
"Free from Addiction,
Safe from Abuse" project

# Training Manual for Professionals on Supporting Women Survivors of Intimate Partner Violence (IPV) with Problematic Substance Use (PSU) Issues

ΙΔΡΥΜΑ ΚΡΑΤΙΚΩΝ ΥΠΟΤΡΟΦΙΩΝ
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# Intellectual Output 2 – Training Manual for Professionals on Supporting Women Survivors of Intimate Partner Violence (IPV) with Problematic Substance Use (PSU) Issues

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## Contents

## Introduction

According to the relevant literature and research, Intimate Partnership Violence (IPV) and Problematic Substance Use (PSU) are significantly correlated. However, the vast majority of IPV and PSU services operate on a segregate level, and address these issues as separate domains. Furthermore, specialised training for IPV and PSU professionals on co-occurring IPV and PSU ranges from total absent to scarce, while in the case it exists, it does not comply with the ECVET principles.

Taking into consideration the aforementioned needs, the "FASA" Project ("*Free from Addiction, Safe from Abuse*") constitutes a supporting innovation in the field of vocational Education & Training, aiming at enhancing the work-based skills of professionals in the field of IPV victim support, through capacity building regarding the treatment of women survivors of IPV with PSU issues.

Highlighting the necessity for comprehensive and specialised in co-occurring IPV and PSU training material and tools for IPV practitioners, VET material (manual & course) and online learning tools would be developed and disseminated as part of the FASA Project. These training materials and tools aim to improve the work-based competencies of professionals; facilitate the implementation of innovative interventions in the context of multi-agency approach, and thus, improve the support service provision to women survivors of IPV with PSU issues.

The first step towards this direction is the development of the "*Training Manual for professionals on supporting women survivors of IPV with PSU issues*" for individual use, as part of Intellectual Output 2. This curriculum consists of pedagogical material based in part in the results of the "*Analytical Report on women survivors of IPV with PSU issues*", developed in Intellectual Output 1, and is in line with ECVET and EQF. The primary target audience of this Training Manual is aimed to be the victim support professionals like you, either staff or volunteers, working in the field of IPV. Being a self-administered learning tool, the FASA Training Manual intends to provide specific knowledge and competencies, that would assist not only IPV professionals and

experts, but also IPV services in adequately addressing and treating co-occurring IPV and PSU; in their ongoing VET development to provide better services to survivors.

To this end, this Training Manual encompasses topics reagrding: the Basic Counselling Principles and Skills; the Correlation between IPV and PSU; Comprehensive Approaches for women survivors of IPV with PSU issues; Multi-agency Approach and Collaboration between professionals in cases of co-occurring IPV and PSU; Designing and Implementing an efficient intervention for women survivors of IPV with PSU issues; Risk Assessment and Crisis Management of IPV, and Monitoring, Supervision and Assessment of IPV services.

The FASA Training Manual would be tested and evaluated in Greece, Estonia, Iceland and UK and would be replicable for all EU countries. This material will in-turn serve as the basis for the VET Course and Online Learning Tools that will be developed in Intellectual Output 3.

# 1. Counselling Principles and Skills

**What will you learn in this Chapter?**

- Revising the Basic Counselling Principles and Skills.
- The counselling process when working with IPV women with PSU issues
- **<u>Implementing</u> all rules and boundaries of therapeutic relationship with the clients** based on:
  - Anonymity,
  - Confidentiality, and
  - Positive rapport (making clients feel safe and protected).

**Key words:** Confidentiality, Counselling, Ethical issues, Principles, Rapport Building, Skills

Professionals working with survivors –and especially with women survivors- of Intimate Partner Violence (IPV) with co-occurring Problematic Substance Use (PSU) issues should cultivate specific counselling skills, abilities, and capacities.

As professionals who work in the IPV field, we should be aware of the phenomenon of co-occurring IPV and PSU, as well as of its prevalence. More specifically, we

should have knowledge and acquaintance with the most prevalent types of IPV and PSU among this population; the existing theories that try to explain this relationship and its effects on women and therapy in general. We should also be aware and familiar with the existing good practices and therapeutic interventions, and the specific obstacles and challenges that we may face while working with women survivors of IPV with PSU issues.

However, when dealing with this specific population, we should first be aware of the core principles and aspects of counselling. Being committed to these principles enables the protection of women survivors' rights, who have been repeatedly encroached, mainly by the perpetrator, and secondarily by the society and its discriminative gender-related norms, attitudes and beliefs. Consistently, we need to acquire knowledge of all the following principles and guidelines, and constantly strive to develop our corresponding skills; while, at the same time, we should steadily strive to implement them when working with women survivors of IPV with PSU issues.

We, from our side, really believe that most (if not all) of us who work on the field, may possess the aforementioned counselling knowledge and skills. However, we also think that it would be useful to "refresh" them, perhaps through featuring a different perspective and position this time; breathing, in this way, new life to them!

- **So, let us get started!**

### 1.1 Basic Counselling Principles and Skills

The first and most important principle that guides counselling, including IPV counsellors as well, is that our behaviour should always be conditioned by **empathy, compassion, and respect**; **valuing** at the same time **client's insight** (Stella Project, 2007). Remaining empathetic, compassionate, and respectful may often be a challenge when working with women survivors of IPV, and especially with those dealing with

PSU issues. This challenge relates to the fact that very often, these women -due to their multiple traumatisation, stigmatisation and marginalisation- seem to be frustrated; in a denial or reluctance to either seek or receive help, whereas their coping strategies seem to be unhelpful or even dangerous to us (Stella Project, 2007). Notwithstanding, through personal therapy and supervision, we - as IPV professionals - could be assisted in overcoming these challenges[1]. To achieve that, we should try to be empowered enough, so as not to be afraid to ask for help when we need it.

Additionally, as professionals working with women survivors of IPV with PSU issues, we need to follow a non-judgmental approach, have a listening ear, and possess the ability to "*be with the client*" (Stella Project, 2007). We should also be capable of feeling and empathising with our clients. Especially in the case of women survivors of IPV with PSU issues, we should be even more sensitive and empathetic with the violent experiences, the trauma, and the gender-related issues that these women are suffering from. In regards to the adoption of a non-judgemental approach, it is suggested to follow a "not knowing" approach; be willing to learn more and get taught by clients; maintain a "curious" spirit; as well as avoid making assumptions, giving advices and making suggestions and recommendations.

Concurrently, we, as professionals working in the IPV field, should be adequately trained in order to be able to:

- show flexibility and ingenuity,

- be receptive to change,

- bear always in our mind that we are working with individuals who are unique human beings and thus, individual interventions are required,

- act like sources of reinforcement, support and remedial experience,

- maintain balance within the therapeutic relationship,

[1] For more information about Supervision, please read Chapter 7.1.

- be good listeners,

- pose the right questions at the right time,

- teach clients new skills,

- provide the appropriate information,

- create expectations and motivations,

- foster changes,

- enhance progress and development,

- provide support, and

- inculcate hope (Stella Project, 2007).

The most prevalent principles of counselling, that all professionals –including IPV professionals like us- should know and be capable of utilising are: Self-knowledge/ self-awareness; Self-improvement; Autonomy; Non-maleficence and Justice.

- **Self-knowledge/ self-awareness** is defined as the individual's acquaintance and possession of actual genuine information regarding him/herself, which derives mainly from multiple self-reflective and social processes, rather than self-processes. Self-knowledge includes information about our behaviours and behavioural patterns; attitudes and beliefs; personality traits; emotions and typical emotional states; values, opinions and goals; preferences and needs; physical attributes; social relationships and social identity (Carlson, 2013; Morin & Racy, 2021). As a result, we, as counsellors, should be aware of our capacities, abilities, skills, and strengths, as well as of our limits, fears, weaknesses, and blind spots.

Regarding self-knowledge,

and towards <u>enabling helpful humility and productive self-doubt</u>,

we –as professionals- could pose to ourselves specific questions

that would ***reflect*** **whether we are valid and to what extent**…

**Thinking Pills[2]:** Some indicative examples of reflective questions are detailed below.

*So, relax, take your time, and turn to your inner self,*

*asking yourself the following questions:*

- Do I recognise my **immediate emotional reactions**?
- Do I judge my **competencies** accurately?
- Do I recognise that I might harbour **implicit prejudices**?
- Am I aware that I might succumb to **cognitive biases** or **unhelpful heuristics**?
- Am I fully aware of my own **values**?

[2] These Thinking pills are based on Knapp et al.'s (2017) recommendations.

- **Self-knowledge/ self-awareness:** Furthermore, when working with women survivors of IPV, we need to be fully aware of our own attitudes and beliefs regarding violence, victimisation, and perpetration, and especially of those deriving by possible personal traumatic experiences. At the same time, we should exhibit zero tolerance towards any kind of violence. We should also be aware of our attitudes and beliefs towards PSU, including negative stereotypes about people with PSU issues. Provided that the vast majority of IPV survivors are women, we should also be aware of our own attitudes and beliefs towards gender-related issues. It is suggested that we probe and reflect on our own attitudes and beliefs towards different cultures and social classes, as often survivors of IPV that have PSU issues originate from low socio-economical levels, and belong to marginalised groups. In addition, our professional skills should include the capacity to recognise and manage all types of conflicts. For instance, we should be able to efficiently resolve conflicts between different value systems inside ourselves; conflicts between our values and our behaviour; conflicts between our values and other persons' values (e.g. colleagues, clients etc.), and conflicts between our values and the counselling values.

- **Self-improvement** is also a very important principle for mental health professionals offering counselling, like us, constituting an essential skill to cultivate. However, we should keep in mind that possessing this skill does not mean that we have reached the desired level of improvement, but that we are committed to it as a continual process. Thus, we should constantly be aware of our values, knowledge, skills, attitudes and beliefs; reconsidering them on a regular basis, and always try to improve and evolve ourselves.

- Another core principle of counselling is **autonomy**, namely the individual's ability to think, decide, and act based on his/her thought and decision, in a free and independent way. IPV professionals should foster clients' autonomy and overcome their urge to guide, direct and suscept clients, rushed by their personal motives and blind spots. When working with IPV survivors, we should be very careful so as not to impinge on their autonomy, especially since others have controlled these women for a long period of their lives. Actually, the autonomy acquired in the context of

counselling/ service provision consists one of the main goals of IPV and/or PSU therapy, due to the low self-esteem and stigmatisation that those women have suffered from.

Self-knowledge and clients' autonomy constitute two correlated issues. Personal motivations affect our ability to provide adequate help and by extension, our ability to foster our clients' autonomy. Through self-knowledge, we would be able to separate helpful from harmful motivations. For instance, although being a "positive" motivation, the counsellor's willing to help others may comprise a harmful practice when it becomes a need that tramples women's wishes and needs (e.g. willing the client to be "dependent" on the counsellor in order to raise the counsellors' self-esteem).

In this line, we should not omit another crucial issue related to self-knowledge: **the psychological pain of the counsellor**. Indeed, many mental health professionals choose the counselling/ therapeutic profession, driven by their personal experiences of mental health issues and/or trauma. According to Farber et al.'s (2004) literature review, the most prominent reasons that motivate individuals to enter the counselling profession are the feelings of isolation, loneliness, and/or sadness, as well as the presence of traumatic experiences, mainly occurred during childhood. As a result, counselling and/or therapy may be perceived and be used by those professionals as a means to find answers for themselves, and to fulfil their unmet needs for attention and intimacy (Farber et al., 2004). At this point, it is worth mentioning that, in the PSU field, due to the influence and dominance of the philosophy of the 12-step approach and Alcoholics Anonymous, it is quite usual for services to occupy "recovered therapists" (namely professionals with personal experiences of PSU who have successfully recovered from PSU) (Rule, 2010). In fact, it is estimated that the percentage of recovered therapists working in PSU services varies between 40% and 57% (Manejwala, 2014).

In case of having personal experiences of PSU, you should be very careful and aware of them, taking into consideration counter-transference issues as well; since such experiences may act as weaknesses and obstacles, which could negatively affect

counselling. More specifically, our personal (unprocessed) experiences of PSU may lead to:

- Intense and indistinguishable identification between the client, and us

- Violation of the therapeutic boundaries,

- Obstruction of the transference,

- Directional and dogmatic approaches and behaviours, and

- Negative effects on scientific approach, neutrality, anonymity, and objectivity

(Ham et al., 2013; Wollf & Hayes, 2009).

Similarly, regarding counsellors' IPV and violent personal experiences in general, the corresponding motives may be extremely dangerous as clients' experiences may trigger counsellors' trauma, and especially in cases in which counsellors' traumatic experiences and feelings are unprocessed.

- **Non-maleficence** constitutes a non-negotiable principle as all professionals have the obligation not to harm clients. However, in many complicated cases such as co-occurring IPV and PSU, it is often difficult for professionals to define where to put the line between "benefit" and "harm"; since this assessment is based on subjective evaluation and as such, involves the risk of paternalism.

- Another core principle of counselling is **justice**, according to which, all clients should be equally treated and not become victims of discriminations. Especially for women survivors of IPV - with or without PSU issues - justice, and non-discrimination in the therapeutic relationship, may act as a remedial experience that would tackle and deconstruct the long-term discriminations and inequality they have suffered due to their gender and/or PSU issues.

**Task 1. Basic Principles:** In terms of self-reflecting, you could fill in the grid below by rating how important are the following principles for you, from 1 (non-important) to 5 (really important):

| PRINCIPLES | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Self-knowledge/ self-awareness | | | | | |
| Self-improvement | | | | | |
| Autonomy | | | | | |
| Non-maleficence | | | | | |
| Justice | | | | | |

### 1.2 Assessment of Client's Suitability for IPV and/or PSU Counselling

First of all, in terms of counselling/therapy provision, we, as IPV professionals, should assess our client's suitability for IPV and/or PSU counselling and/or therapy, by following the steps provided below:

- ✓ Probe the related to IPV and/or PSU issues, which are considered as important by the woman (i.e. current symptoms, how they affect her life/ surrounding people), while screening for both IPV and PSU.
- ✓ Try to understand the woman's world, and focus on the areas that are not saturated with the "problem".
- ✓ Instead of focusing on the problem, recognise and embed into therapy the broader picture of the issue.
- ✓ Similarly, instead of focusing on problem solving, focus on the woman's strengths, desired change, and available support and resources.
- ✓ Assess the woman's motivation and willingness to change.

By following these steps and adopting such an approach, the woman would get empowered and would be assisted in gaining an alternative and/or wider perspective, making, in this way, change seem feasible.

As IPV counsellors, we should also assess the ability of the client to focus on herself and consider if she is an appropriate referral for our service. If we have any doubts, we should not hesitate to consult our coordinator or supervisor.

Last but not least, we should screen about possible health issues –including mental health issues- co-morbidity, medication, previous counselling history, previous suicide attempts etc[3].

[3] For more information about Screening and Assessment, please read Chapter 5.

### 1.3 Counselling: Introduction and Procedure

The first contact with women survivors of IPV with PSU issues is of great importance, as they need to feel safe and protected in order to commit to the counselling procedure. All professionals, regardless their professional experience, should always get prepared for the first meeting. In addition, the place where the session will take place should be welcoming and friendly (e.g. ready, clean, heated, without noise and other distractions, without IPV or PSU triggers/ cues etc.).

In this line, we should introduce ourselves and then proceed with setting a framework with clear boundaries and adequate provided information regarding the process and the intervention that we follow. *Remember to provide this information in a simple and understandable way!*

One of the main issues that we should discuss and clearly explain to our client is confidentiality; addressing its basic principles and the occasions that it may be broken. The client should sign the agreement form and if possible be given information leaflets.

Onwards, we should focus on the reasons the client sought help and probe her expectations regarding IPV and/or PSU therapy. At this point, we should keep in mind that it is not necessary to discuss all possible issues, and slow the pace if necessary; reassuring the client that we would have plenty of time to discuss whatever concerns her.

### 1.4 Promotion and Facilitation of Counselling

In order counselling to be successful and effective, we should also follow some additional principles, aiming at supporting and helping women survivors of IPV with PSU issues.

The first step towards this direction is **rapport building** and the implementation of the therapeutic relationship, since clients, and especially women survivors of IPV,

need to feel contained in a safe, delimited and structured environment. When dealing with women survivors of IPV with PSU issues, we should keep in mind that those women may face additional challenges that complicate and incommode rapport building, due to the fact that they have been multiply traumatised, stigmatised, and marginalised. Particularly in terms of IPV, traumatisation and stigmatisation usually take place within close relationships, where trust, love, and empathy are expected.

**So, how do women survivors of IPV need to feel, in order to trust us?**

- ✓ Feel safe
- ✓ Feel that they are being believed
- ✓ Feel that they are not being blamed
- ✓ Feel that they are not alone

*As a result*, the IPV professional would be perceived as a **genuine, warm empathetic** person who truly cares about them.

In order to tackle both external and internal stigma, we should on the one hand, believe in ourselves, and on the other hand communicate to clients that all individuals are basically "good"; that nobody is born "bad/ evil" and thus, all clients could be helped to change. The desired by the client change should comprise the goal of counselling and framed as a positive advancement. In order to accomplish that, a basic condition is the client's willingness to be helped. However, from our side, we should always clarify to our clients that ***change involves struggle and –possibly- pain.***

### 1.5 Closure of the Counselling Cycle

The closure of the counselling cycle should be very well organised and prepared in detail. We should be certain that all main issues regarding both IPV and PSU that have put women in danger or have made them suffer have been sufficiently addressed. It is also suggested that clients attend Social Reintegration programmes in order to integrate; manage stigmatisation and marginalisation; broaden their supportive networks, and improve their social skills. Additionally, as therapy termination resembles loss and mourning, clients should be aware and prepared for the corresponding feelings that may arise. Finally yet importantly, follow-up is required so as the transition and change to be smoother.

### 1.6 Managing the Therapeutic Relationship: Rules and Boundaries

All counsellors have the responsibility to manage the therapeutic relationship and set clear rules and boundaries. In this line, setting boundaries constitutes a significant parameter, since if we fail to delimite the therapeutic relationship, the client may depend on us; endangaring in this way the therapeutic outcome, and leading in treatment's failure.

To be effective, delimitation on our part, should include the following aspects:

⌦ Implement clear boundaries regarding the **duration** of the counselling session and our **availability** as counsellors (e.g. when the client could call us), as well as the corresponding encouragement or dis-encouragement to do so.

⌦ Setting clear **time boundaries**, which would not be exceeded.

⌦ Do not **discuss** about other clients or about our issues. Such discussions should not be acceptable under no circumstances, even if all parts do not have a problem with that.

⌦ Do not **accept or offer gifts** to the client; neither assign or accept from her any kind of services; or use for our own benefit information given by the client.

⌦ Do not promote your own **perceptions and beliefs** to the client (e.g. religious beliefs).

⌦ Avoid **physical contact** with the client. *Especially when working with women survivors of IPV, we should be very careful with physical contact, as it may be perceived as intrusive and abusive; triggering negative emotions, flashbacks, and revivals of the traumatic experience!*

⌦ Avoid **dual or multiple relationships** between you and the clients, not only during therapy but also after its termination. Dual relationships include conditions and situations such as being friends; being work-partners; exchange of therapy with goods or services; counselling provision to relatives or close friends; being client's counsellor and expert or supervisor at the same time; socialising outside the therapeutic framework, and emotional and/or sexual involvement.

### 1.7 Professionals' Ethical Issues

As we mentioned above, all professionals, including us who work in the IPV field, should be fully aware and strictly committed to the ethical issues; the violation of which constitutes malpractice and is explicitly forbidden.

The first and most significant ethical issue is clients' right to **anonymity and confidentiality**. Confidentiality constitutes a fundamental aspect of therapy, as it is the basic condition for the implementation of the therapeutic relationship. Confidentiality concerns all information about client's personal, sexual, professional and family life, as well as experiences of her family and her close social relationships. It also includes aspects of inner self such as habits, thoughts, opinions, expectations, fantasies, fears, vulnerabilities and desires. Clients' anonymity and confidentiality should be ensured by all professionals working in the IPV and/or PSU field. Exchange

of information between corresponding professionals and/or services should be in line with this principle and follow clear guidelines. Clients' personal data should be anonymised and kept in a safe place. The client should be informed orally and in writing about occasions in which confidentiality may be broken.

Confidentiality breach constitutes a big challenge, and both a professional and personal ethical dilemma for counsellors. However, it should be clear to all professionals that confidentiality has to be broken in specific occasions such as suicide intents and danger for one's life. We should be absolutely sure for the existing danger in order to breach confidentiality, since, in such cases, the principle of client's autonomy is fully encroached. For this reason, risk assessment is crucial and essential while working with women survivors of IPV with PSU issues, and thus, IPV and/or PSU services should have clear protocols and guidelines for risk assessment, in order to determine the severity of danger and harm[4]. In cases of IPV and PSU, the danger is diffusible either due to IPV re-victimisation or to PSU related risks, such as overdose. Thus, it is important for us to keep in mind that only the people that could take action and prevent the harm are those that should be informed (e.g. police, possible victim), whereas the information revealed should be restricted to those that are related to the prevention of the harm. In any case, the client should be informed about the confidentiality breach, and if possible, provide her consent.

According to the counselling ethics, **malpractice** should also be avoided by all professionals. As malpractice could be considered the failure to obtain client's consent; the wrong diagnosis; the insufficient and negligent therapy provision; the failure to prevent harm; the sexual intercourse with the client; the inappropriate referral; the insufficient supervision; the unreasonable confidentiality breach; the deliberate exercise of emotional stress, as well as influence and slander exercising.

[4] For more information about Risk Assessment, please read Chapter 6.

## 1.8 Communication and Counselling Skills

Within the context of effective communication, the **language** we use when talking to women survivors of IPV with PSU issues, should be simple, easily understandable, corresponding to their level of understanding, and without excessive scientific terminology. When it is not possible to avoid terminology, or when the discussion is revolving around complex issues and terms, we should regularly ask for feedback in order to ensure that she has understood us.

When working with women survivors of IPV with PSU issues,

we should adopt

a **gender-sensitive language, discharged of stereotypes and discriminations**;

that would reflect our empathy, understanding, and support,

as well as our **feminist and non-judgemental approach**.

Regarding the counselling skills, we, as professionals, should use in a systematic basis the following techniques:

- **Reflecting:** Counsellors could paraphrase and reflect the content of the discussion, as well as the feelings of the client. Through reflection, we could probe if we have understood correctly the facts revealed by the client and check if the shared feelings (content, volume, and tone) are in synchronisation with our perception. In this way, client's self-awareness is facilitated and she has the opportunity to listen carefully and reconsider the meaning of what she just said. By reflecting her feelings, we express our willingness to accept her emotions and enable her to vent these feelings as well.

Reflection of emotions is related to empathy and concerns the skill according to which the counsellor pays selective attention and reflects to the client the emotional state that he/she has observed. In this way, cognitive elements are removed from

communication; whereas responses and reinforcements concern only the emotional elements that lurk. In this line, we could use phrases such as *"You seem to feel…", "It looks like you feel…", "I feel that (you)…"* in order to reflect client's emotions. Although reflection of emotions does not include reflection of the discussion context, it includes paraphrasing of the content of the emotions.

According to the principles of effective reflection, emotions should be recognised, characterised and processed. Attention should be paid to mixed or ambiguous emotions; while reflection of emotions could bring into light the impairment between verbal and non-verbal communication.

- **Clarification and problem identification**

Through clarification, we could actively check with the client that we have fully understood the presented facts, while at the same time we bring into light feelings that have not stated directly. To accomplish that, we could ask for additional information in order to identify the main concerns that the woman, directly or indirectly, shares with us. This technique assists clients to better listen to themselves, and as a result, leads to greater self-understanding. By constantly paraphrasing, the urgent and relevant points, which need to be considered, are highlighted.

