MARISSA

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

Impact Assessment Report

July 2022

Co-funded by the Rights, Equality and Citizenship (REC) Programme of the European Union

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

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

WP4 – Impact Assessment Report

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1. Introduction to MARISSA Impact Assessment

The MARISSA project is a 2-year (2020-2022) transnational project, co-funded by the EU in the framework of Rights, Equality and Citizenship (REC)DG Justice Programme, that aims to address the phenomenon of co-occurring Intimate Partner Violence (IPV) victimization & Problematic Substance Use (PSU) problems. Existing victim support programmes do not address the scenario of addicted victims of IPV with co-occurring PSU and vice versa. Survivors are treated separately, while it is necessary to provide services under a common protocol.

The main activities of the project include:

- Analysis of the needs of professionals in IPV & SA regarding multi-agency and co-management of cases;
- Development of capacity building & coordinated intervention material;
- Piloting & Impact Assessment of intervention tools;
- Awareness Raising Activities & Dissemination of project results.

Pilot Interventions (GA WP4) here is used as a generic term referring to planned activity to test the intervention tools by IPV and PSU professionals and provide the trainings in the partner countries.

The University of Tartu coordinates the piloting and robust evaluation of the intervention tools developed in WP3. **RIKK** develops the training material and intervention tools for IPV & PSU professionals to build their capacity and address the co-occurrence of IPV victimization and SA. MARISSA partners pilot the intervention tools with professionals in IPV & PSU centres during November 2021-March 2022 (M18-M22) in project countries: **Greece by UWAH, Estonia by WSIC, and Iceland by ROOT**.

The Pilots aimed to:

- Promote innovative & coordinated intervention for intimate partner violence & problematic substance use treatment programmes by providing common intervention tools (screening, risk assessment & follow up forms) for professionals in IPV & PSU settings.

This assessment aims to measure the impact of MARISSA activities by:

- Evaluating the efficacy of MARISSA intervention tools for IPV and PSU professionals to serve the survivors of co-occurring IPV and PSU and identify the gaps and strengths of the developed intervention tools.
- Assessing the change of knowledge and attitudes of professionals involved in the capacity building activities.
- Documenting how the intervention tools were implemented in each three countries.

This document lays out the structure of MARISSA pilots and impact assessment of the intervention tools. It also presents the results of the evaluation.

2. Structure of MARISSA Pilots

Pilots consisted of **capacity building workshops** with professionals based upon the MARISSA Manual and training materials and **Pilot Interventions** using MARISSA Intervention Tools**.** In terms of the capacity building workshops, 116 professionals participated as follows:

- The Greek workshop was organised by UWAH, with the participation of the UoC, online, via ZOOM, (due to increased cases of COVID-19 in the implementing period) on 10 November 2021, from 10:00 to 16:00, with a total of 38 participants. The workshop focused on the first two modules of the MARISSA handbook: Module 1 – What is PSU; and Module 2 – What is IPV.

- The Estonian workshop was organised by WSIC online, via ZOOM, (due to increased cases of COVID-19 in the implementing period), on 18 November 2021, from 10:00 to 16:30, with a total of 62 participants. The workshop focused on the two modules of the MARISSA handbook: Module 3 – Gender and Power and their Links to IPV and PSU; and Module 5 – Multi-Agency and Integrated interventions.

- The Icelandic workshop was held at Hallveigarstaðir, Túngata 14, 101 Reykjavík, on 24 November 2021, from 9:00 to 15:30, with a total of 16 participants. It was organised by RIKK and Root. The workshop focused on three modules of the MARISSA handbook: Module 4 - Trauma, IPV victimisation and PSU correlation; Module 5 - Multi-agency and integrated interventions; and Module 6 - Screening, Risk Assessments, Referrals, and Follow-up.

Pilots were administered over four months with 12 professionals (7 PSUs and 5 IPVs) in three partner countries (Estonia, Greece, and Iceland) making use of the different intervention tools as described below:

Estonia:	2 PSU professionals from Libertas Kliinik
	2 IPV professionals from WSIC
Greece:	4 PSU professionals from Kethea Ariadni and OKANA Chania
	2 IPV professionals from UWAH
Iceland	1 PSU professional from Hladgerdarkot Treatment Center
	1 IPV professional from The Women's Shelter

Table 1 summarizes the targets and the actuals for each.

Table 1 Quantitative indicators according to GA

Country	Partner	WP3 Workshops		WP4 Pilots			
		N of Workshop	Targeted/Actual # of Participants (both IPV/PSU)	N of IPV Centre	N of PSU Centre	N of IPV Professional	N of PSU Professional
GR	UWAH	1/1	30/38	1/1	1/2	3-4/2	3-4/4
EE	WSIC	1/1	30/62	1/1	1/1	3-4/2	3-4/2
IC	Root	1/1	30 /16	1/1	1/1	3-4/1	3-4/1
Total		**3/3**	**90/116**	**3**	**3**	**9-12/5**	**9-12/7**

