSU) are two major public health concerns in European societies today. Problematic substance use is referred to by different terms, such as substance abuse, or substance use disorder for example. Early on in the implementation phase of the project, the project partners had a discussion on what terminology should be used. It was decided that the FASA project should be guided by a feminist and survivor-supporting vision and the terminology used should reflect that vision. Following a discussion on zoom, it was agreed that problematic substance use had the least negative connotation and would therefore be the term used throughout the project.

The two issues of IPV and PSU have traditionally been treated as separate domains. However, in the last two decades, it has become increasingly clear that IPV and PSU co-exist and intersect in various complex ways and require a holistic, coordinated response (Covington et al. 2008; Macy & Goodbourn 2012). This is especially the case for women suffering from IPV victimisation and women accessing treatment or services for problematic substance use; as they are highly likely to have co-occurring IPV victimisation and PSU (Rivera et al., 2015; Brown et al., 2003). Research indicates that services are likely to be more effective when a holistic, integrated approach is applied and both substance use and trauma, which is often a result of IPV or abuse, are treated together in the same programme or treatment centre (Covington et al. 2008; Bennet & Bland 2008; Sharpen 2018).

Theoretical underpinnings

Intimate Partner Violence against Women

Gender-based violence is a manifestation of the inequality between the sexes, and therefore disproportionately affects women. According to the World Health Organization; "violence against women is a public health problem of epidemic proportions. It pervades all corners of the globe, puts women's health at risk, limits their participation in society, and causes great human suffering" (WHO 2013, p. 35). According to the same source, 35% of all women globally have experienced violence by an intimate partner and/or sexual violence by a non-partner in their lifetime (WHO, 2013). Furthermore, 38% of all murders of women worldwide are committed by an intimate partner (WHO, 2013). In the European Union, 18 women are murdered every day on average, thereof 12 by their current or former intimate partner (UNDOC, 2011). According to a survey of all 28 European Union member states, 43% of women and girls aged 15 and above who had ever been in a relationship had experienced psychological IPV and 22% had experienced physical and/or sexual IPV (FRA, 2014). The actual percentage of women who have experienced IPV is likely to be even higher, as IPV has been shown to be highly underreported, with for example only 33% of affected women in the EU ever contacting authorities (FRA 2014).

Intimate partner violence is wide-spread and is entrenched in and supported by gendered societal and cultural ideas, traditions, and stereotypical gender roles (Bancroft, 2003; Stark, 2007; WHO 2013; EIGE 2019). Rivera et al. (2015, p. 1) define IPV as "an ongoing pattern of power and control in romantic relationships that is enforced by the use of abusive tactics, such as intimidation, threats, physical or sexual violence, isolation, economic abuse, stalking, psychological abuse, and coercion related to mental health and substance use". It should be noted that IPV is also common in same-gender relationships (Breiding et al. 2014), following a similar pattern of coercive control as in heterosexual relationships (Frankland & Brown 2014). However, further research on IPV in same-gender relationships is clearly needed.

Stark (2007) argues that in heterosexual relationships, the dynamics of coercive control, as a specific type of violence, is most commonly, and almost exclusively, perpetrated by men against women. Women perpetrate different forms of violence against male partners, such as incidents of verbal abuse or, more rarely, physical assault; but women in heterosexual relationships do not abuse their male partners by use of coercive control as men do to women. This difference is argued to be rooted in and caused by societal gender inequality. As men have a higher status in society historically, politically and economically, they can easily employ this advantage to control and subjugate their female partner in personal life. Nevala (2017) has shown that coercive control is indeed a specific type of violence, common in the EU, and that it is more severe than other forms of violence, leading to more serious consequences and having a more serious impact on survivors. Nevala's study also shows a correlation between gender equality and coercive control.

The above definition by Rivera et al. (2015, p.1) emphasises how IPV is a type of all-encompassing, usually long-term, form of violence where the perpetrator has, or strives to have, full control over the victim. There is a common misconception that IPV is characterized as mainly a few separate incidents of physical assault. This misconception trivializes the most common form of IPV, coined by Stark (2007) as 'coercive control' and by Johnson (2008) as 'intimate terrorism', and fuels the myth that women need only to be better at leaving their abusers to solve the problem of IPV. According to Stark (2007, 2009), coercive control or intimate terrorism is not only a form of violence but also a human rights violation, akin to kidnapping or hostage taking, where the woman's liberties and rights are taken away and where intimidation, isolation and control play a part even more important than the (also regularly employed) verbal, physical and economic violence. This has been supported by more recent research as well (e.g. Nevala, 2017; Sharp-Jeffs et al., 2018).

Survivors of coercive control suffer more severe consequences, often suffering mental health issues and/or problematic substance use, because this form of violence is on-going, pervasive and all-encompassing, severely restricting survivors' human rights usually over a long period in their lives, keeping them from reaching their full potential (Klein et al., 2018; Nevala, 2017; Stark, 2007). The pervasive nature of coercive control is often missing when IPV is researched, which according to Stark (2007) and Rivera et al. (2015), is one of the main reasons why the results vary greatly and so little is still known about IPV, and why legal systems, police and courts are still often powerless to protect women. The same issue emerges in research on the relationship between IPV and substance use. Most research employs a method where IPV is defined as separate incidents of physical assault, and fails to measure the all-encompassing coercive control that most often accompanies the assaults and has a far more serious impact on the victim than the incidents of physical assault.

Prevalence of Intimate Partner Violence and Problematic Substance Use

Existing research and literature suggest that there is a strong correlation between Intimate Partner Violence (IPV), trauma and Problematic Substance Use (PSU), as women undergoing IPV treatment often have PSU issues; and individuals under PSU treatment report high rates of abuse, IPV and Post Traumatic Stress Disorder (PTSD) (de Bruijn & de Graaf, 2016; Low et al., 2016; Mason et al., 2017; Schumm et al., 2018; Weaver et al., 2015). It is worth mentioning that in many cases PTSD is linked to IPV, as PTSD is the result of the exposure to violent and traumatic experiences and IPV comprise acts of physical, psychological and sexual aggression (Nathanson et al., 2012; Sullivan & Holts, 2008). Results from Nathanson et al.'s study (2012) show that more than half (57.4%) of the women victims of IPV, meet the criteria for PTSD.

Moreover, women survivors of IPV are 2.9 – 5.9 times more likely to develop PTSD and 5.6 times more likely to have PSU issues (Golding, 1999 as cited in Sullivan & Holt, 2008). Depending on the definition and the population studied, rates of coexisting IPV and PSU range between 25% and 80% (Friend et al., 2011; Langenderfer, 2013). More specifically, 21% - 43% of individuals (both males and females), suffering from PTSD are reported to be addicted to substances (Schäfer & Najavits, 2007). Research shows that a considerable percentage of women dealing with addiction have been abused during their life span. One of the early studies conducted on this issue was done among women dealing with alcoholism in California. There, 74% reported sexual abuse and 52% reported having experienced physical abuse. In addition, this study revealed that alcoholic women were more likely than non-alcoholic women to have experienced the most extreme forms of sexual violence, including incest and sexual abuse by the same perpetrator extending for a period of over 10 years (Covington & Kohen, 1984, p. 50). Other studies have shown that drug abuse prevalence ranges between 7% and 25% among women experiencing IPV (Weaver et al., 2015). Additionally, PSU seems to be significantly higher among women who have recently experienced physical IPV, or 3.6% vs 0.7% (Afifi et al., 2009). Another study revealed that of women victims of IPV, 6.4% met the criteria for drug dependence and 18.1% for alcohol dependence (Nathanson et al., 2012).

In their study, Schumm et al. (2018) found that addicted women under treatment have experienced psychological aggression at 96.7%, physical assault at 53.7% and sexual coercion at 49.2% the year prior to treatment. In women seeking therapy for PSU, the prevalence of IPV is three to five times higher than prevalence across nationally representative samples of women, ranging from 25% to 57% (El-Bassel et al., 2011). The phenomenon does not differ when we are referring to adolescents and young adults (Cohen et al., 2003; Schäfer & Najavits, 2007).

IPV is correlated with PTSD symptomatology and people experiencing both issues (PTSD & PSU) present more severe difficulties; for example, they begin experimenting with substances earlier; their PSU is more long-term and severe; the possibility of being poly-substance users is higher than people without dual diagnosis, and they face more psychological and social difficulties (Schäfer & Najavits, 2007). Addicted women survivors of IPV also suffer from more health problems – including HIV (Weaver et al., 2011). Additionally, it is possible to suffer from other co-existing mental health issues such as emotional, anxiety and personality disorders (Bernstein, 2000; Schäfer & Najavits, 2007). History of trauma and the reduction of functionality related with IPV and PSU in health, mental, social and occupational level defeat the help seeking, the therapeutic commitment and outcome, while at the same time, they are related to higher rates of drop-out (Berenz & Coffey, 2012; Bernstein, 2001; Davis, 2006; Mcgovern, et al. 2009; Schäfer & Najavits, 2007; van Dam et al., 2012).

Intimate Partner Violence and Problematic Substance Use

Research indicates that IPV and substance use commonly co-exist. When groups of women accessing substance treatment services are studied, results show consistently that a high percentage of these women are survivors of IPV (Schneider & Burnette, 2009). Women are more likely to use substances after being exposed to IPV, as opposed to women who have not been exposed to IPV (LaFlair et al., 2012; Lipsky & Caetano, 2008; Eby, 2004). Moreover, a number of studies show how IPV often causes trauma and trauma-related mental health conditions, such as depression or post-traumatic stress syndrome, in survivors (Nathanson et al., 2012; Vos et al., 2006; Beydoun et al., 2012; Dutton et al., 2006; Jones et al., 2001). Evidence also shows that suffering from mental health conditions increases the risk of survivors using substances as a coping mechanism (Sullivan & Holt, 2009, 2008). Sullivan and Holt (2009, 2008) found that PTSD could act as a mediating factor between IPV and PSU, in the sense that IPV victimisation increases the risk of a survivor developing PTSD, which in turn increases the risk of her developing problematic substance use behaviours.

