MARISSA

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

Review of existing data and analysis of existing interventions regarding Intimate Partner Violence and Problematic Substance Use

Greece,

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Women's Support and Information Center
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MARISSA – Multi-agency approach to support victims of intimate partner violence with substance abuse issues

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Introduction

Intimate Partner Violence (IPV) and Problematic Substance Use (PSU) are two distinct but interconnected phenomena. IPV and PSU exist and co-occur in every social class, region, country and culture, inducing costs at emotional, physical and psychological level and affecting not only individuals but also their families, their communities and the wider society as well. In the last decades, the co-occurrence of IPV and PSU as well as their treatment are gaining growing recognition, pointing to the need for bringing the gender dimension into drug policy and vice versa (Pompidou Group, 2017).

Consequently new, integrated interventions have been developed and applied on the field of IPV and PSU (Easton et al., 2007; Weaver et al., 2015). However, literature, research and clinical practice indicate that there is a need for multi-agency co-operation between IPV and PSU services in order to address these phenomena (AVA, 2013; Macy & Goodbourn, 2012; Stella Project, 2007). Multi-agency co-operation includes the adoption of specific protocols regarding local strategic multi-agency partnerships; integrated strategies; integrated care and referral pathways; information sharing and provision of specific training for IPV and PSU professionals.

1. Intimate Partner Violence and Problematic Substance Use

According to literature and research, Intimate Partner Violence (IPV) is strongly related with Problematic Substance Use (PSU) (Afifi et al., 2012; Cafferky et al., 2016; Flanagan et al., 2020; Kraanen et al., 2014). Co-occurrence of IPV and PSU ranges between 25% and 80%, depending on the definition being used and the population studied (Friend, et al., 2011; Langenderfer, 2013). In a study conducted in Amsterdam (Netherlands), almost 33% of patients in PSU treatment had perpetrated or experienced IPV in the year prior to intake (Kraanen et al., 2014). More specifically, almost 25% had severely abused their partners, while 17.4% were severely abused by their partners (Kraanen et al., 2014).

The experience of IPV may lead to physical and mental health problems, including PSU (Afifi et al. 2010; Crane et al., 2014). The prevalence of IPV among females seeking treatment for PSU is extremely high (Afifi et al., 2012; Crane et al., 2014; El-Bassel et al., 2011; Engstrom et al., 2008). More specifically, 47% - 90% of women in PSU treatment report a lifetime history of IPV (Engstrom et al., 2008; Schneider et al., 2009). According to El-Bassel et al. (2011) the prevalence of women survivors of IPV seeking treatment for PSU ranges between 25% and 57% (El-Bassel et al., 2011). The prevalence of IPV in women seeking therapy for PSU is much higher (three to five times) than in the general population (El-Bassel et al., 2011).

Depending on the population studied (IPV survivors or women with PSU issues) studies provide different percentages regarding the co-occurrence of the two phenomena. According to Weaver et al. (2015) study, among women experiencing IPV, PSU ranges between 7% and 25%, while another study showed that 34.5% of women victims of IPV were dealing with PSU (Nathanson et al., 2012). The most prevalent form of IPV in PSU female population under treatment, the year prior to treatment, seems to be psychological aggression (96.7%), followed by physical assault (53.7%) and sexual coercion (49.2%) (Schumm et al., 2018).

Regarding IPV perpetration, PSU seem to be associated with perpetration of IPV (Afifi et al., 2012; Crane et al., 2014; El-Bassel et al., 2012). In both PSU treatment-seeking and at-risk samples, male substance use seems to be related with increased odds of male-perpetrated violence against women (Feingold et al., 2008).

According to Afifi et al. (2012) all types of PSUs, namely alcohol, cannabis and stimulants such as cocaine, seem to be associated with increased odds of IPV perpetration (Afifi et al, 2012). However, Crane et al. (2014) did not find any association between cannabis and opioids and IPV. On the other hand, another research indicates that male-perpetrated IPV is related to alcohol but not drug use by the perpetrator, while at the same time IPV is related to female victims' both alcohol and drug use (Cunradi et al., 2002). Still, female perpetrators and victims are less likely to use or depend on alcohol and/ or drugs compared to male perpetrators and victims (Afifi et al., 2012). Women are also more vulnerable to use not only opioids, but also legal and prescription drugs, narcotic analgesics and anti-anxiety medication (Hwang et al., 2016; Poole, 2019; Simoni-Wastila, 2000). However, research on PSU of legal drugs and medication and IPV remains scarce.

Alcohol and cocaine seem to be related in a more stable manner with both IPV perpetration and victimization (Afifi et al., 2012; Crane et al., 2014; Flanagan et al., 2020; Kraanen et al.,

2014). More than 40% of people in alcohol treatment settings report IPV perpetration in the last 12 months (Walsh et al., 2020). Negative interactions (e.g. conflicts), such as those involved in IPV, increase alcohol craving, precipitating alcohol use, which in turn, leads to increased alcohol use as a means of reducing stress and discomfort; however, this path seems to result in strengthening the psychological and physical IPV perpetration and victimization (Flanagan, et al., 2020). Indeed, males with more severe psychological IPV perpetration and victimization report greater alcohol craving (Flanagan et al. 2020). Alcohol use increases the likelihood of IPV perpetration approximately twice and the likelihood of IPV victimization 1.5 times, while 12-month cocaine abuse/ dependence increase the likelihood of IPV perpetration more than 8 times for men and more than 7 times for women (Afifi et al., 2012). However, this relationship becomes non-significant when adjusting for other mediators, indicating that co-morbidity is important for understanding and intervening to the phenomenon of IPV and PSU (Afifi et al., 2012).

At the same time, IPV victimization, for both male and female victims, seems to increase the odds of all types of PSUs (Afifi et al., 2012). The only observed exception is for sedatives/ tranquilizers abuse and/ or dependence among women victims of IPV. Alcohol and cannabis victims' use seem to be related with higher odds of IPV victimization, as indicated in current research (Afifi et al., 2012). In Nathanson et al.'s (2012) study 6.4% of women victims of IPV were addicted to drugs and 18.1% to alcohol (Nathanson et al., 2012). However, Cafferky et al. (2016) research found that IPV victimization is related mostly with drug use, rather than alcohol use.

Opioids are related to IPV regarding injective practices. More specifically, women who inject drugs for the first time usually do this with the assistance of their intimate partners due to their lack of injecting knowledge, experience and skills (Wright et al., 2007). This practice evokes a lot of dangers and increases women's vulnerability, possibly leading to IPV, as women report coercive injection for economic reasons; economic abuse; dependence upon intimate partners for the preparation and the injection itself; abuse of trust; control and dominance and conflicts, which in turn, lead to fearful reactions, negative emotional and physical effects in general as well as indirect physical abuse (Wright et al., 2007).

According to Afifi et al. (2012) and Kraanen et al. (2014) polysubstance use/ dependence increases the odds of both IPV perpetration and victimization, especially when it comes to co-morbid alcohol and cocaine or cannabis use diagnosis. On the contrary, Crane et al. (2014) did not find any association between IPV and co-morbid alcohol and cannabis use disorder. However, IPV perpetration was more likely in people with co-morbid alcohol and cannabis use diagnosis rather with cannabis use diagnosis alone (Crane et al., 2014).

2. Theories trying to explain IPV and PSU relationship

The (combined) IPV and PSU phenomenon may occur for several reasons. Although current literature and research indicate that PSU is related to IPV, it does not seem to be a direct causal relationship. Rather, it is mostly a multi-factorial phenomenon in which PSU acts as an important risk factor, increasing the likelihood of IPV, while at the same time, other factors such as personality traits (e.g. impulsivity) mediate this relationship (Afifi et al., 2012; Kraanen et al., 2014). Additionally, this phenomenon depends on the drug type but also on additional factors related to victim and perpetrator gender, history of violence as well as psychological and cultural factors (Cafferky et al., 2016). As a result, integrative theories have been developed, which take into account several possible mediating and moderating factors in order to explain the relationship between IPV and PSU. Most of these theories are not explicitly referring to IPV, but they are mostly referring to Post Traumatic Stress Disorder (PTSD), as the experience of violent and traumatic incidents, such as IPV, often lead to PTSD. Indeed, research shows that 57.4% of women survivors of IPV meet the criteria for PTSD (Nathanson et al., 2012).

According to the **Biopsychosocial Model**, IPV and PSU is the result of the interplay between various distal factors, proximal factors, contextual influences and the possible consequences of substance withdrawal (Moore & Stuart, 2005). The distal factors include stable characteristics such as the temperament, the gender role expectations, the peer influences and the cultural norms, that are always present during relationship conflicts. The proximal factors include the substance use, e.g. the pharmacological effects and the emotional arousal caused by each substance. The contextual influences include the assessment of threat in that particular setting/ encounter. The possible consequences of the substance withdrawal include irritability, difficulty in information processing etc. (Moore & Stuart, 2005).

Negative interactions (e.g. conflicts), such as those involved in IPV, increase alcohol craving, precipitating alcohol use, which in turn, leads to increased alcohol use as a mean of reducing stress and discomfort; however, this path seems to result in strengthening the psychological and physical IPV perpetration and victimization (Flanagan, et al., 2020). According to Kaysen et al. (2007) alcohol and cannabis are being used by survivors in order to cope with stress, anxiety and pain deriving by IPV.

Thus, according to the **Self-Medication Model**, first described by Khantzian in 1992, IPV leads to PSU, as the stress that derives from IPV and trauma governs the self-monitoring mechanisms of development in a neurobiological, as well as in an emotional and behavioural level, increasing in this way, the possibilities of PSU (Ford & Russo, 2006; Khantzian, 1992; Garland et al., 2013; Overup et al., 2015; Schäfer & Najavits, 2007; van Dam et al., 2013). PSU's benefit is that it helps the person to reduce relief and beat the negative consequences of IPV, including symptoms of trauma and PTSD (Cohen et al., 2003. Khantzian, 1992; Norman et al. 2010; Torchalla et al., 2012; van Dam et al., 2013). Inexorably, this practice (reducing relief and beating negative consequences of IPV) triggers craving and relapse even through trauma-related cues (Cohen et al., 2003; Khantzian, 1992; Norman et al., 2007; Torchalla et al., 2012; van Dam et al., 2013). Trauma-related cues (e.g. specific places, sounds/ songs) that were present during the traumatization and thus related to the trauma are so strong that they can

lead to relapse even six months after the termination of therapy (Schäfer & Najavits, 2007), leading at the same time to more frequent and severe PSU (Driessen et al., 2008; Pizzimenti & Lattal, 2015; Tipps et al., 2014; van Dam et al., 2012). As a result, through the repeated and long-term self-medication, PTSD symptoms, and thus IPV, are being automatically correlated with PSU; hence, withdrawal symptoms, stimulating fearful reactions of traumatic incidents, such as IPV, cause flashbacks and trigger symptoms of PTSD (van Dam et al., 2012). Accordingly, IPV experiences constitute a robust risk factor for PSU (Ahmadabadi et al., 2019).

The **High-risk Hypothesis** suggests that PSU fosters PTSD; PSU gets involved inthe implementation of traumatic memories as the abstinence from substances can trigger traumatic memories and PTSD symptoms (Schäfer & Najavits, 2007; Torchalla et al., 2012).