In order to clarify certain topics, phrases or emotions, counsellors could use either encouragement or paraphrasing. Regarding encouragement, we could use small indications, showing in this way to the woman that we are paying attention to her; encouraging her at the same time to keep talking. Encouragements could include verbal and non verbal prompts. Verbal prompts could be short expressions; repetitions of one or two key-words; repetitions of the exact words of client's last phrase and silence ("response latency time"). Non-verbal prompts could be the processing of body communication such as visual contact; tilt of the body forward; absence of nervous movements and appropriate gestures. Encouragements assist clients in processing an incidence in detail and foster elaboration and clarification of what has been said.

Paraphrasing is the exact repetition of what the client has said. Paraphrasing gives the client the opportunity to understand that we are carefully paying attention to her and try to understand her. It also clarifies the client's words and phrases, and offers us the chance to check the accuracy of our perceptions regarding the client. In order to be efficient, paraphrasing could include: use of client's name or the corresponding personal pronoun; use of the exact, most significant client's words; and a brief and clear statement by the counsellor that conveys the meaning of what the client has said.

- **Psycho-education and information**

The use of psycho-education and the provision of relevant to IPV and PSU information could lead to the clarification and deconstruction of women's survivors of IPV with PSU issues myths, related to corresponding topics and/or experiences. Psycho-education and information about IPV and PSU constitute counselling empowerment methods that could normalise clients' experiences, thoughts, and feelings, and assist them in changing their perspective; by providing universality. We could achieve universality through stating that all women, IPV survivors -with or without PSU issues- face similar –if not the same- challenges. These empowerment methods could also be used as good practices, offering ways to ensure safety from IPV and abstain from PSU; making in this way recovery feasible. Finally, psycho-education could include the provision of community and other relevant resources, offering at the same time options that once may have seemed impossible.

- **Ethical Decision Making**

Professionals like us, who work with challenging populations such as women survivors of IPV with PSU issues, frequently have to make decisions that exhibit an ethical subsistence. A practical tip that would assist us in making more accurate decisions is to ask ourselves the following questions:

**Thinking Pills:**

- Why am I concerned about this issue?
- Is it really an "issue"? Am I at a dilemma/ awkward position or am I afraid to do what I know that is right?
- Who else is affected by this decision?
- Is this problem my own problem?
- Have I created this problem or somebody else has? How far can I go in order to solve it?
- What kind of ethical dilemma is this? Legal obligation/ a matter of justice/ keeping a promise/ a matter of honesty?
- What other people think about this dilemma? Who could I consult? Can I learn something from those who disagree with my judgment?
- Am I being honest with myself? What kind of person would do what I am thinking of doing? Could I share my decision –with clear conscience- with my family, my colleagues or my superiors?

- **Feedback:** providing effective feedback to clients should follow some specific rules. Read more at the table below:

| Tips for Effective Feedback | |
|---|---|
| **Do's** | **Dont's** |
| Our feedback should include<br><br>both **positive** and **negative** points<br><br>e.g. "*It was very brave of you reacting instantly; however, next time, think twice before acting impulsively*" | Our feedback should not include<br><br>only **negative** points<br><br>e.g. *"You acted impulsively and this was not right"* |
| Our comments should address the client's **behaviour**<br><br>e.g. "*Your behaviour was annoying*" | Our comments should not express our **impression** of her<br><br>e.g. "*You are annoying*" |
| We should describe what<br><br>we **observe** or **feel**<br><br>e.g. "*Your voice scared me*" | We should not **judge** or **assume/ explain** why something has happened<br><br>e.g. "*Shouting is awful, you raise your voice because you are mean*" |
| We should express our **own thoughts**, **emotions** or **beliefs**<br><br>e.g. "I *think/ feel/ believe that*…" | We should not speak **on behalf of others**<br><br>e.g. "*Everybody thinks…/ It is clear to everyone that*…" |
| Our feedback should concern **specific circumstances** and **behaviours** | Our feedback should not concern **generalisations** |

| | |
|---|---|
| e.g. "*When you did this…you made me upset"* | e.g. *"You always make me upset…"* |

- **Attention Skills**

In order to enable communication and implement rapport building, we, as professionals, should pay attention to clients. This could be accomplished by taking into consideration the following four dimensions.

| **Tips for Attention Skills** |
|---|
| ➢ **Maintain visual contact:**<br>make frequent breaks and look somewhere else from time to time,<br>so as the client would not feel awkward or violated |
| ➢ **Have a loose and friendly body language that shows interest and acceptance**<br>*Please, keep in mind that body language constitutes the 85% of communication.*<br>*In this line, we should be aware of our posture and find our personal style.* |
| ➢ **Have an appropriate vocal style,**<br>including low speech rate, volume and tone. |
| ➢ **Have verbal sequence,** |

by focusing on the topic and not making unnecessary interruptions.

! Please, keep in your mind that

all the above dimensions of attention

(namely the verbal and non-verbal ways of communication)

should *be in consistence with*

the **social and cultural framework**

of both the counsellor and the client !

In addition, we should be aware of the most common "communication mistakes" that are related to:

⌦ The approach: inefficiency at the first contact,

⌦ The interpretation: failure to phenomenological understanding,

⌦ The verbal sequence: failure to understand client's responses,

⌦ The criticism: when the counsellor judges the client instead of assessing her,

⌦ The mistake of omnipotence: when the counsellor believes that, he/she is responsible for the client's behaviour (Conte, 2009).

- **Active Listening Skills**

In order the client to feel that we are paying attention to her and that we are actively listening, we should be trained and exercise the following techniques, in order to develop the corresponding professional skills:

- Open invitation for discussion: We should combine the use of open and close questions; ensuring at the same time, the balance between these two categories of questions. The advantages of such questions are as follows:

| **OPEN QUESTIONS:** |
| --- |
| ➢ **Encourage clients to speak and express themselves**<br>*e.g. "What do you mean by saying…?"* |
| ➢ **Foster the beginning of the discussion**<br>*e.g. "What would you like to discuss today?"* |
| ➢ **Assist elaboration**<br>*e.g. "Could you tell me more about……?"* |
| ➢ **Assist gaining paradigms of client's behaviour**<br>*e.g. "How do you usually manage to/ cope with…?"* |
| ➢ **Assist focusing on the client** |

| CLOSE QUESTIONS: |
| --- |
| ➢ **Help the counsellor to gather specific information** |
| ➢ **Highlight aspects of the incidence, instead of the emotion** |
| **Make the client speak about issues that mainly the counsellor is interested in** |

**!** When posing these questions, we should be very careful in order

**NOT to use directional, guiding, or complex questions.**

**Summarising:** summarising is the recapitulation, condensation and clarification of the essence of what the client has said. It includes the careful observation and selective repetition –with as much accuracy as possible- of the decisive dimensions of client's statements and behaviour. Summarising emphasises both the verbal and non-vernal messages of communication. It aims to help the client unite all her thoughts; check the correctness –or not- of counsellor's reflection regarding what she has said; showing her, in this way, that we have listened all her story/ narrative. In this line, we could summarise either the content or the emotions aroused, through paraphrasing and reflecting the emotions, respectfully. The difference between summarising and paraphrasing, and reflecting the emotions is that summarising is more extent and includes a greater range of emotions or topics which have been presented either in one session or in a series of sessions.

Through summarising, we could detect and highlight the consistent and repeated patterns that arise, as well as the inconsistencies and the polarisation of client's emotions and incidents. While summarising, we should remain enquiring in order the client to feel free to add or correct anything she wants.

- **Focusing:** There are many different types of focusing that could be used by professionals in order to check client's emotions, thoughts and ways of communication, and assist her in developing new visions of herself, of others, as well as of the difficulties and challenges that preoccupy her. Focusing could concern the client; the counsellor; other persons; the problem or the issue/matter; the counsellor-client relationship; the environmental and/or cultural context of the issues discussed.

- **Self-disclosure:** Self-disclosure includes the ways according to which, the counsellor lets him/herself to reveal aspects of themslves to his/her client. Despite the fact that during counselling/ therapy, always something is being disclosed (e.g. through office decoration, clothes, ways of speaking, degrees on the wall etc.), counsellor's self-disclosure is defined as the intentional, verbal statements that reveal personal information, elements and aspects of counsellor's experience and life (Hill & Knox, 2001). Consistently, and based on its content, self-disclosure could be divided into, at least seven, subtypes: disclosures of facts; feelings; insight; strategies; reassurance/support; challenge, and immediacy (Hill & Knox, 2001).

Self-disclosure may induce positive consequences, since it:

- brings into therapy new knowledge and perspectives,

- enables empathy and compassion,

- provides validity,

- moves individuals from "I" to "We",

- demonstrates a new, useful skill,

- reduces the inequality that -by definition- exists within the therapeutic relationship,

- implements greater parity between the counsellor and the client,

- makes the counsellor seem more "human" and real,

- makes the counsellor stand as a role model, motivation, and inspiration,

- normalises traumatic experiences, along with the difficulties and challenges that stem from such experiences,

- enables de-incrimination of the survivor,

- reduces shame and fear of change,

- enables sharing of relational dilemmas,

- enables focusing on "here and now",

- provides confirmation and hope, and

- exudes optimism and inspiration (Audet & Everall, 2010; Duffy, 2010; Fingerson & Ruf, 2014; Ham et al., 2013; Henretty & Levitt, 2010).

However, as it has already been mentioned, we should be very careful when using self-disclosure, as, apart from the positive consequences, it may increase women's risk; increase concerns, and induce negative consequences in general (Himelstein, 2017; Substance Abuse and Mental Health Services Administration/ SAMHSA, 2008). Furthermore, by self-disclosing, the focus may be shifted to us instead of the client; we may encumber the client with our problems; we may be seen as a "weak" and unstable person, and the client may become dependent on us (Rule, 2010).

In any case, self-disclosure constitutes an ethical dilemma. If used, it should be implemented cautiously, sparingly, with sensitivity to client's responses, and with respect to her individual needs. We should also pay attention to counter-transference, check the ethical/moral base of self-disclosure and seek supervision if needed (Audet & Everall, 2010; Fingerson & Ruf, 2014; Miller & McNaught, 2016).

## 1.9 Risk and Crisis Assessment and Management Skills[5]

In order to be efficient and ultimately help and support survivors of IPV with PSU issues, counsellors should have the knowledge and the capacity to assess and manage risk and crisis situations regarding both IPV and PSU. In this sense, we should posess the appropriate skills in order to assess and evaluate the possible risks and formulate the case, accurately and promptly. After the risk and crisis assessment, we should proceed with defining the essential goals and actions. Risk and crisis management of IPV could include prevention of additional violence and corresponding harms, re-traumatisation and reveal of the traumatic incidence. Risk assessment and crisis management of PSU could include harm reduction, prevention of overdose and relapse prevention.

## 1.10 Scientific Supervision and Assessment of Counselling[6]

As it has already been mentioned, scientific supervision is of great importance in all cases, including working with survivors of IPV with PSU issues. It is important that counsellors have the opportunity to get help and guidance in order to improve themselves and provide more efficient support for clients. In this context, supervision would assist us in overcoming obstacles such as frustration and offputing/ vain, emotions which are very common and prevalent in this field. It would also help us to make ethical and rationale decisions upon the dilemmas that we previously described. Moreover, working with survivors and reasuring them “that they are not alone”, requires the reassurance that neither we, as counsellors, are alone.

At the same time, the assessment of counselling and services provision in general, constitutes one of the main conditions of qualitative services provided to survivors of IPV with PSU issues. As a result, the involved services should implement clear and structured assessment protocols that would help them recognise their own gaps and

[5] For more information about Risk Assessment and Crisis Management, please read Chapter 6.

[6] For more information about Supervision and Assessment, please read Chapter 7.1 and 7.2.

"blind-spots", and would settle the fundamentals for evidence-based improvements and developments in the field.

**Task 2. Basic Skills:** Fill in the grid below by rating how **important** are the following skills for you, from 1 (non-important) to 5 (really important):

| SKILLS | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Assessment of suitability of client for IPV and/or PSU counselling | | | | | |
| Counselling Introduction and Process | | | | | |
| Promotion and facilitation of counselling | | | | | |
| Closure of the counselling cycle | | | | | |
| Managing the therapeutic relationship: Rules and Boundaries | | | | | |
| Ethical issues | | | | | |
| Communication and counselling skills | | | | | |
| Risk and Crisis Assessment and Management Skills | | | | | |
| Scientific Supervision and Assessment of Counselling | | | | | |

**Task 3. Basic Skills:** Fill in the grid below by rating what is the **level of your familiarity and capability** regarding the following skills, from 1 (not familiar/capable at all) to 5 (very familiar/capable):

| SKILLS | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Assessment of client's suitability for IPV and/or PSU counselling | | | | | |
| Counselling Introduction and Process | | | | | |
| Promotion and facilitation of counselling | | | | | |
| Closure of the counselling cycle | | | | | |
| Managing the therapeutic relationship: Rules and Boundaries | | | | | |
| Ethical issues | | | | | |
| Communication and counselling skills | | | | | |
| Risk and Crisis Assessment and Management Skills | | | | | |
| Scientific Supervision and Assessment of Counselling | | | | | |

## Key Questions for Chapter 1

1. Have you learnt more or freshened up your knowledge and/or your professional skills regarding the basic counselling principles? If yes, which were/are the principles and/or skills that made the biggest impression to you or that you were/are more interested in?

2. Which was the level of your knowledge regarding clients' anonymity and confidentiality rules, as well as their importance, before and after the training? Do you notice any shifts?

3. Have you learnt more about the non-maleficent interventions through this training? If yes, which are they?

4. Which was the level of your knowledge regarding the justice and its importance, before and after the training? Do you notice any shifts?

5. Which was the level of your knowledge regarding the clients' autonomy, its significance, and the ways of fostering autonomy, before and after the training? Do you notice any shifts?

6. How capable do you feel of treating women survivors of IPV with PSU issues with empathy?

7. How capable do you feel of treating women survivors of IPV with PSU issues with compassion?

8. How capable do you feel of being non-judgmental while working with women survivors of IPV with PSU issues?

9. How capable do you feel of showing flexibility while working with women survivors of IPV with PSU issues?

10. How receptive do you feel to changes while working with women survivors of

IPV with PSU issues?

11. How important is self-knowledge, according to your opinion, while working with women survivors of IPV with PSU issues?

12. How important is self-improvement, according to your opinion, while working with women survivors of IPV with PSU issues?

13. How capable do you feel of following the stages of counselling procedure?

14. How capable to you feel of managing the therapeutic relationship?

15. How do you assess your communication and attention skills? How important do you consider them, while working with women survivors of IPV with PSU issues?

16. How important do you think ethical decision making is? How confident do you feel with your ethical decision making while working with women survivors of IPV with PSU issues?

17. How capable do you feel of implementing counselling techniques such as reflection, clarification etc.?

18. How important do you feel that these techniques are for communication and elaboration between you and your client?

19. Regarding self-disclosure (before and after the training):

- How aware were you of the advantages and disadvantages of counsellor's self-disclosure? How aware do you feel after this training? Do you notice any shifts at your beliefs, attitudes or your skills regarding self-disclosure?

- How possible is to use self-disclosure while working with women survivors of IPV with PSU issues? Which are the factors that would condition your decision?

## 2. Correlation between IPV and PSU

**What will you learn in this Chapter?**

- **<u>Describing</u> of the complexity** women with co-occurring IPV and PSU are confronted with, including the additional **barriers** they have to face.
- **<u>Understanding</u> of the phenomenon** of co-occurring IPV and PSU, and how it affects treatment and therapeutic goals.

**Key words:** Barriers, Correlation, Mutual Negative Influence, Non-Judgement, Stigma

### 2.1 Prevalence and Scope of the issue of the co-occurring IPV and PSU

IPV and substance use commonly co-exist. Research indicates this to be the case when looking at the prevalence of PSU among women dealing with IPV or, the other way around, looking at the prevalence of IPV among women dealing with PSU.

***Women who have been <u>exposed to IPV</u>***
***are more likely to grapple with PSU,***
***than women who have not been exposed to IPV***
(La Flair et al., 2012; Lipsky & Caetano, 2008).

A United States overview study from 2012 revealed that 22-72% of domestic violence shelter residents had current or past problems with alcohol or other substance use (Schumacher & Holt, 2012). These numbers vary depending on many factors, such as the population studied, how PSU is defined, and the methodology used. It is worth noting that domestic violence shelters frequently ban substance use on-site and therefore exclude women who suffer from PSU issues. Therefore the percentage of PSU among IPV survivors is likely higher than that found among domestic violence shelter residents. There are also evidently differences between different countries and cultures on the relationship between IPV and PSU, as well as between substances. For example, although research from the United States persistenly demonstrate increased alcohol consumption among women survivors of IPV, Spanish studies have not highlighted this to be the case with alcohol, but to be the case with psychotropic drugs[7] (Crespo et al., 2017).

In another study also conducted with domestic violence shelter residents in the United States, more than 75% of the respondents reported ever using cocaine (Fowler, 2007). More than 80% reported ever using cannabis, while 10.8% reported using cannabis in the past 30 days. Nearly 60% were alcohol dependent, and 55% were drug dependent (Fowler, 2007).

In a longitudinal study (where people are observed over a longer period of time) conducted on women experiencing violence and using substances, women who had experienced violence were twice as likely -two years later- to report PSU, than women who had not experienced violence (Kilpatrick et al., 1997). Women were 2 -3 times more likely to report PSU for alcohol or drugs immediately after experiencing violence (Kilpatrick et al., 1997). Another longitudinal study where young women were monitored for five years, also highlighted that sexual assault predicted an increase in alcohol consumption (Parks et al., 2014).

[7] A psycotropic drug is any drug, legal or illegal, which affectes the mind, emotions or behaviour.

Likewise researches studying the correlation between domestic violence and substance use, several researches explicitly targeted to IPV, also demonstated a close relationship between being a survivor of IPV and suffering from PSU issues (Devries et al., 2014; Sullivan et al., 2016; World Health Organization/ WHO, 2013a).

When individuals accessing PSU treatment services are studied, results indicate consistently that a high percentage of these women are survivors of IPV (Schneider et al., 2009).

In a similar vein, a recent qualitative study in the United States on women using opioids revealed that of the 40 participating women, every single one had experienced some form of IPV in their lifetime (Pallatino et al., 2021). A study conducted in the early 2000s in New York among women in methadone treatment revealed that 87.6% of these women had experienced IPV in their lifetime and 46.6% in the past six months (El-Bassel et al., 2004). In a research from Spain which studied the history of abuse among individuals seeking PSU treatment, 68.3% of the women reported having experiences of abuse (Daigre et al., 2015). Furthermore, this study highlighted that the individuals who had experienced abuse were having more serious PSU issues than the individuals who did not report abuse. Yet another study conducted in five different parts of Europe (Austria, Italy, Poland, Scotland and Spain) demonstrated that among drug-injecting women 70% reported having experienced IPV in the last 12 months; while the most common form of IPV expereinced was a combination of sexual and physical abuse (Tirado-Muñoz et al., 2018).

In general, we should keep in our minds that,

among women seeking treatment for PSU,

the prevalence of IPV is **three to five times higher**

than the prevalence of IPV in community-based samples of women

(El-Bassel et al., 2011).

The high prevalence and strong correlation between IPV and PSU could seem overwhelming to both clients and professionals. However, it is important for us, as professionals, to recognise the scope of the problem in order to be able to take the first steps towards providing support to women dealing with both IPV and PSU.

To that end, we should be aware of the intricate and complex manner that IPV and PSU are being closely linked. In this way, as we all could understand, it is impossible to determine which one affects the other, since they both work towards exacerbating the other problem, thus producing a vicious cycle.

**! Some points we should keep in mind regarding the IPV & PSU correlation: !**

- Individuals with experiences of violence may turn to substance use in order **to cope with the pain, the fear and all the other negative emotions** which accompany being a survivor of violence...
  Many women report that their substance use is a way to deal with negative emotions (Abulseoud et al., 2013; Jamison et al., 2010).

- Women are more likely than men to be **injected by their intimate partner**, both the first time they use injected drugs and on a regular basis following this; being in this way more likely not to have control over their injections... (Mayers et al., 2020; Simmons et al., 2012; Wright et al., 2007).

- Some IPV perpetrators use substances as **a tool to control their partners**. Perpetrators may force victims to use a substance, and/or even control when and how substances are used... (Warshaw et al., 2014).

## 2.2 Additional Barriers for Women Survivors of IPV with PSU issues

There are several additional dangers or harms that survivors of IPV who are also dealing with PSU face. We, as professionals working on supporting these survivors should be aware of the following aspects:

**a.** The acute and chronic effects of alcohol and/or drug use may prevent a survivor from accurately assessing her levels of danger.

**b.** Substance use may brew up to the individual a misguiding sense of increased power and, thus, an erroneous belief that self-defense against an assault is possible.

Apart from the dangers and harms we mentioned above, individuals –and especially women- face several additional challenges as well, given the two-fold, interconnected issues of IPV and PSU. Further down, we are trying to give answers to some of the most prevalent questions regarding survivors' of IPV with PSU issues challenges and barries; providing, at the same time, some tips that you may find useful. If you are interested and/or curious to find out more about this topic, please have a look at the following table!

| QUESTION | ANSWER | TIP |
|---|---|---|
| What are some of the possible reasons a woman may not want to disclose or discuss with us (as IPV professionals) about her PSU? | Due to the fear of being arrested or referred to a child welfare agency (and/or even losing the custody of their children), women may be reluctant to disclose or discuss about their PSU when seeking | Undoubtedly, for all IPV professionals, including us as well, it is crucial to be aware that possible PSU issues may exist, and to be capable of screening and dealing with them. |

| | | |
|---|---|---|
| | for help for their IPV victimisation. | However, before providing clients the relevant support, we should step back and cogitate and ensure that we have established trust between us and the client, with that being the first, as well as the most impostant step of our interventions. To that end, we focus on then relationship with the client, rather than pressuring her into seeking official help for her PSU. |
| What are some of the possible reasons a violent partner may not support or even making it more difficult for a woman toseek for help for her PSU issues? | Social isolation could produce further dependence on the partner and as a result, women's attempts to become sober or reduce PSU may perceive as threatening by a controlling partner. Sometimes, violent men actively encourage women to leave treatment – that is if they are able to access services in the first place. | This is an indicative example of the necessity of IPV and PSU professionals and services' to work together. Consequently, professionals working in the PSU field should suspect that IPV is an issue, and that the PSU treatment may possibly cause more threat to the woman. As a result, it is of |

| | | |
|---|---|---|
| | | utter importance for PSU and IPV services and professionals like us, to co-operate, since we could assess the risk, discuss with the woman her options and help her create a safety plan. |
| Do the existing services accept survivors of IPV with PSU issues?<br><br>Are there services available for individuals –and especially for women- with co-occurring IPV and PSU? | Many services are not available at all, or they are only partly available. This means that for many women there is nowhere to go for getting support in order to deal with both these issues and explore the linkages between them as well. As a result, women may feel forced to conceal their PSU in oder to get support for their IPV issues or vice versa, namely that they may feel that PSU treatment does not provide themany support for their IPV issues. | At this point, it could be worth exploring how to open up our approaches and by extention our services,partially or totally, in order to embrace women survivors with PSU issues. |
| What is the general attitude towards women dealing with PSU and especially | Generally, it is almost unquestionable that there is a lot of stigma against people experiencing PSU across | Regarding the attitudes towards women with co-occurring IPV and PSU, we should be conscious |

| | | |
|---|---|---|
| towards women survivors of IPV dealing with PSU? | almost all communities. Women, who often already have low self-esteem and negative feelings about themselves due to IPV, are more likely to have internalised the stigma that stems from PSU and thus, they have to battle additional negative emotions such as guilt and shame. The stigma and discrimination against women who deal with both IPV and PSU may act as a benefit for the perpetrators, since they count onthe poor system responses to survivors. | about being part of the solution rather than part of the problem. Normalising the substance use and discussing about it in a non-judgemental way is very important to gain trust and not to intensify the guilt and shame likely already felt by these women. |
| What happens when women with co-occurring IPV and PSU become sober? | Since intoxicated survivors are usually easier to control, and substance use is sometimes used as a form of control, abusive partners may increase violence as the recovering survivor becomes less easily controlled. | At what point in time to deal with which issue is thus a very delicate matter. Moreover, it should be decided on a case-to-case basis and always in co-operation with the survivor. |

## 2.3 The Effects of IPV on PSU and vice versa

As we have established, IPV and PSU are intricately linked in complex ways; one issue affects the other, exacerbating in this way the overall problem. Given that, we consider it as quite important at this point to expand our understanding of how these two issues influence each other and contribute to make the recovery from the other issue more challenging.