When looking at the relationship between IPV against women and women's substance use, it is important to understand the nature of coercive control or intimate terrorism. Coercive control is usually perpetrated over a long period and contrary to common belief, often does not end when the woman ends the relationship and leaves. In many cases, leaving the abuser is precisely the most dangerous time for the woman, as the perpetrator is most likely to inflict serious harm when the victim leaves. Staying is often the most logical choice for a victim of coercive control/IPV and based on strategic analysis of what is the safest option in her situation (Davies et al. 1998). This is important to keep in mind when providing a service for women with problematic substance use, as they might have recently left an abuser who is still a threat, or they might still be in an abusive relationship.

Another factor that is important to keep in mind in this context is that some IPV perpetrators use substances as a tool to control their victim. A perpetrator might force a victim to use a substance, or completely control when and how substances are used (Warshaw 2014). Often perpetrators actively seek to sabotage the victim's efforts to sober up or complete a treatment programme. If the victim attends a treatment programme, the perpetrator might use this against her, seeking to control her via tarnishing her image as a mother with the authorities, claiming her to be unfit as a mother, etc. Many women choose not to seek services such as therapy or substance treatment because of the threat that their abuser might use the fact that she seeks such help to have the authorities remove her children from her care (Bennett & Bland, 2008).

Relationship between Intimate Partner Violence, Problematic Substance Use and Post-Traumatic Stress Disorder

One of the main difficulties in the understanding and therapy of trauma deriving from IPV and PSU is whether this is a causal relationship or not. Does IPV lead to PSU or PSU creates and/or fosters IPV? Many theories have been developed in order not only to answer this question, but also to explain the complexity of this phenomenon.

According to the Self-Medication Model, IPV leads to PSU (Khantzian, 1992). Under this model an individual uses substances to cope with negative events and their effects on the individual's life (Ford & Russo, 2006; Khantzian, 1992; Garland et al., 2013; Overup et al., 2015; Schäfer & Najavits, 2007; van Dam et al., 2013). Substances are used in order to reduce and relief the negative symptoms of IPV, trauma and PTSD, which in turn, trigger craving and relapse (Cohen et al., 2003; Khantzian, 1992; Norman, et al. 2010; Torchalla et al., 2012; van Dam et al., 2012). Even trauma-related cues can trigger craving and relapse, leading to more frequent and severe PSU (Driessen et al., 2008; Pizzimenti & Lattal, 2015; Tipps et al., 2014; van Dam et al., 2012), even 6 months after the termination of therapy (Schäfer & Najavits, 2007). Repeated and long-term attempt of self-medicating leads to the automatic correlation of PTSD symptoms and PSU and as a result, withdrawal symptoms produce flashbacks and trigger symptoms of PTSD due to their similarity with the fearful reactions to traumatic experiences, including experiences of IPV (van Dam et al., 2012). Ahmadabadi et al.'s results (2019) indicate that IPV experiences remain a robust risk factor for PSU, supporting the self-medication hypothesis. The susceptibility hypothesis, on the other hand, suggests that PSU increases the odds of PTSD, after the exposure to a traumatic incidence, due to higher psychological and biological vulnerability of people who misuse substances long-term (Schäfer & Najavits, 2007).

It is well documented in research that IPV can lead to PSU and that PSU increases vulnerability, especially for women, making them extremely vulnerable to abuse and IPV, through the exposure to unsafe situations (Abasi & Mohammadkhani, 2016; Schäfer & Najavits, 2007; Simonelli et al., 2014; van Dam et al., 2013; Vandemark et al., 2004).

In fact, it seems that there is a vicious cycle in which negative symptoms of IPV trigger substance-abusing behaviors, which in turn, affect the body, the brain and the mental state, intensifying IPV, PTSD symptoms and PSU, often leading to additional traumatic and abusive experiences (Abasi & Mohammadkhani, 2016; Simonelli et al., 2014; van Dam et al., 2013).

Intimate Partner Violence & Substances

A significant amount of research claims that there is a strong correlation between IPV and overall substance misuse (Cafferky et al., 2016; Low et al., 2016; Schumm et al., 2018). This relationship is also associated with the use of certain types of substances, mainly with alcohol and cocaine (Low et al., 2016; Schumm et al., 2018; Testa, 2004). On the other hand, Cafferky et al. (2016), did not find differences of different substances, including stimulants and non-stimulants, on IPV. As a result, it is not certain whether IPV derives from acute use, or from withdrawal symptoms or other spurious variables (Shorey et al., 2011). The correlation between IPV and PSU is also mediated and moderated by the pattern of use, gender and history of both victim and perpetrator, psychological and cultural factors and the type of IPV (Cafferky et al., 2016; Low et al., 2016).

Relevant literature suggests that the more severe is the PSU, the more likely and/or severe is the IPV (Ahmadabadi et al., 2019; Cafferky et al., 2016; de Bruijn & de Graff, 2016; Leonard & Quigley, 2017; Low et al., 2016). Heavier alcohol and drug use patterns (i.e., binge drinking, problematic use, or de-

pendence) seem to have more severe impact on IPV as compared to mere alcohol or drug consumption (de Bruijn & de Graff, 2016; Leonard & Quigley, 2017; Overup et al., 2015; Stuart et al., 2009).

Substantial evidence does exist for the relationship between alcohol use, and especially heavy alcohol consumption, and IPV perpetration and victimization due to psychological, physiological, emotional and cognitive changes induced by alcohol (de Bruijn & de Graff, 2016; Low et al., 2016). Furthermore, alcohol increases the sense of personal power, domination and expression of masculinity, while it stands for an acceptable excuse for misbehavior, non-acceptable by the society (de Bruijn & de Graff, 2016). According to Friend et al. (2011), alcohol is by far the most frequently used substance by perpetrators of IPV (84.2%). It has been found that males' and females' alcohol use increase the likelihood of perpetrating physical IPV and same-day psychological aggression, while in young adults alcohol increases the likelihood of psychological IPV (de Bruijn & de Graff, 2016). On the other hand, Schumm et al. (2018) and Cafferky et al. (2016) found that drugs have higher positive correlation with IPV than alcohol use. Perpetrator's substance use has been found to increase the likelihood of IPV instances, as almost one third of people under therapy for PSU, was involved in IPV perpetration, but also IPV victimization as well (Kraanen et al., 2014). Almost 25% of them had severely abused their partners while 17.4% have been severely abused by their partners. According to Schumm et al., (2018) victims' substance use constitutes a compounding factor of IPV perpetration. However, most researchers agree that a very strong predictor for IPV, and especially physical IPV, is the polysubstance use both for the IPV perpetration and the victimization of men and women, respectively (de Bruijn & de Graff, 2016; Low et al., 2016).

Apart from alcohol, some perpetrators use other drugs, in most cases, combined with alcohol (Friend et al., 2011 se de Bruijn & de Graff, 2016). Men's and women's use of stimulants seems to severely increase men's perpetration and women's risk of becoming a victim of same-day or general IPV, as it increases irritability and aggression (de Bruijn & de Graff, 2016). Research has suggested that among illicit drugs the most prevalent on IPV perpetrators is cocaine and the strongest relationship is found between cocaine use and IPV (Cafferky et al., 2016; de Bruijn & de Graff, 2016; Moore et al., 2008; Stuart et al., 2009).

There are a limited number of studies on IPV perpetration and cannabis use, but results portray little to no correlation between the two (de Bruijn & de Graff, 2016). The link between trauma/PTSD and cannabis use of the survivor have however been documented (Browne et al., 2018; Buckner et al., 2018), thus cannabis can be assumed to not lead to violence but being a survivor of violence can lead to cannabis use.

Women's, rather than men's, alcohol and marijuana polysubstance use seem to mediate the relationship between use and men's sexual and physical IPV perpetration, making women more vulnerable to IPV (Low et al., 2016), although the responsibility of IPV is always that of the perpetrator.

Support Services on IPV and PSU

Most mainstream treatment programmes for problematic substance use were initially designed for men with substance use issues. Programmes would normally focus only on the addiction itself, and, if participants suffered from any other ailments, it was assumed that they would be solved separately at a different time (Covington 2008). As a result of the feminist movement, in the 1970s and 1980s, women and issues faced by women, started being included in many studies of various academic fields, mostly in the social sciences. Today, it has become clear through research that women experience alcohol and drugs in different ways than men do. As with most other facets, issues and activities, in our society, substance use is highly gendered (Ettorre 2004, 2015). One example of this is how

women are more likely than men to be injected by their intimate partner, both the first time they use injected drugs and on a regular basis following this (Meyers et al., 2020; Simmons et al., 2012; Wright et al., 2007). Women are thus more likely not to have control over their injections. Gender shapes all of our experiences, but the male experience is generally seen as normal or the default. Treatment programmes meant to be gender-neutral are often in reality based on the experience of men, catering to the needs of men (Covington 2008). Women are seen by society according to - and judged based on - the standards set for men. However, since the 1990s a more gender-responsive and trauma-informed approach has been called for (Abbott, 1994; Peralta & Jauk, 2011).

