MARISSA

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

NEEDS ASSESSMENT REPORT

The Needs and Challenges of Professionals working in the fields of Intimate Partner Violence and Problematic Substance Use

Greece,

June 2021

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

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WP2 – Needs Assessment Report

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Introduction

The high prevalence of Intimate Partner Violence (IPV) and Problematic Substance Use (PSU), as well as the overlap and the complex interplay between them, render this phenomenon (co-occurring IPV and PSU) as immensely challenging, for both IPV and PSU professionals. Due to the lack of corresponding policies and protocols regarding dealing with co-occurring IPV and PSU, professionals working in the field have multiple unmet needs that prevent them from treating survivors of IPV with PSU issues effectively.

In terms of the MARISSA project, partners from Estonia, Iceland, and Greece, conducted research to assess IPV and PSU professionals' needs, regarding co-occurring IPV and PSU. The research was divided into two parts. Firstly, the three participating countries collaborated on conducting a literature review concerning the existing data, interventions, tools, methods, material, and practices in Europe and beyond regarding multi-agency co-operation between IPV and PSU services. At the same time, each country composed a report, demonstrating the existing national context and providing specific information about their countries (e.g. policy, legislation, and services). Secondly, all partners conducted focus groups with IPV and PSU professionals, to identify their knowledge, needs, challenges, experiences, institutional practices and protocols/tools, level of existing collaboration. The results derived from the focus groups were integrated into the analytical report on professional training needs, and the educational materials developed in MARISSA Project.

The key findings of the Review, the Country Reports and the Focus groups' results regarding the needs and challenges of IPV and PSU professionals working with survivors of IPV with PSU issues are presented in this Needs Assessment Report.

1. Prevalence of Intimate Partner Violence & Problematic Substance Use

Gender-based violence derives from gender inequalities that in turn, formulate power inequalities; leading in this way to violent and harmful acts, as the manifestation of the existing abuse of power by the powerful one, namely the perpetrator. Being part of gender-based violence, Intimate Partner Violence (IPV) is defined as "*the behaviour within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by current and former spouses and partners*." (World Health Organisation/ WHO, 2021a, p. 1). Consequently, both gender-based violence and IPV are directed against an individual due to gender-related reasons (European Institute for Gender Equality/ EIGE, 2021). Gender-based violence, and especially IPV, constitute one of the most notable violations of human rights within all societies; disproportionally affecting women and girls, rooted on gender and power inequalities between women and men (EIGE, 2021; WHO, 2021b). According to EIGE, in the European Union, nine out of ten victims of IPV are women (EIGE, 2012). Due to its high prevalence and adverse consequences, IPV is perceived as a significant public health problem and an urgent public health priority (Garcia-Moreno & Watts, 2011; WHO, 2021b).

Problematic Substance Use (PSU) is also perceived as one of the major health and social issues. In Europe, 29% of adults aged 15-64 (namely around 96 million) are estimated to have used illicit drugs at least once during their lifespan (European Monitoring Centre for Drugs and Drug Addiction/ EMCDDA, 2020). According to the National Institute of Drug Abuse (NIDA), which adopts the Brain Disease Model of Addiction, addiction could be defined as a chronic, relapsing brain disorder (NIDA, 2021; 2020). The functional, long-lasting changes caused by addiction to brain circuits involved in reward, stress, and self-control lead to compulsive use or difficulties to control drug-seeking behaviours, despite the adverse consequences.

However, it is worth mentioning that the Brain Disease Model of Addiction has been challenged and rejected by many –if not by the majority of scientists working in the field-, based both on strictly scientific perspectives, and on the consideration that this model leads in avoiding and reducing harm deriving from addiction (Heather et al., 2018)[1]. In this line, some scientists claim that addiction and its types are not usefully thought –and as a result, not efficiently addresses-, when perceived as a brain disease; some claim that addiction could not be defined as just a brain disease in the absence of other kinds of determinants, such as psycho-social factors, while others claim that addiction is not best seen as brain disease of any kind or in any way (Heather et al., 2018). In any case, according to Hall et al. (2014, 2015), the domination of the Brain Disease Model of Addiction upon the public discourse and the policies regarding addiction has also resulted in limiting the alternative approaches to addiction, especially psycho-social approaches, which, at the same time, seem to be not only cheaper, but also more effective in reducing harm deriving from addiction (Hall et al. 2014, 2015).