### 2.3.1 How does PSU interfere with healing from IPV?

As previously stated, substance use could be a coping mechanism, utilised by survivors of violence –including IPV as well- in order to deal with the many difficult emotions that accompany these traumatic experiences. However, the use or abuse of alcohol and/or drugs, does not manage to heal the pain caused by IPV after all. Provided this "failure" and the fact that pain and other negative emotions are present – although hidden sometimes- we should always keep in our mind that, in such cases, counselling or therapy sessions could bring out strong emotions. Additionally, substances cut off these emotions and suppress the survivor's feelings. This could mean that itmay become difficult for our work to go forward, the healing may not happen, and the pain may continue. As you would have already understood, we as IPV professionals need to be aware of this phenomenon and decide along with the woman when the time is right to start working on reducing PSU.

### 2.3.2 How does IPV interfere with recovery from PSU?

Since women may use alcohol or drugs to subdue their feelings about the abuse, when they stop drinking alcohol or using drugs, the buried emotions may surface. These feelings of pain, fear, or shame could lead to a relapse if they are not addressed. Moreover, within an abusive relationship, a woman's recovery may threaten her partner's sense of control. Therefore, to regain control, her partner may try to

undermine her recovery by pressuring her to use alcohol or drugs, discouraging her from seeing her counsellor, from completing treatment, or from attending meetings. He may even escalate the violence. Here, it is necessary for PSU services to work with IPV services so that the work done on dealing with the PSU is not in vain, nor leads to more violence.

### 2.3.3 How could a woman break the vicious cycle of IPV and PSU?

Some women feel that they are able only to address one of these issues at a time. Others feel that they need to address PSU and violence at the same time to break this vicious cycle. A domestic violence service, and more specifically we as professionals, could help a woman who is in an abusive relationship. At the same time, PSU treatment could help her overcome her PSU issues. So, remember:

No matter where the individual with co-occurring IPV and PSU goes for help first, professionals should provide her support by informing her of the other services and -if required-, by making the appropriate referrals.

**This ensures that she could get all the services and help she needs!**

### 2.3.4 What to deal with first?

Survivors respond to their unique situation in their own way and in their own time. There are many paths to safety and recovery, which are unique to each survivor. A survivor may seek safety first, sobriety first, or alternate, working on one or the other or on both by making choices along the way based on the reality of what is happening in her life. There are many paths, and each person's choices are unique and therefore should be respected. A survivor's decision to not stop substance use immediately or to

decline treatment, advocacy, or shelter should not be viewed as a failure (*neither of the survivor nor their counsellor!*). Decisions about choices and timing belong to survivors. Keep in mind that we should listen to survivors and respect their decisions even if they differ from what we think is best!

### 2.4 Acknowledging our own Prejudice regarding PSU

Negative attitudes towards PSU are very common across different societies. Acknowledging that the negative attitudes of our community affect all of us –despite our scientific background!- does not make us a bad person. We all have prejudices and acknowledging them is the first step to deal with them!

**Thinking Pills:**

- Think about how substance use/abuse was/is discussed in your home, community, and country.
- Reflect on how this discussion and/or the experience of knowing someone dealing with PSU has influenced your attitudes and beliefs towards this issue.
- Think about your position, your cultural background, socio-economic status, ethnicity, status in society, etc., compared to that of the women seeking your services:
  - What are the power differences?
  - How do they affect the exchange and how do these differences need to be taken into account in your work?

Apart from ackowledging our own prejudices, negative attitudes and views on individuals with PSU issues, it is equally important not to allow them interfere with our responsibility to work on behalf of our clients.

Women who start using substances as a result of the violence, experience a wide range of negative feelings which stem from the violence. As a consequence, they are often compounded by a sense of shame and anger towards themselves for their PSU. Based on that fact, these women need from us to help them get rid of the shame and negative feelings, and not to reinforce them.

### 2.5 Practising non-judgement and Normalising substance use

Any person harmed while under the influence of alcohol or drugs should get a clear message from us as professionals: that the survivor of violence is never at fault! The perpetrator is always the one responsible for the violence, no matter whether the survivor was intoxicated or not. In this line and according to what we mentioned above regarding professionals' attitudes and beliefs, when working with survivors of IPV with PSU issues, we should on one the one hand be non-judgemental; while on the other hand we need to normalise substance use. At this point you may reasonably be wondering:

**Why do we have to follow a non-judgemental approach**

**and normalise substance abuse???**

*We follow such approaches due to the fact that.....*

- Our job is to make the client feel at ease
- They would help us gain client's trust more quickly
- It is more likely to work to get the correct information about PSU.

To avoid having questions sound judgemental it could be helpful for us to frame our questions in relation to the coping mechanisms. Here are some possible questions that could be used to start talking about PSU with survivors of IPV. Please, feel free to use and adapt them depending on what fits best in your scenarios!

✓ *Survivors I see often tell me they feel stress. There are several ways to deal with stress. What works best for you?*

✓ *Many survivors tell me they try to sleep more, eat better, or go shopping. Have you tried any of those ways of coping?*

✓ *Many survivors also tell me the best way to cope is to smoke a cigarette, have a drink, or take something else. Have you tried that? Has it worked? Do you find it is still working?*

**Assume drug and alcohol use:**

✓ *How much alcohol and/or drugs do you consume each day?*

✓ *What sorts of substances do you use?*

**Normalise the drug use:**

✓ *Some people find that the use of drugs and/or alcohol help them cope with the abuse – does drinking or using drugs help you cope with your situation?*

**Ask in the context of specific stresses:**

✓ *What do you use to cope with the violence/pain?*

**!** Remember to offer **respect**, not rescue;

**options**, NOT orders.

- *Survivors are more likely to benefit from our services if they <u>feel safe</u>,*

*if they are <u>able to share their stories</u>,*

*and if they feel a <u>sense of connection</u> !*

Validation is also very important. Here are some examples:

✓ *No one has the right to hurt you. You do not deserve this.*

✓ *It is never your fault when someone harms you even if you were drinking, or using drugs. You did not cause this to happen! The perpetrator chose to be violent.*

✓ *I'm glad you found a way to cope.*

✓ *Drinking or using drugs could numb pain for a while but there are safer ways of coping that could cause you less grief.*

✓ *You deserve a lot of credit for finding the strength to talk about this. Your safety can improve your children's safety and well-being too.*

## Key Questions for Chapter 2

1. How frequent and strongly correlated is, according to your opinion, the phenomenon of co-occurring IPV and PSU?
2. What barriers do women with co-occurring IPV and PSU face when trying to find support?
3. Name some of the effects that IPV has on PSU and vice versa
4. Name some of the reasons and ways of implementing non-judgement and normalising substance use approaches and interventions
5. How capable do you feel of implementing the aforementioned approaches and interventions?
6. Have you learnt more regarding the effects of your own prejudice towards women with PSU issues through this training?

# 3. Comprehensive approaches for Women Survivors of IPV with PSU issues

| What will you learn in this Chapter? |
| --- |
| ➢ **<u>Implementing</u> specific interventions** for women survivors of IPV with PSU issues.<br><br>➢ **<u>Understanding</u> the need of gender-sensitive, trauma-informed, harm reduction interventions and other approaches** for women survivors of IPV with PSU issues. |

**Key words:** Approaches, Gender-sensitive, Harm-reduction, Integrated Models, Trauma-informed

In this chapter we are going to present you the current situation, and consequently, the existing needs regarding the available treatment for women with PSU issues, and the comprehensive treatment approaches for women survivors of IPV with PSU issues.

Before proceed reading this chapter, please take some time to reflect on your knowledge and experiences regarding this topic, by asking yourself the following questions:

**Thinking pills:**

- What are the treatment needs of women survivors of IPV with PSU issues?
- What are the challenges and/or obstacles that women survivors of IPV with PSU issues face while seeking help/ treatment?
- What is the existing situation in your country for treating women survivors of IPV with PSU issues?
- What are the available approaches in your country/ agency for treating co-occurring IPV and PSU?
- What are the challenges and/or obstacles that you face while treating women survivors of IPV with PSU issues?
- What are your needs in order to effectively treat women survivors of IPV with PSU issues?
- What are your agency's needs in order to effectively treat women survivors of IPV with PSU issues?

### 3.1 Existing Situation and Needs of co-occurring IPV and PSU treatment

In the following table you can find some facts about the currently available service provision and the existing therapeutic approaches for IPV, PSU and co-occurring IPV and PSU, as well as facts about the corresponding gaps and barriers[8]:

[8] To learn more about this topic you can read: Covington, 2019; Klostermann et al., 2010; Manandhar et al., 2018; MARISSA Project, 2021; Schamp, 2019; United Nations Office on Drugs and Crime/ UNODC, 2016).

| |
|---|
| Physical and mental health systems do not take into consideration gender-related issues, and tend to neglect the ways according to which the unequal gender norms, roles and relations affect health; leading, in this way, to discriminations against women |
| Lack of knowledge and preparation regarding gender-related issues, induce to policy and decision-makers difficulties in the understanding, and thus, in the effective responding to the gender determinants of the major emerging burdens, related to physical and/or mental health problems |
| The existing underlying power and hierarchy relations between men and women - which affect and shape not only health, but also health service provision- have not been explicitly acknowledged and addressed |
| Inequalities deriving from gender stereotypes and gender-related stigma create gaps in health coverage; in turn, these gaps negatively affect service provision to women, leading in many cases even to the failure of therapy provision |
| The existing support and treatment services for IPV and/or PSU, in European as well as in global level, traditionally treat IPV and PSU separately |
| The service provision for women survivors of IPV with PSU issues, usually falls into “treatment-as-usual”, as there is almost a total absence of IPV and PSU services specialised in co-occurring IPV and PSU |
| Treatment-as-usual for individuals with PSU issues could be characterised as gender-blind, including the standard PSU treatment; referrals to domestic violence services; conjoint therapy (such as behavioural couple-therapy for PSU), and individually-based PSU interventions |

| |
|---|
| Treatment-as-usual for survivors of IPV includes individually-based and/or couple-based interventions for IPV |
| The interventions and approaches applied by IPV and PSU services, could be reasonably characterised as rigid and inflexible, lacking sensitivity towards the special needs of women survivors of IPV with PSU issues |
| IPV services' interventions and approaches do not take into account or deal with PSU; while, on the othe hand, PSU services' interventions and approaches lack sensitivity towards gender-related issues and trauma |
| There are few to no resources and therapy options for women with co-occurring IPV and PSU; while in most of the cases, it is required by those women to be sober in order to receive any kind of therapeutic assistance |

Consequently, while getting in contact and interacting with these services -and by extension with the corresponding professionals-, women survivors of IPV with PSU issues face multiple barriers related to their gender. The most prevalent gender-related barriers, that all professionals, should be aware of, are:

⌦ gender norms and stereotypes,

⌦ gendered patterns of employment and work and gendered stereotyping by health-care providers,

⌦ poverty,

⌦ accessibility and affordability of IPV and/or PSU services,

⌦ absence of childcare services that intensifies the fear of losing custody of their children,

⌦ social stigma, and

⌦ shame and guilt that derive from women's gender, their IPV victimisation, and their PSU identity (Manandhar et al., 2018; Schamp, 2019).

On these grounds, women's survivors of IPV with PSU issues access and uptake to IPV and/or PSU services, as well as the diagnostic and treatment pathways applied to them are being affected in a negative way.

As a result, in order to be effective, IPV and/or PSU professionals should apply approaches and interventions that would tailor and take into consideration the different types of IPV and PSU, as well as the gender-related issues, focusing - at the same time - more on women's needs (Against Violence and Abuse/ AVA, 2013; United Nations Office on Drugs and Crime/ UNODC, 2016).

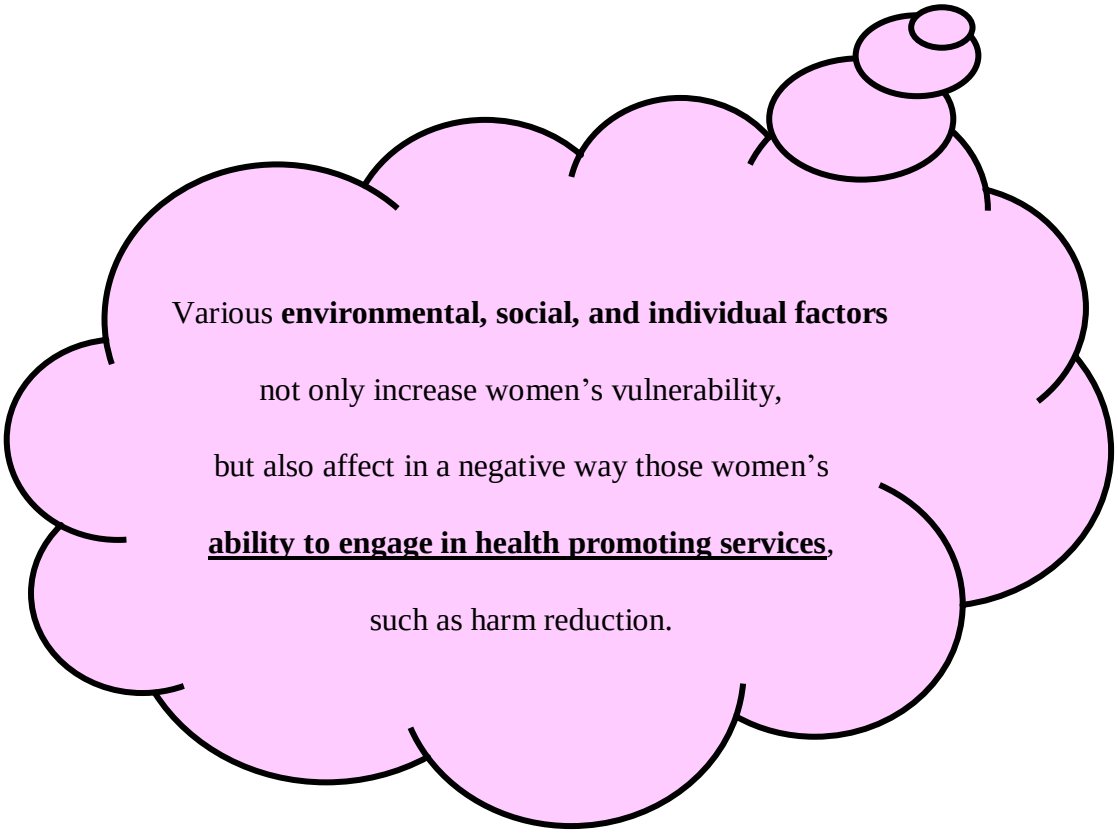
Regarding the co-occurrence of IPV and PSU, in recent years, this phenomenon has become increasingly provident. Due to the observed overlap between them, their complex interplay, and given that the separate treatment of IPV and PSU seem to yield limited results, a need for holistic, coordinated responses has emerged (Cohen et al., 2013; Gilchrist & Hegarty, 2017; Schumacher & Holt, 2012). Indeed, according to the relevant research and practical experience, service provision seems to be more effective when IPV and PSU are treated together, in the same programme or treatment centre (Sharpen, 2018). As a result, along with the already provided services and the applied interventions that treat IPV and PSU as separate domains, holistic and integrated approaches, which would simultaneously treat IPV and PSU, have begun to be of central focus within the scientific community. Such approaches should be comprehensive and based on gender-responsive and trauma-informed approaches (AVA, 2013; Macy & Goodbourn, 2012; Schumacher & Holt, 2012; UNODC, 2016). This urgent need for gender-sensitive, feminist, trauma-informed and whole-person strength-based approaches, especially in the PSU field, reflects not only professionals', but also women's survivors of IPV with PSU needs.

Aiming at providing high quality services and effectively treating co-occurring IPV and PSU, comprehensive approaches should be governed by core principles and embrace core aspects, like those described below.

### 3.2 Harm Reduction Approach

**A**part from PSU treatment interventions, all approaches should integrate interventions that aim to change unsafe behaviours and minimise the harm caused by PSU. A fundamental principle of harm reduction interventions, which takes into consideration and shows implicit respect to substance users' needs and desires, is that complete -or even partial- abstinence from substances is not required. Being in line with the principle of autonomy described in Chapter 1, harm reduction's philosophy considers PSU as a complex and inevitable part of life, and as such, is being acknowledged, rather than judged (Vakharia & Little, 2017). In this way, we, as professionals, are declaring our empathy to clients, through acknowledging and respecting the fact that they may not be ready, willing, or able to pursue sobriety at this particular time (Skewes & Gonzalez, 2013). In terms of harm reduction, our focus should be on personal safety, aiming at maximising at the same time individuals' self-efficacy and autonomy.

Even though data about women with severe PSU issues are scarce, the available data indicate that women who inject drugs are at greater risk of HIV and hepatitis infection, in comparison to men who inject drugs (Shirley-Beavan et al., 2020). In this line, we, as professionals, should be aware of the fact that:




Likewise the aforementioned barriers that women face when accessing health care services, women with PSU issues also face multiple barriers when accessing harm reduction services; and professionals should be aware of them. An indicative list of barriers is presented in the list below:

- stigma (the stigmatisation of those women stems not only from society, but also from health and harm reduction professionals working both in prison settings and in the community),
- gender-based violence,
- lack of services that simultaneously address the interaction between IPV and PSU,
- criminalisation in the form of legal barriers to access to PSU and/or IPV services,
- arrest and harassment from law enforcement,
- incarceration,
- lack of services focused on the specific needs of women, and

- lack of sexual and reproductive health services and childcare.

As a result, and consistently with the fact that all mental health services should have specific approaches and programmes explicitly referring to women, harm reduction services should also take into consideration the gender factor and develop services only for women. Having said that, we believe that it is worth mentioning here the example of Metzineres harm reduction centre, in Barcelona, which constitutes a good practice of the IPV and PSU field[9]. Metzineres is the first comprehensive harm reduction programme in Barcelona, exclusively for women with PSU issues; offering direct, comprehensive and individualised approaches tailored to their particular needs, and responding in this way to their expectations, concerns, curiosities, and interests. A survey conducted on women with PSU issues who received Metzineres' services, studied the key barriers that women usually face when accessing such services (Shirley-Beavan et al., 2020). These barriers, quite often, lead to the perception that harm reduction services are masculine spaces; discouraging in this way the access to women (since they are not identified as males), and could be divided in the following four intersecting categories:

a) stigmatisation and structural violence,

b) gender-based violence,

c) criminalisation, and

d) lack of female-specific services.

The results of this survey also revealed that those barriers had and could be moderated to some extend through the application of holistic, specifically tailored to women approaches, that mainly focus on responding to women's needs, in a personalised way.

At this point, we consider it quite significant to present you the factors that helped those women to mitigate -or even overcome- the aforementioned barriers, by creating

[9] For more information about Metzineres harm reduction service, please read Chapter 4.6.

a safe environment that tackled marginalisation. So, according to women's testimonies, the most prevalent factors were the following:

- Creating an environment that enables and facilitates social inclusion,
- Putting emphasis on human rights,
- Applying and emphasising gender responsiveness,
- Creating a safe space that enables experience sharing,
- Fostering the sense of solidarity, and
- Intensifying service's ability to combat, not only social stigmatisation, but also self-stigmatisation.

Despite the corresponding approaches and the fact that tackling stigma and structural violence constitutes one of the main goals of Metzineres, women with PSU issues revealed that they continued to face and suffer from structural barriers. We, as professionals, should always keep in mind that the negative experiences that result from those barriers reinforce stigma and discrimination, and escalate quite often, leading in the demonstration of structural violence (e.g. extreme poverty, homelessness, family breakdown and the loss of custody of their children). Although it is incumbent on states to act accordingly in order to address structural barriers and violence, and although widespread policies and societal changes are required towards this direction; both IPV and PSU professionals, like us, should be aware of these barriers and their impact on women with PSU issues, as they directly affect those women's ability and willingness to access harm reduction services.

### 3.3 Gender-sensitive and Feminist Approach

The application of a gender-sensitive and feminist approach could enable and foster recognising and intervening to sex and gender-related consequences of IPV on PSU, and vice versa. Through such approaches, we would have the opportunity to recognise

the ways according to which social and gender inequalities affect women's vulnerability to PSU, as well as their capacity for change (Ettorre, 2019; Poole, 2019). Through gender-sensitive and feminist approaches, we could be assisted as professionals in preventing and/or tackling women's survivors of IPV –with or without PSU issues- prior and future experiences of victimisation (e.g. secondary victimisation), and especially of the victimisation that derives from:

- structural violence,
- the already existing or further stigmatisation,
- their marginalisation, and
- the disempowerment they suffer from.

Furthermore, we could be helped to understand that neither IPV nor PSU constitute a choice for individuals - and especially for women - suffering from them. Such an understanding could result in receding, on the one hand, from the medical approach that for many years dominated our attitudes, beliefs, and interventions/ approaches towards PSU, while on the other hand it could result in mitigating the stereotypes that saturate IPV. In addition, the existing approaches and stereotypes seem to have contributed to the stigmatisation of women survivors of IPV and women with PSU issues, and to the so-called "victim blaming". Therefore, through the gender-sensitive and feminist approach, IPV and PSU professionals would understand that women are not to blame for none of these two issues, and would possibly alter their attitudes, beliefs, and behaviour towards them.

We should also keep in mind that the application of a gender-transformative approach by IPV -and especially in PSU- services, could contribute to the concurrent integration of positive health outcomes and improvements towards gender equity, through:

- questioning and changing the negative gender stereotypes and norms related to women with PSU issues,

- redressing the existing imbalances of power,
- empowering these women, and
- fostering their autonomy.

As a result, the gender inequities that condition mainly the PSU responses could be mitigated; the access to IPV and/or PSU services (including harm reduction and HIV prevention services) could be enabled, and the available resources for women survivors of IPV with PSU issues could be increased.

### 3.4 Trauma-informed Approach

When applied to the IPV and/or PSU field, the trauma-informed approach would provide us a holistic intervention for addressing the co-occurring IPV and PSU; since it focuses on the traumatised person, instead of perceiving IPV and PSU as individual problems. Within the context of the trauma-informed approach, we would be able to acknowledge the traumatic and embodied experiences related to violence and abuse, and take trauma into account; without, however, requiring the disclosure of such experiences (Covington, 2019; Ettorre, 2019). At the same time, we would attribute PSU and relate it to the past and current experiences of violence and trauma (Poole, 2019).

Women's empowerment, as well as the identification, ensuring and fostering of their physical and emotional safety constitute two of the core principles of the trauma-informed approach (Anyikwa, 2016). Through assisting women in making informed and free decisions, IPV and/or PSU professionals like us, aim to promote those women's need for self-determination; make their own choices, and regain the control of their lives. Concurrently, we would foster and promote those women's strengths and sense of value; their trustworthiness; confidence; self-efficacy and collaboration (Covington, 2019; Poole, 2019). In this way, health and social priorities could also be

fostered; while the chances of benefiting from the provided IPV and PSU services are increased.