According to the **Susceptibility Hypothesis**, long-term PSU increases psychological and biological vulnerability, increasing in turn the odds of PTSD, after the exposure to a traumatic incident (Schäfer & Najavits, 2007). Additionally, it is well documented in research that IPV can lead to PSU and that PSU increases vulnerability, especially for women, making them 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).

The Self-Regulation Model suggests that PTSD, and thus IPV, disturb the bond and the attachment with the significant other, leading to limited self-regulation skills; in this case, PSU is regarded as the person's attempt to self-regulate herself due to her lack of adaptive mechanisms (Padykula & Conklin, 2010).

The model, according to which, IPV leads to PSU is the most acceptable and scientifically well-documented in the relevant literature; equally well-documented is the theory that PSU increases women's vulnerability 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).

As for alcohol and IPV, according to the **Social Exchange Theory**, alcohol precipitates stressful and maladaptive conflict interactions in a relationship, explaining the mutually-causal link between PSU and maladaptive relationship functioning, often leading to IPV (McGrady, 1982; McGrady, Epstein & Sell, 1996 as cited to Flanagan et al., 2020). As a result, alcohol is used to reduce the stress deriving from the negative relationship interactions and their consequences; alcohol thus reinforces addiction and leads to further IPV perpetration and/ or victimization. In the same line, **Alcohol Myopia Theory** explains the relationship between alcohol and IPV, suggesting that alcohol reduces the attentional focus and the adaptive cognitive ability as well as the information processing. As a result, there is a reduction of attention to the most salient cues, and thus, cues related to partners' conflicts may trigger perpetrators' aggressive behaviour (Giancola et al., 2010; Steele & Josephs, 1990).

In general, societal and relational power discrepancies against females by male partners compose primary contributors to IPV. When it comes to women survivors of IPV with PSU

issues, financial dependence and substance use may limit their power, range of options and problem-focused coping mechanisms in order to address IPV or end the abusive relationship (Engstrom et al., 2012). Additionally, marginalised social representations of women who use drugs, reliance on partners for drugs, conflicts with partners about obtaining and sharing drugs, states of intoxication, substance-fuelled aggression and drug effects add to the difficulty of those women to address IPV and ask for help (Engstrom et al., 2012).

To sum up, the correlation between IPV and/ or PTSD and PSU seems to be intricate, multi-layered and bidirectional (Mason & O'Rinn, 2014), creating a vicious cycle where negative consequences of IPV trigger PSU behaviours, which can intensify IPV, PTSD and PSU through their effects in body, brain and mental state in general, leading in many cases to further IPV and/ or PSU (Abasi & Mohammadkhani, 2016; Simonelli et al., 2014; van Dam et al., 2013).

3. Country Reports regarding IPV and PSU

3a. ESTONIA

Estonia is a country with a population of 1.3 million. IPV & PSU data are fragmented, derived from different ministries and agencies. Health and PSU data from the National Institute for Health Development (NIHD, TAI in Estonian)[1] and IPV data come from law enforcement agencies. Annual crime report (incl. IPV prevalence) is prepared by the Ministry of Justice.

PSU data

NIHD is responsible for development and organization of drug prevention, treatment, rehabilitation, harm reduction and counselling services regarding PSU. The national focal point is located within the Infectious Disease and Drug Monitoring Department of the NIHD. The recent report is from 2019 based on data from 2017 (European Monitoring Centre for Drugs and Drug Addiction/ EMCDDA, 2019a).. The drug-induced mortality rate among adults aged 15-64 years was 130 deaths per million in 2017, considerably higher than the European average of 22 deaths per million. Estonia has the highest rate of overdose deaths in the European Union (Terviseriskide program, 2020).

The available data indicate that cannabis remains the most commonly used illicit drug among those aged 15-64 years in Estonia, and its use is concentrated among young people, with males generally reporting cannabis use more frequently than females. Amphetamines were the most commonly used stimulants among adults in 2008 and 2015, use has declined in recent years. Possible changes in the drug market, illicit drug use and availability of support services in times of local and global restrictions due to COVID-19 pandemic was studied and data were collected from people with drug addiction in age of 18-44 in May 2020 in Estonia (Kütt, 2020). 84 % of the respondents (n=1146, 38 % female) had used at least one substance in the past 30 days. Most of respondents were cannabis users (92 % had used cannabis in the past 12 months; 76 % in the past 30 days). A third of the respondents had not made any changes to their use of illicit drugs during the lockdown and another third claimed that they used less. A quarter of respondents began using drugs more frequently.

Data from specialised treatment centres in Estonia indicate that opioids (mainly illicit fentanyl or 3-methylfentanyl) were the most commonly reported primary substances for first-time clients entering treatment in 2016. Nearly 70 % of all treatment clients whose primary substance of use was opioids reported injecting as their main route of administration. Overall, females account for approximately one out of five treatment clients, but the proportion of females among treatment clients varies by the type of programme and type of illicit drug used.

[1] The National Institute for Health Development (NIHD, TAI in Estonian) is a government established research and development body collecting, connecting and providing reliable national information from a multitude of sources, related to the health and health awareness of the Estonian population. The NIHD has the national health programmes within the framework of which the health promotional activities are carried out, drug addiction prevention programme is included

Alcohol misuse

Excessive consumption of alcohol in Estonia is a major problem, and the associated healthcare costs are significant. In 2018, 15 % of the adult population in Estonia consumed alcohol at a level that was harmful to their health (Vorobjov & Kaal, 2020). Estonian Institute of Economic research conducts each year a survey of the population's alcohol consumption. Since 2015, the proportion of alcohol non-users has been on a downward trend, but in 2018 the proportion of alcohol users among the adult population increased by 3 percentage points to 86% (in 2017, 83%) (Eesti Konjunktuuriinstituut & Tervise Arengu Instituut, 2019).

While the proportion of alcohol users went upwards, the positive side is that the proportion of heavy drinkers fell (from 5% in 2017 to 3% in 2018) and the proportion of light drinkers increased (from 52% to 57%). The most popular consumer alcoholic beverage continued to be grape wines, which was consumed in 2018 by 92% of adult alcohol users. Beer and strong alcoholic beverages had been consumed by 66% and 64% of adult alcohol users, including 51% of vodka consumers. Ciders and long drinks had been consumed by 49% and 44% of adult alcohol users, respectively. The gender profile of alcohol users shows that the proportion of women who consume wine is higher than that of men. Men consume significantly higher amounts of strong alcohol and beer than women. The age group 65-74 consume more strong alcohol, while the age group 18-29 consume more vodka.

There are negative consequences to the society and families related to alcohol consumption, but data about are rare. A total of 8580 persons sought medical advice from specialist doctors and family doctors due to illnesses caused by excessive consumption of alcohol in 2018, which was 1% more than in 2017. Alcohol-related psychosis was diagnosed the most with 3708 patients, which was 3% more than in 2017. 84% of hospital residents rated alcohol-related domestic violence along with 83% rated alcohol-related health problems as a serious or very serious problem. Alcohol-related crimes against an individual (82%), family problems (82%) and public order offenses (81%) are also seen as significant problems (Eesti Konjunktuuriinstituut & Tervise Arengu Instituut, 2019).

IPV data

In 2019, 4119 domestic violence cases were registered. At least almost 30% of domestic violence cases were witnessed by children. 85% of perpetrators are men and 81% of victims are women. According to preliminary data, five people died in 2019 due to domestic violence. Out of domestic violence cases the most prevalent is a physical abuse (86 %) and a threat (11 %). These data show deficiencies in statistical data of crime. This shows a problem of the understanding violence and Articles of the Penal Code - psychological abuse is underreported and this is hard to have a successful court procedure.

Specific policies about survivors of IPV

Violence prevention is coordinated by the Ministry of Justice in cooperation with Ministry of Social Affairs. Victim support and prevention services developed and implemented by the

Department of the Victim Support and Prevention Services of the Social Insurance Board, they also coordinate women's support services and work.

National Action Plan for preventing intimate partner violence exists. Slightly more than one in ten crimes in Estonia is a domestic violence crime, one third of which is related to children. Violence prevention and helping to get out of violent relationship is important. There is an Action Plan for prevention IPV for 2019-2023 and violence prevention programme (Memorandum Valitsuskabineti Nõupidamisele, 2019).

Specific policies about people with PSU issues

There are several action plans:

1997-2003, National Plan for Combating Alcoholism and Drug Addiction;

2005-2012, Drug Prevention Strategy;

2014, Estonia's Drug Prevention Policy: White Paper;

2008 (2012) -2020, the National Health Plan; a draft Health Population Plan for 2020-2030;

Green Papers on Alcohol and Tobacco Policy;

The action plan for the implementation of 'Estonia 2020' for 2018–2020.

The White Paper on Drugs states that in 2014, the systems for prevention, treatment, rehabilitation, social reintegration and harm reduction of drug abuse are underdeveloped. There are separate services, but many vital services are either lacking altogether or are of less than satisfactory quality or coverage (Ministry of Interior, 2014a; 2014b).

Specific legislations about survivors of IPV

The Victim Support Act. Pursuant to the Victim Support Act, there are many ways how to help the injured party to cope better with his or her situation and information on how to get support must also reach him or her.

The Family Benefits Act. Family benefits are benefits in cash financed from the state budget through the Ministry of Social Affairs which are paid to ensure the well-being of families with children.

The Social Welfare Act stipulates services compulsory to be offered by the local government. Also, an emergency social assistance should be provided to persons who find themselves in a socially helpless situation due to the loss or lack of means of subsistence which guarantees the persons at least food, clothing and temporary accommodation. Emergency social assistance shall be provided to a person until he or she is no longer in a socially helpless situation due to the loss or lack of means of subsistence.

The Code of Criminal Procedure provides a protection of private life or other personality rights of a victim, a person suspected or accused of a crime against the person or against a minor may be prohibited to stay in places determined by a court, to approach the persons

determined by the court or communicate with such persons at the request of the Prosecutor's Office and on the basis of an order of a preliminary investigation judge or on the basis of a court order. In urgent cases, the protection order may be established by an order of a prosecutor's office and regardless of the consent of the victim. According to law, a temporary restraining order could be set. In 2019, 57 temporary restraining orders were requested in criminal proceedings for the protection of the victim.

Important measure is a home support for families with many children. If survivor children and is employed, this measure can help to buy a new home. The goal of the support is to improve living conditions for families of modest means who have three or more children. Families can use the support to purchase, renovate or expand their home and modernize the systems within their home.

Specific legislations about people with PSU issues

Important legal texts regarding PSU issues are Mental Health Act, Alcohol Act, Narcotic and Psychotropic Substances and Precursors, Medicinal Products Act, Health Care Services Organisation Act, Health Insurance Act, Social Welfare Act. The Act on Narcotic Drugs and Psychotropic Substances and Precursors Thereof regulates the field of narcotics and psychotropic substances in Estonia. Personalised drug treatment cases shall be entered in the drug treatment register since 1 February 2020. The drug treatment register is a database which is maintained to analyse the occurrence of drug addiction, prevent the spread of drug addiction and evaluate the efficiency of treatment, organise health services, evaluate the diagnostics and treatment, develop the health policy, organise statistics and scientific research, including epidemiological research. Upon the provision of psychiatric health services, the service providers who provide drug treatment are required to submit data (incl. risk behaviour data) to the drug treatment register and the service provider has the obligation to maintain confidentiality arising from the law.