According to the relevant literature and research, IPV is strongly related to PSU (Afifi et al., 2012; Cafferky et al., 2016; Flanagan et al., 2020; Kraanen et al., 2014). More specifically, it has been suggested that IPV experiences may lead to physical and mental health problems, including PSU (Afifi et al. 2010; Crane et al., 2014); while PSU may increase the likelihood of IPV victimisation, acting as an important risk factor (Afifi et al., 2012; Kraanen et al., 2014). The Adverse Childhood Experiences (ACE) Study studied the impact that childhood adverse experiences, such as experiencing psychological, physical, or sexual abuse; violence against mother; living with household members who were substance abusers; who were mentally ill or suicidal; or who were imprisoned, have on individuals (Felitti et al., 1998). According to this study, more than half of the 9.508 participants reported exposure to at least one category of these adverse experiences during childhood; one-fourth reported exposure to two or more

[1] At this point we should mention that the MARISSA project is focusing on the psycho-social determinants of health (SDH), rather than the biological models. However, in terms of a comprehensive presentation of addiction/ PSU, all the existing evidence-based models are presented.

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categories; while 15% of the women and 9.2% of the men reported exposure to four or more categories. A graded relationship between the number of categories of childhood exposure and adult health risk behaviours and diseases, including addiction, was also revealed. More specifically, individuals who had experienced four or more categories of childhood exposure had four- to twelve-fold increased health risks for being addicted to alcohol and drugs; two- to four-fold increase in smoking and poor self-rated health, while 50 or more had sexual intercourse partners, and sexually transmitted diseases. Consistently, a strong interrelation was found between these adverse childhood experiences, whereas the experiences of multiple categories of childhood exposure seemed to be linked to multiple health risk factors later in life. More specifically, as the number of childhood exposures increased, so did the prevalence and risk of alcoholism, illicit drugs use, injection of illicit drugs, intercourse partners, and history of a sexually transmitted diseases. Similarly to Felitti et al.'s study (1998), a more recent study, revealed that women had higher percentages of exposure to two or more ACEs (65%), in comparison to men (55%), while men were more likely to have more than four ACEs (33%), in comparison to women (25%) (Almuneef et al., 2017). In a similar vein, following a dose-response pattern, high exposure to ACEs in childhood seems to be related to "health-risk behaviors" (including drug use, alcoholism, violence, and crime), even in adolescence (Dube, et al., 2003); underlying in this way the role of gender in the relationship between adverse childhood experiences and PSU (Almuneef et al., 2017; Dube, et al., 2003).

Finally yet importantly, highlighting the vicious circle of violence/ abuse, and especially childhood violence/ abuse, and PSU, Felitti et al.'s study (1998) revealed that the most prevalent category of childhood exposure was the substance abuse in the household (25.6%). In turn, experiences of violence/ abuse during childhood, not only lead not to an increased risk and prevalence of PSU, but also to IPV victimisation, especially for women (Reddy et al., 2020). Provided all the aforementioned facts, and expanding the corresponding theory, the relationship between violence/ abuse and PSU should not be perceived as a

direct causal relationship, but rather a multi-factorial phenomenon, mediated by multiple factors, including personality traits as well (Afifi et al., 2012; Kraanen et al., 2014).

1.1 Prevalence of Intimate Partner Violence

According to WHO, in 2016, the global proportion of women victims of IPV, physically and/or sexually abused by their partner during their lifespan, was estimated to be 30% (WHO, 2016). Similarly, in the European Member States, according to EIGE's survey conducted in 2012, the prevalence of women victims – survivors of physical IPV was ranging between 12 and 35% (EIGE, 2012). Regarding the adverse consequences resulting from IPV violent and traumatic experiences, women survivors may suffer from direct and/or indirect physical (e.g. injuries) as well as mental health issues (e.g. chronic health problems deriving from prolonged stress). Indicatively, according to the American Psychiatric Association (APA, 2021) and WHO (2021a), the most prevalent mental health issues, which are related to the stress and trauma that derive from IPV experiences, are the following:

- depressive and/or anxiety symptoms and disorders;
- Post Traumatic Stress Disorder (PTSD);
- self-harm practices and behaviours;
- suicidal ideation and attempts;
- poor psychological adjustment, emotional functioning and self-esteem;
- physical inactivity;
- compulsive and obsessive behaviours;
- unsafe sexual behaviours;
- eating and sleep disorders and
- Problematic Substance Use (PSU), including Substance Addiction Disorder.