Although aiming at addressing trauma, the trauma-informed approach prevents re-traumatisation by focusing on ensuring that trauma triggers are avoided (Covington, 2019; Poole, 2019). Re-traumatisation of women survivors of IPV with PSU issues is also prevented by taking into consideration the physical environment in which treatment takes place, as well as their interactions with us and other significant people (Anyikwa, 2016).

Similarly to gender-sensitive and feminist approaches, trauma-informed approaches, could also induce improvements on the treatment outcomes (e.g. reduced PSU, lower relapse rates, higher retention rates in services, increased satisfaction with services) and on women's access to services (e.g., earlier help-seeking, readiness for change, higher rates of completing treatment, increased engagement in preventative service). Such approaches would also improve our retention and increase our satisfaction with employment, by reducing, for instance, burnout, compassion fatigue, vicarious or secondary trauma (Schmidt et al., 2018).

**Task 1.** Are you aware of any of the available and most prevalent evidence-based trauma-informed approaches??? If yes, name some of them in the list below. If you are not aware of any, this is a very good opportunity to try to investigate on your own some of the most prevalent trauma-informed approaches. Afterwards, you could compare your results with our list, which you could find below (no cheating, please!):

1 ……

2 ……

3 ……

4 ……

**Our Reply to Task 1:**

**At present, the most prevalent evidence-based trauma-informed approaches are:**

- Cognitive-Behavioural Therapy,
- Guided Imagery,
- Relational Therapy,
- Mindfulness,
- Eye Movement Desensitisation and Reprocessing (EMDR),
- Emotional Freedom Technique (EFT), and
- Expressive arts.

### 3.5 Whole-person Strength-based Approach

In line with the gender-sensitive and trauma-informed approach, the **whole-person strength-based approach** could provide IPV and PSU professionals, like us - and by extension women survivors of IPV with PSU issues-, the opportunity to embrace all the strengths, difficulties and/or mental health issues that they may face, and deal with them in an efficient way (AVA, 2013; Covington, 2019).

### 3.6 Integrated models for co-occurring IPV and PSU

Based on the clearly expressed need for a comprehensive approach towards co-occurring IPV and PSU, targeted models that would simultaneously address IPV and PSU are now available. Developed by Covington (2008), **Women's Integrated Treatment (WIT)** is built on the foundation of gender-responsiveness. Taking into

consideration the relevant research and clinical practice, this treatment model is grounded on the theories of addiction, trauma, and women's psychological development. According to WIT, IPV falls under the larger umbrella-term of trauma. In this model, a curriculum named "Beyond Trauma: A Healing Journey for Women" is used in order to emphasise the connection between trauma and PSU; focusing on violence, abuse and trauma.

Another available model, based on Cognitive-Behavioural Therapy, is **Seeking Safety** (Najavits, 2007). As with the WIT model, neither Seeking Safety specifically focuses on IPV. However, since it focuses on co-occurring PSU and Post Traumatic Stress Disorder (PTSD), it is closely linked to IPV and PSU; and thus, it is appropriate for women survivors of IPV with PSU issues. In terms of addressing simultaneously PSU and PTSD, each woman is treated based on her individual needs, and is being offered a number of coping skills that are appropriate for both PSU and PTSD (Najavits, 2002).

Finally, Trauma Recovery and Empowerment approach specifically focuses on group therapy for vulnerable women who are dealing with trauma due to abusive experiences (Harris & Anglin, 1998).

At present, only few approaches that are explicitly targeted to IPV and PSU are available. Most of these approaches focus on pairing and integrating the already existing IPV and PSU services and aim to establish and promote formal collaboration between them.

In this line, the "**Stella Project"** (2007), launched in the UK in 2002, provides training and development work with both IPV and PSU professionals; underlying at the same time, the many similarities that could be found among women with IPV and PSU experiences.

**Task 2.** Which are, according to your opinion and experience, the similarities among women with IPV and PSU experiences????

1 ……..

2 ……..

3 ……..

4 ……..

5 ……..

6 ……..

**Our reply to Task 2** (based on information from the Stella Project, 2007)[10]:

**Similarities among women with IPV and PSU experiences**

- ✓ Traumatisation
- ✓ Stigmatisation (*social and internalised stigma)*
- ✓ Reluctance
- ✓ Fear of seeking help and support
- ✓ Denial of the problem
- ✓ Feelings of shame and guilt
- ✓ Isolation
- ✓ Low self-confidence

[10] For more information about the similarities among women with IPV and PSU experiences you can visit: https://avaproject.org.uk/ava-services-2/multiple-disadvantage/

The Irish IPV agency Cuan Saor has changed the provided services in order to include women with co-occurring IPV and PSU. Furthermore, the shelter, following the 'Housing first' approach, focuses on providing housing to individuals with PSU issues as well, since these people are excluded from IPV and other housing facilities due to their PSU (Pauly et al., 2013). At the same time, the shelter staff receives specialised training (e.g. on the effects of different substances and risks of use, including prescribed medication), and is motivated and supported to confront their own prejudices regarding illegal PSU.

**Task 3: Approaches for women with IPV, PSU or co-occurring IPV and PSU issues:** Fill in the following grid by reporting the existence and the development (e.g. how widespread is) of each approach, as you think it is in your country. Then fill in the third column by rating the importance of each approach from 1 (non-important) to 5 (really important), according to your opinion:

| **APPROACHES** | **DOES THIS APPROACH EXIST IN YOUR COUNTRY?**<br>**Yes / No**<br>If yes, how **well developed/ widespread** is this approach in your country? | **HOW IMPORTANT DO YOU THINK EACH APPROACH IS?** |
|---|---|---|
| Harm Reduction | | |
| Gender-sensitive & Feminist Approaches | | |
| Trauma – informed | | |

| | | |
|---|---|---|
| approach | | |
| Whole-person strength-based approach | | |
| Integrated models | | |

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## Key Questions for Chapter 3

1. How would you assess your knowledge regarding the comprehensive approach towards dealing with co-occurring IPV and PSU? Do you feel more informed after this training? What are the (new?) aspects of this approach you would like to find out more or get trained on?

2. Name the core principles and advantages of the gender-sensitive and feminist approach? How informed and capable do you feel of applying this approach?

3. Name the core principles and advantages of the trauma-informed approach? How informed and capable do you feel of applying this approach?

4. Name the core principles and advantages of the whole-person strength-based approach? How informed and capable do you feel of applying this approach?

5. Name the core principles and advantages of the integrated models for addressing co-occurring IPV and PSU? How informed and capable do you feel of implementing these models?

6. How informed do you feel regarding the existence, the goals and the significance of PSU approaches, including Harm reduction as well?

7. How willing are you to inform and refer your clients to PSU and/or Harm reduction services, based on you corresponding knowledge regarding the approaches and interventions they use?

# 4. Multi-agency Approach and Collaboration between Professionals and Services in cases of co-occurring IPV and PSU

**What will you learn in this Chapter?**

- **Identifying limiting and enabling factors** to Multi-agency co-operation.
- **Planning coordination strategies** in Multi-agency and integrated settings.
- **Fostering the holistic concept of person** in the integrated practice of co-occurring PSU and IPV (as well as mental health issues).

**Key words:** Coordinaton mechanisms and strategies, Integrated services, Multi-agency co-operation, Person-oriented approach, Universal screening

## 4.1 Local Diversity in Multi-Agency Co-operation

As you have read in Chapter 2, in the last two decades, it has become increasingly clear that IPV and PSU co-exist and intersect in various complex ways, requiring as a consequence, a holistic, coordinated response (Covington et al., 2008; Macy & Goodbourn, 2012). All mainstream research indicators found in FASA Project's Analytical Report point at the need for a joint multi-agency action and a more holistic orientation to tackle co-occurring IPV and PSU. Multi-agency co-operation is linked to detection and prevention of IPV by the joint action of various state and non-state

services in order to detect and prevent IPV, which is known as "**MARAC**" (Multi Agency Risk Assessment Conference) and it is defined as:

The Effective coordination of actions among relevant actors playing a role in preventing and combating violence against women, including the judiciary, public prosecutors, law-enforcement agencies, and local and regional authorities, as well as non-governmental organisations and other relevant organisations and entities...

Multi-agency coordination needs to respond to this widely perceived need in whichever possible ways available in each country and local context. It stands out clearly that multi-agency coordination and professional joint action in each European country, region, and/ or autonomous community, city, and municipality; is hindered or facilitated by certain environmental and structural factors which may be differing in each territory depending on cultural views, values and public service capacity and culture of implementation of shared strategies and protocols. Such factors would influence the intervention's success:

- **The likeliness of joint action following local, regional and state level protocols** for diverse institutions and dimensions of administration that may have different political orientation or that may be competing for political reasons.
- Absence or prevalence of a shared **person-oriented approach** focusing on a holistic view of the person and which considers, first and foremost, each individual woman's needs, human rights, unique circumstances and integral well-being as its core value.
- Absence or prevalence of a dominating **medical approach** that ignores environmental factors, PSU and trauma-inducing experiences lived by clients. A broader perspective on the issue, which includes trauma, symptoms of trauma and how to deal with trauma-affected individuals, is much needed.
- Absence or prevalence of a **gendered perspective, a feminist approach and critical psychiatry** which moves away from medicalising, stigmatising and further victimising women.
- **The local views and practice on how to address co-occurring IPV and PSU** and whether shelters and services are willing and ready to welcome or not women

suffering from IPV with co-occurring PSU issues and if enough additional staff is deployed for ensuring 24/7 service. For instance, in Estonia and Greece such facility is not offered, for "safety reasons" women with PSU issues cannot access shelters and there is no alternative place for them to resort to; it is back to the street or to the perpetrator for them. Such facility is also not available in Northern Ireland and other countries and at times not even in countries where the possibility exists, due to lack of available capacity and lists.

- **The lack of specialists and professionals** who have knowledge and training in co-occurring IPV and PSU and the type of training the professional communities involved are receiving. In that sense, all staff involved need to be trained, not only the designated expert/s on IPV and PSU. The need has been pointed out for basic training being made available for staff that is completely new to the idea of co-occurrence to IPV and PSU and more advanced trainings for those that are already tackling these issues jointly in the field.
- **The lack of Master's degrees that deal jointly with IPV and PSU.** Such programmes do not seem to be occurring as yet in any European universities, leaving aside specialised in-trainings designed by NGO's and private institutions.
- **The degree of integration of services and networks** may positively affect women seeking help for co-occurring IPV and PSU if other determining factors are tackled in favour of our clients. Many women choose not to seek services such as therapy or PSU treatment because of the threat that the perpetrator might use this fact to have the authorities remove her **children's custody** from her care (Bennett & Bland, 2008a).

State-level, regional and autonomous communities' capacities in eliminating such threats to multi-agency and holistic approach success need to be strengthened. Nevertheless, the combined and integrated approach is gaining terrain: recently, useful trainings on the co-occurrence of IPV and PSU twice a year have started in Iceland and informative trainings on the co-occurrence of IPV and PSU have taken place in Greece. Other countries' services, foundations and NGO's are already working in the lines of combined IPV and PSU attention; such is the case of Catalonia in Spain.

***Is the integrated approach developing in your country? The need to translate great ideas into action is underscored by many. How to make it happen? Read on for practice and action-oriented thought.***

**Thinking Pills:**

- How would you describe the situation in your country/ region/ city based on the variables described above?
- Which of the environmental factors mentioned above need to improve in your area in order to become more successful in supporting clients' integration back to a normal life?

**Task 1: Multi-agency national dimensions:** Fill in the following grid reporting about one fact about each variable as you think it is in your country. Then fill in the third column by rating the variable's importance from 1 (non-important) to 5 (really important) as you think it is in your country:

| VARIABLES | DOES THIS VARIABLE EXIST IN YOUR COUNTRY?<br><br>Yes / No | HOW WELL DEVELOPED IS THIS VARIABLE IN YOUR COUNTRY?<br><br>If you are not sure, you can guess and cross-check later with some reliable source or professional. |
|---|---|---|
| **Joint action of diverse services** following local, regional and state level protocols | | |
| **The person-oriented approach** ("the person's needs are first, and the services' needs come second") is prevalent. | | |
| **The medical approach is NOT prevalent** when professionals deal with combined IPV/PSU. | | |
| The **gendered perspective** is prevalent. | | |

| | | |
|---|---|---|
| The **feminist approach** is prevalent**.** | | |
| **Psychiatry** operates from a **critical focus** | | |
| **There are specialists and professionals** who have knowledge and training in co-occurring IPV and PSU. | | |
| **There are Master's degrees** that deal jointly with IPV and PSU. | | |
| **There** are integrated services (integrated services deal jointly with IPV and PSU) | | |

! You may want to **review** your answers to this task after you reach the end of this chapter...

## 4.2 Focus and Efficacy of the IPV and PSU Services

There is a high diversity of types of multi-agency intervention in what we could well describe as a spectrum ranging from separate and/or disconnected IPV and PSU attention and treatment services, to public parallel co-operation networks of professionals which eventually intersect, to (finally!) integrated services where the intersection of professionals and services is part of operational protocols.

According to the type of multi-agency service co-operation, we have basically three types of "designs": **circuits**, **networks**, and **integrated services**. Our observation on the functioning and success of multi-agency service, in one or the other style, depends on how well this co-operation places the person's unique needs at the centre. When such needs cannot be cared for, the circuit tends to turn into a "pilgrimage", the network tends to turn into a "maze", and the integrated service -if existing at all- is the promised land to be accessible only after going through a (sometimes long) waiting list while life goes moon. How is the concept of person the key to it all?

### 4.2.1 The Underlying concept of person

Psychologist Gemma Maudes (personal communication), who is a professional psychologist and coordinator of the drug addiction services of FSYC, as well as one of the key persons of Espai Ariadna operating mostly in the Barcelona Metropolitan Area, reminded us about the fact that women seeking help for co-occurring IPV and PSU, suffer from "a triple stigma":

*When a woman decides to enter a drug centre to be treated, she must face a triple stigma, as we say; being a consumer, being a victim of violence, and not fulfilling the roles assigned to her as a mother. From her close circles blame arises; "You are a bad mother; now you're going to a spa in the mountains to take care of yourself." This reproach is never made to the father; he is not told "you are a bad father", but the mother is told that she is a bad mother.*

Almost all clients have suffered not just from a serious degree of abuse by their current partner or ex-partner, but from severe environmentally-gendered violence during most of their life. Many, if not all of them, undergo some degree of "institutional violence", and almost all of them undergo some degree of PTSD induced by the violence endured (there is not enough research as yet and reliable data bases of clients' profiles in terms of PTSD suffered need to be set up).

Even when so many similarities and typologies of violence cases could be described, each woman lives a unique situation in every way. For instance, her income; her educational background and professional experience; family support or presence or absence of children she cares for and whose legal custody she holds or not; her legal status in the country; type of PSU/Substance Abuse (SA), and whether she suffers from the so-called **dual pathology** (mental disease associated or co-occurring with IPV and PSU).

An individual is not one or the other aspect but all of them and many others. Integral attention implies considering all these factors and that the person would not be dealt simply as "consumer", or "survivor/ victim", or "mother", or "immigrant", or "transgender person", etc. Addressing all aspects would make it possible to support the woman's right to health, to housing, to be and feel protected in her mental and physical integrity. Thus, there is need for a holistic versus a fragmented person's approach. Having the clinical approach at the basis of the operational protocol is likely to cause what is suggested by the diagram below:


The more a service endorses a clinical view, the more fragmented its approach to who the client is, would be. Also, the circuits for IPV and PSU attention would be more

disconnected, and the attention the client will receive would be less integrated each step of the process. The person-oriented focus is based on an integrated approach. Consequently, the less clinical the approach is, the more capable the service would be in order to really help the client as a whole in the goal of regaining a normal life.

The 2021 Report by the Catalan government on IPV & PSU (Spora Sinergies SCCL/ Sol & Caussa, 2020) intends to find out about the services offered to women undergoing co-occurring IPV and PSU and even mental disease ("dual pathology" on that report):

"*Thus, the Department of Health of the Generalitat de Catalunya is interested in knowing how this care is provided and what situations may be hindering access to services or adequate care by services specialising in mental health, gender-based violence and care for drug addictions*".

This comprehensive report, based on focus group discussions amongst professionals on the field, as well as reference literature on the subject, indicates that:

"*Most professionals point out that there is a professional profile that has special resistance to addressing -and therefore also to detect- situations of gender-based violence: psychiatrists,,.*

One of the professionals interviewed indicates:

*"I mean, for instance, in our (name of service) most patients go to the psychiatrist, and those people do not spot it (IPV). And you say (curse word) what do we have to do for them to be aware that this (IPV) is important too, just like when we ask them (clients) at some point if they have got their Hepatitis C vaccine?".*

From a clinical approach, a client seeking public support due to IPV issues would be perceived only as a consumer if she consumes, and be left to her own devices (oftentimes, the unavoidable return to the perpetrator). A trans-gender person surviving by means of prostitution, would most often be perceived from all types of stereotypes when addressing a police station to launch a complaint for an aggression.

Similarly, when addressing a service to detox herself, a mother may risk losing the custody of her children to her perpetrator (in almost all cases, the father of the children when there are kids involved) when he succeeds in using this fact in order to undermine the woman's credibility in front of the court. The fragmented view is filtered by all sorts of stigmas and stereotypes. An example of how the fragmented approach negatively affects the care for women accessing the PSU service:

*On the one hand, there is a lack of a gender perspective in (...) and mental health services, which have been designed with men as a reference. Thus, it is not usually investigated to find out whether problematic consumption and / or mental health issues are related to gender* (Castaño et al., 2017; Red2Red Consultores, 2015). *On the other hand, difficulties are identified due to the fragmented approach to the different problems. In this sense, attention is given to PSU (...) and/or to the symptoms of mental health problems (from mental health resources) to the detriment of tackling gender-based violence, which may prevail and be at the forefront of the problem* (Castaño & Martínez, 2009; Spora Sinergies, 2017).

So, multi-agency work and professional co-operation may be hindered from the inception due to the fragmented approach, as professionals of PSU services lack IPV training, while professionals of IPV services lack PSU training; resulting in one or the other issue being sidetracked and/ or not addressed at all. Thus, women ultimately have the feeling that the IPV and/or PSU service is doing nothing for them:

*"In this way, the lack of gender training prevents the cases from being addressed in a comprehensive way, taking into account the interrelationships that may exist between mental health, problematic consumption and sexist violence, and means that professionals are not clear from which service should be cared for these women or in what way it should be done"* (Castaño & Martínez, 2009).

For women with dual pathology, the approach becomes even more complex. It is clear that these women are not only more impaired when they access resources but do not perceive that treatment could help them or that the centres are adapted to their needs.

In addition, professionals may feel helpless and overloaded in such situations (Castaño et al., 2009).

Aligning the views of professionals, training them in the combined IPV and PSU approach, and fostering a gender perspective, are necessary steps in order to ensure the woman client's rights' protection. Whichever is the combination, coordination and networking of services that exists in a given area, a first rule towards service efficacy is: operational protocols should guarantee universal access and avoiding further victimisation of clients. This could be avoided from the very beginning by organising the intervention of all involved services based on a ground rule: placing the person's needs at the centre.

! Operational protocols should guarantee placing the person's needs at the centre and avoiding further victimisation of clients.

### 4.2.2 Defining service efficacy from the person-centred approach

Certain operational factors would make multi-agency co-operation successful:

Most of the literature reviews and papers agree on one fundamental principle, as the key factor to successful intervention and risk management of an IPV case, and that is the multi-agency approach. Collaborating professionals from social services, judicial system, NGOs, police, local authorities and other related services working towards a strategic response by monitoring and controlling any further potential harmful occurrences, that could ultimately result in high risk situations, could have more chances of a positive outcome. The United Nations/ UN Women(2012) indicated multi-agency co-operation as the key for the success of a planning strategy to combat domestic violence/IPV, by allowing solutions to be defined and for a holistic intervention package to be implemented.

At this point, we would like to stress four operational principles that would help us -as IPV professionals-, and our services as well, organise our co-operation:

- **Individualised follow-up strategy** centralised by one service operating in a network of other services and professionals as core responsible of the follow-up, deferral, and calling for a MARAC.

- **Structured intervention** (clear definition of WHO does WHAT and WHEN according to the local protocol).

- **Intervention designed according to the person's needs** and the degree of emergency for all the involved in the situation (e.g. maybe children or dependent relatives).

- **Integrated databases with a unique file per person and strategic use** of the relevant information based on secrecy and confidentiality in order to protect the survivor in accordance with Caldiccot principles endorsed by the Government of the UK, and widely used internationally as reference for secret and strategic use of information.

Efficient multi-agency co-operation should reduce the number of inappropriate referrals; the number of times survivors 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. To **eliminate complexity** as far as possible and reduce the inefficiencies and damages that may arise, we believe it is important to have a person-centred care approach, rather than focusing on the needs and interests of each institution, professional or professional group in particular.

As indicated by professionals working in the field, it is frequent that each one tries to protect one's interests of continuity of the service, positions and working conditions, particular views of the subject from a concrete point of view, etc. This leads on many occasions to prioritise our comfort and interests over what is most convenient in care (typically, for example, the hours of attention to clients –and especially women- with PSU issues or survivors of IPV, which are rigidly structured, typical of work of office

workers, and little adapted to the needs of individuals with PSU issues, lacking gender awareness).

Services may tend to prioritise their own need to show their usefulness and the intensity of their work, and thus prefer to see each person, who counts for this purpose as a case attended… and thus may become blinded to her actual needs. Another example was suggested to us by Ms. Gemma Maudes: emergency services under the COVID-19 pandemic may offer women and men alike only one, hour access to public personal hygiene facilities, which may suit organisers and social workers, but which actually resulted in a biased androcentric planning. Efficiency may seem to somebody adding one more case tended on our list; but quantity over quality may involve turning complexity into complication. See the instance facilitated to us by Mr. Xavier Ferrer, Executive Director of FSYC:

*"We tried to begin to draw up the family organisation chart of a girl, a drug user, at the beginning of an interview, at an outpatient centre. Sure enough, the girl, with very good criteria, said: "sorry, but I think I have already told you this at least four times." Indeed, she had already explained it in the reception, to the doctor, social worker and nurse who had seen her before. This was a problem of internal coordination of the same centre, where each professional handled her file. ... (...) It is like six people trying to drive a car; absolute mess".*

**Thinking Pills:**

- Which is the underlying concept of person in the centre (s) you know/ work for?
- In this section of the chapter, we have mentioned about "Institutional violence" … are you familiar with this concept?

- If not, may we suggest you do your own research online?

- Which is the underlying concept of person in the centre (s) you know / work for?

### 4.3 Advantages of the Integrated Approach for Women Survivors of IPV with PSU issues

While the multi-agency approach remains necessary, it is not opposed to offering integrated services whenever possible, which avoid creating difficulties for the users of public networks, including women survivors of IPV with PSU issues. These, may be lacking in specially-trained professionals or lacking a shared approach and multi-agency joint clear operational protocols.

Dependence on various institutions, sometimes municipal, in other cases regional, or state-level - not always being in good harmony, or not sharing the same political colour- sometimes does not help either. Moreover, oftentimes, services have rigid, slow operating structures, and are plagued by political interests, among others. An integrated service for co-occurring IPV and PSU probably would reduce many of these problems, especially if it could be entrusted to a professionalised but independent, non-governmental organisation, vocationally motivated by this issue. In addition, it should have been chosen as the field of intervention, instead of having officials from an institution sometimes forcedly assigned to a service, for which they may not be motivated and often not trained.