The rehabilitation of and social assistance to persons suffering from drug addiction shall be organised by the Government of the Republic and local governments. Actual service providers are other organisations.

Article 9.1(1) of the Mental Health Act prohibits substances and objects in in-patient psychiatric treatment and provides that a person under in-patient psychiatric treatment is prohibited to possess the alcoholic beverages and narcotic and psychotropic substances. Article 10(1) stipulates that all persons in the territory of Estonia are provided with emergency psychiatric care. Persons with mental disorders receive emergency psychiatric care on a voluntary basis; there are exceptions dependent on the mental health status. Involuntary psychiatric treatment shall be applied only on the basis of a court ruling. Involuntary psychiatric treatment may also be applied without a court ruling in some cases (if it is inevitable for the protection of the person or the public and if a court ruling cannot be received as quickly as necessary), then permission shall be made by a psychiatrist of the psychiatric department of a hospital. Psychiatric care is financed pursuant to the procedure established in the Health Care Services Organisation Act, the Health Insurance Act, the Social

Welfare Act and this Mental Health Act. The expenses of the provision of emergency psychiatric care to persons who are not covered by health insurance, incl. addiction treatment of nine months and psychiatric treatment of persons committed to a psychiatric hospital by the courts shall be covered from the state budget.

Available services for survivors of IPV

Similar to other countries, Estonia has taken additional steps to guarantee support for the victims of gender-based and domestic violence, as well as for the specialists of shelters. A victim support service is a public service aiming at maintaining or enhancing the ability to cope of persons who have fallen victim to criminal offences, negligence or mistreatment or physical, mental or sexual abuse. The provision of victim support services includes counselling of victims and assisting victims in communicating with state and local government authorities and legal persons. In addition to counselling and in more severe cases compensation, the victim of crime may, on the basis of the law, claim for compensation for the cost of psychological care.

There is also 24/7 crisis helpline 116006, women's support centres and shelters are in every country. In 2020, a crisis hotline 1247 of the Emergency Response Centre offers psychological first aid. During the emergency situation (COVID-19) for women`s support centres (also shelter) additional guidelines from the Health Board about the shelter activities and management. Recommendations and instructions to work from home and with telecommunication and online options where possible were suggested. Mapping extra women's shelter accommodation options in cooperation with the local government and also mapping volunteers' reserves for extra help, if the need arises. Regular web briefings held with women's support centres all over Estonia to share good practices and solutions, co-ordinating through state level. Messages through the media about help services and helpline. Some women's support centres have been practicing and communicating (especially through social media) about web-based solutions and chat options, as a possibility to get help if making a phone-call is not possible.

Multi-Agency Risk Assessment Conference (MARAC) meetings continue to operate. MARAC teams had also virtual meetings to share information about survivors of domestic abuse who have been assessed to be at risk of serious harm or homicide.

Available services for people with PSU issues

There are different services for people with alcohol and drug abuse. National programmes on tackling alcohol and drug abuse/misuse exist.

Alcohol misuse treatment

There are some services available, mostly on voluntary basis. Participation in the programme can be made compulsory by a court decision. The National Institute for Health Development

(TAI) and the Ministry of Social Affairs of Estonia compiled the so-called Green Paper on Estonian Alcohol Policy to reduce alcohol abuse and harm in 2014. This was followed by various initiatives that included the programme "More Sober and Healthier Estonia", funded by the European Social Fund. The main aim of this programme is to improve the availability and quality of services needed to prevent and treat alcohol abuse. There is also the self-help programme. The "Selge" programme is the first and only internet programme for the intervention of alcohol misuse in Estonia, programme adapted from the "Take Care of You" programme developed in Switzerland, implemented now in many countries. There is also available the e-coach, who a real person who can be contacted by e-mail and provide individual guidance. Satisfaction among members of the intervention group who obtained access to "Selge" programme materials was high: Out of the 182 respondents, 87% were satisfied with their decision to join and according to 84% the programme met their expectations (Vorobjov & Kaal, 2020).

Other substance misuse treatment

The government funds needle and syringe programmes (NSPs), and around 2 million syringes were distributed in 2017 at 14 fixed and 20 outreach syringe programme sites, mostly located in Tallinn and the eastern part of the country, where the problem of injecting drug use is concentrated. Around 5 500 clients used harm reduction services in 2017 and more than 110.000 service contacts were registered across the country. In addition to clean injecting equipment and condoms. The National Health Plan 2020-2030 defines the main objectives in the area of drug treatment. Treatment in the public sector is funded by the state budget allocated by the Ministry of Social Affairs; almost half of the budget funds opioids substitution treatment (OST), with the remainder allocated to detoxification and drug-free programmes. Some larger municipalities also fund drug treatment. Traditionally, drug treatment in Estonia is provided through hospitals, which need to obtain a licence for mental health services to provide inpatient and outpatient treatment for dependency. According to the Mental Health Act (RT I 1997, 16, 260), only psychiatrists can provide drug treatment. In general, drug treatment is primarily provided in outpatient treatment units, and inpatient treatment services remain limited.

Data from specialised treatment centres in Estonia indicate that opioids (mainly illicit fentanyl or 3-methylfentanyl) were the most commonly reported primary substances for first-time clients entering treatment in 2016. Nearly 70 % of all treatment clients whose primary substance of use was opioids reported injecting as their main route of administration. Overall, females account for approximately one out of five treatment clients, but the proportion of females among treatment clients varies by the type of programme and type of illicit drug used.

The Ministry of Justice is responsible for administering healthcare and social services in Estonian prisons. Drug treatment in prisons includes detoxification, opioids substitution programmes (OST), and social programmes, also rehab and re-entry programme exist and peer support, counselling and social accommodation is offered. Estonia has currently 100 women in fertile age in prison, half of them due to drug misuse (Estonian Prison Service,

2019), and relationship and ties with their children and family members are broken. It is actually near impossible to get the rehabilitation and re-entry services funded for this target group, because there are about 2000 men in prison, why to pay the special attention to women?

NGO Libertas (2020) offers three approaches to outpatient treatment: individual counselling, intensive outpatient programme and continuing care programme. Intensive outpatient programme is medically and evidenced-based and includes group therapy, substance use disorder education, weekly family participation sessions, weekly drug screens. Weekly drug screens required to pass, compulsory, for people during their probation period. Clients come to Libertas voluntarily (pay themselves) and some probationers are sent to pass the programme. Libertas has experienced with the Minnesota model of 12-step treatment.

The Estonian drug laws are more punitive than intervention and service oriented, with the exception of a couple of amendments providing for the option to choose treatment or social programmes instead of punishment.

Screening and dealing with PSU in IPV services and the opposite

There is some informal cooperation based on personal contacts. Clients with problematic substance use (PSU) come sometimes to get some advice, but among shelter clients only some cases happened. There could be suspected more survivors of violence with PSU in Estonia, but they are invisible for people working in shelters and shelter managers. This could be a caused by existing network around victim protection, namely, police is not 'sending' such clients to the shelter. Survivors of violence come to counselling and for getting some advice to the women's support centres (shelters, mostly manages by NGOs) and to the victim support specialist (offices located in every county in Estonia, civil service by state).

Practical knowledge about how to deal with shelter work-related problems that may be connected with alcohol use disorder or problematic substance use (PSU). Effective communication and problem-solving skills in the work with the client with PSU disorder is needed.

Clear referral pathways for referrals not exist, if not to mention that specialists of the local government are contacted, because the local government is responsible for several welfare services (social housing, peer support service etc). PSU centres have quite a wide range of different specialists, they hope that their psychologists can identify IPV, but there is no procedure how to tackle this problem. Organisations, which are using the Minnesota model of 12-step programme, have usually the follow-up programme (usually 9 months). Participation once a week is free for those who have finished the basic programme.

In theory, according to law amendment regarding personalized data for the drug treatment register (drug treatment database), should make it possible to protect the life and health of an addicted person by improving the quality of drug treatment services and by creating opportunities for linking treatment data to assess the effectiveness of existing treatment (Government Office of Estonia, 2019).

Available data about the training of IPV professionals on PSU issues and the training of PSU professionals on IPV issues

Such training has been rare, and if any was available earlier, it was not targeted to personnel working with survivors. There was one training in March 2019. This training was on a larger scale and initially planned for family doctors (GPs), but the Social Insurance Board invited women's support centers' and shelters' personnel also to participate. The training was titled "Early detection of alcohol abuse. Short intervention and assistance options". Training was offered by the National Institute for Health Development (NIHD, TAI in Estonian). PSU centre people think they need adequate inventories and screening tools to discover co-occurring problems, included IPV related problems, whether a victim or abuser or both. PSU centres do not know background of their clients; problems may be discovered in ongoing treatment and consultation process. Only about probationers some personal information is disclosed.

Collaboration between IPV and PSU services

Policies regarding IPV and PSU are fragmented and different ministries and agencies deal with different issues and look the phenomenon from different angles. IPV and PSU is not tackled in the framework of integrated programme. There is a violence prevention action plan and then there are national health plans.

The Minister of Social Affairs holds overall responsibility for the National Health Plan 2009-20 (Health Plan 2020-2030 is drafted), the Minister of the Interior is responsible for drugs issues within the plan and its action plans. The Minister of the Interior chairs the committee, which has members from all relevant ministries; in addition, a group of experts and representatives from relevant ministries, agencies and service providers in the drugs field meet regularly with the Minister of Interior and play an important role in implementing drug policy. The Minister of Social Affairs informs the government on the progress made in the implementation of the national drugs strategy. At the local level, health coordination committees, which exist throughout Estonia, address drug-related issues as part of their work (Libertas, 2020).

3b. ICELAND

Prevalence of IPV and PSU

There is no disaggregated data on the co-occurrence of IPV and PSU specifically, but some limited data exists on the two phenomena.

Firstly, data on IPV is difficult to come by given that the issue is a hidden one and data from women shelters, police and hospitals do not provide an accurate picture on the totality of the problem. The latest research that was conducted on the prevalence of IPV is from 2010 using data that was collected in 2008 (Karlsdóttir og Arnalds, 2010). This research revealed that 22% of women asked, had experienced violence by an intimate partner some time in their

lifetime and that between 1% and 2% had experienced physical violence from their partner in the last 12 months. This research had very similar results to a former research conducted in 1996 by the Ministry of Justice.

Data on PSU has similar challenges. A report from 2013 (Gunnlaugsson, 2013) revealed that 23% of adults had at some point in their lifetime tried cannabis, but only 8% 10 times or more and only 2,5% in the last 6 months. Cannabis usage was more common amongst men than women. There is only a small group with serious and excessive use of drugs in Iceland according to Gunnlaugsson's data from 2013.

In a survey from the Directorate of Health, conducted in 2018, 62% of Icelanders claimed they had never tried illegal substances and 36% of those who had, had tried cannabis, 14% amphetamine, 12% cocaine, 6% MDMA and 2% LSD. Men are more likely to use illegal substances the women. The survey also asked about prescription drugs and the outcome showed clear gender differences where women were much more likely to use tranquilizers and pain killers, but men were more likely to use drugs used for ADHD like Ritalin and Concerta (Directorate of Health, 2019).