The most prevalent physical health issues that result from IPV experiences are transmissible diseases such as HIV and sexually transmitted infections, sexual

and reproductive health problems, pregnancy problems and/or termination, unplanned pregnancy, and adolescent pregnancy (WHO, 2021a). At the social level, IPV experiences pose additional difficulties and challenges to women survivors, such as stigmatisation as well as lack of trust and challenges in creating or maintaining relationships, since violent and traumatic experiences affect the emotional regulation, the facial interpretation, and the reading of social cues (APA, 2021). Nevertheless, the most adverse and irreversible consequence of IPV is women's homicides. According to a study conducted in 2011 by the United Nations Office on Drugs and Crime (UNODC), each day, in Europe, 18 women become victims of homicide on average; whereas 12 of them are murdered by intimate partners or other family members (UNODC, 2011). Recent data from 16 EU Member States indicate that in 2017, 854 women were victims of homicide by intimate partners or other family members (Eurostat, 2017).

Regarding the prevalence of IPV in the three participating MARISSA project countries, according to the European Union Agency for Fundamental Rights (FRA), the proportion of women aged 18–74 years, who have experienced physical and/or sexual IPV at least once in their lifetime is 20% in Estonia; 22% in Iceland and 19% in Greece (FRA, 2014). Significantly lower, is the proportion of physical and/or sexual IPV in the last 12 months, namely 2% in Estonia, 2% in Iceland and 6% in Greece.

According to the Estonian country report, slightly more than one in ten crimes is a domestic violence crime. In 2019, 4119 domestic violence cases were registered and five people died due to domestic violence. In those 4119 cases, 85% of the perpetrators were men, and 81% of victims were women, and the most prevalent types of domestic violence were physical abuse (86 %) and threat (11 %) (Kuritegevus Eestis, 2019).

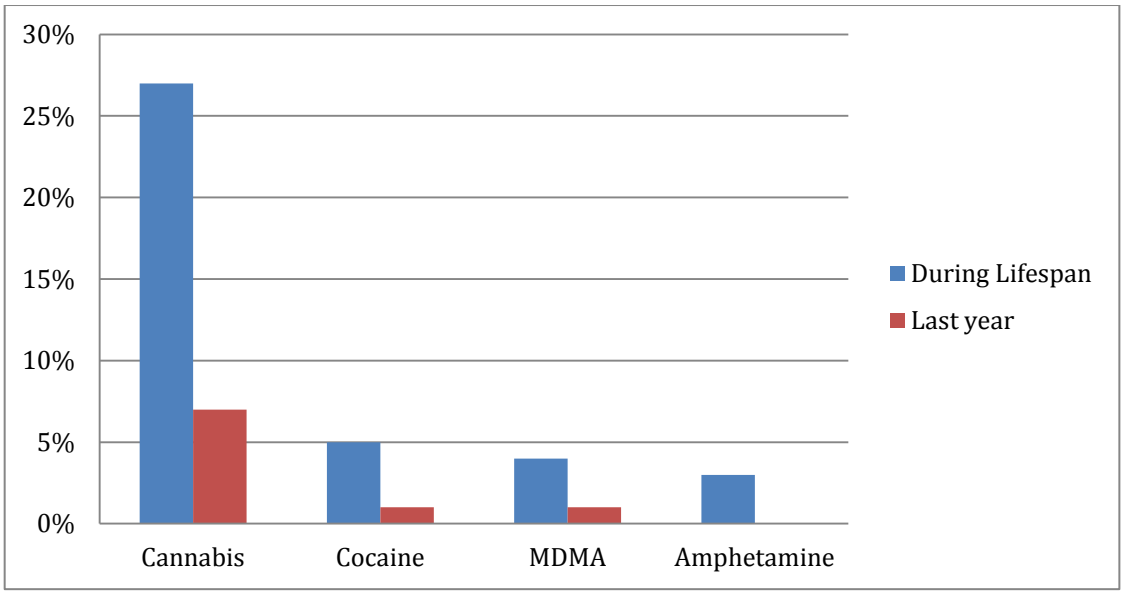
In Iceland, the latest research that was conducted on IPV prevalence dated back to 2010, using data collected in 2008 (Karlsdóttir & Arnalds, 2010). According to this research, 22% of women had experienced IPV during their lifespan; while 1-

2% of women had experienced physical IPV in the last 12 months (Karlsdóttir & Arnalds, 2010).