We believe that an integrated approach for the co-occurrence of IPV and PSU is compatible with that of most countries, except for those that have a very powerful nationalising tradition. For example, an integrated service could serve women with PSU issues who are survivors of IPV and violence in general from their first contact at the outpatient level, to their potential admission to specialised centres when required,

through the entire subsequent mechanism of rehabilitation, job placement and finally regained autonomy. This would include support for their maternal function, restructuring of family relationships if appropriate, recovery from the consequences of violence/ IPV, prevention of future relapses in one issue or another, etc. This means treating both matters related to drugs, violence, and mental health, as well as associated social problems. Mr. Ferrer, the Executive director of FSYC, made us realise that in order for this to happen, a certain "critical mass" of cases is needed, which is more likely in urban areas or rural areas that are highly populated and well connected. Otherwise, the number of cases may be insufficient to prioritise the integrated services approach and we then have to resort to multi-agency co-operation (which in any case, and at a certain level, is always inevitable and desirable).

Mr. Ferrer also pointed out the fact that multi-agency collaboration would vary depending on which services are operating in each territory. For instance, in Barcelona, as well as in Iceland and Greece, there are specific outpatient services for people with PSU issues, harm reduction services, "consumption spaces" (consumption spaces for supervised opioids use), therapeutic communities, day centres, insertion services. Also, outpatient services for survivors of violence, emergency reception centres, reception centres and long-term support floors, etc. The services available in Greece, Estonia and Iceland, are a combination of State to local and public to NGO that provide from shelters to 24/7 hotline to survivor services. Acccording to the MARISSA Project's Needs Assessment Report ("Multi-agency Approach to Support Victims of Intimate Partner Violence with Substance Abuse Issues"/ MARISSA Project, 2021, p.26), the provided services in the aforementioned countries are as follows:

"*The service provision for IPV includes counselling, therapy, legal assistance and accommodation (e.g. shelters for women victims of violence and their children). 24/7 help-lines for survivors of violence are also available in all countries. The service provision for PSU includes substitute and non-substitute PSU treatment programmes and harm reduction programmes, and PSU treatment programmes operating within prisons*".

Yet, the crux of the matter is that most PSU services lack a gender focus, since not only Estonian and Greek, but also most of European, as well as international PSU services, suffer from "gender blindness" (AVA, 2013; Manandhar et al., 2018; Stella Project, 2007; UNODC, 2016). Nevretheless, an exception was spotted: despite the previous gender blindness, over the last years, the Icelandic PSU services have mainly focused on the gender dimensions of PSU, while, at the same time, they are following trauma-informed and gender responsive approaches (MARISSA Project, 2021). For instance, the Rótin ("The Root"), following trauma-informed and gender responsive evidence-based approaches, provides services for women focusing on the link between trauma and PSUWithin this context, Rótin, the Association on Women, Trauma and Substance Use, provides group-counselling, courses, support groups and individual specialised counselling, collaborates with shelters, and offers training to professionals working in this field (Root/ Rótin, 2021).

Consequently, regarding the treatment of co-occurring IPV and PSU, the case certainly is that there is a diversity of the (separate) corresponding services. Both IPV and PSU professionals from Estonia, Iceland, and Greece interviewed in terms of the MARISSA Project's Needs Assessment Report indicated that:

"*According to the country reports and focus groups, the vast majority of IPV services are aimed at women, whereas, on the contrary, there is lack of specialised PSU services for women. Only in Iceland and Greece, such services are available. However, in Greece, in contrast to Iceland, these services are extremely limited. Most professionals who participated in the focus groups, underlined the need for specialised PSU services for women, regardless if they are survivors of IPV or not* (…)" (MARISSA Project, 2021, p.34-35).

In some parts of Spain, the organisation of IPV and PSU services is very different, and you have from well-organised intervention networks and even integrated services, to areas where there are fewer resources, or almost none. In other European countries the organisation of care for people with PSU issues and women survivors of violence - including IPV- is different. For instance, in Finland it is set up around care homes for mothers with their children, some of them specialising in violence survivors,

whereas others are mixed. Some of the clients there could be, for example, single mothers.

In short, multi-agency collaboration would depend on which services are active, but also on whether easy access is granted to clients (which boils down again to respecting women's rights and upholding a gender approach).

**Task 2.** **What do you reckon are the practical advantages of integrated IPV and PSU services?** Fill in the following grid (and compare your answers with our own in the next page … no cheating, please!):

| ADVANTAGES FOR THE CLIENTS | ADVANTAGES FOR THE PROFESSIONALS |
|---|---|
| **An integrated/ holistic service may avoid:**<br>……<br>……<br>……<br>……<br>**An integrated/ holistic service may foster:**<br>……<br>…… | **An integrated/ holistic service may avoid:**<br>……<br>……<br>……<br>……<br>**An integrated/ holistic service may foster:**<br>……<br>…… |

| | |
|---|---|
| …… | …… |
| …… | …… |
| | |

Along with all the advantages integrated services do offer, there are setbacks too; and both are connected with the fact that most integrated services are not part of the public network per se, but linked to NGO's Foundations, associations, etc. In case you are intigued to learn more about the main setbacks of integrated services, please read the following list:

- **Waiting lists**: accessing the service may involve women undergoing a life change; a fact which is incompatible with the access to the service during too long a wait. Long waiting time may lead finally to dropping out from the service when –ironically- the vacancy has finally taken place.
- **Lack of sufficient funding:** ensuring enough access capacity involves funding. It needs to be taken into account that funding to existing services comes most often under separate concepts; either as IPV services or as PSU ones. UK's Government-endorsed National Institute for Health and Care Excellence (NICE) recommendation about Multi-agency coordination in the UK (Recommendation nº 3: "*Develop an Integrated Commissioning Strategy*") recommends having "*aligned or, where possible, integrated budgets and other resources*" (NICE, 2014, p.70).
- **The role of specialists may be diluted:** A danger to the integrated service is for it to go in a direction in which in order to provide integral attention, specialist are erased from the global picture; and this is not the goal of integrated services; but appropriate and timely coordination between specialists.
-

**Our reply to Task 2:**

| ADVANTAGES FOR THE CLIENT | ADVANTAGES FOR THE PROFESSIONALS |
|---|---|
| **An integrated/ holistic service may avoid:**<br><br>-The pilgrimage from service to service.<br><br>-The repetition of client's clinical history and the unnecessary anamnesis of painful episodes.<br><br>- Clear measures undertaken.<br><br>- Loss of energy.<br><br>- Counterproductive clash of measures and/ or points of view due to political reasons or operational modalities.<br><br>**An integrated/ holistic service may foster:**<br><br>-Receiving clear information about next steps that the client should undertake.<br><br>-The experience of high great quality SUPPORT. | **An integrated/ holistic service may avoid:**<br><br>-Confusion and repetition in management of clinical histories and anamnesis.<br><br>-Clash of competing political interest between various services depending of diverse administrations (municipal, regional, State level, autonomous governments etc.), which may trigger lack of coordination.<br><br>-Loopholes and/or information gaps.<br><br>**An integrated/ holistic service may foster:**<br><br>-More professional attitudes.<br><br>-Shared protocols and team alignment.<br><br>- Shared training methodology and goals.<br><br>-Enhanced efficacy.<br><br>-Coordinated actions. |

### 4.4 Multi-Agency Coordination: "Circuits" and "Networks"

Lack of timing, quick access to services and first and above all, of swift and clear coordination, are the most significant obstacles towards providing the proper attention to our clients. Coordination between professionals –including us as well, as we could assume- seems to happen at times "by default" and "in extremis". When there is, for instance a court case hearing, and all involved actors (e.g. social services, health services, and specialised child care services), meet "by chance" and "de facto" coordination is undertaken; which is of course not an ideal situation, pointing though at the structural limits of the system.

A strength of this system would be that all professionals dealing with the public in social, health, or educational facilities are trained with spotting possible sexist violence. Within this context, and also constituting a good practice of this field, a set of questions has been drafted in the National Protocol in Catalonia, by which a woman could share or even come to realise about her own condition of being a victim and a survivor (Institut Català de les Dones, 2019). At the same time, there seems to be at times a great degree of integration and coordinated response between professionals of the same sector (for instance, medical teams involved in the same case) than between the medical sector and other sectors. This is ensured by a protocol with well-defined territorial mechanisms:

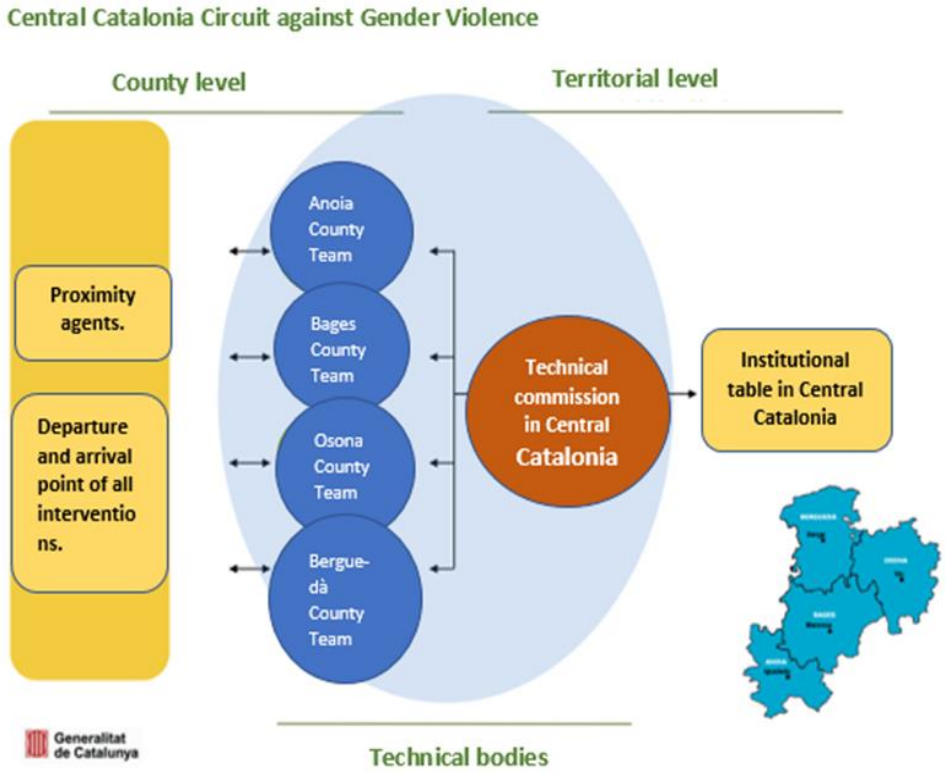



**Image translated and adapted from: "Protocol marc per a una intervenció coordinada contra la violència masclista„ (**Institut Català de les Dones, 2020)**.**

As you may have noticed in the image above, the whole of the Catalan territory is divided in regions (IE: Central catalonia on the image featuring 4 counties). County teams ensure the information transmission circtuit between the Institutional table and the Technical commission in the region, and the proximity agents.

The degree of perceived urgency of the case would trigger one or the other circuit, and activation of resources for each phase of intervention. A set-back of this network is that it does not design any specific circuit for those suffering from co-occurring IPV and PSU. As a result, IPV and PSU would be tackled according to the level of urgency determined by the professionals involved. In general, and even in integrated services parallel to the public networks, sobriety is encouraged and worked towards as a goal that enables survivors to overcome IPV.

### 4.4.1 Universal screening for the co-occurrence of IPV and PSU

There are social and health care systems based on universal screening about domestic violence, including as expected also IPV. All professionals of social and health services are then trained and have the tools to detect it. This is a primary stage of multi-agency coordination, as upon detection the necessary co-operation and referral circuits would be activated. The same needs to be ensured in cases of co-occurring IPV and PSU. The World Health Organization stressed the importance of improving the response of the health sector in the face of domestic violence through the use of universal screening for women and children (WHO, 1998). It was recommended to regularly ask all clients if they have suffered sexual or physical violence, as well as the creation of written action protocols that define, for a specific environment, the procedures to be followed in order to identify survivors of violence and respond appropriately.

Among healthcare settings there has traditionally been some controversy surrounding utility of screening in relation to sexist violence by their partners. However, it is necessary to point out that there is a significant increase in recognition of its importance as an appropriate and effective means of identifying and being able to address these cases of violence response, beyond the fact that they are presented in the emergency services or in the services' primary care.

The fact that we do not have ample evidence to recommend universal screening in this case of gender-based violence, does not mean that there is sufficient evidence not to recommend it. The Canadian Task Force on Preventive Health Care notes that:

"*Although not yet sufficient evidence has been gathered to recommend or discourage the use of screening, prevalence and damage associated with domestic violence are sufficient reasons to maintain a high degree of suspicion when women are examined*" (Wathen & MacMillan, 2003).

**Practical Conclusion:**

Whichever existing service coordination should decrease women's survivors of IPV –with or without PSU issues- emotional distress,

and not have the opposite effect.

The clients' interest and well-being, comes first.

### 4.5 Coordination between Professionals and Services in cases of co-occurring IPV and PSU

Notwithstanding is the fact that the definitions are not always the same in all countries; we could surely agree with as to the description of professional profiles for social workers, psychologists and doctors; often psychiatrists. A profession such as nursing in Spain and other countries, including Iceland and Greece as well, is a university degree, while in Germany it is more of a specialised vocational training, more similar to clinical assistants in Spain. The profession of social educator is not identical in all countries, in other places they speak of a social educator and it does not have its own entity (in Spain and Catalonia it did not have it until a couple of decades ago); and more basic profiles, doing tasks of continuous support, containment, accompaniment, etc., they could be subject to various definitions. For instance, not until very recently, we have had social integrators as a professional profile. There are many people acting as monitors, who sometimes have different or no backgrounds, based more on their vocation and personal motivations (e.g. former PSU users/ "recovered therapists", or members of the feminist movements).

At the same time, teamwork within IPV and/or PSU services is obviously a field of both co-operation and conflict, not only due to the differences between personal work styles and personality that would occur in any type of task, but also due to the possible

differences in approach and due to the multiplicity of professions that may intervene. When working in this field, we would find ourselves –or we may even have already found ourselves- with the difficulty of organising teamwork, since, for example, there are some tasks that are quite clearly assignable to one or another profession, but it is not so with others (e.g. leading a group exercise could be done by various profiles). In addition, other tasks are more dependent on specialities and professionals' previous training, which may not even be the same for the same profile in all universities in the same country.

In terms of co-occurring IPV and PSU, a comprehensive multi-agency group should consist of a diversity of professionals and services, such as –among many others-: police, judiciary, specialist victim support service provider (NGO), health professional, PSU service and mental health, local government specialists (casework specialist, social worker, specialist of child protection), housing/accommodation providers, probation officers (if there was already conviction by court) and representative from the perpetrators' programme. Alongside other specialist services may need to be included, such as: adult safeguarding, educationemployment advice, employer, voluntary and community groups and support services. The question arises as to what form of communication and information sharing flow and action-planning process is generated between these professionals when working with women survivors of IPV with PSU issues.

### 4.5.1 Coordination strategies and mechanisms

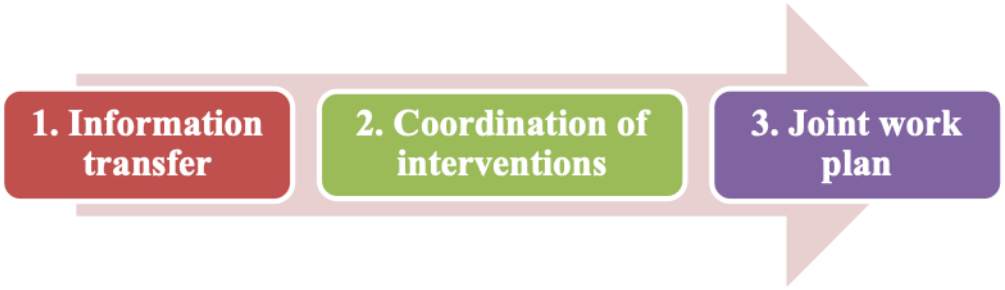
Referrals and/or case coordination and networking are some of the main strategies used towards multi-agency coordination in all cases, including of course cases of co-occurring IPV and PSU.

- By **referral** is understood the action carried out by a professional of a specific service by recommending the client being attended to another specific service or resource in order to receive specific attention or advice, for instance by an IPV to a PSU professional/ service and vice versa.

- **Case coordination and networking** are all those actions within the framework of a work strategy based on collaboration and interprofessional exchange, beyond the derivation of a specific case. That is, collaboration and exchange between IPV and PSU professionals in the framework of service information, knowledge, training, planning, etc.

Coordination would increase the effectiveness of both IPV and PSU interventions, since it involves detecting gaps and duplications of these services. Different mechanisms are used to achieve this coordination. These refer to the structures, methods and tools that allow coordination and networking. It is noted, though, that there is no clear and consensual definition of case coordination. Under these umbrellas emerge different types of coordination that extend in a gradual continuum around the professional involvement in the coordination of the case:

**Types of coordination requiring lowest (1) to highest (3) professional and services' involvement:**




**Information transfer:** it allows knowing previous interventions in order to avoid further victimisation and duplication of interventions.

**Coordination of interventions:** it involves designing a shared strategy involving deeper engagement of IPV and PSU professional and services' coordination meetings and communications.

**Joint work plan:** it involves interdisciplinary together intervention of various services, including of course IPV and PSU services. It also involves highest engagement due to shared decisions and face to face meetings under a single operation and management style.

**Mechanisms often used towards coordination among IPV and PSU professionals and services:**

**a. Participation of PSU services in the circuits of gender-based violence**: the main advantages of participating in the circuits in terms of coordination and networking are:

- **Making visible the problems and specialised resources about consumption**, usually more invisible or relegated to the background compared to other problems or networks of services.
- **Advancing the generation of synergies between professionals from different networks:** the fact that there are PSU service professionals within the circuits of gender-based violence, encourages a less stigmatising view of consumption to begin to spread, albeit gradually. Reference is made, for instance, to the training on consumption offered by PSU services' staff to other professionals in the circuit, and especially IPV professionals.
- **Choosing which should be the reference service** (amongst other important elements) analysed and agreed for a comprehensive and coordinated approach to the case. As described by one of the professionals interviewed in the aforementioned Catalan drug report:

*"We, for example, in the (name of the municipality), there may be on the circuit the (names of drug area services) ... and when it is detected, it is decided among the professionals, which is the reference where the woman feels most identified (...). It depends on the person with whom she is linked, where she feels best protected ... But for that you need a colossal networking (GD1)".*

**b. Participation in the case by monitoring committees of the circuits:**

In order to work in a coordinated way in complex cases, such as the cases of women survivors of IPV with PSU issues, it is not enough to participate in the circuit. It is important to participate in an ad hoc coordination space whose aim would be to draw up comprehensive and coordinated intervention plans between IPV and PSU services, in order to avoid duplications. Despite being a time and energy-consuming technique, which also requires a lot of involvement, it is considered to be the most effective when it comes to doing real networking.

**c. Using ICT:** virtual platforms for coordination with other services.

**d. Generation of joint worksheets:** it is a shared file by various services about a single case; it is not too widely used but it is highly valued as a tool. It is an asset to working committees' meetings.

**Task 3**. (Tricky question alert!):

***Please, give good thought to your reply to task 3 taking into account that there is no universally valid response for all the issues, but local solutions which are appropriate to individual needs. Inspiration for these could be found in sound protocols and good local practice wherever these are available.***

**In case of an integrated service being absent, who should take the lead and become the service of reference for a woman experiencing co-occurring IPV and PSU?**

a. The drug attention service.

b. The IPV service.

c. Both of the above.

d. None of the above

**Our reply to Task 3:**

**Well, yes, as said above, it was a trick question!**

The answer is -in the absence of an integrated service- depending on: service's hours, clients' access' flexibility or rigidity and the personal bond created between us (namely the professionals) and the client.

Some professionals believe that the PSU service being the leading one, offers a number of advantages that are lost if you opt for referral. Instead, other professionals believe that it is better to refer women to specialised resources and then work in a coordinated manner.

As you would see below, sometimes the arguments used from these two positions could well be just the opposite.

More specifically, the suggested advantages of dealing with gender-based violence from PSU care resources according to the arguments of professionals interviewed in the Catalan report on IPV and PSU (Spora Sinergies, 2020), are as follows:

- Due to their clients' needs and lifestyles, PSU services offer greater flexibility and proximity. PSU services are usually able to make visits without prior appointment and that this is usually more in line with the needs of individuals, and especially women, who suffer from PSU issues.

- IPV services are oftentimes quite saturated, operating with standardised processes and rigid schedules. These elements seem to be antagonistic to the logics of consumption or gender-based violence, as well as to most clients' lifestyles.

- It is not uncommon for both members of a couple to attend the same PSU service at the same time, which gives professionals the opportunity to intervene around the situation of IPV, not only with the woman (namely the survivor), but also

with the man (namely the perpetrator). In this way, they feel more capable of avoiding escalation of violence and situations that are more dangerous. As a result, some professionals consider this fact/characteristic of PSU services as quite important.

- The therapeutic relationship already established with the PSU professionals facilitates a quicker intervention. Women who suffer from PSU issues already have to endure a very large stigma as women consumers. Referring them to the resources of the IPV network could increase this burden, as the stigma associated with the victim label is likely to appear.

- Addressing the IPV issues from the PSU services, offers more protection to women survivors against possible retaliation that the couple may undertake. This renders to the fact that for men (the perpetrators) only attention would be paid to the PSU issues and thus, theywould not know that, at the same time, the issues of IPV are also being addressed.

### 4.6 A Good Practice Case: Metzineres


**Screenshot of Metzineres' website. The subtitle in Catalan says: "*Sheltered environments for women who use drugs while surviving violence*".**

Metzineres: is the first comprehensive harm reduction programme exclusively for women in Catalonia. This resource is valued very positively by the professionals who have participated in the discussion groups of the 2020 Drug Report in Catalonia (Spora Sinergies, 2020). The fact that stands out the most is that it is a truly comprehensive service, focused on the client and the perspective of her rights, as it seeks to adapt to the particularities and needs of each woman and offers flexible proposals for direct and immediate access. From this service, a special effort is being made to visualise, quantify and respond to the needs of women (for instance, it highlights the fact of having free access to beds in order to rest, since the women who are on the street have a lot of trouble being able to sleep at night, as they need to be alert to possible assaults). Within Metzineres, a woman to woman safety network is generated. In addition, it is indicated that it is a type of intervention that is proving to be more effective than other harm reduction programmes, precisely due to its commitment to the transversal incorporation of the gender perspective, especially in the design of the service itself. Constituting an innovation and good practice, "Metzineres" participated in the Women and Harm Reduction International Network (WHRIN) Project's campaign regarding the "*Elimination Of Violence Against Women Who Use Drugs*" (WHRIN, 2020).

If you would like to learn more about the concept and context of "Metzineres", you could watch Ms. Aura Roig's (anthropologist and "Metzineres" director) interview[11].

[11] As the interview is in Catalan language, you may want to use an online translator.

**Task 4.** After finding out more about “Metzineres“, could you please name:

**Three ways in which itconstitutes an integrated service:**

a. ……..

b. ……..

c. ……

**Three ways in which the concept of person involved is a holistic one?**

a. ……..

b. ……..

c. ……..

## Key Questions for Chapter 4

1. Which ones, would you say, are the factors that enable Multi-agency and professionals' co-operation?

2. How prevalent are these in your country?

3. What is/should be the impact in your view of the gendered and feminist approach, and of critical psychiatry on the functioning of IPV and PSU services?

4. Who do you think should lead a specific case in co-occurring IPV and PSU? IPV services or PSU services and why?

5. What advantages could you name for PSU services being the reference service for a specific co-occurring IPV and PSU case?

6. What coordination strategies between IPV and PSU professionals could you think of?

7. What strategies could you think of in order to "reduce further victimisation" of women survivors of IPV with PSU issues?