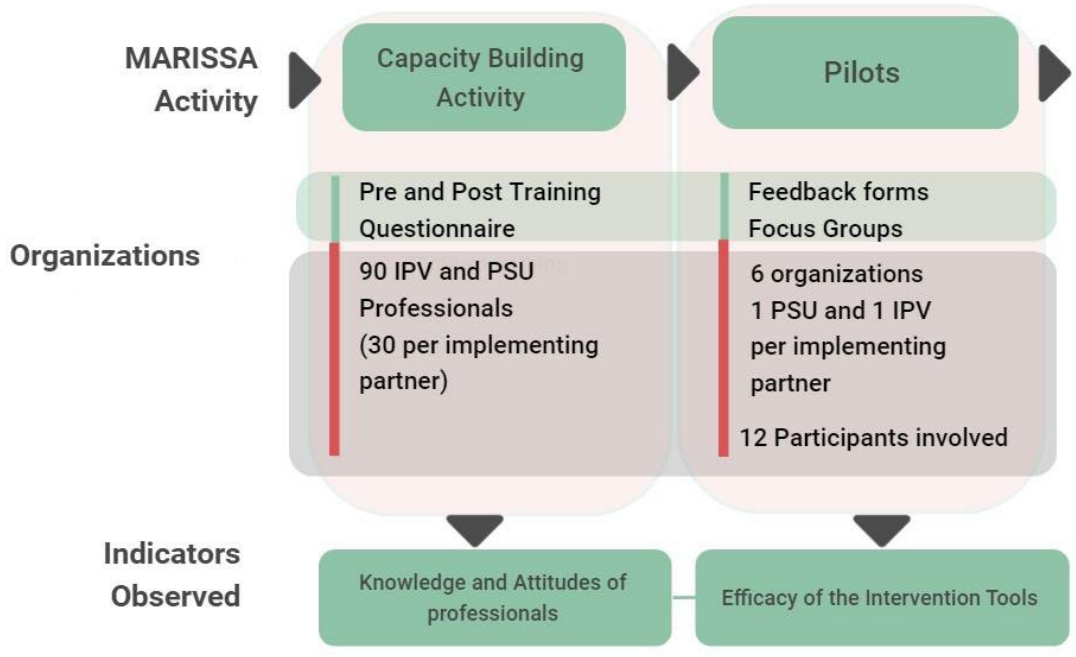

Figure 1 Impact Assessment Framework.

Figure 1 illustrates the assessment model of MARISSA pilots and capacity building activity. The Impact Assessment has two significant phases.

1. During the first phase (M17-M18, October-November 2021), **before and after evaluation was applied to assess professionals' knowledge and attitude change towards the IPV and PSU after attending the capacity building activities. At this stage, we also gathered feedback from capacity building participants and facilitators on the efficacy of intervention tools and usability of the manual.**
2. During the second stage (M18-M21, November 2021–March 2022), WSIC, UWAH, ROOT implemented the pilots in each country. The intervention tools developed in 3.2 were piloted in the setting for four months. The critical aspect of pilot intervention assessment **is to measure the efficacy of the pilots and whether the developed intervention tools can be commonly used and improve the frontline service provision to survivors.**

3. Conceptual Framework

The critical concept explored in the MARISSA impact assessment is multi-agency cooperation between IPV and PSU organizations. The intervention tools tested during the pilots aim to facilitate collaboration between the IPV and PSU institutions.

The multi-agency work involves two or more agencies deciding to work together in partnership. It begins when several agencies become aware that they share the same concerns and beneficiaries and start exploring the possibilities of working together.

The first step towards a multi-agency approach is screening and referral, coupled with ongoing contact and coordination with the agencies where the clients are being referred. Sometimes agencies seek to go further than this and create arrangements in which their work is integrated. Integrated intervention is an approach by which IPV and PSU services are combined within the same service. There are differences in the degree of integration sought and achieved and how working arrangements are set out. Parallel intervention is an approach to tackle IPV and address PSU simultaneously, but by different agencies and service providers, often in different settings and in separate service systems.

Adopting a more cohesive and close collaboration approach by all involved agencies/actors with institutional coordination is necessary to address violence against women who are also grappling with problematic substance use[1].

Although the research shows a strong co-occurrence between IPV and PSU, much still needs to be learned about tested tools that professionals can use when providing cohesive treatment to clients with IPV and PSU.

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[1] Logar, R. & Marvánová Vargová, B. (2015), Effective Multi-agency Co-operation for Preventing and Combating Domestic Violence, Council of Europe Training of Trainers manual, http://fileserver.wave-network.org/trainingmanuals/Effective_Multi_Agency_Cooperation_2015.pdf.

NICE (2014), Public Health Guideline: Domestic Violence and Abuse: multi-agency working. *National Institute for Health and Care Excellence.* Available at: https://www.nice.org.uk/guidance/ph50/chapter/1-Recommendations

3.1 Screening

Women dealing with co-occurring IPV and PSU may find it challenging to seek help for one issue and not be ready to discuss the other. The first step towards assisting women dealing with the co-occurrence of IPV and PSU is to be aware of the issue. A person conducting the screening needs to do it skilfully so that the woman in question does not feel that she is being interrogated, resulting in being excluded from services. The screening is simply part of information gathering to provide the best service possible to the woman. For professionals working in IPV services, this means normalizing substance as the preamble to their questioning. For PSU professionals screening for IPV, it is also important to make questions about violence a natural part of the questions asked on arrival and throughout their clients' services.