In Greece, according to the Hellenic General Secretariat of Family Policy and Gender Equality (GSFPGE), 76% of the 3.147 calls at the National Support Telephone Line SOS (15900), for the year 2019, were related to IPV incidents (GSFPGE, 2020a). In 56% of those IPV cases, the perpetrator was the current husband, followed by the current partner (11%), the ex-husband (5%), and the ex-partner (5%). 16% of the perpetrators were dealing with PSU issues; whereas 61% were addicted to alcohol, 36% to drugs, 8% to gambling, and 2% to the Internet. Similarly, in the same year, 79% out of the 348 new cases addressed by the Union of Women Associations of Heraklion Prefecture were IPV cases.

1.2 Prevalence of Problematic Substance Use

According to the 2019 Drug Report of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), it is estimated that in Europe, 27.4% of adults aged 15-64 years, have used cannabis during their lifespan; 5.4% have used cocaine; 4.1% have used MDMA, and 3.7% have used amphetamines (EMCDDA, 2019a). In the last year, it is estimated that, among adults aged 15-64 years, 7.4% have used cannabis; 1.2% have used cocaine; 0.8% have used MDMA and 0.5% have used amphetamines (EMCDDA, 2019a).



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Graph 1: Drug Use of adults aged 15-74 years in Europe (EMCDDA, 2019a)

At the same time, high-risk opioids users in Europe were approximately 1.3 million; 85% of fatal overdoses were related to opioids use. In 35% of PSU treatment requests the main substance used were opioids (EMCDDA, 2019a). Regarding PSU treatment clients, approximately 10% of them are females, with this proportion varying according to the type of primary drug used and the PSU programme attended (EMCDDA, 2017a).

In Estonia, according to the Drug Report of EMCDDA for the year 2017 (EMCDDA, 2017b), the most prevalent drugs for young adults aged 15-34 years, were cannabis in the proportion of 13.46%; followed by amphetamines (2.5%); MDMA (2.3%) and cocaine (1.3%). In the vast majority of treatment entrants, namely 93%, the primarily used drug was heroin, followed by cannabis (4%). The available data for high-risk users indicate that most people who inject drugs primarily use opioids, with fentanyl becoming the primary injected opioids substance over the recent years. At the same time, 88 overdose deaths were related to opioids, while 55 HIV diagnoses were attributed to injecting (EMCDDA, 2017b). In 2017, the drug-induced mortality rate among adults aged 15-64 years was 130 deaths per million, considerably higher than the European average of 22 deaths per million, indicating that Estonia has the highest rate of overdose deaths in the European Union (Terviseriskide Programme, 2020).

Although PSU data from EMCDDA are not available in Iceland, a report from 2013 revealed that 23% of adults had tried cannabis at some point in their lifetime. Still, 8% of them had used cannabis ten times or more, and only 2.5% of them had used cannabis in the last six months (Gunnlaugsson, 2013). Cannabis use was more common amongst men, than women; whereas there is only a small group with severe and excessive use of drugs. In a survey from the Directorate of Health, conducted in 2018, 62% of Icelanders claimed they had never tried illegal substances and 36% of those who had, had tried cannabis, 14% amphetamine, 12% cocaine, 6% MDMA and 2% LSD. Similar to Gunnlaugsson's report, men were more likely to use illegal substances compared with women. An interesting outcome of this survey was that regarding prescription drugs,

apparent gender differences were identified. More specifically, women were much more likely to use tranquilizers and painkillers. At the same time, men were more likely to use drugs used for ADHD, such as Ritalin and Concerta (Icelandic Directorate of Health, 2019). According to the RIKK and the Root's (Rótin) research conducted with 110 women, members of the Root who had attended PSU treatment of any kind, 76.4% of them were using alcohol; 24.5% cannabis; 22.7% amphetamine; 20% sedatives; 10.9% cocaine; 10% sleeping medication, and 5.5% opiates.