As for other prevalence data regarding PSU, the only thing available are data on the number of people seeking rehabilitation services which is not an indicator of the prevalence as such. What may be of interest to the MARISSA project is smaller research on PSU and trauma. For example, research from 2019 conducted with 200 clients (men and women) of the country's biggest rehab centres disclosed that 99% of them had experienced severe trauma some time in their lifetime, 81% had experienced physical violence and 55% sexual violence (Sigurðardóttir, 2019). Another research conducted with 67 individuals from the same rehab centre depicted that 59% of men and 75% of women had PTSD.

RIKK and the Root (Rótin) have conducted research on women's experience from rehab and part of that was a questionnaire which got replies from 110 respondents who were all members of the Root (Rótin). Below is the table of the specific substances the respondents were using (some using more than one).

Substance	**Percentage of respondents**
Alcohol	76,4
Cannabis	24,5
Amphetamine	22,7
Cocaine	10.9
Sedatives	20,0
Opiates	5,5
Sleeping medication	10,0

Specific policies about survivors of IPV

The Icelandic government endorsed an action plan against domestic and sexual violence in 2006. The part on gender-based violence focuses a lot on public education and advancing knowledge of professionals who work in the sector of IPV survivor support. It also emphasizes strengthening intervention opportunities for perpetrators.

Reykjavík City Council has an action plan against violence which focuses mainly on domestic violence. It includes actions and support for survivors, perpetrators and children living in homes where domestic violence takes place.

The National Health Service has official instructions for health care workers on first response to IPV. Its aim is to guide nurses and midwives on identifying and supporting survivors of IPV.

Specific policies about people with PSU issues

Policy and treatment in Iceland has been characterized by abstinence-based policy, and a focus on the reduction of supply, since the beginning of the 20th century. Iceland's Alcohol and drug policy, *Drug and Alcohol Prevention until 2020,* was adopted at the end of 2013 (Icelandic Ministry of Welfare, 2013). The main goals of the policy are:

• To restrict access to alcohol and other drugs

• To protect sensitive groups against harmful effects of alcohol and other drugs

• To prevent young adolescents from initiating the use of alcohol and other drugs

• To reduce the number of those who develop harmful use of alcohol and other drugs

• To secure access of those affected by misuse and addiction to continuous and integrated services, built on best knowledge/practices and high quality

• To reduce harm and prevent deaths caused by one's own, or others', use of alcohol or other drugs.

The goal was to implement the policy the following year, in 2014, but little has happened in that direction. Already, in January 2014, a month after the publication of the new policy, the Parliament, with the initiative of the Pirate Party, started discussions on changing the policy towards a more harm-reductionist document. As a result, a working group was founded in May 2014 to revise the new policy with the aim for "the health and social systems to assist and protect the users of substances and their social rights" (Alþingi, 2016).

The working group delivered a report in August 2016, proposing a policy more in the direction of harm-reduction. In the policy from 2013, the first signs of harm-reduction are seen in the Icelandic drug and alcohol policy, where it is stated that one of its main goals are "To protect sensitive groups against harmful effects of alcohol and other drugs" (Icelandic Ministry of Welfare, 2013, 3).

Under the goal to protect sensitive groups against harmful effects of alcohol and other drugs, there is a single mention of women in the Alcohol and drug policy document:

Some social groups are more sensitive than others, for example the children of parents with alcohol and drug problems, pregnant women, and adolescents. All children and adolescents have the right to grow up in an environment that they are protected against the negative effects of alcohol and substance abuse. In addition, women are in far more danger of experiencing violence than others. Screening, public health care services, and the services of municipalities, such as welfare services, are examples of measures to protect individuals (Icelandic Ministry of Welfare, 2013, 7). (Emphasis added)

Reykjavík City Council has taken up the ETHOS typology on housing and homelessness ETHOS categories attempt to cover all living situations which amount to forms of homelessness across Europe:

- rooflessness (without a shelter of any kind, sleeping rough)
- houselessness (with a place to sleep but temporary in institutions or shelter)
- living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)
- living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding). (FEANTSA, 2020).

This has made women much more visible in the system, illuminating vulnerable women in insecure or temporary housing, such as women shelters.

The council also has a new policy: *Policy regarding homelessness and people with complex needs 2019-2025* that contains four pillars:

- **Ideology/ methodology:** Harm-reduction and Housing first
- **Users:** Human dignity, professionalism, empowerment, and active participation of those receiving services
- **Staff:** Aspect, knowledge, experience, and job satisfaction of staff affects the quality of services
- **Community (cooperation and constant development):** Using opportunities in the environment and cooperation with other agencies and NGOs. Monitoring of the situation of users.

In the policy there is strong focus on the lack of services for women and the need for acknowledging the special needs of women with long histories of substance use and trauma, not the least the need for secure housing.

Specific legislations about survivors of IPV

Iceland signed the Istanbul convention in 2011 and ratified it in 2018. In response to the ratification of the Istanbul convention additions were made in 2016 to the penal code focused specifically on IPV. The legislation on IPV is under the chapter on manslaughter and bodily injury. The reason for the legislations being there, in the penal code is to emphasize the severity of intimate partner violence. The maximum prison sentence for minor offenses is 6

years and major offenses 16 years. Sentences are never near to being this long in reality even though the law allows for it and there is a tendency for a large part or the whole sentence to be on parole. The legislation mentions that violence is not only physical but can be mental, social or financial.

Additionally, the criminalization of forced marriage was also put into Icelandic law. Currently there is work ongoing to have a specific law on stalking.

Specific legislations about people with PSU issues

Substances other than alcohol and tobacco are illegal according to Icelandic law and being in the possession of other substances has the maximum sentence of 6 years in prison. For a while people possessing an amount of substances that is considered to be small enough to be for personal use, have rather been fined than sentenced. A change was made to the law in 2020 and now there is no punishment for individuals possessing small amounts of illegal substances (but the substances are still illegal and will be confiscated by the police). The legislation is starting to focus more on the health of people with PSU issue rather than their criminalization. The change in the law in May 2020 also allows local councils to establish a protected environment, so-called "consumption spaces" where individuals over the age of 18 can safely inject themselves under supervision and where cleanliness and sterility of needles is ensured.

The law on treatment for individuals dealing with PSU falls under the medical insurance law and gives the right to anyone who has medical insurance (everyone that has lived in Iceland for six months or longer) to receive treatment at centres/institutes that have a contract with the Icelandic Health insurance.

Available services for survivors of IPV

The health care system is one of the services for IPV survivors. Some health care centres screen for IPV during maternal health appointments and provide counselling. The National Hospital has an emergency reception for survivors of sexual violence where survivors can go for physical checks (after rape), psychiatric support and legal advice. The hospital also has a trauma centre where survivors receive counselling.

The Red Cross has a hotline where survivors can call or chat on the internet to seek guidance.

The local councils provide various services. Reykjavík city council offers counselling for survivors. It also follows up in cases where the police have been called due to domestic violence by asking the perpetrator to come in for interviews. Various sections of the city council have independent projects focusing on survivor support.

There is one women's shelter in Reykjavík and one in Akureyri, in the north of Iceland. Substance use is not allowed in either one, and the shelter in Reykjavík at least has not got facilities to cater to women with disabilities.

There are a few other institutions that offer counselling, support and educational material, Aflið and Bjarmahlíð in Akureyri (north Iceland) and Stígamót, Bjarkahlíð and Drekaslóð in Reykjavík. Women living outside Reykjavík and Akureyri can use phone services of any of the service centres available, but many would have to travel long distances to receive other services.

Available services for people with PSU issues

For the last four decades the treatment system for drug and alcohol misuse, in Iceland, has been characterized by the 12-step approach. Most of the treatment for alcohol and drug abuse in Iceland is paid for by the state but run by NGO's. The National University Hospital of Iceland (LSH) services people with dual diagnoses, that is, severe mental health symptoms and addiction. Apart from SÁÁ, the largest rehab centre in the country, and the National Hospital, there are a few organizations offering treatment, founded either on Lutheran belief or the 12-step model, or on both. This is only a small part of the treatment that is offered in Iceland, with SÁÁ being the dominant treatment provider.

The Root (Rótin) Association on Women, Trauma and Substance Use was founded in 2013 and has been pushing for more focus on gender in policy and treatment and is also increasing services for women focusing on the link between trauma and substance use.

The Minnesota model (abstinence model using the 12 step programme and the philosophy of Alcoholics Anonymous), or what has been called the Icelandic model, has dominated treatment for alcohol and drug abuse in Iceland since the foundation of SÁÁ. This means that there has not been a diverse offer of therapy and treatment. Addiction is defined as a brain disease with minimal focus on social or psychological factors.

Although SÁÁ has offered some form of gender specific treatment since 1995 it can be argued that the treatment system in Iceland has been characterized by gender blindness.

The City of Reykjavík is one of the biggest service providers for the marginalised and those using substances in a harmful way. The services of the city are undergoing important changes with more focus on gender and harm-reduction in recent years.

One of the problems regarding services, however, is that women seeking shelter from intimate partner violence who have substance use problems cannot go to the women's shelter. The shelter does not have the facilities to service these women at the moment. Thus, there is a need for more diverse and harm reducing services.

Screening and dealing with PSU in IPV services and the opposite

This issue varies between providers. The two women shelters do not allow substance use on the premises but they do not screen for it. Some of the other service providers do ask about substance use, but their services are provided whether women are dealing with PSU or not. Some providers insist on their clients being sober for counselling sessions. If an IPV survivor shows up intoxicated she is usually given another session at a later time. If women are caught

using substances within the shelter they are not thrown out immediately but the issue is discussed and a solution sought. The rules are clear however and if the woman cannot stop using substances within the shelter she will be made to leave. Often women leave themselves when they feel they cannot be free from substances since they know the rules. It is also deemed likely that IPV survivors dealing with PSU do not go to the shelters in the first place since the rules are clear.

PSU providers do not screen for IPV or other trauma. Some of the PSU providers have group therapies and at times discussing traumatic events is encouraged, but it does not seem to be followed up with appropriate counselling.

Specialized services for women with PSU issues and their operation

Root (Rótin) offers group counselling, courses, support groups and individual specialized counselling to women based on trauma-informed and gender responsive evidence-based programmes. Root (Rótin) cooperates with Bjarkarhlíð Family Justice Center for survivors of violence and offers it services there. Root (Rótin) is also collaborating with the Women's shelter, offering training for staff and support for the women in the shelter. In 2021 Root (Rótin) will also offer training and group counselling in Hlaðgerðarkot which is the second largest residential treatment centre in Iceland.

Data about women addressed by these services (type of IPV, type of substances used etc.)

Root (Rótin) does not inquire about the type of substances the women use or have used or lived experiences except in the research done with RIKK and mentioned above, but collects information on how the women estimate the usefulness of the programmes they attend (Root/ Rótin, 2018).

Available data about the training of IPV professionals on PSU issues and the training of PSU professionals on IPV issues

Training is severely limited. Root (Rótin) has conducted some training on PSU for IPV professionals (Root/ Rótin, 2020).