Despite there being a growing body of research that indicates that a high number of women seeking support for intimate partner violence are also dealing with problematic substance use, few IPV service providers have thus far moved towards a more integrated response (Morton et al., 2015). The need for this to change has been acknowledged (Schumacher & Holt, 2012) although there is no consensus in existing research on how this should be done exactly. There are of course reasons why shelters and services for survivors of intimate partner violence may be reluctant to accept women who are also dealing with problematic substance use, the main reason being fear of the safety and comfort of other women using the services provided (Macy et al., 2010, p. 1152). Thus many service providers may feel torn between genuinely wanting to have their services accessible to all women suffering from intimate partner violence and wanting to keep their shelters or services safe spaces and non-intoxicated environments for other women and children making use of the shelter.

Although many service providers do not allow intoxicated women into shelters or counselling, they are probably nonetheless working with women dealing with co-occurring IPV and PSU. Since this is likely the case another issue is that staff members are inadequately trained to respond to PSU. Financing training for staff removes precious resources that are usually very limited for service providers for IPV (Hovey et al., 2020, p. 192), which may cause reluctance from managers. A lack of resources has been mentioned as a reason why service delivery for IPV usually does not include specific responses for women with co-occurring IPV and PSU (Morton et al., 2015). Additionally, women that are dealing with co-occurring IPV and PSU may not be able to fully benefit from a conventional substance use programme before they are in a place where they do not need to worry about their safety and the subsistence of themselves and their children (Andrews et al., 2011). The danger of having completely non-trained staff is in worst case scenarios harmful. Even though substance use is not a healthy or a constructive coping mechanism, pressuring a woman to abandon it before other coping mechanisms are in place is not a good or supportive practice (George et al., 2011).

When IPV services do not address problematic substance use within their premises, clients may respond by hiding their use, denying it or leaving the shelter to use. A 'don't ask, don't tell' policy deprives the woman the opportunity to reflect on her substance use and explore the connection of it and her experience of violence (Morton et al., 2015). A recent qualitative research from the UK provides insight into the difficulties that result from this for women with co-occurring IPV and PSU. There is a lack of connection of the needs of these women one the one hand and the support available to them on the other hand. The women in this research prioritised seeking assistance for substance use rather than intimate partner violence, never receiving support for both issues (Fox, 2020).

There are also other factors to consider such that women are less likely to seek support regarding their PSU if they fear a negative reaction from their abusive partner (Miller et al., 2000) and that

abusive men may indeed stand in the way of their partners' attempt at sobriety, isolating them from support services and use the survivor's dependence on substances as a tool for controlling them (Rivera et al., 2015).

Successful Interventions

A number of researchers argue that the best approach to address co-occurring IPV and PSU is through a holistic, gender-responsive and trauma-informed approach (Bennett & Bland, 2008; Fowler & Faulkner, 2011; Macy & Goodbourn, 2012; Schumacher & Holt, 2012). As a response to this there are now treatment models on problematic substance use that make use of this approach.

The idea of harm reduction has also been gaining ground since the early 2000s. Harm reduction is an intervention that aims at changing unsafe behaviour, such as problematic substance use, and minimising the harm that it does without requiring complete abstinence, when the individual for one reason or another is not ready, willing or able to pursue full sobriety at that point in time (Logan & Marlatt, 2010; Skewes & Gonzalez, 2013). Instead substance use is acknowledged and not judged, but considered a complex and inevitable part of life (Vakharia & Little, 2017). The focus is then on personal safety and maximising the individual's self-efficacy and autonomy (Covington, 2008).

Related to this is the trauma-informed approach. The idea of this approach is to view neither IPV nor PSU as individual problems but to focus on the traumatised individual and offer a holistic treatment. The focus is then to avoid re-traumatisation both by thinking of the physical environment where treatment takes place as well as interactions with the individual (Anyikwa, 2016). Making the woman seeking the service feel safe and empowered are also core aspects of this approach (Anyikwa, 2016).

There are a few models that take trauma and gender into account. First of all there is the treatment model developed by Covington (2008), the Women's Integrated Treatment (WIT) which is built on the foundation of being gender-responsive and founded on research and clinical practice and grounded on theories of addiction, trauma, and women's psychological development. IPV is not considered specifically here but falls under the larger umbrella term of trauma. Under this model a curriculum named *Beyond Trauma: A Healing Journey for Women* which emphasises the connection between trauma and PSU and focuses on violence, abuse and trauma has been established. Evaluations portray this model to contribute to significant improvement among women using it (Covington et al., 2008). Another model worth mentioning is the Seeking Safety (Najavits, 2007) model which does not focus on IPV specifically either but on PSU and PTSD. This model is an adaption of the cognitive-behavioural therapy. As with the WIT model it is closely linked and appropriate for many women with co-occurring IPV and PSU. The focus in this model is on dealing with PSU and PTSD at the same time and treating each person based on their individual need, offering a number of coping skills appropriate for both PSU and PTSD (Najavits, 2002). Finally there is the *Trauma Recovery and Empowerment* approach which focuses specifically on group therapy for vulnerable women who are dealing with trauma due to abuse (Harris & Anglin, 1998).

Apart from the holistic trauma-informed approach there are also approaches that focus more specifically on IPV and PSU and on pairing and integrating services that already exist to collaborate. A UK project worth mentioning is the Stella Project[1] launched in the UK in 2002, which provides training and development work with practitioners both in IPV and PSU. The project emphasises the many similarities that do exist between those who experienced problematic substance use and intimate partner violence. These include experiences of trauma, reluctance and fear of seeking support, possible denial of the problem and feelings of shame, isolation, low self-confidence and guilt, to name a

[1]For more information see https://avaproject.org.uk/ava-services-2/multiple-disadvantage/

few (Stella Project, 2007). According to the creators of the Stella project, the sector for intimate partner violence and the sector for problematic use of drugs and alcohol should logically work together so that resources can be used more efficiently and the outcome of the intervention is more likely to be successful (Stella Project, 2007).

The toolkit provided by the Stella project encourages a number of advanced changes needed regarding training and collaboration between service providers. This thus aims for a re-conceptualisation of services both for IPV and PSU. The idea is that this advanced work is preferable, since in the long run, close collaboration between service providers in IPV and PSU will lead to better results. However, as big change may seem daunting to initiate, there are a number of smaller basic steps that can be undertaken which can also make a difference and lead to more change and collaboration further down the line. Sarah Galvani (2010) has introduced some of these basic level responses in a factsheet on alcohol and domestic violence. These basic level responses include displaying information material such as posters, leaflets etc in visible places at the other service providers. IPV service providers should thus have this information available and accessible on service providers for PSU and vice versa. It is also recommended that service providers have a position statement on the other issues visible to visitors, have a directory of services for the other issue and that all staff, including managers receive training on the other problem (Galvani, 2010). It has been reported from service providers who have used this approach that using this, a clear and relatively easy start induced confidence in staff members of the service provider making them feel they could in fact make changes to the work of their organisation (Stella Project, 2007).

Cuan Saor is an Irish IPV agency that has gone through the process of changing their services to include women with co-occurring IPV and PSU. The shelter followed the 'Housing First' approach which focuses on providing people with housing irrespective of their substance use (Pauly et al., 2013). Initially it was decided that women who used substances would be allowed into the shelter but not to use any substances on the premises, but soon this changed to substance use only being allowed in the private apartments and not in communal areas. Shelter staff had to be trained and had to confront their own prejudices regarding illegal substance use. One key strategy was to provide staff with training on the effects of different substances and risks of use, including prescribed medication. In an attempt to combat stigma related to substance use a number of posters on substance use and harm minimization were put up all over the building. Standard screening questions for substance use were also incorporated into the intake process (Morton et al., 2015). A key worry for the agency throughout the change process was how to balance the tension between wanting to support women's autonomy and respect their choices in their complex lives whilst ensuring safety for these women, other women, and children using the shelter, as well as shelter staff. However, for the first year after women using substances were admitted, there were no incidences of conflict between women using substances and those who did not. There was not an increase in clients being intoxicated on the premises nor where there reports of problems of violence or abuse of other residents, staff or children (Morton et al., 2015). This project is thus a concrete example of how it is possible to work with women with PSU on their IPV problem without requiring them to sober up first. Importantly, it also provides evidence that making the changes necessary for IPV service providers does not require substantial amounts of resources nor large outside specialist support (Morton et al., 2015).

As has been demonstrated IPV and PSU are interlinked and have a complex, reciprocal connection. Viewing one as a clear cause of the other is therefore not helpful. In other words, reducing one problem as an intervention for the other problem is not likely to be successful. On the contrary, agencies and organisations that work on addressing these co-existing problems need to understand and be able to manage all the complexities involved (Bennett & Bland, 2008).

Assessment on Training Needs of IPV Service Providers in the Project Countries: Estonia, Greece, Iceland, Northern-Ireland, and Spain

To obtain a clearer picture of the training needs of IPV service providers, two approaches were used. First a questionnaire was sent out to service providers in the project countries in July 2020, the deadline to answer the survey was in August 2020 and then a report was made of the accumulative data. A total of 83 responses were collected from 44 different organisations. 16 responses were collected from Estonia, 12 from Greece, 10 from Iceland, 16 from Northern-Ireland, and 29 from Spain. Following this and a discussion of all project partners in a zoom meeting, a mix of focus group discussion and interviews took place in all the countries in September and October 2020.