There is no available data regarding drug use and prevalence of specific substances in Greece. According to EMCDDA Drug Report (EMCDDA, 2017a), it is estimated that in 2017, there were 16.701 high-risk opioids users, while 94 overdose deaths were related to opioids and 70 HIV diagnoses were attributed to injecting (EMCDDA, 2017a). Like Estonia, although in lower proportion, in the vast majority of treatment entrants (64%), the primarily used drug was heroin, followed by cannabis (19%). In contrast with Estonia, in Greece, there were treatment entrants for other substances, such as cocaine (7%), amphetamines (1%) and other, non-specified drugs (9%) (EMCDDA, 2017a). According to the National Centre for Documentation and Information on Drugs, in 2018, at least 3698 people with PSU issues were admitted by the specialised and recognised by law treatment programmes in Greece[2] (National Centre for Documentation and Information on Drugs, 2020). In recent years, people entering treatment for the first time due to heroin use have halved, while treatment demands for cannabis use have increased (EMCDDA, 2017a). At the same time, the number of people who seek treatment for cocaine or other stimulants has also increased (National Centre for Documentation and Information on Drugs, 2020).

[2] This number refers to new intakes but not necessarily to the person's first intake to the therapeutic programme.

1.3 Prevalence of co-occurring Intimate Partner Violence & Problematic Substance Use

Depending on the definition being used and the population studied, the co-occurrence of IPV and PSU varies, ranging between 25% and 80%, (Friend, et al., 2011; Langenderfer, 2013). According to Weaver et al.'s study, amongst women IPV survivors, PSU ranges between 7% and 25% (Weaver et al., 2015), while Nathanson et al.'s study showed higher prevalence, namely 34.5% (Nathanson et al., 2012). In the PSU female population under treatment, psychological aggression seems to be the most prevalent form of IPV (96.7%), followed by physical assault (53.7%) and sexual coercion (49.2%) (Schumm et al., 2018).
Regarding the co-occurrence of IPV and PSU, and similarly to the prevalence of IPV and PSU in isolation, one significant similarity was the absence of official and disaggregated data, especially in Greece and Estonia. The only slight exception was Iceland, where two surveys had been conducted in two PSU services. According to research conducted in 2019 to 200 men and women PSU clients of the biggest rehabilitation centres, 99% had experienced severe trauma some time in their lifetime; 81% had experienced physical violence and 55% sexual violence (Sigurðardóttir, 2019). Another study to the same rehabilitation centre (N= 67) revealed that 59% of men and 75% of women had PTSD (Garðarsdóttir, 2018).

1.4 Prevalence of co-occurring Intimate Partner Violence & Problematic Substance Use according to Focus Groups' Results

Regarding the absence of official data, professionals participating in the focus groups were not adequately informed regarding IPV and PSU co-occurrence prevalence. According to their experience, professionals from Estonia claimed that although cases of women survivors of IPV with PSU issues are rare, more could be suspected. As professionals highlighted, such cases are invisible for people working in shelters, due to the existing network around victim

protection, and in particular, because the police are not referring such clients to shelters.

Like Estonia, professionals from Greece working in an IPV shelter and IPV counselling centre stated that they had admitted only a small number of IPV and PSU co-occurrence cases in the last eight years of their operation. On the contrary, professionals working in PSU services mentioned that most of the women admitted to their centres had been abused. The most prevalent form of violence was physical violence, followed by sexual and psychological violence. Master's (active and graduate) students participating in the focus groups, believe that gender-based violence –including IPV- results from patriarchal and power-relations within the community. This trend intrudes into the world of PSU. As a result, and due to the main characteristics of PSU, IPV in this population is expected to be higher than in the general population. According to their experience though, the percentage of co-occurring IPV and PSU is even higher in PSU services specialised in women and/or mothers, or parents in general. More specifically, they claimed that it is not unusual for couples to enter PSU therapy together or become couples during PSU therapy. In such cases, women are often coerced into prostitution in order to gain money for their dose, thus experiencing high rates of mainly sexual and economic IPV. In addition, especially in alcohol therapy (and specifically in alcohol group therapy), couples usually attend meetings together, although many face IPV issues (mainly physical and psychological IPV). Among migrant and refugee population -according to participants' experience and opinion- in most of the cases of physical and sexual IPV, the perpetrator (and not the victim) had had PSU issues, as a matter of their culture, according to which, IPV and maybe PSU as well, are being accepted.