Also the aforementioned training planned for the staff at the Women Shelter and Hlaðgerðarkot.

In Iceland there are no specific policies and legislations for –especially women- survivors of IPV with PSU issues.

Collaboration between IPV and PSU services

Root (Rótin) initiated a Forum of Women working with Women with Substance Use and Marginalized groups. This is a forum of individuals, not an organizational collaboration, and aims at creating a space where dialogue and the sharing of experience and knowledge

between individuals who work with this group of women can take place. The parties to the forum are women who are interested in improving the situation of marginalised women and women dealing with PSU, want to work with a human rights centred harm reduction approach and a strengths based approach. Currently the forum has come to a standstill due to Covid-19.

Main issues (e.g. difficulties, facilitators) regarding the collaboration of IPV and PSU services

Issues and challenges in collaboration include trust issues and different philosophies. The dominance of AA and the 12 step approach in the Icelandic rehab environment can also be seen as problematic as it is in its essence very isolating and does not encourage support from other service providers.

In addition, there is a lack of both general education and specific education and training about IPV among professionals working on substance use issues. Assessments were made in 2016 by the Directory of Health where rehab treatment centres did not do well (Icelandic Directorate of Health 2016a; 2016b; 2016c).

3c. GREECE

Prevalence of IPV and PSU

In Greece there is no official data regarding the co-occurrence of IPV and PSU.

IPV

A recent retrospective study, conducted in 2016 in Athens, Greece, reviewed the archives of clinical examinations about allegations for interpersonal violence that were conducted at the Department of Forensic Medicine and Toxicology of the School of Medicine of the National and Kapodistrian University of Athens during a 5-year period (2012–16) (Katsos et al., 2020). Among 2466 patients, 26.93% (namely 664) were victims of IPV (Katsos et al., 2020). The vast majority of victims were women (86.75%).

According to the Hellenic General Secretariat of Family Policy and Gender Equality (GSFPGE, 2020a), that collects and presents data about Domestic Violence, for the year 2019, 3.147 calls for gender and domestic violence were addressed by the National Support Telephone Line SOS (15900); while 4.317 cases of gender and domestic violence were addressed by the Municipalities' Network of Supporting Structures for Women (Observatory for Gender Equality of GSFPGE, 2020). Data deriving from GSFPGE indicate that 76% of the calls were IPV incidents, as the vast majority of the perpetrators were related to the victim with a current or previous romantic relationship. More specifically, regarding the calls to the National Support Telephone Line SOS (15900) for the year 2019, in 56% of them the perpetrator was the current husband, followed by the current partner (11%), the ex-husband (5%) and the ex-partner (5%). 7% of the offenders were dealing with mental health

problems, while 16% of them were dealing with PSU issues. Among them, 61% were addicted to alcohol, 36% were addicted to drugs, 8% were addicted to gambling and 2% were addicted to the internet. Regarding the cases addressed by the Municipalities' Network of Supporting Structures for Women, in 58% of the cases the offender was the husband (current or ex) and in 13% of the cases the offender was the partner (current or ex).

In the Union of Women Associations of Heraklion Prefecture (UWAH, 2020) 348 new cases sought for help during the year 2019, asking for either counselling, or legal advice, or shelter for themselves and/or their children as victims of violence. Of them, 79% had suffered violence from their current or previous partners, or their current or previous spouses. The remaining percentage of admitted cases had experienced many forms of violence from other members of their family (father, mother, brother, sister) or from their working environment. The age group for IPV ranges from 18 to 80 years old. The intensity of the incidents, as well as the form of violence varies, with physical violence being the most frequent one

PSU

According to the National Centre for Documentation and Information on Drugs (2020), in 2018, at least 3698 people with PSU were addressed by the specialised and recognized by law treatment programmes in Greece (this number refers to new intakes but not necessarily the person's first intake to the therapeutic programme). This number is lower than 2017 and 24% lower than in 2013. 72% of the people addressed reported polysubstance use. Although the number of polysubstance users remains stable in recent years, the percentage of drug users that report use of three or more substances has increased in the last 2 years. At the same time, the number of people who seek treatment for opioids is decreasing, while the number of people who seek treatment for cocaine or other stimulants is increasing. The number of people injecting drugs has decreased the last years. For the year 2018, the estimated number of high-risk drug users aged 15-64 years, mainly using opioids, was 13.513. In 2017 225 deaths were related to PSU, in 73.3% of those the substance used was opioids. In 2018, the total amount of people receiving PSU therapy services was 12.311. 73% of them (8.975) were in substitution therapy (receiving buprenorphine and methadone); 20% of them (2.420) were in non-substitution therapy (receiving psychological therapy); 5% of them (647) received interventions in the context of the penitentiary system; and 2% of them (269) attended a physical detoxification programme.

Specific policies about survivors of IPV

In Greece, IPV is considered under the umbrella of domestic violence. In 1982 Greece signed the UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and it was ratified by Law No 1342/1983 one year later. It was only in 2006 that crimes of domestic violence were criminalised, including sexual abuse of the spouse.

Until 2006, crimes of violence in families were not specifically criminalized. Law 3500/2006 (2006), entitled as «Tackling domestic violence and other provisions» was the first systematic attempt to deal with domestic violence in Greece and establishes that any violent

activity occurring within family boundaries is criminal in nature, and should be treated as an inherent offense.

Moreover, harmonising with Directive 2012/29/EU, Law 4478/2017 (Part 4) (2017) establishes the minimum standards on rights, support, and protection of victims of crime, strengthening in this way the rights of the victims of crime. In 2018, Greece ratified and incorporated into the Greek legal order the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), through the Law 4619 /2019 (2020).

Regarding gender-based violence, in 2019, Greece adopted Law 4604/2019 (2019) entitled "Enhancement of Substantive Gender Equality, Prevention and Combating of Gender Based Violence", implementing a comprehensive legal framework for gender equality that enhances the equal treatment of women in all aspects of their lives.

Specific policies and legislations about people with PSU issues

According to Law 4139/2013 (Article 20) (2013) the dealing of illicit drugs (import, export, transit, sale, purchase, possession, offer, disposal, distribution, shipping/ delivery, save, deposit, prepare, transport, counterfeiting and selling counterfeit substances, administration of substances to replace addiction, address of a store where the perpetrator is systematically trafficked, financing, organization or management of trafficking activities, counterfeiting of medical prescriptions, sending and receiving parcels and mediation in any of these operations) by individuals with no legal permission is punished by imprisonment of at least 8 years and a fine of up to 300.000 Euros.

Drug-depended offenders have the right to participate in a special treatment unit operating inside prison settings or –as is often the cases- the penalty for a drug-related committed crime, can be replaced by mandatory attendance at a community drug treatment programme operated by a lawfully recognized addiction agency; both upon the order of the prosecutor and the investigating judge (EMCDDA, 2019b) Moreover, drug-dependent offenders have the right to a conditional release regarding crimes related to drug dealing, under the provision that the perpetrator is either certifiably attending or has successfully completed drug treatment or he has served a minimum of one fifth of the sentence (Pompidou Group, Council of Europe, 2020).

In the last 3 years, Ministerial Decisions have been issued, solving two chronic problems: the legalization of medicinal use of cannabis and the institutionalization of Supervised Drug Use Areas (Areas for supervised opioids use) (National Centre for Documentation and Information on Drugs, 2020).

Policies regarding PSU include the provision of specialized services to people with PSU issues. In Greece, both substitute and non-substitute treatment programmes are available, as well as harm reduction programmes. Moreover, the Municipality of Athens participates in a worldwide programme entitled «Partnership for Healthy Cities», which is focused on the training of drug users, their families, health professionals and other relevant parties on

naloxone provision to active drug users in order to prevent overdose and corresponding deaths (Partnership for Healthy Cities, 2020).

Additionally, in 2020, the Municipality of Athens implemented, in cooperation with OKANA, KETHEA and NGOs related to addictions, the first Hosting Structure for drug users. This structure offers housing services, personal care and hygiene services, inclusion in Therapeutic Dependence Programmes and connection with other relevant services and can accommodate 70 persons (OKANA, 2020).

The provisions of PSU treatment programmes in Greece are based on specific guidelines regarding their structure and operate are evidence-based. As a result, PSU treatment is available in almost every region; is easily accessible; affordable (as in most cases the services provision is with no charge); science-based and following already existing good practices (Pompidou Group, Council of Europe, 2020). Systematic data collection is a major priority as it fosters the right of the community and professionals to have access to relevant information.

As a result, research funding is provided by several government sources to university departments and KETHEA (Pompidou Group, Council of Europe, 2020). Moreover, PSU treatment programmes, through specialised services provision and relevant programmes/ units, ensure the access to treatment and care for specific, vulnerable populations such as people who use drugs in prison, sex workers, pregnant women, migrants, refugees, elderly, minor drug users, young offenders who use drugs, disabled children, children from dysfunctional environments, children living in care institutions and at-risk families (Pompidou Group, Council of Europe, 2020). In terms of harm reduction, PSU treatment programmes in Greece promote the right of drug users to access treatment for all the consequences of drug use (e.g. HIV, Hepatitis etc.), while at the same time they promote strategies aiming at reducing the health, economic, social and legal consequences of drug use (Pompidou Group, Council of Europe, 2020). Last but not least, these programmes fight against stigmatization of drug users and try to raise awareness among individuals as well as at the societal level (Pompidou Group, Council of Europe, 2020).

Special policies have also been implemented in response to the COVID-19 pandemic. More specifically, treatment programmes have intensified their services and have made them much more flexible (e.g. intensify of street work interventions) in order to assist their patients in this emergency situation and in order not to be excluded or neglected (National Centre for Documentation and Information on Drugs, 2020).

Available services for survivors of IPV

In Greece, the available services for survivors of IPV are mainly operating under the umbrella of Hellenic General Secretariat for Family Policy and Gender Equality (GSFPGE) or are NGOs active in the field.

Established in 1985, GSFPGE is the official governmental agency which is responsible for the planning, implementation and monitoring of policies regarding gender equality (GSFPGE, 2020b). Belonging to the Ministry of Labour and Social Affairs and being part of the National Mechanism for Gender Equality at central national level, GSFPGE includes: a 24-hour SOS

15900 helpline, 42 Counselling Centres at the capitals of the Regions of the country, 20 Safe shelters for Abused Women with a total capacity in hosting approximately 400 women survivors and their children or women at increased risk of violence.

The Union of Women Associations of Heraklion Prefecture (UWAH, 2020) is an NGO, established in 2001, that belongs to the Voluntary Non-Governmental Organizations, operating at Heraklion Municipality, Crete, Greece. UWAH is active at the promotion and protection of women's and children rights; while it also engages with raising awareness and advocating for human rights. In this context, its main mission is to promote, implement and supervise the application of the Istanbul Convention (Council of Europe Convention on preventing and combating violence against women and domestic violence, 2011), at local, national and European level.

The major activity of the organization is to provide support services to victims of domestic and intimate partner violence. It has been recently certified for its counselling services under the ISO 9001:2008 protocol. It operates the 24/7 emergency help line, the Shelter and the Counselling Centre for women victims of domestic violence.