The project countries: Estonia, Greece, Iceland, Northern-Ireland, and Spain vary in many ways. The service providers targeted within each country also vary. The service providers in Spain for example focused on women with co-occurring problematic substance use and intimate partner violence. Therefore, the data from Spain is kept out of many of the figures on substances and how often service providers encounter clients grappling with problematic substance use. The interviews taken with the Spanish organisations are however used as they provide an insight into the views and experiences of those service providers that are used to offering services to women with substance use issues.

The information gathered provides a useful insight into the reality faced by service providers for survivors of intimate partner violence, their ideas, challenges and training needs to be able to support women with co-occurring IPV and PSU. Similarities as well as differences between the countries depict differences yet some common themes apply.

Prevalence

When service providers were asked in the questionnaire about their estimate of clients who are dealing with problematic substance use, the majority estimated this to be less than 25%.

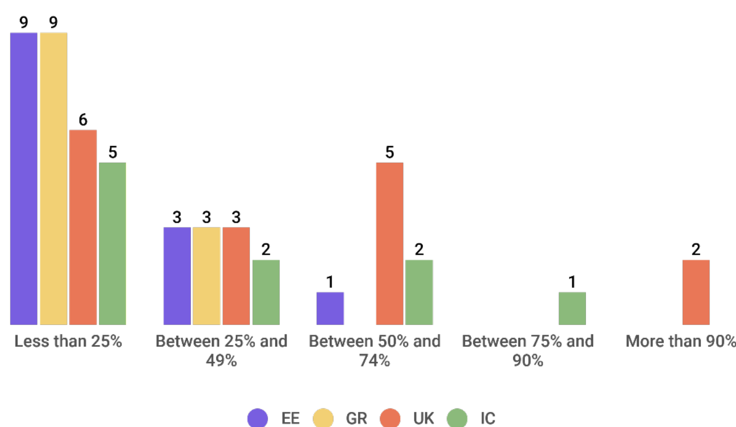

Figure 1. What percentage of your clients would you estimate are currently dealing with substance abuse issues? (By country)

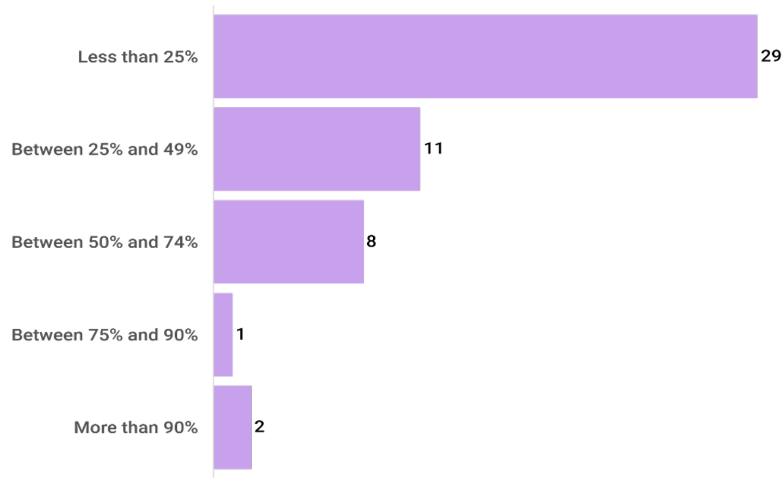

Figure 2. What percentage of your clients would you estimate are currently dealing with substance abuse issues? (Total)

However, less than 25% is a relatively broad definition. When asked how often service providers meet with women survivors of intimate partner violence who are also dealing with problematic substance use, the results became more varied. The most common response in Greece for example was a few times in a year (which was the answer that also came up in the focus group discussion held there). In Iceland and Northern-Ireland, once a week or once per month was more frequently stated, and responses from Estonia were interestingly divided between a few times a year on the one hand and on a daily basis and at least once a week on the other.

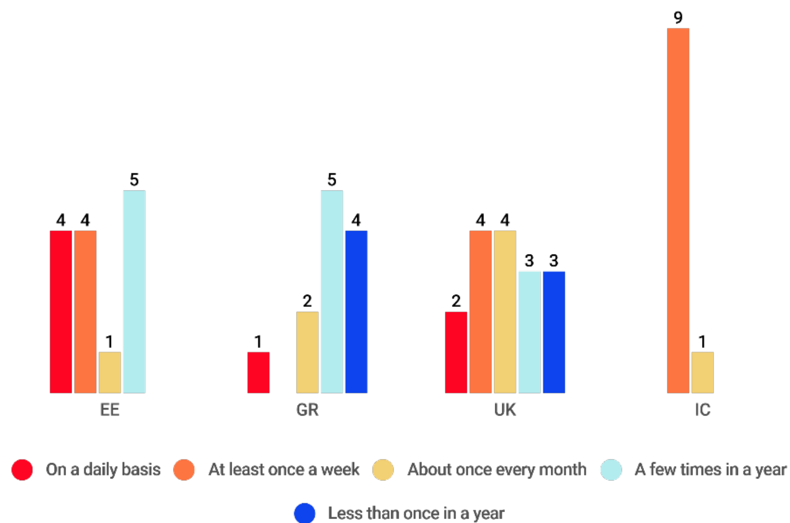

Figure 3. How often do you meet women survivors of IPV with substance use issues in your work? (By country)

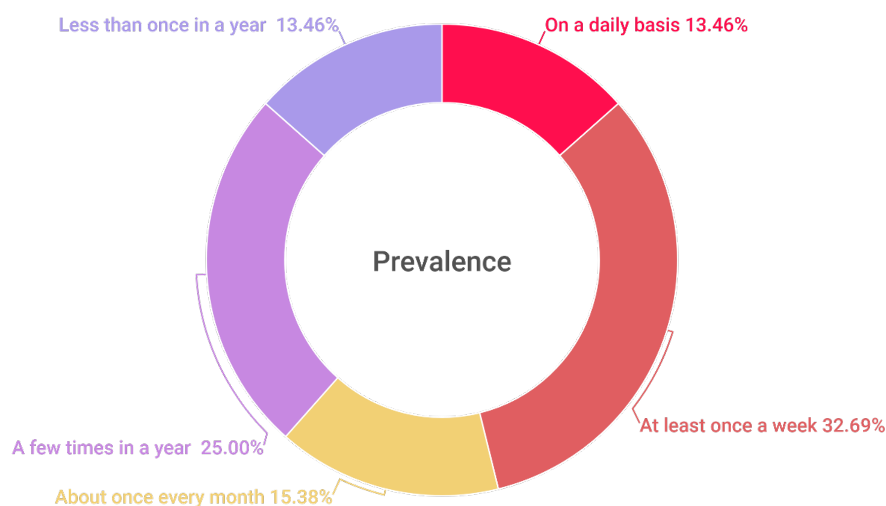

Figure 4. How often do you meet women survivors of IPV with substance use issues in your work? (Total)

The differences that appear between countries may have more to do with differences between the types of service providers asked, rather than country specific discrepancies. An interesting discussion on this occurred in one of the focus group discussions. First of all, as came up in all project countries, most participants agreed that it was difficult to estimate how many of their clients were dealing with problematic substance use because it is impossible to say how many of them admit to their use when asked, whether they actually consider it problematic, and how good they are at hiding it from the IPV service providers, should they choose to do so. More interestingly however was when one focus group discussant in Iceland mentioned that she met a couple of women every week now and that this number had gone up immensely after they started collaborating with another organisation that works on issues of problematic substance use. It seems that word got out very quickly to rehab centres that one of the IPV service providers was now in collaboration with a PSU provider and very quickly the number of women with this co-occurring issue started coming to ask for their services. A participant who worked in a shelter where substance use was not permitted added that their experience was that very few women with co-occurring IPV and PSU came to their services and she feared that it was because it was known that the shelter was substance free. Therefore, she assumed that women who use substances heavily do not seek any of the services of that organisation, neither shelter nor other services provided. This sentiment was echoed by an Estonian respondent who reported that there were probably a number of women dealing with co-occurring IPV and PSU, but they remain invisible to shelter staff. It was hypothesised that one reason for this could be that the police do not bring these women to the shelter.

Judging by this, it seems clear that prevalence cannot be estimated based on how many cases of co-occurring IPV and PSU service providers of IPV come across. Low numbers are only an indicator of low numbers seeking their services, not of the extent of the problem in society at large. It can therefore be assumed that ***should IPV service providers change their regulations and be open to supporting all survivors of IPV, the number of women dealing with PSU seeking the services would increase***. For this to occur, clearly training of staff would be necessary.

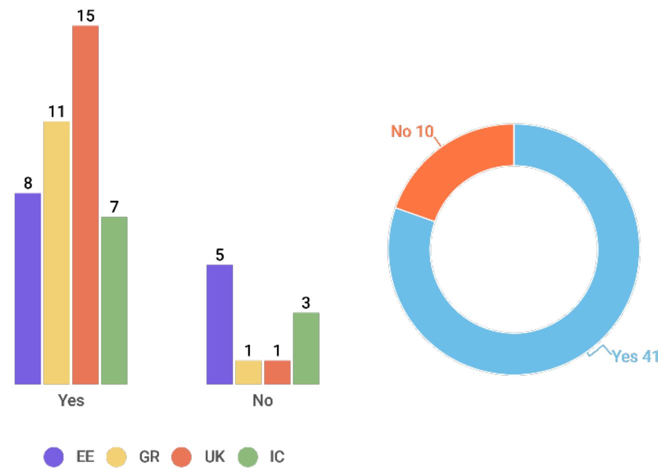

Figure 5. Do you ask clients about their use of drugs or alcohol when taking them in for services?