According to the MARISSA project's research, data regarding IPV and PSU populations in all three participating countries seems to be fragmented. One significant similarity identified was the challenges regarding data collection and dissemination, as –when available- they stem from different ministries and agencies/services. More specifically, in Estonia, data regarding IPV mainly come

from law enforcement agencies. In contrast, data regarding PSU mainly come from the National Institute for Health Development (NIHD), which is responsible for the development and organisation of PSU prevention, treatment, rehabilitation, harm reduction, and counselling services[3]. In Iceland, data regarding IPV mainly stem from services that work with survivors of IPV (e.g. shelters, police and hospitals), the Ministry of Justice, and surveys conducted by individual researchers/private researchers. At the same time, data regarding PSU mainly come from the Directorate of Health and individual researchers/private researchers. In Greece, data regarding IPV largely stem from IPV services, such as GSFPGE, which operates under the instruction of the Ministry of Labour and Social Affairs (GSFPGE, 2020). Data regarding PSU mainly comes from the National Centre for Documentation and Information on Drugs (2020). Finally, yet importantly, a finding related to gender discrimination that aroused from country reports was that, in many cases such as in Greece, data regarding mental health co-morbidity, including PSU, are being collected only for perpetrators of IPV, neglecting in this way survivors, and thus, their challenges and needs.

Another challenge regarding data collection is that, in most societies, IPV constitutes a "hidden problem", which is significantly under-reported. According to the MARISSA project's research, this under-reporting is probably related to the understanding of violence and the Articles of the Penal Code, even among professionals who work with survivors of IPV with or without PSU issues. Hence, as it is hard to have successful court outcomes, gender-based violent crimes, and especially psychological IPV, are under-reported. Regarding PSU, the main issue that prevents its estimation, is the use of legal substances such as alcohol and prescription drugs (e.g. tranquilizers and painkillers). Moreover, in all three participating countries, the vast majority of data regarding PSU are referring to

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

people seeking rehabilitation services. As a result, they cannot be used to indicate the prevalence of PSU and the co-occurrence of IPV and PSU in the general population.

Apart from the obstacles in systematic data collection regarding IPV and PSU mentioned above, the co-occurrent IPV and PSU estimation faces similar barriers, common in all three participating countries. One major similarity identified, especially in Estonia and Greece, was the –almost total- absence of official and disaggregated data regarding survivors of IPV with PSU issues. However, even in the few cases that these data are available, such as in Iceland, their fragmentary nature prevents the provision of an accurate picture of the problem's totality.

Based on the facts and gaps presented above, and according to focus groups' results, official and systematic data collection regarding IPV, PSU and the co-occurrence between them, constitutes a basic need for professionals working with survivors of IPV with PSU issues. According to both IPV and PSU professionals who participated in the focus groups, data collection should be focused not only on the prevalence of IPV and PSU co-occurrence in IPV, PSU, and the general population, but also on the particular characteristics of women survivors of IPV with PSU issues, their challenges, needs and strengths as well.

2. Legislation about Intimate Partner Violence & Problematic Substance Use

In all three participating countries in the MARISSA project, specific legislation regarding IPV and PSU does exist. Overall, Estonian, Icelandic and Greek legislation regarding gender-based violence, including IPV, follows the European standards in the field; ensuring the protection of victims' safety, interests, and needs. On the other hand, legislation regarding PSU mainly focuses on the criminalisation and punishment of drug dealing and possession; offering in some cases mandatory PSU treatment as an alternative which could replace penalty.

2.1 Legislation about survivors of Intimate Partner Violence

Estonian, Icelandic, and Greek legislation regarding gender-violence -and by extension IPV- includes the signing, ratification and incorporation of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention).

In Estonia, several pieces of legislation have been enacted to protect and support survivors of violence, including women victims of IPV. In 2017, the Istanbul Convention was ratified, and in 2018, it was entered into force. The Victim Support Act stipulates multiple ways for helping the injured party to cope better with his or her situation and how to get support. Additional laws and corresponding Acts include and constrain protection of private life or other victim's personality rights, financial aid, home support, and provision of emergency social assistance. In 2019, temporary restraining orders were requested in the criminal proceedings regarding the protection of the victim. Another critical measure is the home support for families with many children. In severe cases, and in addition to counselling, victims of crime have the right, based on the law, to claim for compensation for the cost of psychological care.

In 2011, Iceland signed the Istanbul convention and ratified it seven years later. In 2016, additions were made to the Icelandic penal code focusing specifically on IPV. The legislation on IPV is under the chapter on manslaughter and bodily injury to emphasise its severity. The legislation includes physical violence, psychological, social, and/or financial violence. Additionally, the criminalisation of forced marriage was also put into Icelandic law. Currently there is work ongoing to have a specific law on stalking. The maximum prison sentence for minor offenses is six years, and for major crimes 16 years. However, in reality, sentences are never near to being this long, even though the law allows it. There is also a tendency for a large part or the whole sentence to be on parole.