3.2 Risk Assessment

Proper risk assessment depends on a professional reading between the lines and what is left unsaid. Some risk factors are not a risk on their own but become a risk with other factors (substance use, economic stress, and the perpetrator's mental health). Assessing risk properly is thus more complicated than simply filling in a checklist and should be left to specialists on the issue.

Similarly to risk assessment concerning IPV, there is a need to assess substance use's extent and potential harm if screening has confirmed that the substance use is possibly problematic.

3.3 Referral and Follow-up

Working with vastly different organizations/institutions can be considered challenging. Organizations focusing on PSU or IPV can work in different ways. They may have different philosophies and limited cooperation arrangements.

Before referrals, it is best to understand how the IPV/PSU organization/ professional operates and what specific information is needed. Generally, the more information you give on a referral form, the more effective the response service can be, and it will also help prevent inappropriate referrals.

3.4 Self-Efficacy and Effectiveness of intervention tools.

Self-reported efficacy of the intervention tools is the key element assessed in the MARISSA pilots. Because individual practitioners' commitment to routine screening for IPV is the most significant predictor that women will be screened and referred for services, screeners must be dedicated, knowledgeable, and confident in their ability to recognize and assist survivors of violence. Self-efficacy has been consistently linked in the literature with successful outcomes of interventions (Chapin, J. R., Coleman, G., & Varner, E. 2010). Chapin study (2010) defined self-efficacy as the conviction that one can successfully execute the behaviour needed to produce the desired outcome.[2] O'Campo et al. (2011)[3] reviewed four program components that appeared to increase provider self-efficacy for screening, including institutional support, effective screening protocols, thorough initial and ongoing training and immediate access/referrals to onsite and offsite support services. These findings support a multi-component comprehensive IPV screening program approach that seeks to build provider self-efficacy for screening. Further implications for IPV screening intervention planning and implementation in health care settings are discussed.

Together with the MARISSA grant agreement, this conceptual framework defines the key indicators and impact assessment framework discussed in chapter 6.

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[2] Chapin, J. R., Coleman, G., & Varner, E. (2010). Yes we can! Improving medical screening for intimate partner violence through self-efficacy. *Journal of Injury and Violence Research*, *3*(1), 19–23. Retrieved from https://www.jivresearch.org/jivr/index.php/jivr/article/view/62

[3] O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review. *Social science & medicine*, *72*(6), 855-866.

4. Impact Assessment Framework and Methodology

UT implemented an evaluation of the MARISSA Training and intervention tools developed in WP3 (Screening tools, Risk assessment questionnaires, Referral form and Follow-up template). The evaluation looked at the effectiveness of the training materials in improving knowledge of participants and of the usability and usefulness of the intervention tools.

Figure 1. Stages of MARISSA Evaluation

Stage 1: Baseline focus groups: Was administered to assess the starting situation for IPV and SA professionals in the three intervention countries.

Stage 2: Development of Training Materials and Training of Professionals: Were carried out for IPV and SA professionals from targeted settings to increase their knowledge and awareness regarding the co-occurrence of IPV and SA. Trainings were based upon materials developed as part of WP3. Implementing partners collected **questionnaires** to assess changes in knowledge and attitudes on cooperation.

Stage 3: Piloting Intervention Tools: UWAH, WSIC and ROOT conducted information sessions for IPV/SA professionals. During the information session, partners administered a **pre-pilot questionnaire** with professionals who use the WP3 intervention tools. The tools were then piloted for 4 months. During the pilot intervention, 3 senior professionals were involved in each country. After the end

of the piloting period, a **post-pilot questionnaire** was collected to measure the efficacy of the intervention tools from professionals who used them.

Stage 4: Follow-up Surveys of Professionals: The three implementing partners administered **follow-up online surveys** from professionals to establish the change of knowledge and attitudes toward the usefulness of the tools.

Table 2 Definition of Impact Indicator in the MARISSA project.

Indicator Title	MARISSA Definition	Judgement Criteria
Impact	Impact assessment provides evidence on the efficacy of the intervention tools and the change of knowledge and attitudes among the professionals involved in the project.	An immediate change in knowledge, attitude, and reported efficacy of intervention tools.

4.3 Data analysis

The analysis conducted was mainly descriptive. This statistical process serves to most accurately and succinctly describe the raw data. Since much of the data was gathered through surveys, the analysis included frequencies for discrete responses and measurements of central tendency (mean, median, standard deviation, etc.) for continuous or other interval data. It was originally intended to use matched data to make comparisons between multiple points in time, but it was not possible to effectively match responses due to desires to preserve the anonymity of respondents.

5. Key Indicators

As described in the grant agreement, the pilot interventions' impact assessment was based on three critical measures. As Figure 2 shows, outcome evaluation will focus on changing the knowledge and practices via capacity building actions, changing the attitude towards recognizing the needs and importance of frontline service provision for IPV and PSU and measuring efficacy of the intervention tools.