Regarding whether PSU was identified from the beginning, most agencies stated that they did ask their clients about their level of use of drugs or alcohol when taking them in for services. It did however come up in some focus group discussions that the question asked does not in general necessarily receive an 'honest' answer, either because of trust issues and the women do not want to admit to this in the first interview, or they simply do not view their use as problematic even though the counsellor may do so. In open ended answers it also came up from most the countries that problematic substance use often came to the surface later on in the counselling process, both because of trust having then been established or because the use becomes difficult to hide.

Substances

It varied whether respondents reported that they were well aware of different substances or not. There were some that felt that they were well aware. Others, as the Estonian respondents for example, stated that they had very limited knowledge about different drugs and how to recognise them. However, two respondents who work only with women with PSU, one in Iceland and one in Spain, mentioned the importance of continuous trainings on drugs, drug use, and new patterns of consumption. Given that these respondents should be amongst the more knowledgeable about the subject, yet stress the importance of continuous training on the subject, it can be assumed that everyone would benefit greatly from an increase in knowledge about substances in general.

Both the survey and the focus groups revealed that it was difficult to estimate the number of women dealing with problematic substance use. I some instances it was revealed that PSU was not necessarily disclosed, especially in the early stages when seeking support from service providers as came up in Estonia and Iceland for example. In other instances, it was reported that service providers did not frequently come across women who were battling co-occurring IPV and PSU, such as in Greece for example. Despite this, respondents were asked what the substances were that they most frequently encountered being used by their clients.

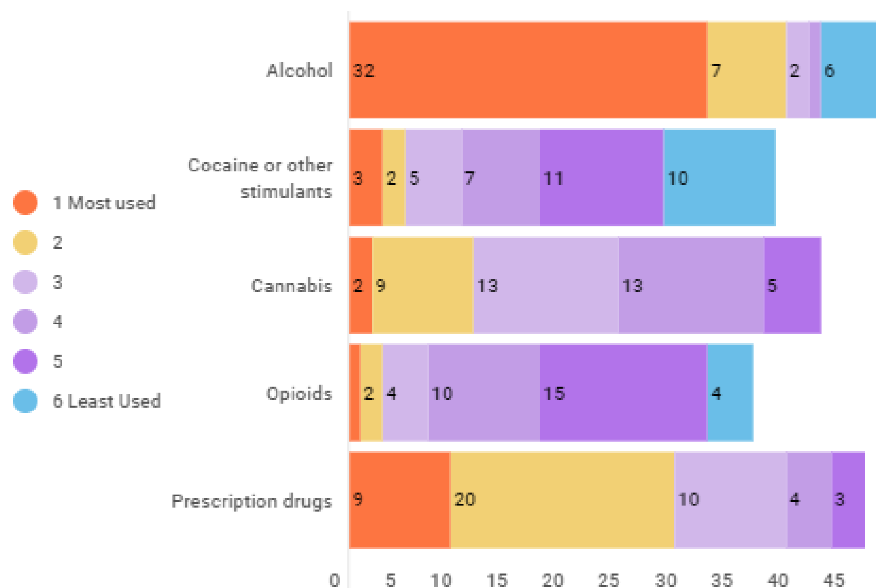

Figure 6. Of the clients for whom PSU has been identified, what substances are they using most?

Alcohol was by far the substance mentioned most often. The focus groups yielded similar results with alcohol and cannabis usually being mentioned as the most common substances used. It should not come as a surprise that these substances are most mentioned. Alcohol, as a legal substance is both most easily available and perhaps due to its legality bears less stigma than illegal substances. Cannabis, although not legal, is often quite easily available and considered as a "softer" drug. Cannabis as a coping mechanism for trauma has also been documented in the literature (Browne et al., 2018; Buckner et al., 2018) and with its sedative effects it is often used as a coping mechanism for women suffering from intimate partner violence.

However, other drugs were mentioned as well, including cocaine and other stimulants, indicating the complex relationship between substance use and IPV and that the substance use is not only used to dampen feelings and emotions. As previously mentioned, the service providers in Spain vary from the others as they only work with women suffering from co-occurring IPV and PSU. They are thus well acquainted with different substances and addiction more broadly. Interviews with them reveal a new dimension of addiction that their clients deal with as they mention other types of addictive or non-conforming behaviour, such as shopping addiction and eating disorders. Although this lies outside the scope of the FASA project, it illuminates the complicated issues that interlink with being a survivor of intimate partner violence. A focus group discussion in Spain also revealed that using more than one substance was very common. A participant in one of the focus groups in Iceland who worked with women with multiple problems such as homelessness, violence and drug use also mentioned this. Both these focus group discussions revealed that sedatives were perhaps used regularly and then one or even two other drugs also used in different circumstances.

Another important point made in a focus group discussion in Spain was their aim to not distinguish between substances which would lead to different levels of stigma being associated with them. This echoes what was one of the changes made at Cuan Saor shelter in Ireland (Morton et al., 2015), mentioned in an earlier chapter of this report. It seems to be an important part of re-training service providers supporting survivors of intimate partner violence to not think of substances as legal or illegal or make particular distinctions between them. It is more important to know the effects and the risks of all substances. In some of the focus groups it was mentioned that some women were using prescription drugs, which they had been prescribed from their doctor, but that service providers were suspicious that they were using much more of than prescribed. This needs to be kept in mind as well when looking into problematic substance use.

Challenges of Working with Women Who Suffer from Co-Occurring IPV and PSU

Stigma came up clearly when participants were asked about the problems working with women with co-occurring IPV and PSU. As described well in a focus group in Spain this is both social stigma, which the women face from their surrounding society, as well as stigma that they have internalised and need to deal with. Women being ashamed or afraid to admit their problem also came up in the focus group discussion in Greece and this was considered the reason why women did not seek assistance from IPV counselling centres. The general stigma in society against people with problematic substance use was also mentioned and how they were in general treated like second class citizens by the system.

Another issue mentioned was the lack of resources for this group of people, and that there were few to no organisations with the expertise to deal with this dual issue. It was further mentioned that there is a need for more support for these women in early stages, as things can easily spiral down quickly. It was mentioned in one of the focus groups in Iceland that once these women lose custody of their children for example, due to heavy substance use, helping them becomes even more difficult since this increases the vicious cycle of using substances to reduce the emotional pain. There is thus a need for a lot of support to be available before it gets to these kinds of drastic measures.

The fact that there are few to no therapy options available to women with co-occurring IPV and PSU also came up. It is by far most common that women are required to be sober to receive any kind of therapeutic assistance. As was mentioned in one of the focus groups in Iceland the type of therapy used by the health care system for example, is not appropriate for people using a lot of substances. The trauma therapy used is cognitive behavioural therapy, but even if the women manage to sober up for the sessions themselves the therapy itself is so deep and cognitive that they cannot deal with it in the state they are in and thus do not gain anything from it. There is therefore a need to not only offer women with co-occurring IPV and PSU support without forcing them to sober up first but also to find appropriate means of therapy that can be helpful to them in the state they are in.

There were some important issues that came out in the responses to this question as well that relate to training needs of IPV service providers. To get the women to admit to their substance use problem came up in more than one focus group and it was clear that there are instances when counsellors view the substance use of their clients as problematic but the clients do not share their view. It also came out of one focus group that these women might not realise that they are more vulnerable to IPV when they use substances. Based on this it seems imperative that training for service providers has a clear key message that despite there being correlation between IPV and PSU the causation is unclear and mixed. Treating substance use should never be considered a solution to IPV.

Additionally, although counsellors are well meaning when trying to point out the issue of problematic substance use the women are facing the timing of when this is appropriate is a delicate matter. When women come in for services it is essential that they get met with a welcoming approach and that their substance use is normalised (Stella Project, 2007), not stigmatised. In one of the interviews it came up that women dealing with co-occurring PSU and IPV drop out of the counselling early in the process. When probed regarding the reasons behind this the participant stated that possibly the women felt that they had come to this organisation seeking support for the violence they endured at home but then counsellors started talking about their substance use, which was not what they wanted support for. Thus, they simply stopped showing up. The reason given by the participant is quite credible. Therefore, training for IPV service providers needs to keep this in mind, that although counsellors find it important to support women with their problematic substance use, the timing needs to be right. In the beginning it is important that women are met where they are at, receive support

for what they have come to receive support for and that their substance use is normalised. The frustration that comes with working with women dealing with PSU who are continuously relapsing was brought up by an Estonian participant. There is an immense amount of work and energy that goes into supporting these women and when staff feels that it is not yielding results, they feel exhausted and frustrated. This is something that should be kept in mind for the training of service providers, i.e. how to support staff in these difficult cases, perhaps the most obvious support being to lower the expectations of staff members.

Regarding the main challenges that women with co-occurring IPV and PSU face, some of the responses were similar to what has been discussed above. Stigma and the lack of resources/support services available to them are among the main challenges these women faced. It was pointed out in one of the focus groups in Spain that these women are not a homogenous group and their challenges vary considerably, for example depending on their social status. However, stigma, which came up clearly in all the focus groups, makes it more difficult to reach out for help. Examples were given that when the police are called to their homes, intoxicated women are not taken as seriously regarding the violence as sober ones. Another participant mentioned how she often felt that these women were "stuck", taking the example that it is perhaps their abuser that provides them with the substances so leaving can be difficult for that reason. Another participant pointed out that it was important, given these women's difficulties, to welcome them and offer them services no matter what state they were in when they show up. It is known that substances are used to dampen difficult emotions and therefore it is very understandable that a number of survivors of intimate partner violence self-medicate in this way. Yet, it is also important, as time passes that women get support to deal with their problematic use since there is a need to get rid of the dampener of difficult emotions in order to be able to start dealing with those same emotions.