In Greece, Law 3500/2006, entitled "*Tackling domestic violence and other provisions*" was the first systematic attempt to deal with domestic violence (Law 3500/2006, 2006). Until 2006, crimes of violence within families were not

explicitly criminalised. The law establishes that any violent activity occurring within family boundaries (including sexual abuse of the spouse), is criminal in nature, and should be treated as an inherent offense. Harmonising with Directive 2012/29/EU, Law 4478/2017 establishes the minimum standards on rights, support, and protection of victims of crime, strengthening in this way their rights (Law 4478/2017, 2017). In 2018, Greece ratified and incorporated into the Greek legal order the Istanbul Convention, through Law 4619 /2019 (Law 4619/2019, 2020). Regarding gender-based violence, in 2019, Law 4604/2019 entitled "*Enhancement of Substantive Gender Equality, Prevention, and Combating of Gender Based Violence*", implemented a comprehensive legal framework for gender equality that enhances the equal treatment of women in all aspects of their lives. However, there are not specific pieces of legislation targeting IPV, as intimate partner crimes are considered under the umbrella of domestic violence.

2.2 Legislation about people with Problematic Substance Use issues

According to their national legislation, psychotropic substances, except for alcohol and tobacco, are illegal in all three participating countries, and the possession of them is prosecuted. An exception is being made for personal use and/or possession of a small amount of illicit substances.

There are several important legal texts regarding PSU in Estonia, stipulating issues such as Mental Health; Alcohol; Narcotic and Psychotropic Substances and Precursors; Medicinal Products; Health Care Services Organisation; Health Insurance and Social Welfare. The Act on Narcotic Drugs and Psychotropic Substances and Precursors regulates the field of narcotics and psychotropic substances. Personalised drug treatment cases shall be entered in the drug treatment register, a database which is maintained to analyse the occurrence of drug addiction; prevent it; evaluate the diagnostics and the efficiency of treatment; organise health services; develop health policy and organise statistics and scientific research, including epidemiological research. Article 9.1(1) of the Mental Health Act prohibits substances in in-patient psychiatric treatment, providing clients are prohibited to posse alcoholic beverages and psychotropic

substances within in-patient psychiatric facilities. Article 10(1) stipulates that all persons in the territory of Estonia be provided with emergency psychiatric care. Individuals with mental disorders receive emergency psychiatric care on a voluntary basis, while involuntary psychiatric treatment shall be applied only based on a court ruling. Psychiatric care is financed pursuant to the procedure established in the Health Care Services Organisation Act, the Health Insurance Act, the Social Welfare Act, and the Mental Health Act. The expenses of the provision of emergency psychiatric care to individuals, who are not covered by health insurance, include addiction treatment of nine months; psychiatric treatment of people admitted to a psychiatric hospital by court order is covered by the state budget.

In Iceland, substances other than alcohol and tobacco are illegal according to the law and their possession has a maximum sentence of six years of imprisonment. In 2020, a bill legalising possession of doses of drugs for personal use has been presented to the parliament, stipulating no punishment for individuals possessing small amounts of illegal substances that could be attributed to personal use (but the substances are still illegal and will be confiscated by the police). As a result, people possessing an amount of substances that are considered small enough to be for personal use, have rather been fined than sentenced. At the same time, another change to the Icelandic law, legalised the consumption rooms; allowing in this way the local councils to establish protected environments where individuals, over the age of 18, could safely inject themselves under supervision, while cleanliness and sterility of needles would be ensured. Treatment for individuals dealing with PSU, falls under the medical insurance law and gives the right to anyone who has medical insurance (everyone that has lived in Iceland for six months or longer) to receive treatment at centres/institutes that have a contract with the Icelandic Health insurance.