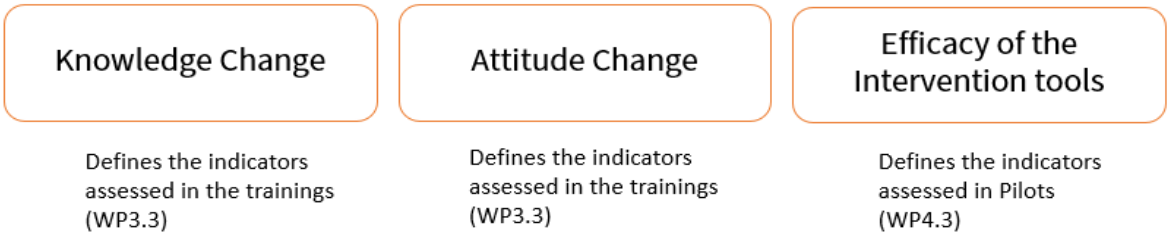

Figure 2. Three Critical Indicators measured in MARISSA (According to GA)

5.1 Indicators collected in capacity building activities on knowledge and attitude.

When gathering pre and post questionnaires from professionals attending the local capacity building activities, the knowledge and attitude change assessment will specifically explore the following indicators:

- Indicator 1 – New knowledge received in the local capacity building activities based on the MARISSA training manual
- Indicator 2 – Attitudes towards recognizing the needs and importance of frontline service provision for IPV and PSU and towards the multi-agency cooperation
- Indicator 3 – Satisfaction with the training materials and interventional tools among MARISSA stakeholders and partnership.
- Indicator 4 – Self-reported usability of training materials and interventional tools among MARISSA stakeholders and partnership.

5.2 Indicators collected via pilots on the efficacy of the intervention tools

- Indicator 5 – Comprehending the complete profile of the clients in the Screening, Risk assessment, and Follow-up tool (conceptual framework on risk assessment).
- Indicator 6 – Usefulness and completeness of referral - PSU assessing the IPV referral and IPV assessing the PSU referral (conceptual framework for referral and follow-up).
- Indicator 7 – General satisfaction of the professionals with the tools.
- Indicator 8 – Identification of improvements of tools by professionals.

6. The Outcome of Impact Assessment

Based on the assessment framework and the indicators, there were several assumptions that were tested to answer relevant evaluation questions for both the MARISSA capacity building activities and intervention tools.

6.1 MARISSA capacity building activities Evaluation Questions

1. **How well did MARISSA Capacity Building Activities improve knowledge or awareness regarding important concepts among professionals?**

- *H1 Professionals participating in the capacity building activities positively changed their opinion related to knowledge and attitudes towards the IPV and PSU co-occurrence treatments after attending the MARISSA training.*
- *H2 After attending the capacity building activities, training participants will agree more to the statements addressing the new knowledge received during the MARISSA training.*

2. **Whether the manual corresponded to the needs of professionals?**

- *H3 After attending the capacity building activities, training participants will agree more to the statements addressing the attitudes on recognizing the needs and importance of frontline service provision for clients with co-occurring IPV and PSU.*

3. **To what extent were professionals satisfied with the local trainings?**

- *H4 Participants express satisfaction with the MARISSA manual material and intervention tools after attending the local capacity building activities.*

4. **How user-friendly is the manual for individual readers by looking at the manual and feedback from the MARISSA facilitators of the local trainings?**

- *H5 Participants report high usability of MARISSA training materials after attending the local capacity building activities.*
- *H6 Facilitators of the capacity building activities report high usability of training materials.*

6.2 MARISSA Pilots

5. **How did participating professionals make use of MARISSA Intervention tools**

- *H7 Participating professionals will make use of all MARISSA intervention tools, including screening, risk assessment, and follow-up tools.*

6. **Did MARISSA Intervention Tools improve service delivery?**

- *H8 After implementing the MARISSA pilots, professionals confirm the high efficacy of intervention tools*
- *H9 After using the MARISSA intervention tools, pilot participants report that screening, risk assessment, and follow-up tools provide sufficient information needed to coordinate the integrated service for the client.*

7. **Were there improvements needed for the Intervention Tools?**

- *H10 Pilot Participants identified further improvements with the intervention tools to ameliorate better services provided to survivors of IPV with the PSU issues and vice versa.*

8. **Were professionals satisfied with the Intervention Tools?**

- *H11 Pilot Participants express satisfaction with the MARISSA intervention tools.*

7. Impact Assessment Tools

Table 3 Impact Assessment Tools

Action	N[4]	Tool	Target	Purpose	Indicator	Technique	Platform	Deadline of data collection
D3.3 Local trainings	1	Pre/post evaluation forms for the training Participants	Professionals	● Measure Knowledge and attitude change ● Collect feedback on tools and trainings from participants	Change in knowledge and attitude on cooperation	Statements and close-ended questions	Questionnaires are gathered on 1ka	Right after the trainings are done November 2021
	2	Feedback Form for Facilitators of the trainings	MARISSA Facilitators	● Collect the feedback on the manual from facilitators	Self-explanatory nature of manual satisfaction with exercises	Close and open-ended questions	Questionnaires are gathered on 1ka	Right after the trainings are done November 2021
D4.3 Pilots	3	Post-pilot questionnaire for pilot participants	Professionals	● Collect the feedback on the efficacy	Self-reported Efficacy	close-ended questions	Questionnaires are gathered on 1ka	After pilots are finished March 2022