Policies

When asked in the questionnaire whether their organisation or agency had a policy for clients with co-occurring IPV and PSU most responded that they did.

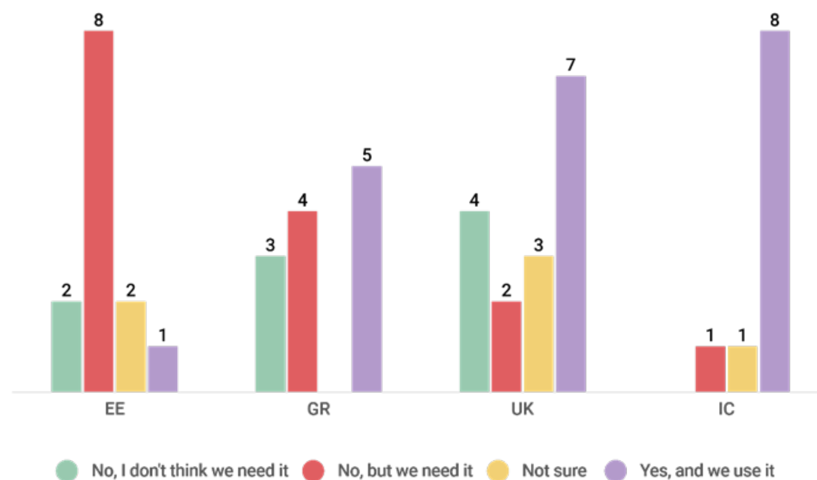

Figure 7. Do you have a formal policy for clients with co-occurring IPV and substance use? (By country)

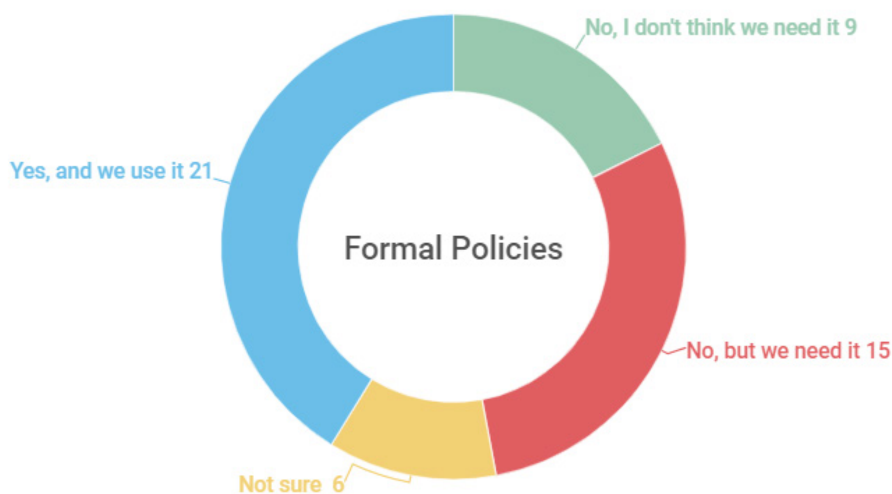

Figure 8. Do you have a formal policy for clients with co-occurring IPV and substance use? (Total)

Of those that did not have a policy, a majority felt that it was necessary. However, what having a policy actually meant to the respondents of the questionnaire is not clear and the focus group discussions revealed a somewhat different picture. Differing from responses provided in the questionnaire, the focus group discussion in Greece disclosed that none of the participants' organisations had a policy on this issue, but this was of interest to the focus group participants. In Estonia and Iceland, the discussion went into a different direction and this question was answered with what rules were in place in regard to substance use in the different programs of the organisation and agencies. It can therefore be assumed that some of the responses in the questionnaire refer to these kinds of rules rather than concrete policies of co-occurring IPV and PSU. Therefore, policies on this double issue are possibly less common than what the responses from the questionnaire indicate.

In the focus group discussion in Estonia the question on policy was answered by explaining that substance use is prohibited in all shelters and this is guided by a national level regulation on women's shelters. This national regulation explains that weapons, alcohol and drugs and other items that pose a threat to life are not allowed in shelters. Substances are thus put into the same category as weapons, obviously guided by a view that substances pose a grave danger to the individual using them, as well as others. This is in line with what has been reported in the literature, safety of fellow inhabitants of shelters is the most common reason for why substance use usually is not allowed within the premises (Macy et al., 2010).

Similar answers came up in the Icelandic focus group discussion although regulations there are not as centralised as in Estonia so therefore, easier to change; at least, in theory. No one mentioned their organisation having a specific policy on the co-occurrence of IPV and PSU. Their regulations on substance use varied however. Some reported that their services were open to all and women could come for services in any condition they were in as long as they did not show threatening behaviour. Others reported that women were not allowed to show up for sessions intoxicated but were welcome whilst sober.

One participant noted that their regulations on substance use varied between projects. In his agency one project required sobriety, whilst others did not. The participant explained that this particular project was for poor single parents and their children and he claimed that it helped women to stay sober knowing that their substance use could lead to them not being able to participate in a project that benefited their

children. Importantly though, none of the participants in this project are users of heavy drugs, the main issues that have come up are with recovering alcoholics that have taken a misstep and need help to get sober again. It is probably less likely that the benefits for the children would work this well for people with an addiction at a more advanced stage. The only organisation that provided a shelter did not allow substance use on its premises. There the familiar theme came up, that these regulations were in place because of other inhabitants and especially their children since children from violent homes often connect intoxication with violence.

The focus group discussion in Greece provided similar results. Three out of four centres did not admit women who use illegal substances for the same reasons mentioned above, co-habitation with other women and children. One counselling centre admitted women who were using illegal substances, but on the condition that they commit to PSU treatment and regularly provide proof that they remained committed to being sober. Thus, essentially, sobering up is a pre-requisite at all centres. There it also came up that women dealing with problematic substance use tend to not fully comprehend the correlation between their problems and underestimate the importance of tackling their substance use.

In the Icelandic shelter where substance use was not allowed on site, there was no prerequisite of commitment to not use substances at all. The rule is simply to not do it within the premises of the shelter. The regulation is therefore more of a "don't ask, don't tell". If women manage to use substances without anyone knowing about it, it isn't a problem. Thus, women are not completely forced to quit using substances should they not be ready to do so, but it is made more difficult for them. As admitted by the participant from this shelter it does however mean that women with co-occurring IPV and PSU are not given the opportunity to discuss their substance use. As has been discussed in the literature this inhibits women of exploring the connection between the violence they endure and their substance use (Morton et al., 2015). The main change mentioned needed for these regulations to change was a change in mind-set of staff and different housing of the shelter, allowing for more privacy for each individual woman.

In response to the question of what was done upon finding out that a client was using substances, the responses varied somewhat. The focus group discussion in Greece revealed that this is met with an immediate referral to a programme for problematic substance use and taking part in this programme is a condition for the continuation of the IPV counselling. According to participants in this focus group discussion the logic behind this is that it is important for the client to admit to their problem in order to be able to make improvements to their lives and evidence that they are willing to make the commitment to seek assistance. The approach by the Estonian organisations was slightly different. There, the first step was a serious talk with the woman using substances, followed by a probationary period and attempts to support the woman by referring to organisations that provide services for problematic substance use. The challenge mentioned by the Estonian organisation was the scarcity of organisations working on PSU.

The lack of services for problematic substance use in general also came up in the Icelandic focus group discussions. The actions taken when discovering substance use were similar to what was reported in Estonia. Usually the first step was a discussion with the woman and ways to support her in getting help for the substance use looked into. But for those that did not allow substances in their projects or shelters, if there was no willingness to cooperate and try to tackle the issue the women could not continue using the services. The participant from the shelter emphasised that nothing was done if the consumption was outside the premises of the shelter and they tried to avoid having to throw women out. But sometimes the women just left themselves, knowing the rules of the shelter and not being able to follow those rules.

The questionnaire also included a question on whether the organisations/agencies had ever refused to serve women due to substance use.

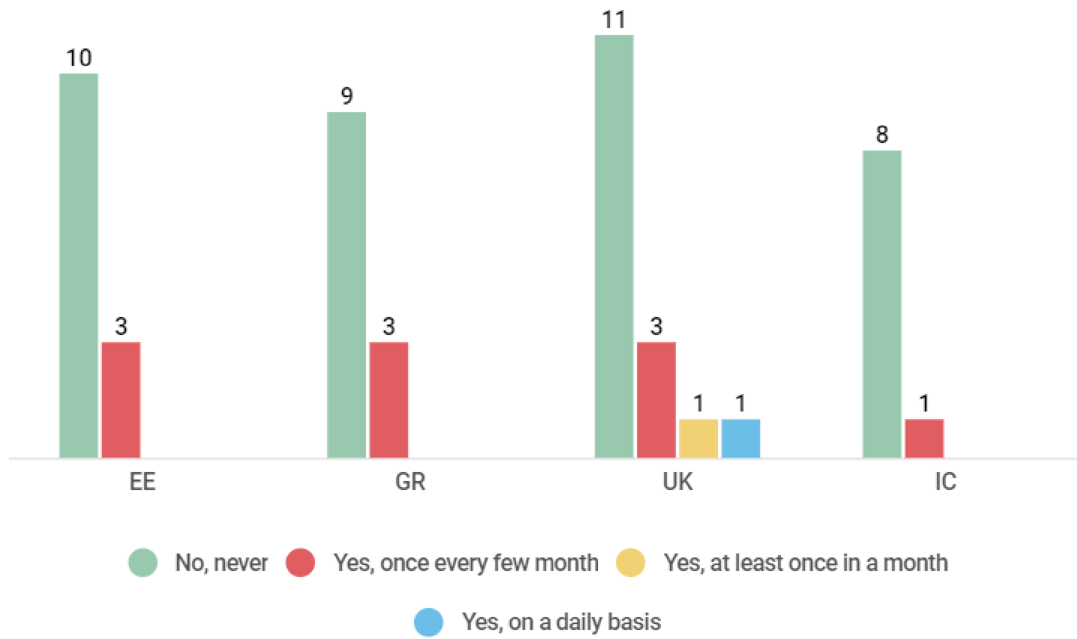

Figure 9. Has your IPV service in the past refused to serve women due to their substance use (By country)