Additional organizations and services, either privately or publicly funded, relating to IPV and Domestic violence, providing services to victims of abuse are the National Centre for Social Solidarity (EKKA) and Diotima. The DIOTIMA (2020) organization is a Non- Profit NGO that operates as a specialized centre for research in gender issues, with a Certified Support Services Centre since 1980. Its aim is to highlight all the aspects of discriminations against women, including all forms of violence.

More specialized work in violence against women comes from the National Center for Social Solidarity/EKKA (2020), which provides counselling and sheltering services to women, children and families coming from vulnerable groups, when they find themselves on emergency situations and crises, as well as counselling for perpetrators. As part of the above organization (EKKA), there is a newly founded network, the National Reporting Mechanism (EMA) that aims at identifying and protecting victims of trafficking.

Available services for people with PSU issues

In 2018, 116 treatment structures and 47 PSU counselling centres were operating in Greece (National Centre for Documentation and Information on Drugs, 2020). The main types for dealing with PSU in Greece are psychosocial interventions ("dry"/ non-substitute therapeutic programmes), substitute treatment/ therapy (Integrated Treatment Units for Addiction and Intensive Psychosocial Support Units) and physical detoxification. The officially recognized bodies that provide the above types of treatment in Greece are the following: OKANA, KETHEA, Detoxification Unit 18 ABOVE, the Psychiatric Hospital of Attica (PSNA), the Psychiatric Hospital of Thessaloniki (PST), the General Hospital of Ioannina, the General Hospital of Corfu, the Psychiatric Clinic of the University of Athens, general public hospitals (in collaboration with OKANA), the independent association THESEAS within the Municipality of Kallithea and the Ministry of Justice, Transparency and Human Rights (Eleonas prison).

In addition to the therapeutic interventions, the counselling services provided by the aforementioned bodies through the counselling centres / stations / reception centres, information and admission centres, which are the first contact of those seeking help for issues, are also important for the address of substance use issues. Counselling centres, especially in the case of psychosocial interventions ("dry" treatment programmes), function as a stage of preparation and integration into the therapeutic process of people seeking support in substance use, where information, assessment of the situation, individual and group counselling, support, health care services and family support are provided.

Screening and dealing with PSU in IPV services and the opposite

In Greece, there is not an enacted protocol for screening and dealing with PSU in IPV services and the opposite. Each treatment programme either for IPV or PSU follows its own guidelines, principles and philosophy. Many of them, such as UWAH, screen for PSU; however there is no official data available regarding the procedure followed and the outcomes deriving. According to UWAH's counsellors, they systematically ask their clients for any possible PSU of any kind, including the frequency and the exact substance they use. This happens during the first interview with the client, where the social history is filled in. In cases where the client admits of PSU, we refer them to the nearest Substance Treatment Centre, which in Heraklion is KETHEA Ariadni. If the PSU is severe and the IPV therapy is problematic due to the use, they request firmly for any proof of admission to the Substance Treatment Centre.

Specialized services for women with PSU issues and their operation

The only specialized service for women with PSU issues is offered by Detoxification Unit 18 ABOVE and includes the Reception/ Counselling Centre for Addicted Women, the specialized Women's Treatment Programme (of internal residence) and the Social Rehabilitation Programme for Addicted Women and Mothers (Detoxification Unit 18 ABOVE, 2020). Through these stages/ programmes addicted women try to realize the reasons that led them to addiction and seek new ways of life through various psychotherapeutic procedures such as individual psychotherapy, group psychotherapy, drama therapy as well as Art therapy.

Data about women addressed by these services (type of IPV, type of substances used etc.)

According to reports from other institutions and organizations, there is a vast difference in numbers relating to survivors' PSU. Only a small percentage of survivors are reporting PSU problems for themselves, mainly alcohol use, whereas there is a large number of perpetrators who have been exhibiting an addiction to substances, especially alcohol.

Available data about the training of IPV professionals on PSU issues and the training

No formal training has been conducted, relating to the co- occurrence of IPV and PSU, either in IPV organizations or PSU centres in the last five years, according to the reports received from their executives. The expansion of their knowledge and further improvement of the providing services depends mainly on each executive's personal quest for development.

Main issues (e.g. difficulties, facilitators) regarding the collaboration of IPV and PSU services

There has been no formal collaboration between PSU and IPV organizations, such as agreements on bilateral protocols. There has been a quite productive cooperation established however, among the organizations and institutions, through personal acquaintances and relations formed in work related events.

3d. Summary of Country Reports

According to the country reports regarding IPV and PSU prevalence, treatment, legislation, policies and multi-agency co-operation; both similarities and differences can be found among the project participating countries (Estonia, Iceland and Greece). More specifically, one major similarity was the –almost total- absence of official and disaggregated data and the challenges regarding data collection on IPV and PSU co-occurrence; Iceland seems to be the only exception, presenting two surveys conducted in rehabilitation services. However, these data are not indicative of the prevalence of co-occurring IPV and PSU. Policies regarding IPV and violence in general in Estonia, Iceland and Greece include violence tackling as well as victim support and preventive interventions and services through the implementation of action plans by governments and other relevant entities and organizations.

Legislations regarding IPV include the signing, ratification and incorporation of the Council of Europe's Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention). Additionally, national legislations and penal codes differ among the Project countries. For instance, specific Estonian Laws and corresponding Acts include and constrain protection of private life or other personality rights of a victim; financial support; home support; provision of support services and information on how to get support conducted by local government and provision of emergency social assistance. Specific Icelandic Laws and corresponding Acts criminalize forced marriage, while there is ongoing work for the implementation of a specific law regarding stalking. Greek Laws and corresponding Acts criminalize domestic violence, including sexual abuse of the spouse, and set a comprehensive legal framework regarding gender equality. According to Iceland legislation, IPV is under the chapter of manslaughter and bodily injury, while in Greece IPV is under the chapter of domestic violence.

All participating countries in the MARISSA Project have various targeted, mainly abstinence-based and reduction of supply policies towards PSU, aiming at the same time both at the prevention and treatment of PSU. These policies concern illegal as well as legal psychotropic

substances such as drugs, alcohol and tobacco. Moreover, policies regarding the treatment of PSU include rehabilitation, social reintegration as well as harm reduction, taking into consideration vulnerable groups such as women, prisoners, refugees etc. However, differences are being noticed in the quantity and quality of these policies and corresponding services between these three countries.

Psychotropic substances, except from alcohol and tobacco, are illegal in Estonia, Iceland and Greece according to their legislation and the possession of them is prosecuted. An exception is being made for personal use and/or possession of small amount of illicit substances. In the last years, there is a shift of legislation from the criminalization to the therapy of PSU offenders in all countries; however, these efforts are at the beginning, and lots need to be accomplished in the future towards this direction. In the context of harm reduction in Iceland and Greece, the law makes provision of "consumption spaces" (Supervised Drug Use Areas).

The available services for survivors of IPV are very similar in Estonia, Iceland and Greece. Victim Support Services are referring to victims of gender and domestic violence, providing counselling, therapy, legal assistance and accommodation (e.g. shelters for women victims of violence). Additionally, in all these countries there are 24/7 helplines available for victims of violence. In their majority, these services are public, operating under national or local umbrella. In Iceland, the health care system acts, when required, as a service for IPV survivors, while the National Hospital has a trauma centre providing counselling to survivors.

Through the country reports of Estonia, Iceland and Greece, similarities were found at the operation of the available services for PSU (e.g. governmental and local funding and NGO's; individual and group therapy; inpatient and outpatient treatment), while differences were found at the models and approaches used. More specifically, in Iceland, the most prevalent model of addressing PSU is the 12-step approach while addiction is mainly defined as a brain disease, leading to neglect of social or psychological factors. On the contrary, in Greece, PSU treatment follows a psycho-social oriented approach (especially in KETHEA and Detoxification Unit 18 ABOVE); although quite widespread (especially in OKANA) is the medical model according to which addiction is a chronic recurrent brain disease. At this point, it is worth mentioning that Iceland is the only country mentioning that despite the previous gender blindness, a particular focus has been given over the last years to the gender dimensions of PSU. For example, there is an organisation specializing in and explicitly dealing with trauma and PSU. Last but not least, all countries provide harm reduction services (e.g. needle and syringe programmes) to people with PSU issues.

Similarities were found between Estonia, Iceland and Greece, regarding screening and dealing with PSU in IPV services, and vice versa, as there is not a clear protocol for such possible cases. Similarly, there are no clear referral pathways as well as official data regarding prevalence among IPV and/or PSU services; procedure followed and outcomes deriving, even in cases that screening and referrals do exist. As a result, procedures and interventions vary between countries as well as between service providers.

Specialized services for women with PSU issues are available in Iceland and Greece. A main difference is that Icelandic services are based on trauma-informed and gender responsive

approaches, while Greek PSU services deal with trauma in the context of the psychotherapeutic approach and therapy.

In Estonia, as well as in Iceland and Greece, formal training of IPV professionals on PSU issues and vice versa ranges from severely limited to totally absent. Training regarding IPV or PSU seems to depend on professionals' personal interests, ethic and quest for development.

Regarding the collaboration between IPV and PSU services, this seems to be informal and not organizational in all countries, while at the same time, when it exists, it is mainly based on personal contacts and acquaintances. As a result, collaboration between IPV and PSU services faces various challenges, commonly in these countries, such as fragmented or absent policies; different angles of approaching the phenomenon; different philosophies; trust issues; isolation and introversion of services; lack of effective communication and problem-solving skills and lack of both general and specific training on IPV issues, mainly among PSU professionals.

4. Current Situation & Recommendations for Interventions, Services and Policies

It has been well documented that women experiencing IPV and/or PTSD and PSU face more severe difficulties at any level (physical, psychological and social), affecting treatment as well (Lipsky et al., 201; Mason & O'Rinn, 2014; Schäfer & Najavits, 2007). More specifically, they start PSU earlier; PSU is more long-term and severe and they have higher possibilities of poly-substance use (Schäfer & Najavits, 2007). It has also been suggested that women survivors of IPV with PSU issues are experiencing high levels of emotional, anxiety and personality disorders (Bernstein, 2000; Schäfer & Najavits, 2007) and suffer from more severe health problems, such as HIV (Weaver et al., 2011). It has been suggested that parallel presence of IPV and PSU burden help seeking, therapeutic commitment and therapeutic outcome as they present higher rates of drop-out and lower rates of treatment completeness for both phenomena (Berenz & Coffey, 2012; Bernstein, 2001; Davis, 2006; Lipsky et al., 2010; McGovern et al., 2009; Schäfer & Najavits, 2007; van Dam et al., 2012).

Within the health system domain, as it can be applied to mental health system domain – including IPV and PSU as well-, gender norms, gendered patterns of employment and work and gendered stereotyping by health-care providers can affect women's access and uptake to health-care services and affect the diagnostic and treatment pathways (Manandhar et al., 2018). At the same time, health systems' ignorance regarding how unequal gender norms, roles and relations affect health and discriminations against women in health-care settings, can lead to gaps in coverage and failure of therapy provision to women (Manandhar et al., 2018).

In this line, gender issues place women survivors of IPV with PSU in greater danger, risk and straitened position (Covington, 2019). Women face difficulties regarding entering and assessing treatment programmes due to gender-related barriers such as social stigma and gender-based stereotypes, shame and guilt, poverty, accessibility and affordability of services, as well as the absence of child care and the fear of losing custody of their children (Schamp, 2019).