[4] To view the templates, please visit the annex section of Initial Impact Report

	4	Focus groups/Interview protocol for pilot participants	Professionals	● Obtain in-depth feedback on the tools	Satisfaction and challenges encountered	Open-ended questions	3 Facilitator reports (1 per country) are gathered on 1ka	After pilots are finished March 2022
	5	Focus groups/Interview Protocol for UWAH, ROOT and WSIC	MARISSA Facilitators	● Document the process of coordinating the pilots	Feedback and challenges encountered when coordinating the pilot	Open-ended questions	1 facilitator report are gathered on 1ka	After pilots are finished March 2022

8. Impact Evaluation Results of Capacity Building

Evaluation Question 1: <u>How well did the manual/training improve knowledge or awareness regarding important concepts?</u>

To assess the possible effects on the change in knowledge/perception of the topic before and after training, only the matched questions asked in each country are included. These questions roughly align with the modules in which training was tested in each country: Greece (Modules 1 and 2: Intros to PSU and IPV); Estonia (Modules 3, 5 and 6: Gender, Multi-agency collaboration and Screening/Referrals) and Iceland (Modules 3, 4 and 5: Gender, IPV/PSU Trauma and Multi-agency collaboration). The flaws with this approach is obvious, as only two modules (3 and 5: Gender and Multi-agency collaboration) were tested in more than one country (Estonia and Iceland). 86 respondents responded to these questions before the trainings and 38 after (44.2%). The tables below depict the matched questions for each country and those that are the same for Estonia and Iceland.

Greek Before and After Training regarding Modules 1 and 2 (Intros to PSU and IPV)			
	Pre	Post	Difference
Total Responses	28	19	
Agree or strongly agree			
9a/2a I am familiar with the different factors that lead to PSU	82%	79%	-3%
9b/2b I believe that the PSU is the result of a complex multi-factorial interaction between repetitive exposures to substances	57%	79%	+22%
9c/2c I am familiar with the different treatment options which are available for people dealing with PSU	52%	79%	+27%
9d/2d IPV is complicated and each individual case is different	82%	89%	+7%
9e/2e I can identify many different forms of IPV	92%	94%	+2%

Estonian Before and After Training regarding Modules 3, 5 and 6 (Gender, Multi-agency collaboration and Screening/Referrals)			
	Pre	Post	Difference
Total Responses	41	11	
Agree or strongly agree			
10e/3e The partnership of agencies takes the burden away from survivors to go between several agencies	88%	82%	-6%

Disagree or strongly disagree			
10a/3a PSU and IPV are two separate problems, and when they happen to coexist, it is due to coincidence	52%	63%	+11%
10b/3b Individuals' experiences of substance use are personal and have nothing to do with gender	15%	18%	+3%
10d/3d Organisations working on IPV and PSU are too different from being able to work closely together to better serve the survivors with co-occurring IPV and PSU	49%	72%	+23%

Iceland Before and After Training regarding Modules 3, 4 and 5 (Gender, IPV/PSU Trauma and Multi-agency collaboration)			
	Pre	Post	Difference
Total Responses	17	8	
Agree or strongly agree			
11h/4h The partnership of agencies takes the burden away from survivors to go between several agencies	94%	88%	-6%
11j/4j Normalising substance use can be helpful when screening for PSU	77%	100%	+23%
Disagree or strongly disagree			
11a/4a PSU and IPV are two separate problems, and when they happen to coexist, it is due to coincidence	88%	100%	+12%
11b/4b Individuals' experiences of substance use are personal and have nothing to do with gender	42%	13%	-29%
11d/4d Many people experience different types of trauma, and gender is not a factor that affects this	64%	63%	-1%
11e/4e PSU is a brain disease, and trauma is not a factor in its inception	85%	100%	+15%
11f/4f In the trauma-informed model, the addictive behaviour is not an attempt to avoid trauma memories	100%	88%	-12%
11g/4g Organisations working on IPV and PSU are too different from being able to work closely together to better serve the survivors with co-occurring IPV and PSU	89%	88%	-1%
11i/4i Risk assessments are simple exercises that can easily be performed by anyone with the right document	50%	26%	-14%

Estonian and Iceland Common Questions Before and After Training Modules 3 and 5 (Gender and Multi-agency collaboration)			
	Pre	Post	Difference
Total Responses	58	19	
Agree or strongly agree			
10e/3e & 11h/4h The partnership of agencies takes the burden away from survivors to go between several agencies	89%	84%	-5%
Disagree or strongly disagree			
10a/3a & 11a/4a PSU and IPV are two separate problems, and when they happen to coexist, it is due to coincidence	62%	79%	+17%
10b/3b & 11b/4b Individuals' experiences of substance use are personal and have nothing to do with gender	23%	16%	-7%
10d/3d 11g/4g Organisations that are working on IPV and PSU are too different from being able to work closely together to better serve the survivors with co-occurring IPV and PSU	61%	79%	+18%

The extremely small sample sizes, small number of matched responses and lack of cross-border corroboration for most modules all greatly weaken the explanatory power of the evaluation of the trainings/training materials. With these important caveats in mind, several questions did demonstrate seemingly significant positive effects on knowledge and awareness of the topic among participants. In particular in relation to basic understanding of PSU, the relevance of co-occurring IPV and PSU (both in Estonia and Iceland) and in relation to the benefits of multi-agency collaboration (in Estonia, no effect in Iceland).