8. How does the underlying concept of person impact the functioning of MARAC and integrated services in cases of co-occurring IPV and PSU?

9. Could you think of some example of institutional violence in connection with co-occurring IPV and PSU?

10. How would upholding a holistic concept of person by services make a difference for the specific cases of co-occurring IPV and PSU?

# 5. Designing and Implementing an Efficient Intervention for Women Survivors of IPV with PSU issues

| What will you learn in this Chapter? |
| --- |
| ➢ **<u>Designing</u> an intervention based on the specificities of the clients' profiles** (fragility, need of respectful treatment, need of emotional support).<br>➢ **<u>Identifying</u> the resources available** to the clients in terms of immediate support and services to make their social reintegration possible.<br>➢ **<u>Implementing</u> proper counselling** by initial bonding with the client as a major intervention and containing the clients' emotional state.<br>➢ Understanding the Change Model of Internvetion and its stages. |

**Key words:** Assessment, Change Model, Follow-up, Relationship building

Before delving into the efficient interventions for co-occurring IPV and IPV, we need to remind ourselves that approaching any service for help to recover from either IPV or PSU is an extremely challenging thing for any individual to do, or even to contemplate. Professionals like us working in the IPV field, should be aware thst this is especially so if the client has relied upon the substance for a long time, and so gained a sense of absolute dependency upon the substance which makes life seem unmanageable without it. Moreover, often, the substance is the only thing that they

feel allows them to cope with the violence and the abuse –including IPV-, as well as with the pain they cause. Even though the cost is high in terms of the physical, psychological, social, and financial damage it causes, the substance enables clients to survive after a fashion. It is only when these costs have become too much to manage, do they eventually, and with some reluctance, seek help, but now with the combined and overwhelming guilt and shame of IPV and PSU. So, at this point, many of us may wonder how we, as professionals, manage these immensly fragile clients in the initial interventions; especially as they may have an enormous impact on clients' ability to engage with the various professionals they meet on the way, or indeed if they even manage to engage at all. In this chapter, we attempt to outline both the role of containment for the client's immediate presenting issues and concerns, their safety and protection, and the important first steps of the multi-disciplinary long-term process of treatment.

The initial interventions when working with survivors of IPV with PSU issues could be broken down into a series of steps. The purpose of these steps is to develop immediate and practical strategies addressing the IPV, together with a safe and cohesive plan of action for the clients' future progress through PSU recovery- a two-fold approach which recognises how IPV and PSU would interact with each other and so cannot be treated independently. Our initial interactions with the client form the first of these steps as it is at this point that we begin to build the effective working relationship that would determine how well the client would engage with the various services and professionals she encounters. If we are truly to be cohesive in our approach towards clients experiencing IPV and PSU, it is essential that we develop a good working relationship both with the client and with any other services the client may become involved with from the very beginning.

While information gathering is an essential part of the initial intervention process, it is also an important step in the client's care pathway, and consists therefore a major intervention in its own right. To that end, it needs to be accepted that women with PSU issues, and especially those who also suffer from IPV, could be extremely vulnerable, presenting with acute self-esteem issues and a very fragile self. Women

often see themselves as helplessly dependent upon the substance used and the thought of letting go of this dependency could often fill them with fear, dread, and self-loathing, a dynamic reflecting the internalising of IPV. This fear often results in either the attempted avoidance of responsibility through transference of the dependency on the professional, or by the creation of defence mechanisms aimed at denying the very existence of a problem. Denial is the primary defence mechanism and is aimed at convincing the substance users against all reality and evidence that they are in control and could stop using anytime they like. Direct challenges to this denial would inevitably result in heightened anxiety and the corresponding escalation of the defences driving a 'fight or flight' response. In fact, just attending the assessment interview could create stress levels high enough to trigger a massive traumatic and often self-destructive response. Often, women who have suffered long-term IPV become locked into this 'fight or flight' state which could make it very difficult to hold onto them when the work becomes challenging. Therefore, attention always needs to be paid to women's immediate state of mind and anxiety levels, and when conducting interview we should be both observant, and well versed in a range of de-escalation skills and grounding techniques. The aim of this process is to create a challenging environment that is always within the client's capabilities to withstand.

Many women with co-occurring IPV and PSU who feel unable to deal with the constant challenges recovery seems to demand, often leave treatment at this point only to try it again at a later date; creating in this way a cycle of engagement and rejection. This leaves us as professionals to deal with the frustration of what could become an ambivalent relationship and one which may feel stagnated and purposeless. It could be very easy under this pressure to be drawn into the position of taking the responsibility for the client's recovery to force change. So....

! We should always be aware of **the power of transference and projections** in these stressful circumstances, <u>especially in the early stages</u>.

These projections inevitably portray the professional as the rescuer and the client as the victim; a disempowering role for all, that demands we become the responsible adult and the client the immature child.

As we mentioned in Chapter 1, well-constructed and firmly held boundaries is an essential part of the therapeutic process and are necessary from the very beginning. IPV could be seen very much as a process of shattering and violating normal boundaries. Re-creating healthy boundaries within the therapeutic process, in a secure way, could be experienced positively- containment viewed as being valued and safe rather than punitive and controlling. Instead of just demand abstinence, we could discuss with the client why abstinence is so important to our work and what the results would be if it is not managed. We should also apply this approach to all boundary issues such as respecting each other, turning up on time, or missing sessions[12]. The purpose for this is to give women a sense of responsibility and ownership rather than subservience, while understanding and accepting the consequences of the choices they decide to make. Ultimately, if the process is going to succeed over the long term, then women should be encouraged from the very beginning to take responsibility for their recovery, and well-maintained boundaries are the building blocks of this process.

It needs to be realised by all professionals working in the field that no one chooses to develop a problem with drugs or alcohol and many of the clients –and especially of the women- we meet may have turned to these substances as the only escape they could see from their underlying trauma. Trauma may be due to childhood violence, sexual abuse, or IPV, and in many cases due to combinations of them all. Each of these abusive experiences could have a profound effect upon the psyche and could generate overwhelming feelings of shame, guilt, and low self-esteem. These feelings are then further exacerbated by both the actions and the lifestyle choices PSU

[12] For more information about Boundaries, please read Chapter 1.

demands, and unfortunately sometimes by the attitudes and responses of those they turn to for help[13].

We should also remember that likewise IPV, PSU affects not just an individual, but is often a whole-family issue. It is common for more than one member in the family to have issues with alcohol or drugs, adding to the complexity of the existing problems; making, in this way, the achievement and maintainance of recovery even more of a challenge. Family history of IPV and/or PSU could also have an immense impact upon children in the household, often leading to neglect and to attachment disorders, that could manifest as complex emotional issues affecting the child's adult life, as well as potential and immediate risks to its safety. Women with PSU issues may also still be involved within an abusive relationship or recently have escaped one; both cases may trigger them to seek help but also influence their ability to cope with any further emotional pressure. These are just some of the main factors which need to be considered when we determine an appropriate model of engagement and pathway of care for women survivors of IPV with PSU issues.

Family circumstances also play a major part in how well we maintain confidentiality with the client. As we mentioned in Chapter 1, it is important that both client and professional clearly understand the limitations of confidentiality and what happens when circumstances demand we break it. If there has been abuse within the family, we need to determine if it is still going on or if there are any children or vulnerable adults at risk. We also need to determine if the client has suicidal thoughts or a history of suicide attempts that place her at risk. Ultimately, we should prioritise safety of the young or the vulnerable above that of any other individual, including our client.

These factors would also form part of the assessment of the women's ability to engage with the therapeutic process; not as a criticism but as an honest review of their resilience to deal with the work of therapy. It emphasises the importance of exploring all aspects of clients' world as part of the assessment and forms the basis of what we mean by a holistic approach. This simply means placing appropriate importance to the

[13] For more information about Stigmatising Attitudes, please read Chapter 2.

influence of all factors, both positive and negative, within women's life that have led them being where they are today and accepting that recovery either from IPV or PSU is a very challenging and difficult process.

### 5.1 The Assessment

The assessment needs to cover a range of areas not only for ourselves but also for any other professionals and services we may refer our clients to, and especially to PSU professionals and services. It would make sense for IPV and PSU -as well as for a range of other services- to collaborate in designing an assessment protocol. This protocol should be suitable for all professionals and services that are involved in IPV and PSU cases; while it would save women from the trauma of repeating their story again and again. However, we need to remember that written permission from the client is necessary before contact is made with any other service to share this assessment[14].

The assessment should be used to explore the following aspects:

| **Basic client information** |
| --- |
| ✓ Full name |
| ✓ Date of birth |
| ✓ Address |
| ✓ Telephone |

[14] For more information about Multi-agency Co-operation, please read Chapter 4.

| |
|---|
| ✓ Email details<br>✓ Emergency Contact Details |
| ✓ Who does the client live with?<br>✓ Are there any dependants such as children or vulnerable adults in the home?<br>✓ If yes, what are their ages and life conditions circumstances? |
| ✓ Are social services involved with the family at present? |
| **Medical concerns** |
| ✓ When did the client last consult a doctor?<br>✓ Does she have any physical health problems?<br>✓ Name and contact details of current doctor are essential. |
| **Mental health issues** |
| ✓ Are there any diagnosed co-morbid issues such as PTSD, anxiety, depressive, personality or psychotic disorders? |
| ✓ Name and contact details of any mental health teams they are or have been involved with are essential. |
| ✓ What support is there for the client's mental health issues when they struggle? |

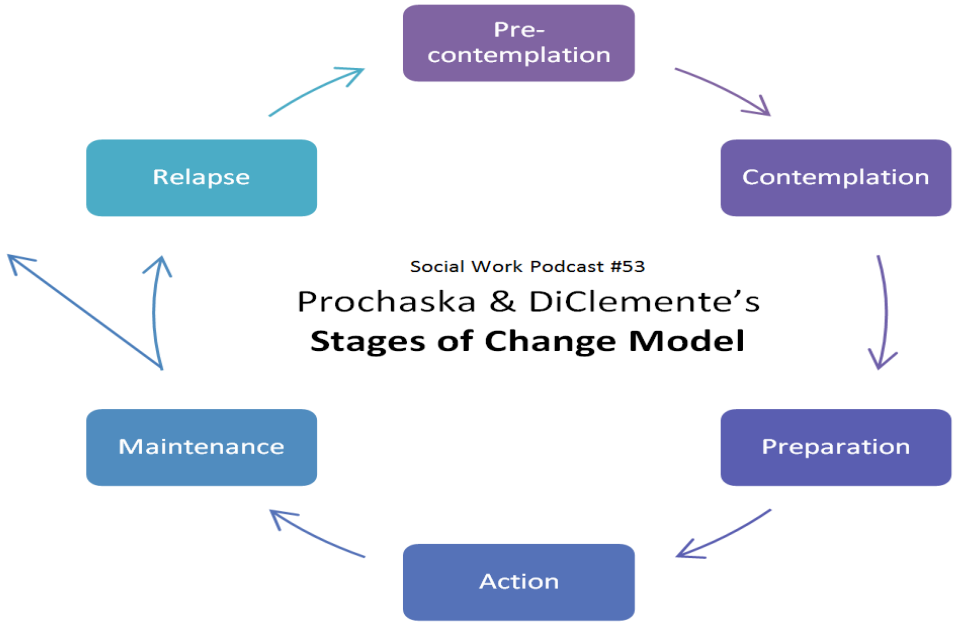
| Suicide and self-harm | |
|---|---|
| ✓ | Does the client have active suicidal or self-harming thoughts? |
| ✓ | Does the client have a history of suicide or self-harm attempts? |
| ✓ | When was the last time she attempted and what did she do? |
| ✓ | Who was aware of this? |
| **Ongoing police or legal issues** | |
| ✓ | Is the client involved with any active police investigations or court action? |
| ✓ | Has she been under the restrictions of restraint or non-molestation orders? |
| **Client attachment history** | |
| ✓ | Family dynamics |
| ✓ | Birth family, attachments, and upbringing |
| ✓ | Education and work |
| ✓ | Past and current relationships |
| ✓ | Friendships and social network |

| | |
|---|---|
| ✓ | Housing and welfare issues. |
| **Aims and motivation** | |
| ✓ | What does the client wish to achieve? |

Identifying problems and going on to develop practical goals and targets as a collaborative process is useful at even this early stage as it gives us an immediate sense of purpose to the work. The Stages of Change Model is a very useful tool towards this direction, as it could break down overwhelming issues into smaller problems, which as such, could be more easily managed. In the following section, we are presenting you the Change Model, since -apart from PSU professionals-, IPV professionals should be also aware and familiar with the existing successful interventions of the PSU treatment. In this way, the gaps between different fields, approaches, and philosophies are bridged; the understanding of our clients' current situation is fostered, while we could even be inspired by interventions like these.

### 5.2 The Change Model and its Stages

This model for promoting change was developed by Prochaska and DiClemente in the 1970's and has proved to be successful when applied to PSU. It is a six-stage cycle designed to create a structured approach to change, which acknowledges the challenges posed by trying to instigate any major change in life.




Having embraced the core principles of the Change Model, PSU professionals are fully concious that no change is easy. From our side, as IPV professionals, we need also to ackowledge this fact, recognising at the same time that change is not easy even if the advantages are blatantly obvious, since individuals simply do not like to let go of what is familiar. In fact, if change was easy, resolving IPV or PSU issues would be simple, our clients would just simply fix these issues and would stop using substances and suffering from trauma. Ironically, many clients are battered by such negative and stigmatising attitudes and narratives used by people who just do not understand the complexity of this phenomenon, while this problem seems to be more intense and challenging for women clients, as they addittionally have to face negative and stigmatising attitudes and narratives related to their gender. More specifically, prior to engaging in IPV and/or PSU services, many clients would attempt to stop using without any plans or support in place, since asking for help would be perceived as an admittance to a problem, being experienced as a shameful confession. Each unplanned and unsupported attempt and its inevitable failure could lower self-esteem and motivation and make success even further away. When working with women survivors of IPV with PSU issues, we should also keep in mind that while the IPV is still an active issue, recovery from PSU has to be seen as an impossible challenge, and

the Stages of Change Model have to incorporate both issues of IPV and PSU if it is to be successful.

Below are the six stages. Each one needs to be worked through carefully before moving on to the next. Often it could be necessary to go back to an earlier stage as unexpected issues may arise. The purpose is to work carefully to make the following stage as easy to achieve as possible.

### *STAGE 1: PRE-CONTEMPLATION*

In this stage the client is not even thinking about change, refusing to see that there is a problem. Many individuals with PSU issues find it extremely difficult to accept they have a problem in the first place and would often go to extraordinary complex lengths to hide it from their self and others. Moving to the second stage by accepting that a problem exists is a task the client usually should face alone and may take many years before gaining the courage to do so. Both PSU and IPV sufferers often see themselves as to blame- feelings often exacerbated by those around them. They view themselves as responsible for everything that has happened feeling they "deserve" punishment rather than help.

### *STAGE 2: CONTEMPLATION*

The first proper stage sees the client facing up to the fact that there is a problem, and it is here where we as professionals could be supportive in helping the client face the truth. Usually occurring within the first few meetings, the client often presents as confused, fragile, and at her most vulnerable phase. This stage therefore requires a lot of empathy and tact by the professional if motivation is to be maintained. Accepting the reality of their problems could be a traumatic experience in its own right filled with grief, despair and often rage.

### *STAGE 3: PREPARATION*

At this stage, the problems have been determined and it is time to get together and decide how both the client and we as professionals could address them. This stage could also be used to look at what resources are available. It is at this stage that goals are created through mutual agreement. This experience of not being alone with their problems could have a huge significance for the survivor of IPV who may have kept the abuse 'secret' for many years. The creation and achievement of goals is an essential part of maintaining motivation for the client as they could give a sense of 'getting somewhere' in a process that is long and arduous. However, to be effective the goals need to be within the abilities of the client to achieve or they would simply become another indicator of failure. For instance, Alcoholics Anonymous (AA) set a goal of 'one day at a time' for recovery and this is always a good starting point.

! Please do not ask of your client what she cannot achieve.

### *STAGE 4: ACTION*

Now, since a plan has been created and goals have been determined, it is time to begin without delay or hesitation. There could often be a lot of prevarication around this point as it involves actually making the change rather than just talking about it. "*It's too near Christmas, I'll start in January*" or "*I'll start next week/month, it's just not a good time right now*" are typical comments to hear at this point from a very scared client. Many women who have experienced IPV feel terrified of leaving in case they make matters worse- it is always a phantasy that is postponed for the future. Putting this 'phantasy' actually into action could be very demanding and would need a lot of organising and support. There would never be a 'good time' to start this process as something would always get in the way if you're scared enough, and it is our role as professionals to work gently through all objections and fears the client may bring to us.

## *STAGE 5: MAINTENANCE*

Now that the plan is up and running, how could momentum be maintained and built upon it? What is not working so well needs to be reviewed and changed, and what is working well should be expanded upon. This stage is a process of working together to constantly fine tune the system and to carefully bring back into the client's life things that have been lost. For the survivor of IPV, it is an opportunity for clarity of thinking perhaps for the first time in years free from coercion and manipulation, and to begin making decisions for herself.

## *STAGE 6: RELAPSE*

This seems an odd part of the process, but it is essential to plan for the possibility of relapse otherwise a small slip could be devastating. Many survivors of IPV would return inexplicitly to the perpetrator at some point, as just as many with individuals with PSU issues would return to alcohol and/or substances seemingly regardless of the consequences or without understanding why. It is important to make sense of what is happening to our client and find a solution that protects the future rather than just condemn her as failed. Everything could be a learning opportunity if the collaborative approach is maintained and each slip including past ones could be drawn upon to gain a greater understanding of the client's strengths and her area of vulnerability.

Used effectively, the Stages of Change Model could act as a collaborative, working process, with the client fully engaged with the therapist in a series of joint tasks. By using careful planning and evaluation at every stage, it could then become possible to address and solve many potential problems before they actually occur. It could be used tightly focused as it often is on PSU professionals and services to concentrate upon maintaining sobriety by tackling the daily issues that could lead to relapse, such as dealing with cravings or avoiding triggers. However, its scope could also be widened to include the roles played by all aspects of the client's life that influence behaviour such as past and present IPV trauma; fragile self-esteem; mental health

issues and abusive relationships. Used in this way, the contemplation and preparation stages would assist us in determining what referrals to other more specialised services would make sense, with the client always in the centre of the process. This pro-active and collaborative initial approach is invaluable in setting the scene for the client's engagement with all the various services they would meet, especially if they believe that all the professionals involved, and especially IPV and PSU professionals, are working together as a team rather than in isolation.

### 5.3 The follow-up Review

Several times, this area is seen as something to be haphazardly arranged with very little effort and input from the professionals and is frequently missed in the demands of a busy department. Follow-up needs to be actively pursued and organised within a time scale appropriate to the individual client's needs, taking advantage of the high motivation the client often experiences during the early stages of therapy, including IPV and/or PSU therapy. The follow up review should not be experienced by clients as a judgemental process where they are viewed as either a success or a failure. Rather, as per the Stages of Change Model, successes, or failures could be viewed equally as learning opportunities to be explored and utilised in the evolution of a revised and refined recovery plan. The follow up review is an essential part of the process in which women feel held and not alone in their struggle, building relationships with a range of professionals, all working together to create a collaborative dynamic rather than the power imbalance of 'us and them'.

The combined fields of PSU and IPV offers complex and unique challenges to clients and professionals alike. For the client, it is the most terrifying thing they have ever attempted and the courage they show just talking to us should always be recognised. For the professionals, it demands an approach that deals with the most vulnerable and fragile of clients. It needs a practical knowledge of the various agencies to involve and the systems they utilise, but it also demands the ability to work with relational depth providing containment for the woman's overwhelming fears and vulnerabilities,

whilst helping her develop ego strength, independence, and long-term resilience through empowerment, freedom of choice, and self-determination.

Above all,

working with women survivors of IPV with PSU issues

demands an approach by professionals like us that accepts that

**there is no simple answers**,

and that **recovery is a life-time journey**,

**<u>with many successes and failures on the way</u>** !!!

## Key Questions for Chapter 5

1. When do you feel the important interventions for women survivors of IPV with PSU issues begin?
2. What effect does IPV and long-term PSU have upon the ego and self-esteem?
3. What do you feel prevents women survivors of IPV with PSU issues from seeking help earlier?
4. What do you feel are the problems specific to this client group?
5. What factors could determine whether women survivors of IPV with PSU issues stay in treatment or flee?
6. How could we gather information in order to develop challenges and maintain motivation?
7. What are the core principles and main aspects of an efficient intervention for women survivors of IPV with PSU issues, according to your opinion and based on what you read in this Chapter?
8. Name some of the main aspects that should be included in a comprehensive assessment of women survivors of IPV with PSU issues

# 6. Risk Assessment and Crisis Management of IPV

| What will you learn in this Chapter? |
| --- |
| ➢ **<u>Preventing</u> further violent incidents** and keep survivors safe by means of Risk Assessment Evaluation scales and approaches.<br>➢ **<u>Recognising</u> the distinctive characteristics of each case**, and the need to personalise the evaluation as well as the intervention method.<br>➢ **<u>Identifying</u> the risk factors** for IPV incidents.<br>➢ **<u>Investigating</u> the categories of violence-triggering factors** and their underlying mechanisms.<br>➢ **<u>Structuring</u> a personalised** Safety plan with the woman in an abusive relationship as an individual case and process. |

**Key words:** Awareness, Crisis Management, Intimate Partner Violence, Risk Assessment, Risk Factors, Safety plan

Violence –including IPV as well- could occur everywhere, in all sexes and in all types of relationships, affecting the lives of millions of people around the globe. Undoubtedly, its effects are negative in all of the cases, since it involves the violation of basic human rights, which, among others, include: the right to equality and freedom from discrimination; the right to life; liberty; personal security; freedom from torture and degrading treatment; the right to equality before the law; the right to a fair trial;

the right to privacy; the right to freedom of belief and religion; and to freedom of opinion (United Nations, 2021).

Domestic Violence is the most known term used to describe the violence within a domestic environment, among people sharing a family bond, mainly affecting women. Later on, the term of IPV became widespread; aiming at expanding the notion according to which abuse could exist in any type of personal, intimate relationship, regardless of sexual orientation, marital status, or gender. Based on this knowledge, the World Health Organization identified IPV as "*any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship*" (WHO, 2021). A worryingly large percentage of this type of behaviour could lead to extreme life threatening situations for the people involved, and especially for women. This is when professionals from various fields, working with survivors or perpetrators of IPV, need to assess the situation, aiming at providing safety guidelines for all parties involved. At this chapter, we attempt to clarify the purpose of a Risk Assessment tool, the existing structures of a Risk Assessment in various settings, the Risk Factors it investigates, and finally the strategies to implement it. Furthermore, this chapter will look into the methods of managing a crisis with an intimate partner, in order to protect women in danger, taking into account at the same time their PSU issues.

### 6.1 Risk Assessment and Crisis Management of IPV: Aims, Types & Benefits

According to relevant research included in international and European papers, it has been noted that the mental, physical and psychological consequences of IPV are more severe to survivors, when the violence is recurring for a long period of time. When the woman experiencing chronic incidents of violence finally decides to seek help from an expert, many issues need to be resolved, analysed, discussed and prioritised in our sessions with her. The main and most basic aim is to assist the survivor remain safe, including cases where the perpetrator becomes more agitated, as for instance when the woman attempts to end the relationship and he realises that his partner leaving him, as

there is evidence that the risk of severe violence and murder (femicide) may increase when the victim attempts to end the relationship, and if she separates from the perpetrator (Spencer & Stith, 2020).