There is also a lack of gender-sensitive PSU treatment for women (UNODC, 2016), as PSU services are designed by men for men and mental health services are designed by men for women and/or men (Covington, 2019). Capezza, Schumacher and Brady's research (2015) showed that in the U.S.A., only 5.266 out of 13.696 PSU facilities, namely 38.4%, offer IPV related services. However, it is not clear how these facilities defined "IPV related services" (e.g. assessments only, referrals or more intensive in-house services) (Capezza et al., 2015).

According to the United Nations Office on Drugs and Crime's (UNODC) World Drug Report (2016), existing drug policies lack sensitivity especially towards women; worsening, through structural violence, the already existing stigmatization, victimization, marginalization and disempowerment of women. Among the factors contributing to this marginalization is the failure to accept or understand that drug dependence is a health condition; the stigmatizing attitudes towards people who use drugs; the corresponding unemployment; homelessness; sex work; vulnerable youth (such as young victims of family abuse and violence) as well as

the punitive approaches of law enforcement authorities, particularly when those approaches lead to high levels of incarceration.

Consequently, there is a huge need of altering and improving the already existing IPV and/or PSU interventions and services as well as creating new services for the benefit of women. There is a need for a whole-person strength-based approach, according to which, all strengths, difficulties and/or mental health issues faced by IPV survivors with PSU issues would be taken into consideration (Against Violence and Abuse, 2013; Covington, 2019).

In a similar vein, gender-sensitive and feminist approaches and policies should be adopted in the PSU field in order to recognize and intervene in sex and gender-related influences of IPV on PSU, recognizing at the same time how social and gender inequalities affect women's vulnerability to PSU and their capacity for change (Benoit & Jauffret-Roustide, 2015; Ettorre, 2019; Poole, 2019; UNODC, 2016). According to WHO (Manandhar et al., 2018) and Schmidt et al. (2018) gender-transformative approaches should be also adopted. Through gender-transformative approaches health outcomes and improvements in gender equity can concurrently been integrated (Schmidt et al., 2018). Applied to PSU treatment, gender-transformative approaches can promote the active examination, questioning and changing of negative gender stereotypes and norms; redressing at the same time the imbalances of power and leading, as a result, to the reduction of gender inequities in PSU responses (Schmidt et al., 2018).

Moreover, trauma-informed approaches should be adopted, recognizing the high prevalence of trauma –including trauma deriving from IPV- (Covington, 2019; Poole, 2019). Trauma-informed approaches could include Cognitive-Behavioural Therapy, Guided Imagery, Relational Therapy, Mindfulness, Eye Movement Desensitization and Reprocessing (EMDR), Emotional Freedom Technique (EFT) and Expressive arts (Covington, 2019). These approaches would help to identify and foster both physical and emotional safety; women's need of self-determination; of making their own choices and regaining the control of their lives through informed and free decision making (Anyikwa, 2016; Covington; 2019; Schmidt et al., 2018; Poole, 2019). Trauma-informed approaches contribute to the avoidance and prevention of women's re-traumatisation and make women able of benefit from the provided services (Schmidt et al., 2018). According to this approach, although its disclosure would not be essential, trauma would be taken into account (Covington, 2019), as well as embodied experiences of women survivors with PSU issues (Ettorre, 2019), recognizing that PSU may be related to past and current experiences of violence and trauma (Poole, 2019). At the same time, avoidance of trauma triggers would be ensured, preventing re-traumatisation (Covington, 2019; Poole, 2019). Through trauma and gender-informed approaches health and social priorities, empowerment, women's strengths and sense of value, trustworthiness, confidence, self-efficacy and collaboration would be fostered (Covington, 2019; Poole, 2019). Research conducted with women in Iceland who have been through PSU treatment reveals that they would like the treatment to be trauma-informed, individualized, holistic, safe spacing, free from distractions and triggers and tailoring to women only (Pálsdóttir, 2019). Consequently, the implementation of trauma-informed, gender-sensitive and gender-transformative approaches, especially in the PSU field, would contribute to the improvement gender and health equity; to the improvement of treatment outcomes for women (e.g.,

reduced substance use, lower relapse rates, higher retention rates in services, increased satisfaction with services); to the improvement of women's access to services (e.g., earlier help-seeking, readiness for change, higher rates of completing treatment, increased engagement in preventative service); to the improvement of staff retention and to the increase of their satisfaction with employment (e.g. less burnout or compassion fatigue, less vicarious or secondary trauma); to the implementation of services that reflect the needs, concerns, and preferences of diverse groups (e.g., pregnant women, gender queer youth, refugees, veterans) and to the improvement of system and programme planning (e.g. ability to respond to trends in substance use such as young women's high rates of heavy drinking) (Schmidt et al., 2018).

Due to IPV and PSU overlap, the complex interplay between these two phenomena and the fact that treatment of PSU alone may yield limited results (Afifi et al., 2012), a holistic, integrated model of IPV and PSU is required (Afifi et al., 2012; Cohen et al., 2013; Crane et al., 2014; Engstrom et al., 2012; Fals-Stewart & Kennedy, 2005; Fowler & Faulkner, 2011; Gilchrist & Hegarty, 2017; Macy & Goodbourn, 2012; Schumacher & Holt, 2012).

This integrated model should take into consideration and tailor different types of IPV (e.g. physical, emotional/ psychological and sexual IPV) among women with PSU issues (Benoit & Jauffret-Roustide, 2015; Morton, 2019), as well as specific substances (Afifi et al., 2012; Crane et al., 2014). Finally, it has been suggested that this model should be implemented both at treatment and harm reduction services (Benoit & Jauffret-Roustide, 2015; Poole, 2019). Last but not least, the management of violence –including IPV- experienced by women with PSU issues should be incorporated in national strategies and plans, securing at the same time sustainable funding (Benoit & Jauffret-Roustide, 2015).

Until now, the most prevalent and usual types of intervention in IPV and PSU population is "treatment-as-usual", namely the standard substance-abuse treatment; referral to domestic violence intervention programmes; conjoint therapy (couple-based interventions for IPV, behavioural couples therapy for substance abuse) and individually based integrated substance-abuse and IPV interventions (Fals-Stewart & Kennedy, 2005; Klostermann et al., 2010). The interventions/ models co-ordinately and holistically addressing trauma and PSU are few and the most prevalent of which are Women's Integrated Model (Covington et al., 2008), Seeking Safety (Najavits, 2007) and Trauma Recovery and Empowerment (Fallot & Harris, 2002).

Despite the model followed, approaches and interventions addressing IPV and PSU should be governed by some specific, basic principles. According to the toolkit regarding domestic and sexual violence, substance use and mental-ill health released by "Against Violence and Abuse (AVA)" (2013), by the Pompidou Group (Benoit & Jauffret-Roustide, 2015) and the Stella Project (2007), professionals working with IPV survivors with PSU issues should follow a non-judgmental approach, have a "listening ear" and the ability to empower others and show empathy and compassion (e.g. "I believe you", "you are not alone", "you are not to blame"). Moreover, in order to effectively respond to IPV and violence in general, professionals should be adequately trained and organizations should have clear policies for addressing IPV and PSU (AVA, 2013; National Institute for Health and Care Excellence/ NICE, 2014). In particular,

professionals should understand the issue of IPV and PSU in its entirety; ask specific questions about violence and IPV; assess the needs and identify possible risks; prioritize safety; take into consideration family dynamics and hold the perpetrator accountable (AVA, 2013). Organizations should implement early detection of IPV and PSU and have clear guidelines about confidentiality boundaries (AVA, 2013).

5. Multi-agency co-operation between IPV and PSU services

Given that integrated models addressing simultaneously IPV and PSU are not common, many researchers highlight the need for multi-agency co-operation between already existing IPV and PSU services and agencies (AVA, 2013; Macy & Goodbourn, 2012; Stella Project, 2007). According to the Bulletin of WHO regarding "Gender, Health and 2013 agenda for sustainable development" concreted and collaborative actions are proposed in order to deliver health equity; foster well being; enhance gender equality and empower women (Manandhar et al., 2018).

This co-operation would formulate a good practice as resources would be used more efficiently and there are increased odds of successful outcome of both interventions as the presence of IPV would not be a barrier for the treatment of PSU and vice versa (Macy & Goodbourn, 2012; Schäfer & Lotzin, 2018; Stella Project, 2007). In order to be effective, multi-agency collaboration requires the implementation of multidimensional strategies at any level (e.g. counsellor/ therapist, provider, director, agency and policy) (Macy & Goodbourn, 2012).

Multi-agency collaboration seems to be beneficial for survivors of IPV with PSU issues, professionals and IPV and/ or PSU services as well. As for survivors, multi-agency co-operation reduces the number of inappropriate referrals; the number of times they are required to repeat their story; the time consumed and stress derived by several appointments with different professionals and the likelihood of getting lost in the gaps between services (AVA, 2013). As for professionals, multi-agency co-operation intensifies the feeling of co-operation and not being alone in a demanding field; leads to a more coherent understanding of the beneficiary and the several aspects of his/her life that may be related to the situation addressed; increases the likelihood of an early intervention and crisis prevention; fosters co-learning, learning from other professionals regarding the field they are specialised in and seeing things from a different perspective as well as inspires innovation, flexibility and creativity (AVA, 2013). At policy level, as gendered institutional responses affect women's physical and mental health, gender parity in decision-making positions and leadership in the health domain –including IPV and PSU field- should be fostered, leading to increased access of women in corresponding services (Manandhar et al., 2018). Local, national and global policy should move beyond equating gender with women and understand gender as a social and relational construct of power that amplifies inequities in health due to the different levels of power that derive and influence roles, behaviours, activities, attributes and opportunities (Manandhar et al., 2018). Through a holistic approach, policies should simultaneously aim to social determinants, health-seeking behaviour and service delivery and health-system responses (Manandhar et al., 2018). At the same time, policies should foster and empower gender analysis of sex-disaggregated data (Manandhar et al., 2018).

Addressing professionals' needs regarding multi-agency co-operation cannot be coherent unless possible barriers are being discussed. Some of the main challenges described in the relevant literature are:

- differences in philosophy, language and terminology, priorities, way of working, interventions and models being used

- frequent staff changes that unsettle communication and professional relationships
- lack of personal, face-to-face contact of professionals in order to understand their approach, to know what they do and how they work
- reluctance or refusal to share information
- over-protection of beneficiaries
- feeling of threat
- limited financial resources
- fragmented governmental, legal, and policy systems

(AVA, 2013; Macy & Goodbourn, 2012; NICE, 2015).

The National Institute for Health and Care Excellence (NICE, 2015) released recommendations on the topic of "Domestic Violence and Abuse: multi-agency working". According to these recommendations, Domestic Violence –including IPV- and/or PSU services should participate in a local strategic multi-agency partnership to prevent domestic violence and abuse; develop an integrated commissioning strategy; create commission integrated care pathways; adopt clear protocols and methods for information sharing; identify and, where necessary, refer children and young people affected by domestic violence and abuse; provide specialist advice, advocacy and support as part of a comprehensive referral pathway and provide specific training for health and social care professionals in how to respond to domestic violence and PSU (NICE, 2015).