9b/2b I believe that the PSU is the result of a complex multi-factorial interaction between repetitive exposures to substances GREECE	57%	79%	+22%
9c/2c I am familiar with the different treatment options which are available for people dealing with PSU GREECE	52%	79%	+27%
10a/3a & 11a/4a PSU and IPV are two separate problems, and when they happen to coexist, it is due to coincidence ESTONIA and ICELAND	62%	79%	+17%
10d/3d Organisations that are working on IPV and PSU are too different from being able to work closely together to better serve the survivors with co-occurring IPV and PSU ESTONIA	49%	72%	+23%
11e/4e PSU is a brain disease, and trauma is not a factor in its inception	85%	100%	+15%

Concerningly, negative effects were observed in topics related to gender (especially in Iceland, no effect in Estonia), the trauma-informed model and the nature of Risk assessments.

11b/4b Individuals' experiences of substance use are personal and have nothing to do with gender ICELAND	42%	13%	-29%
11f/4f In the trauma-informed model, the addictive behaviour is not an attempt to avoid trauma memories ICELAND	100%	88%	-12%
11i/4i Risk assessments are simple exercises that can easily be performed by anyone with the right document ICELAND	50%	26%	-14%
10e/3e & 11h/4h The partnership of agencies takes the burden away from survivors to go between several agencies ICELAND and ESTONIA	89%	84%	-5%

The remainder of the questions did not illustrate any significant change in knowledge or awareness of the topic, one way or the other.

Additional testing of the training materials, especially with larger numbers of participants and multiple countries would be needed to fully validate their effectiveness in improving knowledge and awareness.

Evaluation Questions 2 and 3: <u>Did the manual/training corresponded to the needs of professionals? And to what extent were professionals satisfied with the local trainings?</u>

- *H5 Participants express satisfaction with the MARISSA manual material and intervention tools after attending the local capacity building activities.*

The questionnaires administered after trainings also asked a range of questions assessing participant opinions on how well they met their needs. **97% of respondents indicated that the training would be useful or very useful in treating their clients.** This was consistent in all three countries (91% in EE and 100% in GR and IS). **Likewise, 97% of the participants indicated that they were satisfied with the knowledge they received at the trainings**. A series of questions were also asked regarding the relevance of different aspects of the training (the specific modules and IPV vs. PSU topics), however, because different partners only tested certain modules and respondents were skewed towards one or the other treatment groups, these answers were not considered meaningful to the evaluation questions. (For example, if the respondent group is comprised of 90% participants from IPV agencies, the fact that the majority indicated that the IPV topics were more relevant to them is not meaningful.)

Q5	**4. How useful do you think the MARISSA training will be for you when treating women survivors of IPV with PSU issues or PSU clients with IPV?**				
	Answers	**Frequency**	**Percent**	**Valid**	**Cumulative**
	1 (Not useful at all)	0	0%	0%	0%
	2 (Not Useful)	1	2%	3%	3%
	3 (Useful)	15	32%	43%	46%
	4 (Very useful)	19	40%	54%	100%

Q9	**6. Are you satisfied with the knowledge received at the trainings?**				
	Answers	Frequency	Percent	Valid	Cumulative
	1 (Not satisfied at all)	0	0%	0%	0%
	2 (Not Satisfied)	1	2%	3%	3%
	3 (Satisfied)	20	43%	59%	62%
	4 (Very Satisfied)	13	28%	38%	100%
Valid	Valid	34	72%	100%	

Evaluation Question 4: <u>How user-friendly is the manual for individual readers?</u>

The MARISSA Manual is 90 pages long and divided into six modules. It appears to be well-researched and documented. However, references are inconsistent, with some modules having footnotes and endnotes, some only with endnotes while others that have neither (i.e. modules 3 and 6). Only Module 1 has contents indicated. All modules have indicative times for presentations and exercises, facilitator guidance and learning objectives, although they are not always clearly identified in the text. The modules also include pictures and references to the slides that are part of the training, which is a positive. The manual makes good use of exercises, with 23 in total that represent a good range of learning modalities (case studies, thought exercises and role-plays). All exercises give guidance on how to facilitate them and present strong guiding questions. One small issue is that the exercises are not numbered properly, and no list of exercises are provided in the manual to make it easier to find them. Only three of the exercises have specific handouts.