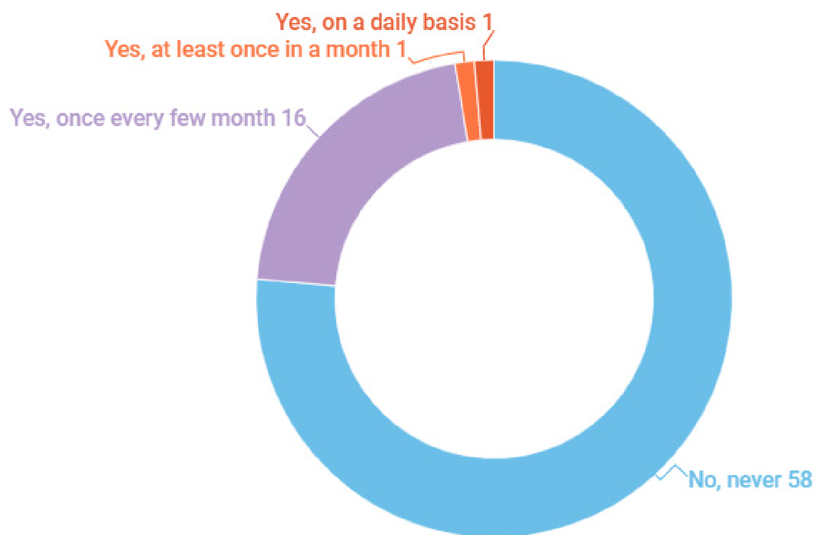

Figure 10. Has your IPV service in the past refused to serve women due to their substance use (Total)

The most common answer was that women were never refused service due to substance use. As has been discussed above however, it varies how rigid organisations and programmes are about

the need for the substance use to end immediately and it also varies how often women with problematic substance use seek the services from organisations they probably know require sobriety. The answers for why women were refused were similar to what came up in the focus group discussions, respondents either noted that the women could not commit to the counselling in such a state or that intoxicated women would negatively affect other inhabitants of the shelter.

When respondents of the questionnaire where asked whether their organisation had ever dismissed women from their service because of their substance use, the numbers did go up slightly. Here even the responses from Spain, which were organisations that dealt with problematic substance use, included some answers saying that this occurred. The reasons for this were the same as before, not being able to commit to the therapy offered or being considered dangerous to other women in the shelter or service programme. As previously mentioned, the service providers in Spain were different to the ones in the other countries, as they all focused specifically on PSU. There, as elsewhere, actions taken upon relapse also varied.

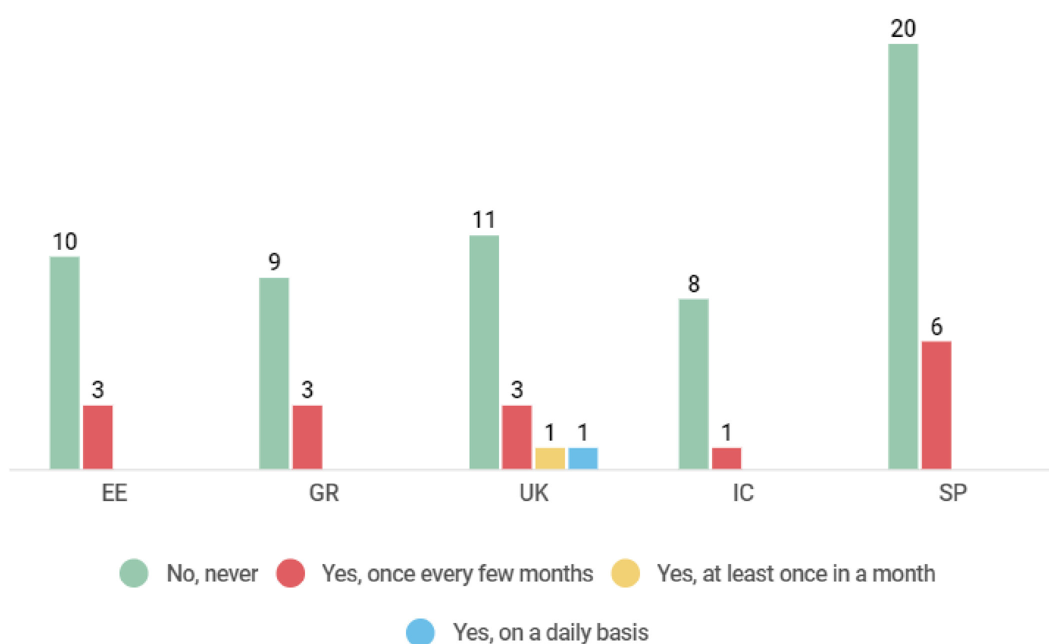

Figure 11. Has your IPV service in the past dismissed women from your service because of their substance use? (By country)

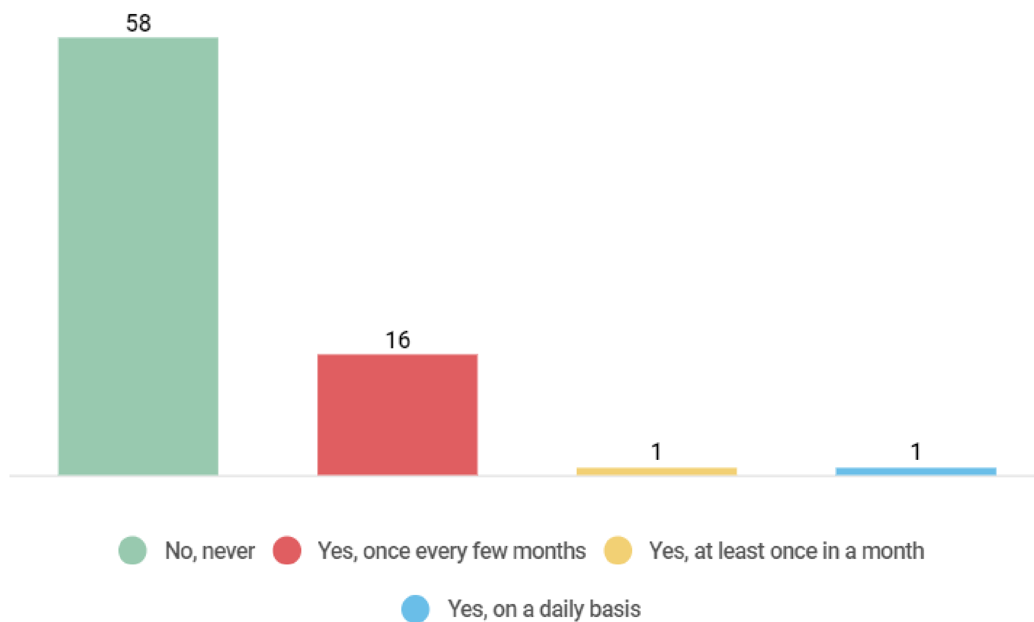

Figure 12. Has your IPV service in the past dismissed women from your service because of their substance use? (Total)

In some organisations this could lead to the ending of the programme for the woman, whilst in others that was never the case but rather looked into what caused the relapse and attempts made at dealing with that situation.

To sum up, even though women do not commonly get outright refused IPV services due to substance use across the project countries, the services provided are often conditioned up to the extent that not all women are able to commit to them and thus in practice services are not available to them.

Training needs

When asked in the questionnaire whether people had received training on women dealing with co-occurring intimate partner violence and problematic substance use the results depicted a surprising number of respondents stating that they or their colleagues had indeed received such training.