Similarly, the Stella Project, launched in 2002 in the UK, provided training and development work to IPV and PSU professionals, creating a toolkit that delineates the guidelines for advanced changes in the already existing training and collaboration between corresponding services (Stella Project, 2007).

The basic recommendations regarding IPV and PSU multi-agency co-operation are the following:

a) Participation in a local strategic multi-agency partnership

First of all, each service/ agency should consider with whom they want to co-operate and for which reasons (AVA, 2013). A good practice for a partnership would include local authorities (e.g. police and crime commissioners), health services (e.g. violence, IPV and PSU services, Children and Family Court Advisory and Support Services etc.) and their strategic partners (e.g. voluntary, community and private sector organizations), with the participation of senior officers, representatives of frontline workers as well as beneficiaries and/or their representatives (NICE, 2015). This partnership can be built upon already existing –even informal- co-operations or create new ones (AVA, 2013). Also, active involvement in both operational and strategic multi-agency initiatives of the mentioned parts should be ensured and the membership of this partnership should be regularly reviewed in order to ensure relevance and inclusiveness (NICE, 2015).

b) Development of an integrated commissioning strategy

These partnerships should establish integrated commissioning strategies and responses to IPV and PSU in order to meet the health and social care needs of those who experience the phenomenon of IPV and PSU (including young people); of children who are affected by IPV and PSU; of perpetrators of IPV with or without PSU issues and the needs of local communities as well (NICE, 2015).

More specifically, partnerships should:

- develop a shared vision
- develop a shared way of communication, co-operation and settle common priorities (e.g. "safety is key", "focus on security", "crisis is common" etc.)
- agree on interventions, needs, potential risks and severity of IPV and PSU through local needs assessment and mapping exercise
- follow evidence-based commissioning principles
- enable relationship building through statutory interactions offering professionals the opportunity to spend time together in order to know each other and interact (implementation of MARAC or CCR models)
- enable communication through clarification of relevant information
- gain familiarity with the language and terminology used by other professionals participating in the partnership
- define a specific person for liaising with certain agencies or around particular issues
- promote joint training
- respect the fact that other services have their own constraints, responsibilities and outcomes to meet
- address satisfaction and complaints directly
- align or, where possible, integrated budgets and other resources
- separate responsibilities (e.g. one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership)monitor the implementation and conduct evaluation of the strategy followed and the partnership in general

(AVA, 2013; NICE, 2015).

c) Development of commission integrated care pathways

Partnerships should develop and ensure that integrated care pathways are implemented. These pathways should be focused on IPV and PSU identification, external and internal referrals and interventions to both victims and perpetrators with PSU issues and they should take into consideration co-morbidity with additional mental health issues (NICE, 2015). In co-ordinance with the strategies mentioned above, pathways should be conditioned by consistent and tailored risk assessment mechanisms for survivors, perpetrators and other

people affected by IPV and PSU, such as children and young people accordingly (NICE, 2015). For example, it is of utmost importance that IPV survivors are not getting in contact with their perpetrators when receiving help (NICE, 2015).

d) Adoption of clear protocols and methods for information sharing

In multi-agency cooperation, information sharing can be either formal or informal, taking place between services and/ or between two professionals (AVA, 2013). Agreements and implementation of interagency information sharing protocols and pathways between IPV and PSU services should be established (AVA, 2013; NICE, 2015; Stella Project, 2007). In order to be effective, protocols should:

- be in line with the Data Protection Act and professional guidelines that address confidentiality and information sharing in health services
- specify reasons to share information (e.g. safety, prevent crime or suffer)
- specify range of information that can be shared and with whom, including sharing information with health or children's services
- include guidelines regarding seeking consent from beneficiaries, cases in which information sharing takes place without consent and information about which data are going to being shared, how, when and with whom in both of the above cases
- enact secure information-sharing methods
- regularly be monitored
- include guidelines and provision of identification and training of professionals responsible for information-sharing
- encourage professionals to remember their duty of confidentiality but also when this duty has to be breached, as well as remembering the fact that information sharing without consent may put safety, trust and therapeutic relationship in danger.

(AVA, 2013; NICE, 2015; Stella Project, 2007).

e) Development and adoption of referral pathways

In order to effectively address IPV and PSU, partnerships should also develop and adopt specific protocols of comprehensive referral pathways, including the provision of advice, advocacy and support (NICE, 2015). In this line, protocols should include provisions of making professionals aware of gender issues, discrimination, prejudice and other issues (e.g. immigration status) may affect the risk faced by beneficiaries (NICE, 2015). As a result, professionals will provide beneficiaries with tailored advocacy, advice and support services as part of a comprehensive referral pathway (NICE, 2015). In order to address all possible scenarios, services should meet individualized national standards of best practice, assuring that there is a common knowledge and implementation of referral pathways by all IPV and/or PSU services (e.g. accident and emergency departments, general practices, refuges, sexual health clinics and maternity, mental health, rape crisis, sexual violence, alcohol or drug misuse and abortion services) (NICE, 2015). Identification and referrals pathways should also

take into consideration indirect victims of IPV and PSU such as children and young people (NICE, 2015).

f) Provision of specific training for IPV and PSU professionals

According to the relevant literature and research, there is a huge need in training IPV professionals on PSU issues and vice versa as there is a lack of sufficient and evidence-based training, while, in other cases, there is no training at all (Benoit & Jauffret-Roustide, 2015; Schäfer & Lotzin, 2018). According to NICE (2015) "Training to provide a universal response should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and alcohol and drug misuse, along with their legal duties". Training should affect multiple levels and aspects of response, including:

1. effective screening of IPV and PSU
2. sensitive response to disclosure of IPV and PSU
3. provision of helpful advices (including advices for relevant services) and direct beneficiaries to specialised services
4. asking the right questions regarding IPV and PSU which presupposes the knowledge of epidemiology and effects of this specific phenomenon and the professionals' role in intervening safely
5. initial response that includes risk identification and assessment, safety planning and continued liaison with specialized support services
6. provision of expert advice and support
7. raising awareness of the phenomenon and tackling misconceptions and stereotypes regarding gender issues, IPV and PSU

(AVA, 2013; Macy & Goodbourn, 2012; NICE, 2015).

Effective training could take place in several ways. For instance, displaying informative material regarding IPV and/or PSU to corresponding professionals seems to be a good practice as the availability and accessibility of such information to professionals as well as beneficiaries increases professional confidence and makes them feel capable of making changes to their work (Stella Project, 2007). Moreover, IPV professionals could train PSU professionals on IPV issues and vice versa, fostering in this way practice exchanges (AVA, 2013; Benoit & Jauffret-Roustide, 2015; NICE, 2015). Another alternative would be experts on both IPV and PSU and relevant integrated models to train IPV and PSU that would participate in these partnerships (NICE, 2015).

Last but not least, partnerships should consider collocation of services as well as aim to make changes in state-level policies in order to foster, facilitate and strengthen multi-agency co-operations at community and state level (Macy & Goodbourn, 2012).

6. Good practices of multi-agency co-operation of IPV and PSU services

Some good practices on the field of multi-agency co-operation on the field of IPV and PSU are the already presented "Stella Project" (2007), the Project "Women Initiating New Goals of Safety" (WINGS), the ACT Alcohol and Other Drugs (AOD) Safer Families Program (2017), the "Victorian Specialist Family Violence Advisor Capacity Building Program" (Evans, 2020) and the STACY (Safe & Together: Addressing ComplexitY) Program (ANROWS, 2020).

The WINGS Project was led in New York by Gilbert et al. (2015), the New York City Department of Probation and the Center for Court Innovation and Bronx Community Solutions. Guided by Social Cognitive Theory and applied to IPV "Screening, Brief Intervention and Referral to Treatment (SBIRT)" models, offered professionals the opportunity to identify and address victimization among women with PSU issues in community supervision settings (Gilbert et al., 2015). The WINGS Project included two modalities of WINGS (computerized and case manager) in order to screen and address basic aspects of IPV and PSU such as enable substance-using women to identify and disclose IPV, provide feedback on their risks for IPV, develop self-efficacy to protect themselves from IPV, raise awareness of drug-related triggers for IPV, develop safety plans considering substance-related risks for IPV and enhance social supports and linkages to IPV services (Gilbert et al., 2015). After the intervention, a 3-month assessment took place. Findings indicate that WINGS have effective outcomes as they seem to be promising, feasible and safe at identifying IPV in women with PSU issues; increase social support and IPV self-efficacy; reduce both IPV and PSU; indicating at the same time high participation and retention rates, absence of reported adverse events and high client satisfaction ratings (Gilbert et al., 2015; Gilbert et al., 2017).

The ACT AOD Safer Families Program aims to prevent and respond to domestic and family violence (DFV) by establishing new coordinated/integrated interventions within the specialist AOD service system, while concurrently enhancing the universal capacity of this service system including services, workforce and service consumers, to respond to DFV (ACT AOD Safer Families, 2017).

The "Victorian Specialist Family Violence Advisor Capacity Building Program" aims to strengthen the mental health and PSU services understanding of family violence and build capacity across mental health, PSU and family violence to better coordinate service delivery through multi-agency co-operation (Evans, 2020).

The STACY (Safe &Together: Addressing ComplexitY) Program is an action research project that targets professional and organizational capacity regarding collaboratively working across services providing interventions to children and families living with domestic and family violence and where parental issues of mental health and PSU are co-occurring (ANROWS, 2020).

Concluding remarks

High prevalence of IPV in PSU female population and vice versa, indicate that there is a relationship between IPV and PSU. Women survivors of IPV with PSU issues face more severe challenges at physically, psychologically and socially. These challenges affect treatment as well.

Additionally, gender issues place women survivors of IPV with PSU issues in greater danger, risk and vulnerable position. Gender discriminations and stereotypes often lead to additional stigmatization and secondary traumatisation, intensifying both IPV and PSU.

Many theories have attempted to explain the correlation between IPV and PSU, however only a few models and approaches offer intervention strategies. At the same time, the current literature, research and clinical practice highlight the need of integrated interventions as well as multi-agency co-operations between IPV and PSU services in order to effectively identify and address this phenomenon. Consistently, reports from the countries participating in MARISSA project (Estonia, Iceland and Greece) indicate that there is a need of systematic data collection and related training to corresponding professionals.

Services addressing women survivors of IPV with PSU should adopt gender-sensitive and trauma-focused/informed interventions. These interventions should tailor and take into consideration different types of IPV and PSU among women with PSU issues.

At the same time, already existing IPV and PSU services should develop and establish multi-agency co-operations and partnerships in order to provide adequate outcomes and prevent the exclusion of women survivors of IPV with PSU issues from therapy due to the presence of either IPV or PSU.

Recommendations offered by corresponding organizations regarding multi-agency co-operation aim to foster good practices, encourage professionals and services to adopt them and tackle possible obstacles and barriers. More specifically, these recommendations include:

- the adoption of specific protocols regarding local strategic multi-agency partnerships;
- the development of integrated commissioning strategies;
- the establishment of commission integrated care and referral pathways, and
- the information sharing and the provision of specific training for IPV and PSU professionals.

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