The general use-friendliness of the survey is also supported from responses from the participants of the various trainings given. **79% of respondents indicated that the manual would be easy or very easy to use for independent training.** Feedback from the MARISSA facilitators of the local trainings was also collected to assess the relative ease each module was to facilitate. The Icelandic facilitators felt that the IPV module was easier than PSU. The Estonian felt Gender was easier than Multi-agency and the Greek facilitators rated Multi-agency easiest, Screening (Tools) and then Trauma. These responses aligned with the similar questions that were asked to the professionals participating in trainings in each country. The facilitators were also asked to assess the exercises that were included in the training. **Half of facilitators said that it would be "very easy" to use the MARISSA manual independently for teaching purposes, the other half said it would be 'easy".**

Q11	**8. How easy do you think the MARISSA manual will be to use independently for educational purposes by you and your colleagues?**				
	Answers	Frequency	Percent	Valid	Cumulative
	1 (No easy at all)	1	2%	3%	3%
	2 (Not easy)	6	13%	18%	21%
	3 (Easy)	19	40%	58%	79%
	4 (Very easy)	7	15%	21%	100%
Valid	Valid	33	70%	100%	

Facilitators were also asked what improvements should be made to the MARISSA manual modules to better empower professionals.

- Greek facilitators indicated that the delivery of trainings online was problematic, limiting interactions and making it harder to engage participants. **More participatory exercises should be used if conducting trainings online. For example, using separate 'break out rooms' where smaller groups can meet to encourage increase dialogue.**
- The Estonian facilitator indicated that **when possible, also use videos in lectures.** Also, **more research and data on the correlation of IPV and PSU correlation** (in particular abut substance abuse) would be beneficial. Including positive, real-world examples successful multi-agency collaboration would also be beneficial.
- The Icelandic facilitators suggested adding more information on staff and trauma experiences and about how staff can be trained to becoming more trauma informed. Information on the difference of Natural or Human-Caused Traumas should also be added, along with a discussion on bullying.

Facilitators were asked if any modules should be removed from the training. **All facilitators indicated that all the modules should kept**. The only minor exception, one of three respondents regarding the Gender module indicated that some changes should be made, but otherwise it should be kept as well. **The facilitators were satisfied with 19 of the 23 exercises that were included in the training**. Exercise 5.4 was criticized for being too long and some facilitators felt that others could be shortened and simplified, including 5.5, 6.5 and 6.6a.

9. Impact Evaluation of MARISSA intervention tools

Multiple complications hindered the running and evaluation of the pilots of the MARISSA intervention tools. These included disruptions caused by COVID, inability to reach large numbers of clients and concerns regarding their confidentiality and lack of time to assess the long-term impacts on victims of co-occurring IPV/PSU. To be able to properly assess intervention tools impact on client outcomes, at least 1 year would have been needed to enable tracking of client pathways from intake, to assessment, referral and follow-up. For these reasons, it was decided that the focus of evaluation activities would be on **the usability of intervention tools for professionals.** This could be done in a compressed timeframe, would not require large numbers of clients or professionals. Usability is a key factor in assessing the quality of intervention tools as the usability of such tools is an important factor in their widespread implementation and use by organizations.

Evaluation Question 5: <u>How did participating professionals make use of MARISSA Intervention Tools?</u>

In terms of usage of the different tools, the screening tools were used most often (45% responded 'often' or 'very often.' This was followed by the follow-up form (36%) and the referral form (23%). This was to be expected as follow-up and referral is only appropriate when co-occurring situations are identified. Despite this, usage of all three tools was less than desired. **Reasons given for this low usage of the screening tool included concerns about the 'straightforwardness' of the questions, making them difficult to apply early in the treatment relationship, as greater levels of trust are needed when addressing such topics.** One respondent indicated that referrals were difficult because clients were not ready to take such a step. In the case of Estonia, referrals were problematic due to concerns regarding state reimbursement for these services. 60% indicated that they had used the screening tool for IPV and 40% for PSU clients. **Only 1 of 8 indicated that they used the screening tool at the first interview.** 3 of 8 indicated that they did so one week after the first interview with clients.

Evaluation Question 6: <u>Did MARISSA Intervention Tools improve service delivery?</u>

83% felt comfortable or very comfortable using the screening tool with clients. One reason given for this is that the tool is convenient to use. Despite this overall comfort, one respondent indicated that at times questions needed to be rephrased for the woman/client taking into account her mental abilities. The one person responding that they were uncomfortable using the tool indicated that the "**questions are too straightforward and detailed for women in the early stages of treatment and those**

who have not reached a general equilibrium and willingness to talk about their lives."

This last idea was reflected when respondents were asked about client comfort. 4 of the 6 (67%) felt that clients were not comfortable or not comfortable at all with the questions of the screening tool. This was demonstrated by observations that were shared regarding client behaviour. For example, "some questions were unwilling to be answered by the client because the question was confusing or avoided the topic (e.g. drug addiction)." Another professional indicated that "women experienced discomfort recalling individual cases, feeling unwell after the interviews." A third wrote that "customers downplayed the problem, did not want to answer questions honestly." Four respondents indicated that **the screening tool made the identification process better**. Three indicated that it added additional workload for them and two said that it complicated service delivery.