Professionals working with women survivors of IPV use **multiple Risk Assessment tools** aiming at:

**a)** helping women to avoid danger hazards and keep themselves and their children safe, and

**b)** predicting perpetrator's aggressive behaviour towards the victim

(Nicholls et al, 2013).

Within the context of a coherent Risk Assessment of women with co-occurring IPV and PSU, the dangers and risks related to the PSU should also be considered. However, IPV professionals are not capable of doing so. The only thing we could do from our side is to be aware of these hazards, stay alerted and co-operate with PSU professionals and services.

To evaluate and understand the importance of a Risk Assessment in cases of IPV, we first need to acknowledge what Risk Assessment is. According to Nicholls et al. (2006, p. 276), Risk Assessment is a "*decision-making process through which we determine the best course of action by estimating, identifying, qualifying, or quantifying risk"*, regarding the safety of each survivor, or the possibility of the repetition of another assault from the perpetrator.

The aim of assisting and guiding women survivors of IPV –with or without PSU issues- to remain safe is not an easy task, and needs to be absolutely personalised to each case, with care and attention. According to the European Institute for Gender Equality/ EIGE, the assessment of the safety risks a particular survivor faces should be conducted on a case-by-case basis, according to standardised procedures and within a multi-agency framework (EIGE, 2019).

## What does Risk Assessment include???

Risk Assessment includes assessments of the:

**a) Lethality risk**

**b) Seriousness of the situation, and**

**c) Risk of repeated violence**.

Since Risk Assessment could promote survivor and professional's awareness of risk for future IPV, as well as motivate and inform strategies to enhance victim safety (Snider et al., 2009), several studies have been conducted to report, test and review the various Risk Assessment methods that have been used by IPV professionals worldwide.

According to many scientific and literature reviews, there are three types of Risk Assessment tools based on:

### a) The structured approach

A structured Risk Assessment method comes in the form of a questionnaire for the survivor or the perpetrator to answer, where all factors and aspects of their lives are examined. The structured method tests also mark and note the frequency and severity of each abusing event during the last year prior to the report, as well as determine the

level of danger an abused woman has of a possible homicide by her current or ex partner or husband. After the questions have been answered and adequate information has been collected, a report is generated to assist us in calculating the possibility of any kind of threat escalating, possible homicide, and risk identification. Such Structured Risk Assessment Tests are the **MOSAIC Threat Assessment System,** designed by Gavin de Becker and Associates in the early 1980s, the **Danger Assessment,** developed by Campbell J. in 1986, and the **Spousal Assault Risk Assessment** – SARA, developed by Kropp, Hart, Webster and Eaves between 1994 and 1999 (Kropp & Gibas, 2020; Van der Put et al, 2019).

*For Instance,*

**The categories of Risk factors, which were finally set to be examined in SARA, were the:**

- History of spousal violence,
- Life-threatening spousal violence,
- Escalation of spousal violence,
- Attitudes supportive of spousal violence,
- General antisocial behaviour,
- Failure to obey court orders, and
- Mental disorder.

**b) The actuarial approach**

The development of a number of actuarial tools was based on multivariate statistical models, using linear regression and discriminate function analysis, among

psychological or sociological factors. The factors that seem to significantly contribute to the establishment of long-term risk of violent recidivism, were age, criminal history, and the family of origin. With the use of statistical methods, as opposed to clinical factors, we are able to estimate the risk of re-offending, while no kind of interview from either the survivor or the perpetrator is required. Police stations mainly use such tools internationally. An actuarial Risk Assessment test is the **Ontario Domestic Assault Risk Assessment** (ODARA), developed by Hilton, Harris, Rice, Lange, Cormier, & Lines in 2004. It could be described as a 13-item scale used by police officers or other professionals related to criminal justice records, with the aim to predict the likelihood of recidivism in perpetrators, combining information with statistical estimations (Kercher et al., 2010).

**c) The unstructured approach** (Northcott, 2012)

IPV professionals collect all needed information and form a risk assessment report, based on their own personal -subjective or objective- judgment. Information comes straight from the survivor or the perpetrator, by filling in:

- Psychological tests,

- Questionnaires with the history of their relationship,

- Previous incidents of violence,

- Any substance use,

- Possession of weapons,

- Children involved,

- Housing and working safety hazards, and last but not least,

- The professional's own opinion from meeting with them[15].

This approach however, entails much of a subjective view from our part; personal prejudices; possible ignorance, and thus, many miscalculations or overlooking of important details, just to mention a few disadvantages. Other problematic issues with unstructured Risk Assessments are the fact that not all IPV professionals conducting the Risk Assessment interviews are adequately trained, there are also no guidelines or constraints to follow and because of all these reasons there could be not enough accuracy in the results of the assessment. Furthermore, major weaknesses include the limited reliability, validity, and accountability of such tools (Litwack & Schlesinger, 1999; Quinsey et al., 1998, as cited in Nichols et al., 2013). The conclusion researchers and professionals reach, where as the unstructured Risk Assessments are concerned, is that "*there is now widespread denunciation of unstructured violence risk assessments, with leading authorities concluding that "unstructured clinical judgment by itself is no longer a useful or necessary approach to appraising violence risk*" (Heilbrun et al., 2010, p. 5, as cited in Nichols et al., 2013).

**Thinking Pill:**

There are both advantages and disadvantages in each of these three approaches, and they are used accordingly by IPV professionals.

Which one would you choose to work with? And for what reason?

One could argue that a well structured Risk Assessment report and the use of appropriate tools could provide us a more accurate view of the case and its risks

[15] For more information about unstructured Risk Assessments, you can visit: https://sites.google.com/site/forpsychadvice/clinical

(Braff & Sneddon, 2007). However, other professionals support the view that since the human factor is so unpredictable, the personal judgment is a valued component to the Risk Assessment outcome.

The main point to remember, however, is that there are certain limitations in most of the above instruments, unfortunately affecting the accuracy of the Risk Assessment results. For instance, the Danger Assessment focuses on designing the prediction of a possible homicide within an abusive relationship or an abusive marriage, whereas the ODARA scale could only be used in different sex relationships. Therefore, we have to choose accordingly!

A large number of services are involved with incidents of IPV and Domestic Violence, all around the world, and the results of a valid Risk Assessment, affect them all. Besides the Support services for women survivors of IPV, where social workers, psychologists and counsellors are occupied, there are also professionals from the health care system; the criminal justice system; the police; and the perpetrator's support services inside and outside prison settings.

All professionals who work in the field of IPV and Domestic Violence, however, agree on the importance of an accurate and valid Risk Assessment for the following three main reasons:.

- The first is to help survivors and their children remain safe and avoid any risk or danger concerning their perpetrator.
- The second is to predict the risk of recidivism in perpetrators, since that would enable us to act in the correct direction to keep all parties involved, including future relationships with other people, safe.
- Finally, the third aim is to guide properly the survivor, as well as the perpetrator back to mental, physical, and psychological recovery, through counselling, and/or psychotherapeutic interventions.

## 6.2 Risk Management Strategies for IPV

**Risk management strategies for IPV include:**

- monitoring, which involves monitoring changes in risk,
- treatment,
- supervision, which involves restricting the perpetrator's rights or freedoms in order to decrease the likelihood of further violent behaviour, and
- victim safety planning (Kropp, 2008).

Hart (2010) stated that the **prevention of future harm against an intimate partner** should be a primary goal, and that could only be achieved through implementing risk management strategies.

The second goal is **accountability**, which increases the transparency and consistency of the decisions made by the Criminal Justice System (Hart, 2010).

Many approaches have been reviewed, and many studies have been conducted over the last decades, offering a wide range of participating factors. There has clearly been an evolvement in the etiological models discussing the cause of such violence within a single group of factors, such as:

- the sociological theories of power relations and dominance of men over women,
- the psychopathological factors of the perpetrators, and

- the establishment of typologies to functional models that adopt a global comprehension of the problem, relating the factors involved and placing them at diverse phases of the aggression (Ruiz-Hernández et al., 2015).

### 6.3 Risk factors for IPV

As surveys studying the impact of Risk factors for IPV demonstrate, any form of violence between ex or current partners is viewed as an interactional behavioural pattern. This pattern is affected by specific factors, which could predict IPV prevalence in adult and adolescent relationships, as long as determine the extent to which each of these factors affect IPV. The factors affecting violent behavioural patterns of IPV are as follows:

a) contextual characteristics (e.g., age, gender, race/ethnicity),

b) developmental characteristics (e.g., family relationships, developmental psychopathology), and

c) relationship influences, such as relationship satisfaction (Capaldi et al., 2012).

These are generally known as the Risk factors, which are linked to a greater likelihood of IPV perpetration. They are contributing factors, but might not be direct causes of IPV. Not everyone who is identified "at risk" becomes involved in violence. According to the Centres for Disease Control and Prevention/ CDC (CDC, 2020), these factors include, among others:

**a. Individual Risk factors**:

| | | |
|---|---|---|
| Low self-esteem | Low income | Low academic achievement/ low verbal |

| | | |
|---|---|---|
| | | IQ |
| Young age | Heavy alcohol and drug use | Aggressive or delinquent behaviour as a youth |
| Depression and suicide attempts | History of being physically abusive | Lack of nonviolent social problem-solving skills |
| Anger and hostility | Having few friends and being isolated from other people | Antisocial personality traits and conduct problems |
| Traits associated with borderline personality disorder | Desire for power and control in relationships | Poor behavioural control/ impulsiveness |
| Emotional dependence and insecurity | Unemployment | Unplanned pregnancy |
| Hostility towards women | Attitudes accepting or justifying IPV | Being a victim of physical or psychological abuse |

**b. Relationship Factors**:

| | | |
|---|---|---|
| Marital conflict–fights | Tension and other struggles | Jealousy, possessiveness, and negative emotions within an intimate |

| | | |
|---|---|---|
| | | relationship |
| Marital instability– divorces or separations | Dominance and control of the relationship by one partner over the other | Unhealthy family relationships and interactions |
| Economic stress | Association with antisocial and aggressive peers | Parents with less than a high-school education |
| Having few friends and being isolated from other people | Witnessing IPV between parents as a child | History of experiencing poor parenting as a child |
| History of experiencing physical discipline as a child | | |

**c. Community Factors**:

| | | |
|---|---|---|
| Poverty and associated factors<br><br>(e.g. overcrowding, high unemployment rates etc) | Low social capital–<br><br>lack of institutions | Relationships and norms that shape a community's social interactions |

| | | |
|---|---|---|
| Poor neighborhood support and cohesion | Weak community sanctions against IPV (e.g. unwillingness of neighbors to intervene in situations where they witness violence) | High density of places that sell alcohol |

**d. Societal Factors**:

| | | |
|---|---|---|
| Traditional gender norms and gender inequality (e.g. the belief that women should stay at home and not work) | Cultural norms that support aggression toward others | Societal income inequality |
| Gender stereotypes according to which men should support the family and thus make the decisions | Weak health, educational, economic, and social policies/laws | |

A combination of the aforementioned individual, relational, community, and societal factors contributes to the risk of becoming a perpetrator of IPV. They interchange, intervene, and interact in multiple levels, and investigating them through Risk Assessment questionnaires could help us as IPV professionals identify, and prevent violent behaviour and recidivism for perpetrators, as well as assist survivors in remaining safe.

## 6.4 Crisis Management of IPV: Safety Planning

To do so, we need to understand exactly what Risk Management, or Crisis Management of IPV includes. Taking under consideration the different needs each individual has, a Risk Management plan is the response to the Risk Assessment report. Many things need to be taken under consideration upon the implementation of a Risk Management action, for the best possible outcome. It is a multi-agency approach, since many fields of services and authorities need to participate, in order to structure a solid safety plan and an accurate risk prediction.

According to EIGE (2019, p. 54), Risk Management is "*the process by which all relevant authorities manage the safety risks identified in a risk assessment. These activities may be directed towards victims (e.g. safety planning), towards perpetrators (e.g. using police powers to pursue, detect and disrupt offending behaviour) or towards victims and perpetrators in combination. The scope and type of activities undertaken should be informed by risk assessment, implemented within a multiagency framework and monitored for effectiveness. The aim of these activities is to try to reduce the threat posed by the perpetrator and protect the victim from further violence and abuse*."

Since, the FASA Project is aiming at professionals' capacity building, regarding women survivors of IPV with co-occurring PSU issues, we need to focus on methods used to keep them, and their children, safe from their perpetrator. Even though, most of the following statements should be part of the Risk Management plan when working with perpetrators, we would focus on the management of women's action plan to escape the danger. As part of a complete and integrated service, we need to be aware of the legislation regarding IPV policies in our country; have adequate knowledge of the human rights and be prepared of all possible dangers each case might encounter, so that the woman could be informed appropriately.

**Additionally, we should keep in mind the following statements:**

| |
|---|
| ➢ An early and appropriate intervention in IPV situations is important for a better risk prevention. |
| ➢ The professional communication skills required to achieve an empowerment approach, include active listening; non-judgmental attitude; the ability to deliver clear information, and respect clients' decisions. |
| ➢ Confidentiality, its boundaries, and survivors' consent to share information are key issues when intervening in IPV and/or PSU situations. |
| ➢ Safety and protection should be our primary concern. |
| ➢ We should also consider women's needs in all areas of their life, including their PSU issues. |
| ➢ We should be culturally competent in the communities we serve. |
| ➢ A holistic and multi-agency approach is crucial to achieve better therapeutic outcomes. |
| ➢ We should validate women's IPV and/or PSU experiences. |

We should also be aware that our notes,

containing very sensitive personal data,

could be used as *evidence in court proceedings*,

**thus avoiding pejorative statements and, as far as possible,**

**using direct quotes rather than summaries**

(E- Maria Project, 2013).

Regarding the aforementioned statements, the most popular method of Risk Management is the personalised **Safety plan**.

It is a vital component of all risk assessment and is the process of identifying and documenting (e.g. in case of keeping notes or via secure online apps) the steps required and resources available, in order to optimise safety for all survivors in a family. It is always discussed with the client, to mark her needs, her weaknesses, and the hazards that need to be avoided in all settings and surroundings, such as her house, her work, or her children's school. It could either be verbally discussed with the woman, but preferably written, as it could contain valuable information and should be kept with her at all times. Safety plans are more efficiently structured when they are categorised into thematic Sections or Steps.

Nine main thematic sections have been identified, according to the situation. We should encourage women to follow as many of the following safety precautions as possible. Filling in the gaps in each of the categories would enable women to remain focused and organised in stressed situations, avoiding thus confusion and disorientation. For instance:

**a) Safety during a violent incident:**

e.g. "*When you expect an argument with your partner, try to move to a place that is low risk such as* …… (State the place you have in mind)."

(Remember to advise the client to avoid arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door).

**b) Safety when you are preparing to leave:**

e.g. "*You can have extra clothes or money in a suitcase with* …… (state the person you would leave your suitcase with)."

**c) What to take with you when leaving**:

e.g. Money (Remember to inform the client that she is still entitled to money from jointly held savings and checking accounts), ID, Birth Certificate, Children's Birth Certificates, etc.

**d) Safety in your own residency**:

e.g. "*You should change the locks on your doors and windows as soon as possible*".

**e) Safety with an order of protection**:

e.g. "*You should keep your protection order at* …….. (Location)"

(Remember to advise the client always to keep it on, or near her, and that if she changes purse that is the first thing that she should put in the new purse).

**f) Safety in, and to, work**:

e.g. "*If you have a problem while driving home, you can …… / If you use public transit, you can ……*(state alternative/escape routes) ".

**g) Safety and drug and/or alcohol use**:

e.g. "*If you are going to use any alcohol or illegal substances, you can do so in a safe place and with people who understand the risk of violence and are committed to your safety*".

**h) Safety and emotional health:**

e.g. "*If you feel down and think about returning to a potentially abusive situation, you can always ……*"

and last but not least,

**i) Safety from technology facilitated abuse:**

e.g. "*Change all computer, mobile, login passwords*" (DIS.CO Project, 2018).

Each of these nine categories entails questions or statements related to the thematic, aiming at:

- collecting information about the specific case,

- assisting the woman focus on the most important points,

- reminding her to consider less known dangers, and

- keeping together all those notes, in times when severe stress, anxiety and maximum fear could block the survivor's mind.

Women and children who are either struggling to remain safe from their perpetrator, or are preparing to leave their house, having suffered chronic abuse and violence, are extremely traumatised. Therefore, the process of structuring a safety plan with them should include providing senses of security, empathy and confidentiality, along with honesty at all times, as the key to securing their collaboration throughout the process of crisis management. However, women still need to be aware that, in cases of perceived danger, certain personal data of them would have to be shared with other – and especially with PSU- services and authorities, always having their own interest and safety our in mind.

Most of the relevant literature and research agree on one fundamental principle, as the key factor to successful intervention and risk management of an IPV case, and that is the **multi-agency approach**[16]. Collaborating professionals from social services, judicial system, NGOs, police, local authorities and other related agencies working towards a strategic response by monitoring and controlling any further potential harmful occurrences, that could ultimately result in high risk situations, could have more chances of a positive outcome.

The network/partnership of professionals from collaborating services, such as IPV and PSU services, should be based on clear protocols which act as formal agreements of co-operation. These protocols should include the following aspects:

- Mission, vision and common objectives,
- Roles and responsibilities of each element,
- Shared definitions of IPV,
- Principles of action,

[16] For more information about Multi-agency Approach and Collaboration, please read Chapter 4.

- Mechanisms of information-sharing,
- Rules on confidentiality,
- Referrals procedures,
- Options and legal / protection procedures, and
- Support services available (E- Maria Project, 2013).

It is important to consider that different countries may have different approaches to IPV (at legal/criminal, social and health level) linked to specific cultural identities and influences. At the same time, the services providing victim support might operate differently, from one country to the other. This is the barrier that needs to be overcome, for successfully managing crisis interventions, as they could all be adapted to each national level. The policies and protocols inherent to the tool are equally important, but nevertheless, the procedure should maintain its humanitarian character, as clients are always the priority!

## Key Questions for Chapter 6

1. How could you decide upon the best course of actions that we, as IPV professionals, need to take to keep the survivor safe?
2. Name some of the main aims and benefits of Risk Assessment Evaluation
3. Name some of the types and strategies for Risk Assessment
4. Which are the main Risk Factors for IPV and what is the connection between them and the Risk Evaluation tests?
5. Each client has different needs and risks in their life. Do you agree?
6. How informed and capable do you feel of helping your client with her Safety Plan? Name some of the main aspects that should be included in it.
7. Safety planning could be filled in by the IPV professional alone: True or False?

# 7. Monitoring, Supervision and Assessment of IPV and PSU services

| What will you learn in this Chapter? |
| --- |
| ➢ **Identifying** the main aspects and benefits of monitoring IPV and PSU services.<br>➢ **Understanding** the significance of different models of supervision in IPV and PSU services.<br>➢ **Describing** various assessment methods of IPV and PSU services. |

**Key words:** Assessment, Monitoring, Protocols, Supervision

Every treatment programme that provides either IPV or PSU services, should have an established protocols and clear guidelines regarding the monitoring, supervision and assessment of its services, in order to ensure both clients and professionals' welfare.

Before proceeding with the relevant information, please take a few minutes to reflect on these topics, following the instructions of Task 1.

**Task 1: Monitoring, Supervision and Assessment of IPV and PSU services, and of services for co-occurring IPV and PSU:** Fill in the following grid by rating the importance of each variable according to your opinion and experience. Then report each variable's existence, and rate their development, as well as your level of

satisfaction, from 1 (not at all) to 5 (very much). Do the same for all three categories of services, namely IPV and PSU services and services for co-occurring IPV and PSU. Then proceed with tracing the similarities and differences between those services.

| **IPV Services** | | | |
|---|---|---|---|
| **VARIABLES** | **Monitoring** | **Supervision** | **Assessment** |
| How important do you consider this variable from 1 (not at all) to 5 (very much)? | | | |
| Does this variable exist in your country?<br><br>Yes / No | | | |
| How well developed is this variable in your country, from 1 (not at all) to 5 (very much)? | | | |
| How satisfied are you with the existence and the development of this variable in your country, from 1 (not at all) to 5 (very much)? | | | |

| **PSU Services** |
|---|

| VARIABLES | Monitoring | Supervision | Assessment |
|---|---|---|---|
| How important do you consider this variable from 1 (not at all) to 5 (very much)? | | | |
| Does this variable exist in your country?<br><br>Yes / No | | | |
| How well developed is this variable in your country, from 1 (not at all) to 5 (very much)? | | | |
| How satisfied are you with the existence and the development of this variable in your country, from 1 (not at all) to 5 (very much)? | | | |

| Services for co-occurring IPV and PSU | | | |
|---|---|---|---|
| **VARIABLES** | **Monitoring** | **Supervision** | **Assessment** |
| How important do you consider this variable from 1 (not at all) to 5 (very much)? | | | |

| | | | |
|---|---|---|---|
| Does this variable exist in your country?<br><br>Yes / No | | | |
| How well developed is this variable in your country, from 1 (not at all) to 5 (very much)? | | | |
| How satisfied are you with the existence and the development of this variable in your country, from 1 (not at all) to 5 (very much)? | | | |

### 7.1 Monitoring of IPV and PSU Services

The monitoring of programmes that are addressed to women survivors of IPV with or without PSU issues, should follow all the aforementioned principles, ethics and guidelines. These principles and guidelines are common, as well as binding, for all agencies providing mental health counselling or therapeutic services[17]. More specifically, all of us working in the field, and our corresponding services in general should be committed and strictly follow the Basic Principles and Ethics that we extensively presented in Chapter 1.

On our part as professionals, these principles include empathy, flexibility, ingenuity, confidentiality, justice, non-maleficence, self-knowledge, and self-improvement; whereas regarding working with our clients these principles include autonomy, safety, and meet of their interests, needs, and rights. Moreover, we should be aware and

[17] For more information about the Basic Counselling Principles, please read Chapter 1.

familiar with the counselling and/or therapeutic procedure, as well as with its promotion and facilitation, including assessing clients' suitability for IPV and/or PSU counselling.

At the same time, IPV and PSU services should have clear protocols that would determine all these aspects. Regarding the managing of the therapeutic relationship, we should be aware, confront, and frequently reflect on our prejudices, attitudes, beliefs, and emotions towards the boundaries and rules related to the therapeutic relationship. Similar to the principles and ethics, these boundaries and rules should also be determined by our service's philosophy, protocols, and policies. In addition, we need to be aware of our skills (e.g. communication, counselling, attention, active listening, risk assessment, crisis management skills etc.) and be committed to their constant development.

From their side, IPV and PSU services should enhance our motivation and provide us opportunities for further improvement of our skills. To that end, specialised and evidence-based trainings that would follow the advancements of the IPV and PSU field should take place on a regular basis. At the same time, such trainings should take into account, not only the advancements of the field, but also our specific needs, that constantly arise, as the phenomenon of the co-occurring IPV and PSU is not remaining the same through time.

In order to achieve a smooth monitoring, IPV and PSU services should have clear operating regulations that would underline the following four aspects:

a) **Philosophy/ ideology:** namely the philosophy and ideology of the IPV and PSU services -and consequently the philosophy and ideology of all professionals who work there. Philosophy and ideology would determine the perspectives and the approaches according to which the IPV and the PSU issues would be perceived, dealt with and treated by us in particular, and by our services in general.

b) **Approaches for people who suffer from IPV and PSU issues:** As we mentioned in Chapter 3, services should follow very clear and specific approaches

regarding their interventions towards IPV, PSU and co-occurring IPV and PSU, including screening and dealing with them. These approaches should be gender-sensitive, feminist, trauma-informed, and whole-person oriented; while efforts are required towards the direction of the implementation of comprehensive, holistic and integrated models that would simultaneously address IPV and PSU.

c) **Staff:** Services should provide us adequate knowledge, experience and training, and focus on our work-related satisfaction, since it directly affects the quality and the outcome of the provided services.

d) **Extroversion:** Services' extroversion is related to the multi-agency co-operation and to the community interactions that would enable communication, dissemination, and collaboration.