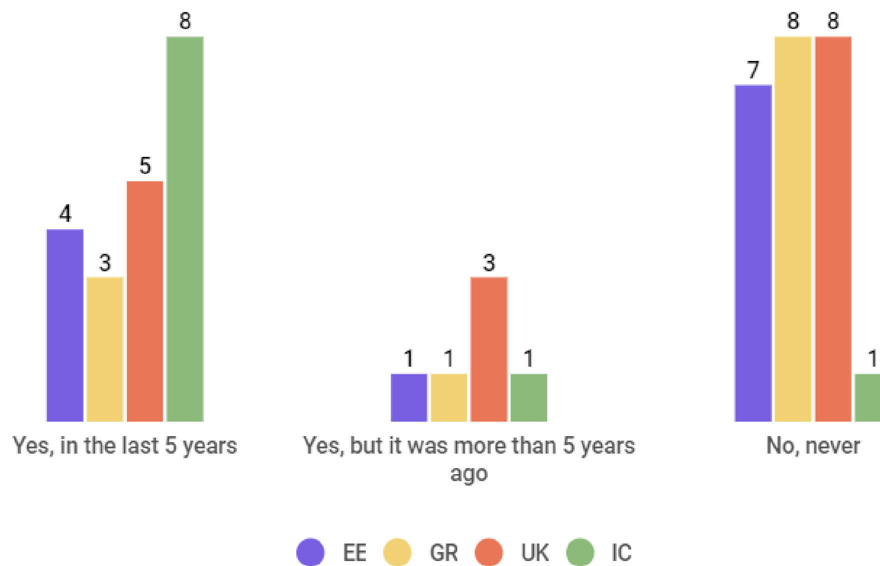

Figure 13. Have you or your colleagues previously received training on women with co-occurring IPV and substance use? (By country)

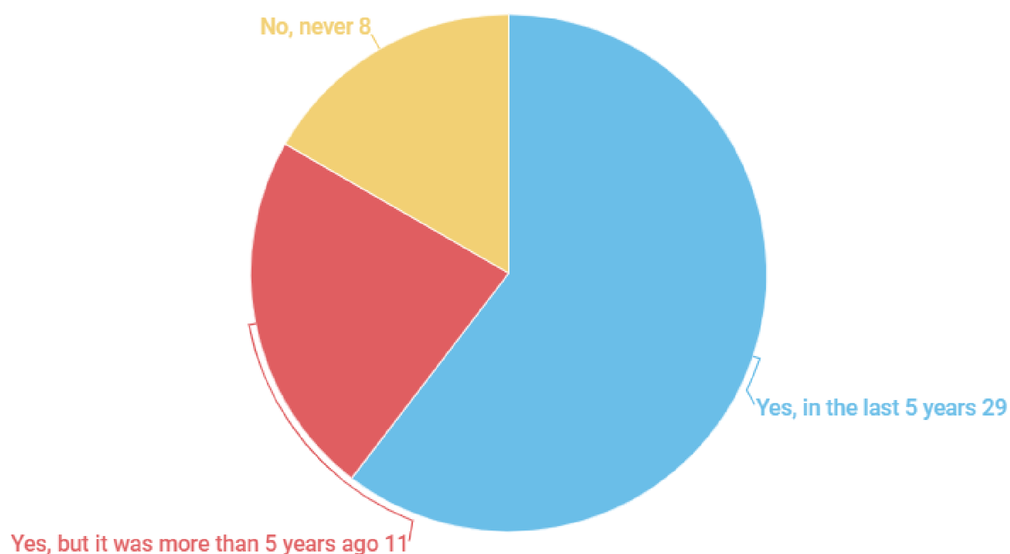

Figure 14. Have you or your colleagues previously received training on women with co-occurring IPV and substance use? (Total)

Focus group discussions and interviews did however provide a picture of very limited training being on offer across all project countries. In Estonia respondents had taken part in a general training on early detection of alcohol abuse more than a year ago, which was aimed at doctors, but staff of women support centres and shelters were allowed to participate as well. According to the respondents the training was helpful as it provided information on the programs on tackling alcohol and drug misuse.

In Greece, one of the centres that participated in the focus group discussion had received a training on the co-occurrence of IPV and SA. This was reportedly an informative training as it provided insight into therapeutic procedures for individuals dealing with addiction. But the training took place five years ago and was deemed to be necessary on a more regular basis.

Few of the Icelandic respondents had received training, although this seemed to be on the rise as several of them reported that training was currently being organised and should happen soon. One participant who worked with women with multi-faceted problems, and all grappling with PSU, stated that only last year had her agency had the first trainings on drugs and drug use. This training also included how to calm angry individuals and other safety aspects that came with the job. These trainings were now occurring twice a year. She stated that the training was helpful and needed to be frequent and available. Another respondent had just had her first training on the co-occurrence of IPV and PSU two weeks ago. She stated that it had been an eye-opener to hear about the approach to not require women to have to be completely sober to come for counselling sessions, the idea that women with co-occurring IPV and PSU should be allowed to participate in their own form of "balance", that is as sober as they get and feel comfortable with, was very interesting to her, also as a way to ensure that these women do show up for the counselling.

In Spain some of the respondents had in fact received a lot of different trainings, including on gender, intersectionality, the LGBTI community, substance use and behavioural addictions, different types of substances, new patterns of consumption, and working with the community to name a few. It was considered helpful as it was always relevant training, based on the needs of the staff of the organisation. It was however mentioned by another respondent that there is a lot of talking, but how ideas are transferred to the projects is more complicated. This brings up the very important point of the need to ensure that trainings are practical and lead to different and better service provision.

In the questionnaire people were asked what they felt were their main training needs.

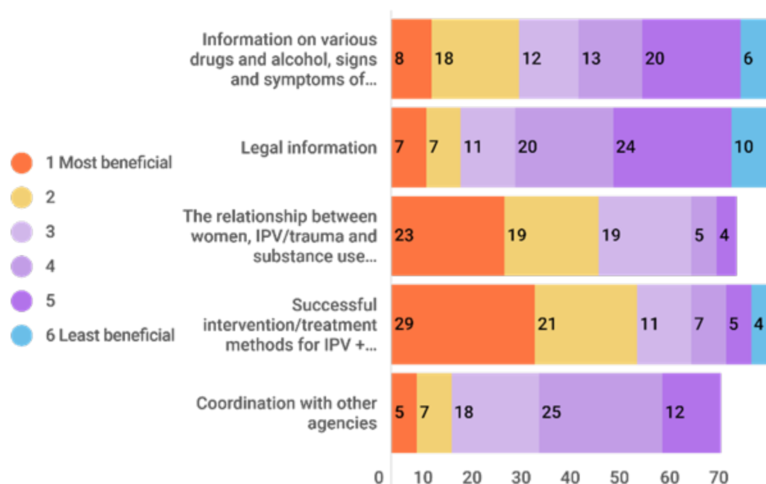

Figure 15. What is the area of knowledge or training that you or your colleagues would benefit most from? (Total)

The answers show relatively clearly that what the respondents feel would benefit them the most were the relationship between women, IPV/trauma and substance use as well as successful intervention methods for co-occurring intimate partner violence and problematic substance use. The focus group discussion and interviews revealed a broader need of capacity building. The focus group discussion in Greece emphasised what came out clearly in the questionnaire, that people were calling for an expansion in their knowledge and understanding of the correlation between IPV and PSU and improved protocols to manage such cases. There was also a call for new counselling skills for these types of cases as the services for women with co-occurring IPV and PSU are inefficient.

In Estonia, the focus was more on practical knowledge on how to deal with difficulties that come up in the shelter, connected to problematic substance use, communication and problem-solving skills and how to engage the client into accepting intervention. There was also a call for learning to recognise problematic substance use, examples of success stories and health professionals' perspectives as well as how to explain to the client the effects of alcohol misuse, connection to health and psychosocial interventions.

The opposite came up in a focus group discussion in Iceland, where it was mentioned that there was a need to get away from the dominating medical approach, and to get a broader perspective on the issue, including on trauma, symptoms of trauma and how to deal with trauma affected individuals. Others mentioned quite basic types of training as all training is still very scarce, therefore there is a need to learn about basic approaches to deal with co-occurring IPV and PSU. Sensitisation was also called for, especially on illegal substances, which carry a lot of stigma and are subject to ignorance. It was therefore discussed that there was a need to assist staff in changing their perspective on substances. More knowledge on drugs and the world of drugs was also deemed necessary. One participant also emphasised that training was needed for all staff for everyone to be aware of the issue, not just one IPV/PSU specialist within an organisation.

Interviews in Spain brought out some of the same training needs. It was again stressed that trainings are not a one-time thing and need to be constant to continuously deepen the knowledge and understanding on addiction and women. There, the need for a feminist perspective and critical psychiatry which moves away from medicalising or stigmatising women was also brought up. The need for sensitisation came up there as well, and that staff must review their own intentions, beliefs, and prejudices.

Concluding Remarks

It is clear that the training needs of staff of service providers for survivors of intimate partner violence are broad. Wide-ranging training is needed so to be able to build their capacity to be able to work with women dealing with the co-occurrence of IPV and PSU. Based on the assessment in the project countries, trainings need to cover a number of topics and allow those wanting to make use of them to pick and choose the most needed and appropriate one for each agency/organisation.

Based on the assessment, topics to be included would be general trainings on substances, substance use, and the 'world of drugs'. The capacity building of staff also need to take into account the development of practical skills such as calming down angry and/or upset individuals, recognising the symptoms of PSU, and knowing what questions to ask at what point in counselling sessions. What was called for the most in regard to training was more knowledge and understanding on IPV and PSU and the correlation between them, thus the trainings should focus substantially on this topic. More knowledge about the effects on health were also called for, as well as a request to move away from the dominating medical approach and focus more on environmental factors and PSU, including trauma.

Finally, it came out very strongly that people wanted to know about best practices and interventions that work. Trainings should therefore take this into account. Here the opportunity to bring different ideas into the service provision for survivors of intimate partner violence can also be taken. It came out in all the project countries that stigma towards individuals with problematic substance use was one of the biggest challenges faced by women with co-occurring IPV and PSU. Naturally, this stigma does not evade service providers of IPV and it did come out in some focus group discussions that there was a need for the participants to acknowledge, and work on, their own ideas and prejudices. Other comments that came out during discussion, especially focus on getting women to admit to their problem and commit to becoming sober immediately, which came up in all project countries; also point towards the benefits of introducing IPV service providers to the work of the Cuan Saor shelter in Ireland for example. There sobering up was not a prerequisite. Other ideas on the importance of safety first (Galvani, 2006) for women with co-occurring IPV and PSU, not sobriety first can also prove beneficial.

It is also worth taking note of the comment from one of the focus groups that all staff should be trained, not only the designated expert/s on IPV and PSU. This should be taken into account and basic training should be available for staff that is completely new to the idea of co-occurrence of IPV and PSU; while more advanced trainings for those that are already tackling these issues jointly.

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