Considering the above concerns, it is not surprising that **only half of the respondents agreed that the MARISSA screening form improved the relationship or level of trust between professional and client**. Despite this, 2/3 felt that it improved communication and that the screening tool improved their ability to support clients somewhat. This is because it "gave the therapist an insight into the mindset of service members and the pain that exists in his life" and it helped to "..support/confirm available info regarding the client." Despite this, it was also expressed that "talking honestly about addiction causes difficulties for clients, giving the impression that we are imposing something on the client that she is not yet ready for.."

Evaluation Question 7: <u>Were there improvements identified for the Intervention Tools?</u>

Professionals also felt that several questions were problematic and should at least be worded differently. Three questions, in particular were considered 'problematic', all asking about the partner of the client:

- Screening Q2 – partner's disapproval (75%)
- Screening Q10 – partner's support of treatment (67%)
- Screening Q12 – partner's presence at treatment area or facility (67%)

This might be due in part to the differing roles that partners can play in the treatment of the two issues. In PSU cases, partners can either help or hinder treatment, depending on the situation, whereas in IPV cases, the partner is quite often the primary source of the abuse and thus an obstacle to recovery. Conversely, questions from the IPV screening tool were considered generally ok. Only one person felt that two questions should be worded differently: Screening Q9 – Pressure to use substance and Screening Q10 – current concerns about use.

Several professionals gave suggestions on how the tools could be improved or properly implemented to better serve clients with co-occurring IPV and PSU: "the tool needs to be practiced so that it becomes habitual"; "we would need to better adapt the tools to women present in the inpatient treatment options." One professional indicated that the tools were good, but expressed concerns regarding which setting was best for them to be used in: "It is not practical to use the tools for victims who have arrived at the support centre, rather, they should be administered in health care settings."

Evaluation Question 8: <u>Were professionals satisfied with the Intervention Tools?</u>

Despite the many reservations expressed by the professionals, **all professionals felt the screening tool, referral tool and follow-up tools were useful or very useful**. There still is room for improvement, as no professionals indicated that they were very satisfied with any of the tools. However, **67% were satisfied with the screening tool, 50% with the risk assessment and referral tools and 1/3 with the follow-up tool.** The average 'useful' and 'satisfaction' scores are indicated in the table below.

Intervention Tool	Avg. Usefulness (5 highest)	Avg. Satisfaction (5 highest)
Screening Tool	3.8	4.5
Referral Tool	3.7	4.5
Follow-up Tool	3.5	4,3

Half of the professionals indicated that they would you suggest to management and decision-makers at their organization to start using the MARISSA intervention tools in practice. Half would also recommend MARISSA intervention tools to other agencies and would use the MARISSA tools in everyday work in future.

10. Final conclusions and next steps

Despite the many difficulties that hindered project implementation and robust execution of the evaluative framework, the outputs of the MARISSA project appear to be promising. Some key findings support this:

- 97% of respondents indicated that the training would be useful or very useful in treating their clients. This was consistent in all three countries (91% in EE and 100% in GR and IS).
- Likewise, 97% of the participants indicated that they were satisfied with the knowledge they received at the trainings.
- Training facilitators indicated that all the modules should kept.
- The facilitators were satisfied with 19 of the 23 exercises that were included in the training
- All professionals felt the screening tool, referral tool and follow-up tools were useful or very useful.
- 67% were satisfied with the screening tool
- Half of the professionals indicated that they would you suggest to management and decision-makers at their organization to start using the MARISSA intervention tools in practice.
- Half would also recommend MARISSA intervention tools to other agencies and would use the MARISSA tools in everyday work in future.

Based upon all of the above, a number of recommendations are suggested as next steps:

- Some elements of the training manual should be improved, for example simplification of some exercises and greater use of videos. Other improvements should be considered to ensure that the trainings are effective online as well as in person.
- All modules of the training manual should be administered and tested with cohorts from different countries. Pre and post testing should be carried out with these cohorts, to enable cross-national comparisons and the groups should also be disaggregated by service offering (IPV/PSU). Doing so would confirm that the manual is effective across countries and beneficial for both IPV and PSU professionals.
- Training modules should also be tested in other countries, to validate efficacy across Europe and longer-term follow-up could be done to verify that training interventions achieve impact over the long term.
- Intervention tools should be modified to ask sensitive questions less directly. And greater thought should be put into the timing of their use (i.e. at which points should screening tools be used considering the sensitive nature of the topic).
- Greater time should be allocated to enable evaluation of the full lifecycle of tools (i.e. from screening to risk assessment to referral to follow-up). Increased amount of time would enable organizations to identify larger numbers of cases for referrals.
- Pre-existing conditions for organizations should be confirmed before piloting is to begin (for example, concerns regarding payment of services related to referrals should be resolved before pilots would begin).

- Feedback should be solicited from clients themselves, to gain a better insight of their perspective on such intervention tools.
- Data regarding client performance and outcomes should be compared to the use of intervention tools (such as through control and test groups) to better assess the impact of such tools
- Pilots should involve larger scale adoption of such tools at the organizational level, enabling feedback from multiple professionals working at the agency.
- Intervention tools should be tested with agencies outside of the partner countries, to determine their suitability throughout Europe.