These regulations and their implementation as well, should be monitored on a regular basis, also following specific guidelines and policies, defined by each agency.

More specifically, regarding the treatment of women survivors of IPV with PSU issues in particular, the monitoring of IPV and PSU services should stipulate the adoption of a comprehensive approach and the implementation of integrated models, as we have described in Chapter 3. We, as professionals, should not only be aware and trained in these models, but also be morally and tamperamentaly in agreement with them. Furthermore, these approaches, models and interventions should be headed by specific, commonly shared values such as, among others:

- Feminism,
- Gender-sensitivity,
- Zero tolerance to violence,
- Absence of discriminations and stigmatisation, and
- Empathy, compassion, and respect.

Notwithstanding, since such kind of operation requires radical changes and keen policies, in many cases, a more realistic solution to the issue of co-occurring IPV and PSU is needed. Towards this end, a recommended good practice would be the collaboration between these two sectors and services. Subsequently, in terms of effective multi-agency co-operation, our services, and we -as professionals- should:

- create local strategic partnerships,
- develop integrated commissioning strategies,
- develop care pathways, and
- develop referral pathways (AVA, 2013; NICE, 2014).

Regarding the referrals, we should keep in mind that, just referring our clients to other services is not enough:

**We should also keep up with them!**

To this end, **follow-up is essential**,

as well as the existence of specific protocols and guidelines

that would determine this procedure.

If you are interested in learning more about the collaboration between IPV and PSU services and professionals, please read the following table:

| **What Should a Comprehensive Model of Collaboration between IPV and PSU Services Include?** (Macy & Goodbourn, 2012; Zubretsky, 2002) |
|---|
| ✓ Cross-training of professionals |
| ✓ Cross-screening of clients |
| ✓ Cross-referral of clients |
| ✓ Mutual and coordinated case management by IPV and PSU services and professionals |
| ✓ Collaborative treatment planning to coordinate services across agencies |
| ✓ Shifting from a ‘‘sobriety first’’ to a ‘‘safety first’’ philosophy |
| ✓ Emphasising the effective working relationships between IPV and PSU services and professionals |
| ✓ Acknowledging and respecting the existing differences between between IPV and PSU services and professionals |
| ✓ Consideration of community-specific resources, needs, and culture |
| ✓ Emphasising an open and honest communication between the collaborating IPV and PSU services and professionals |

| |
|---|
| ✓ Following gender-specific treatment approaches and empowerment-based interventions |

As this Training Manual is addressed mainly to professionals from the IPV field -like you- we are going to provide you some useful guidelines and tips regarding the monitoring of your agency and your work[18]:

| |
|---|
| ➢ Screening for PSU should be a routine for you and your agency. |
| ➢ Screening should be universal; if not, you would possibly not identify the majority of cases, while you may identify only the most profound and extreme crisis cases. |
| ➢ However, screening would be useful only in the case that you are willing to engage and commit to the forthcoming procedure, including referral as well; keeping though in mind that referral is not an individual and non-recurring action, but a fully-featured process. |
| ➢ Regarding referrals, they would be useful only in the case that all services involved are able to assess, educate, or treat the issuess referred to them. |
| ➢ In terms of assessment, educating and treating clients, you should be adequately trained in motivating clients for referrals, since clients who are overwhelmed or do not recognise the correlation between IPV and PSU are very likely not to follow the referral. |

[18] To learn more about the Monitoring of IPV services, please read: Bennet & Bland, 2008b.

## 7.2 Supervision in IPV and PSU Services

Supervision constitutes part of all counsellors' professional and personal Ethical code. Professionals' supervision, both at training and clinical level, should be provided by all services –including IPV services- and could be either internal or external. All of us should be committed to supervision and ask for it, when it is not available or provided by the service we are working in.

Supervision has multiple benefits in personal, professional, and organisational level, and ensures the quality of the provided services. Through supervision, we could be aware of our strengths, skills and abilities, as well as of our vulnerabilities, weaknesses, and blind spots. At a personal level, supervision fosters our self-knowledge and self-improvement; while at a professional level it fosters awareness, empathy, and thus, efficacy. At an organisational level, supervision could highlight our professional needs, the system gaps and the changes needed to be accomplished. Clinical supervision provides us training, education, support, and guidance; while at the same time a positive work environment for all staff is created.

The existing supervision models for mental health professionals and services are quite diverse, and provided that supervision is grounded on observing, assisting, and receiving feedback, plenty of models are available. Consequently, you, as professionals, and/or your agency as well, have the opportunity to choose the supervision model that fits better and responses more at your philosophy, your therapeutic approach/ model/ theory, and at your strengths and needs, as well.

Since, the underlying theory of supervision models is quite extensive and deep, we will attempt to present below the basic characteristics of each supervision model, in a comprehensive way.

According to some scientists, clinical supervision models could be divided in the following three categories:

**a)** **Psychotherapy-based Supervision models** simulate the therapy itself, often perceived as its natural extension (Falender & Shafaanske, 2004). According to Smith (2009): "*Our Theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meanings and relevance of those data*" (p. 9).

Psychotherapy-Based Supervision Models include:

- Psychodynamic Approach to Supervision,
- Feminist Model of Supervision,
- Cognitive-Behavioural Supervision, and
- Person-Centred Supervision.

**b)** The **Developmental Models of Supervision** are characterised by progressive stages of development for the supervisee, proceeding from novice to expert. Each stage consists of concrete characteristics and skills. A fundamental principle of Developmental Supervision Models is that supervisee's current stage is being accurately identified. The supervisor's role is to provide the supervisee feedback and appropriate support, depending on his/ her developmental stage. At the same time, the supervisor facilitates the supervisee to proceed to the next stage, by using interactive processes such as "scaffolding", and to produce new learning by taking advantage of the already existing knowledge and skills. Through this interaction, advanced critical thinking skills are developed for both parties.

The Developmental Models of Supervision include: a) the Integrated Development Model, and b) Ronnestad and Skovholt's Model.

**c)** **Integrative Models of Supervision** do not limit in only one theory, but rather incorporate more than one theoretical paradigm and techniques. Given that, and

provided that most counsellors practice “integrative” counselling, Integrated Models of Supervision are quite widespread. Integration in such models is achieved through technical eclecticism and theoretical integration, and the most prevalent integrative models are: a) Bernard’s Discrimination Model, and b) Systems Approach (Smith, 2009).

However, other scientists and organisations, such as Substance Abuse and Mental Health Services Administration, divide supervision models in the following categories: a) Competency - based models; b) Treatment -based models; c) Developmental approaches, and d) Integrated models (SAMHSA, 2014).

You should keep in mind, though, that, according to SAMHSA (2014), despite the model being followed, supervision should be governed by the following core principles:

| |
|---|
| ➢ Clinical supervision is an essential part of all clinical programmes |
| ➢ Clinical supervision enhances staff retention and morale |
| ➢ Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision. |
| ➢ Clinical supervision needs the full support of agency administrators |
| ➢ The supervisory relationship is the crucible in which ethical practice is developed and reinforced |
| ➢ Clinical supervision is a separate skill that has to be developed |

| |
|---|
| ➢ Clinical supervision most often requires balancing administrative and clinical supervision tasks |
| ➢ Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultur al competence |
| ➢ Supervisors have the responsibility to be gatekeepers for the profession |
| ➢ Clinical supervision should involve direct observation methods |

The collaboration between IPV and PSU services in cases of co-occurring IPV and PSU constitutes a new territory for most professionals, and thus, often leads to the arousal of personal issues that need to be addressed (Domestic Violence/Substance Abuse Interdisciplinary Task Force & United States of America, 2005). Such issues may be related to our personal or family experiences, our attitudes and beliefs about cross-problem populations; cross-problem agencies; clinical issues which emerge during assessment and intervention, or resource management.

Focusing more on IPV professionals, supervision could assist us in understanding the underlying dynamics of PSU and be more understandable, compassionate and patient with clients who are not ready to stop PSU or with those who relapse. In this line, we could also be assisted in overcoming the feeling of "obligation", that many of us have sometimes to "catch" a client who uses drugs, reveal her lies, and validate in this way, our suspictions (Illinois Department of Human Services, 2005). Last but not least, combined with corresponding training, supervision could help us to understand that, when working with survivors of IPV with PSU issues, behaviours are usually the main issue that should be addressed, and not necessarily PSU, which may act as a means of survival (Illinois Department of Human Services, 2005).

### 7.3 Assessment of IPV and PSU Services

The assessment of treatment programmes, and especially of IPV programmes and services, is of great significance, as it:

a) provides quantitative and qualitative data regarding the provided services,

b) broadens the picture and adds additional dimensions that may have been neglected,

c) leads to the implementation of more efficient and evidence-based interventions, and

d) results in the provision of high quality services to women survivors of IPV with PSU issues.

IPV services, as well as professionals like us who work in these services, should determine and enact specific criteria, indicators and methodologies, in order to evaluate, and thus improve the quality of the provided services. Such criteria and indicators should be evidence-based. They should also assess the effectiveness of the interventions, through psychometric tools, which would collect both qualitative and quantitative data, to induce coherent and accurate results. According to Samartzis and Talias (2019), these indicators could be divided into the following eight dimensions of quality assessment:

(1) Suitability of services;

(2) Accessibility of patients to services,

(3) Acceptance of services by patients,

(4) Ability of healthcare professionals to provide services,

(5) Efficiency of health professionals and providers,

(6) Continuity of service over time (ensuring therapeutic continuity),

(7) Efficiency of health professionals and services, and

(8) Safety (for patients and for health professionals).

The criteria, indicators and the methodology of the assessment, mainly depend on the population to which each IPV service is addressed (e.g. women survivors of IPV or women with co-occurring IPV and PSU), and the approach and model being followed (e.g. gender-sensitive; feminist; trauma-informed; integrated models etc.). As a result, the assessment is closely related to the therapeutic goals and the expected outcomes of the IPV service and its interventions. Regarding women survivors of IPV with PSU issues, the assessment should be very comprehensive, focused and carefully planned, in order to evaluate all possible aspects related to IPV, PSU and co-occurring IPV and PSU in our clients' lives, addressed by our interventions. This assessment should combine both practical experience and theoretical knowledge, within the context of all-embracement and coherence.

## Key Questions for Chapter 7

1. How informed do you feel regarding the monitoring of IPV services?

*And more specifically regarding:

- The importance and adoption of guiding principles?

- The importance and development of clear guidelines and protocols?

- The importance and implementation of focused on IPV and PSU Training (context, frequency, target group, way of conducting e.g. in co-operation with PSU services)?

How informed do you feel regarding the importance and the methods that should be followed for the evaluation of the operation and efficacy of an IPV service?

3. How informed do you feel regarding the benefits of supervision?

4. How informed do you feel regarding the existing models of supervision?

5. How willing are you to be supervised?

6. How confident are you with supervision?

7. How informed do you feel regarding the benefits and ways/ methods of assessment?

8. How willing are you to implement assessment?

9. How confident are you with the assessment?

# 8. What was this Training Manual for? VET competencies the FASA Training Manual is meant to help you develop.

If you have gone through this Training Manual, you would have realised that this self-administered learning tool intends to help you develop specific competencies. This last chapter reviews the knowledge and competencies you have worked on upon using the FASA Training Manual. In this chapter we attempt to:

- Summarise and reiterate the key learning outcomes of the Training Manual.
- Identify the EU Vocational Education and Training (VET) competencies linked to the learning objectives of this manual and within Horizon Europe's research and innovation frame.

As the previous chapters have outlined, you, the professionals working with survivors of IPV with PSU issues should have specific knowledge and skills to support your clients in an efficient manner. This Training Manual is a critical deliverable aimed to achieve the essential outcome of the FASA Project: **Enhancing knowledge and skills of frontline professionals in supporting survivors of IPVwith co-occurring PSU issues.**

We intend this chapter to be a place where you, as the Training Manual user, could recap the contents you have been working on and would be reminded of the core concepts of each chapter.

## 8.1 Key Learning Outcomes of FASA Training Manual

As stated in the introductory chapter, the knowledge accelerated in this tool is used to guide IPV professionals, like you, to provide support to survivors –and especially women survivors- and strengthen the efforts towards their social integration. Here is

the general list of what you, the IPV or PSU professionals, practitioners and experts, would be able to do after using the FASA Training Manual:

- Describe and analyse the causes, risk factors, structural context and consequences linked to the correlation between IPV and PSU.

- Uphold the person-oriented approach aiming at placing the clients'rights at the center of the design of interventions in order to avoid further victimisation of women with co-occurring IPVand PSU and catering for their individual needs alike.

- Describe the integrated approach in services dealing with co-occurring IPVand PSU that stems from the person-oriented approach.

- Identify the obstacles that could block or facilitate the efficiency of multi-agency and professionals' co-operation.

- Provide survivors and their children/ dependent relatives' support by ensuring efficient communication and swift referral and coordination mechanisms in collaboration with other professionals to ensure shared knowledge by IPV and PSU services alike in an integrated manner, whenever possible and convenient.

- Support women survivors in an emotionally intelligent way and direct them to the most appropriate resources available according to the individual's case in an empowering manner.

Each chapter has specific learning objectives that fall under the aforementioned overall learning outcomes. You could go through them on the grid below:

| CHAPTER 1 | COUNSELLING PRINCIPLES AND SKILLS |
|---|---|
| Main competencies of Chapter 1 | ➢ **Revising** the Basic Counselling Principles and Skills.<br>➢ The counselling process when working with IPV women with PSU issues<br>➢ **Implementing** all rules and boundaries of therapeutic relationship with the clients based on:<br>➢ Anonymity,<br>➢ Confidentiality,<br>➢ Positive rapport (making clients feel safe and protected). |

| CHAPTER 2 | CORRELATION BETWEEN IPV AND PSU |
|---|---|
| Main competencies of Chapter 2 | ➢ **Describing** of the complexity women with co-occurring IPV and PSU are confronted with, including the additional barriers they have to face.<br>➢ **Understanding** of the phenomenon of co-occurring IPV and PSU and how it affects treatment and therapeutic goals. |

| CHAPTER 3 | COMPREHENSIVE APPROACHES FOR WOMEN SURVIVORS OF IPV WITH PSU ISSUES |
|---|---|
| Main competencies of Chapter3 | **Implementing specific interventions** for women survivors of IPV with PSU issues.<br>➢ **Understanding** the need of gender-sensitive, trauma-informed, harm reduction interventions and other approaches for women survivors of IPV with PSU issues. |
| **CHAPTER 4** | **MULTI-AGENCY APPROACH AND COLLABORATION BETWEEN PROFESSIONALS AND SERVICES IN CASES OF CO-OCCURRING IPV AND PSU** |
| Main competencies of Chapter 4 | ➢ **Identifying limiting and enabling factors** to Multi-agency co-operation.<br>➢ **Planning coordination strategies** in Multi-agency and integrated settings.<br>➢ **Fostering the holistic concept of person** in the integrated practice of co-occurring PSU and IPV (as well as mental health issues). |
| **CHAPTER 5** | **DESIGNING AND IMPLEMENTING AN EFFICIENT INTERVENTION FOR WOMEN SURVIVORS OF IPV WITH PSU ISSUES** |
| Main | ➢ **Designing** an intervention based on the specificities of the clients' profiles (fragility, need of respectful |

| | |
|---|---|
| competencies of Chapter 5 | treatment, need of emotional support).<br><br>➢ **Identifying** the resources available to the clients in terms of immediate support and services to make their social reintegration possible.<br><br>➢ **Implementing** proper counselling by initial bonding with the client as a major intervention and containing the clients' emotional state.<br><br>➢ **Understanding** the Change Model of Intervention and its stages. |

| **CHAPTER 6** | **RISK ASSESSMENT AND CRISIS MANAGEMENT OF IPV** |
|---|---|
| Main competencies of Chapter 6 | ➢ **Preventing further violent incidents** and keep survivors safe by means of Risk Assessment Evaluation scales and approaches.<br><br>➢ **Recognising the distinctive characteristics of each case**, and the need to personalise the evaluation as well as the intervention method.<br><br>➢ **Identifying the risk factors** for IPV incidents.<br><br>➢ **Investigating the categories of violence-triggering factors** and their underlying mechanisms.<br><br>➢ **Structuring a personalised** Safety plan with the woman in an abusive relationship as an individual case and |

| | |
|---|---|
| | process. |
| **CHAPTER 7** | **MONITORING, SUPERVISION AND ASSESSMENT OF IPV AND PSU SERVICES** |
| Main competencies of Chapter 7 | ➢ **Identifying** the main aspects and benefits of monitoring of IPV and PSU services.<br>➢ **Understanding** the significance of different models of supervision in IPV and PSU services.<br>➢ **Describing** various assessment methods of IPV and PSU services. |

## 8.2 FASA Training Manual and VET Competencies of VET Horizon Europe 2021-2027

What you have learned in this Training Manual has a broader dimension to it. It is relevant for this list of Learning Outcomes to be viewed as VET competencies. Hereby, we provide you with a broad description on how these competencies are connected with the VET Horizon Europe 2021-2027 Strategy[19]. We want you to be aware of it in order to stress the relevance of the knowledge and competencies you have worked on through this Training Manual. This positions your learning process with FASA into the broader European context of Research and Innovation.

Considering EU's goals in the current Horizon, six clusters have been defined in the aforementioned field of Research and Innovation:

Cluster 1 – Health.

[19] https://ec.europa.eu/info/sites/default/files/research_and_innovation/strategy_on_research_and_innovation/documents/ec_rtd_orientations-he-strategic-plan_122019.pdf

Cluster 2 - Culture, Creativity and Inclusive Society.

Cluster 3 - Civil Security for Society.

Cluster 4 - Digital, Industry and Space.

Cluster 5 - Climate, Energy and Mobility Cluster.

Cluster 6 - Food, Bioeconomy, Natural Resources, Agriculture and Environment.

Our FASA Training Manual, aiming to further train professionals in attention to women survivors of IPV with co-occurring PSU issues falls within Cluster 2, as it fosters an *inclusive society*. The goal for improved support services for clients with co-occurring IPV and PSU is to integrate back into a society successfully, free from addiction and abuse.

VET Horizon Europe 2021-2027 Cluster 2 describes its goals in the following way (as a final training exercise that we may invite you to, see please, if you could identify how these goals link with our Training Manual's VET goals before we tell you below):

Culture, Creativity and Inclusive Society' aims to meet EU goals and priorities on enhancing democratic governance and citizens participation, and on the safeguarding and promotion of cultural heritage, and to respond to multifaceted social, economic, technological, and cultural transformations. Activities contribute to expanding **civic engagement**; boosting transparency, accountability, **inclusiveness** and legitimacy of governance; improving levels of trust, and tackling political extremism. Activities within the Cluster also promote better access and engagement with cultural heritage and improve its protection, enhancement and restoration. Research and innovation support sustainable growth and job creation through contributing to a European industrial policy for the cultural and creative industries. At the same time, actions help **tackle social, economic and political inequalities, support human capital development** and contribute to a comprehensive European strategy for inclusive growth. This also involves understanding and responding to the impacts of

technological advancements and economic interconnectedness with a view to **social resilience**. Finally, the cluster supports EU migration and mobility policies, both internal and external, while aiming at promoting **integration.**

As you have probably guessed, the underlined and bold text is ours and it stresses the EU priorities in Cluster 2, which apply to our FASA Training Manual Learning Outcomes:

- **Civic engagement**: bringing together the civil society and public services to prevent and combat structural violence against women at all levels.

- **Inclusiveness:** integrating the women survivors of IPV with PSU issues back into a life society successfully.

- **Tackle social, economic and political inequalities**: establishing the complexity of inequalities when working with survivors.

- **Support human capital development**: educating professionals across Europe and enhancing the peer-to-peer learning and practice exchange.

- **Social resilience**: supporting professionals to be equipped to prevent and identify the survivors at early intervention stages.

- **Integration**: building the multi-agency co-operation system to support survivors.

We would like to establish here the relevance of the FASA Training Manual within the VET Horizon Europe 2021-2027 goals. We will now proceed to outline the VET competencies that IPV professionals, like you, could acquire after using the Training Manual as a self-learning tool.

## 8.3 FASA Training Manual and VET Competencies

When transferring the learning outcomes into the competence frame, a double set of competencies was identified, namely:

- Understanding and Design Competencies, and
- Implementation Competencies.

All the Learning Outcomes that were described above fall under these two categories.

Figure 1 (please, see below) presents the summarised description of the actual competencies that you and all of our trainees would -hopefully- have improved upon completing the Training Manual's reading, tasks and exercises.

When developing the double set of categories it features ("*Understanding and Design Competencies*" on one hand, and "*Implementation competencies*" on the other one) we intended to bridge a classical divide between "theory" and "practice" that is not that relevant to our approach *per se*.

For example: "understanding" as a competence has got a dual nature to it; since "understanding" certainly involves gaining and managing objective knowledge (on environmental factors, resources, types of interventions, technical aspects of the interventions, etc.) which was classically called "theory". Nevertheless "understanding" has also a hands-on dimension to it; as it also involves empathy with our individual clients, based on emotional intelligence applied to the intervention, our shared rights, our mutual perception of individual diversity and our common human nature as the goal and basis of it all. All of this ensures a practical dimension to the interactive practice of "understanding" other human beings; our IPV and PSU clients in this case.

The FASA Training Manual aims to assist professionals, experts and services working with women survivors of IPV with PSU issues; in their ongoing VET development in order to provide better services to their clients. Our Training Manual is also supported by FASA Massive Open Online Course (MOOC). Users of the

Training Manual or the wider audience are invited to access the Massive Open Online Course and expand their knowledge on supporting women survivors of IPV with PSU issues on the FASA online platform: https://fasaproject.eu/ .

**Figure 1: Competencies obtained via the FASA Training Manual.**

## Concluding Remarks

In conclusion, the Training Manual produced within the context of the FASA Project, was developed with the aim ti provide professionals and services that are operating in the field of IPV victim support, the required knowledge, competencies and work-based skills regarding the phenomenon of co-occurring IPV and PSU.

Increasing front-line professionals' awareness and building their capacity through this Training Manual, the provision of qualitative services and effective treatment to women survivors of IPV with PSU issues is enabled. In this material you could find both general information about, for instance, the Basic Principles, Skills and Techniques of Counselling, as well as more specific information about Counselling/ Therapy, approaches and interventions explicitly targeted to clients with co-occurring IPV and PSU. More particularly, using this Training Manual, you have the opportunity to learn more about the prevalence and correlation between IPV and PSU, their interference, and the impact of the one to the other. You could also find out more about your own prejudice towards women with PSU issues, reflect and acknowledge your personal beliefs and attitudes towards this topic in general, as well as towards this specific population in particular. Furthermore, you would have the opportunity to expand and deepen your knowledge regarding the existing evidence-based approaches and interventions (e.g. non-judgement, normalising substance use, gender-sensitive and feminist, trauma-informed approaches etc.) that, according to the relevant literature and research, could induce positive outcomes when applied to clients suffering from both IPV and PSU. Comprehensive approaches and integrated models for co-occurring IPV and PSU are also included in this Training Manual, while special focus is given at the designing and implementation of effective interventions and at the Risk Assessment, Crisis Management and Safety Planning. Apart from the professionals, though, our Training Manual addressess IPV services' needs, as well, presenting the core principles and benefits, the ways of operation and coordination, the strategies and mechanisms, and the existing good practices regarding multi-agency co-operation between services, and especially between IPV and PSU services. In this

line, the FASA Training Manual also includes useful information about the monitoring, supervision and assessment of IPV and PSU services.

**We really hope that this Manual will assisst and empower your work in the field!**

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