In Greece, according to Law 4139/2013 (Article 20) the dealing of illicit drugs[4] by individuals with no legal permission is punished by imprisonment of at least eight years and a fine of up to 300.000 Euros (Law 4139/2013, 2013). Drug-depended offenders have the right to participate in a PSU specialised treatment unit operating inside prison settings. Alternatively –as is often the cases-, the penalty for a drug-related committed crime could be replaced by mandatory attendance at a community PSU treatment programme operated by a lawfully recognised addiction agency (EMCDDA, 2019b). Drug-dependent offenders also have the right to conditional release regarding crimes related to drug dealing, under the provision that the offender is either certifiably attending or has successfully completed drug treatment or has served a minimum of one-fifth of the sentence (Pompidou Group, Council of Europe, 2020). In the last three years, Ministerial Decisions have been issued, solving two chronic problems: the legalisation of medicinal use of cannabis and the institutionalisation of Supervised Drug Use Areas (consumption spaces for supervised opioids use) (National Centre for Documentation and Information on Drugs, 2020).

According to the Estonian, Icelandic, and Greek country reports, legislation regarding gender-based violence are quite targeted, comprehensive, and adequate. However, of all participating countries, only the Icelandic penal code allocates specific legislation about IPV. Hence, there is a need for additional laws, provisions, and regulations, specifically focusing on IPV, addressing both its tackling and prevention. Such national pieces of legislation should conform to new trends regarding gender-based violence and IPV, demonstrating fast reflexes and harking society's pulse. For instance, new forms of violence (e.g. stalking, cyber-violence etc.) and other relevant issues should be incorporated in legislation, flexibly and instantaneously, such as in the Icelandic paradigm. Furthermore, apart from stipulating specific laws and regulations, national

[4] Namely the import, export, transit, sale, purchase, possession, offer, disposal, distribution, shipping/ delivery, save, deposit, prepare, transport, counterfeiting and selling counterfeit substances, administration of substances to replace addiction, address of a store where the perpetrator is systematically trafficked, financing, organisation or management of trafficking activities, counterfeiting of medical prescriptions, sending and receiving parcels and mediation in any of these operations.

legislation also needs to stipulate ways of sufficiently implementing and assessing the implementation of those laws. Thereby, it would be ensured that victims' rights, and their interests and needs are being respected and protected by all parties, including the Criminal Justice System, preventing in this way survivors' secondary victimisation.

The existing PSU legislation in Estonia, Iceland, and Greece, despite a couple of amendments providing the option to choose PSU treatment instead of punishment, had been punitive, rather than intervention and service-oriented, for a long time. At present, there is a shift in the Icelandic and Greek legislation, starting to be supportive and focusing more on the health and corresponding needs and challenges of people with PSU issues, rather than their criminalisation. For instance, in the context of harm reduction, the Icelandic and Greek laws make provision of "consumption spaces" (Supervised Drug Use Areas). However, as these efforts are at the beginning, and a lot needs to be accomplished in the future towards this direction, national legislations should continue evolving, through conforming scientific evidence-based data regarding the treatment of people with PSU issues.

3. Policies about Intimate Partner Violence & Problematic Substance Use

In Estonia, Iceland, and Greece, specific policies regarding IPV and violence, in general, do exist. These policies encompass violence tackling, victim support, and preventive interventions and services, through the implementation of action plans by governments and other relevant entities and organisations.

At the same time, specific policies regarding PSU also exist in all three countries participating in the MARISSA Project, aiming at both the prevention and treatment of PSU. These policies are targeted and mainly abstinence-based, focusing on the reduction of supply. They concern with illegal psychotropic substances such as drugs, and legal psychotropic substances, such as alcohol and

tobacco. Policies regarding the treatment of PSU include rehabilitation, social reintegration, and harm reduction, paying particular attention to vulnerable groups, such as women, prisoners, refugees etc. However, during the MARISSA project's research, differences have been identified in the quantity and quality of these policies and corresponding services, among these three countries.

3.1 Policies about survivors of Intimate Partner Violence

In Estonia, violence prevention and assisting victims in leaving violent relationships is essential. The coordinating body for the Istanbul Convention is the Ministry of Justice. The Ministry of Justice coordinates violence prevention in co-operation with the Ministry of Social Affairs, including an Action Plan for 2019-2023 and violence prevention programmes (Memorandum Valitsuskabineti Nõupidamisele, 2019). In addition, a National Action Plan, specifically targeted to the prevention of IPV, does exist. Victim support and prevention services developed and implemented by the Department of the Victim Support and Prevention Services of the Social Insurance Board coordinate women's support services and work.

In 2006, the Icelandic government endorsed an Action Plan against domestic and sexual violence. The part of gender-based violence focuses a lot on public education and advancing knowledge of professionals who work in the sector of IPV survivor support. It also includes and fosters strengthening intervention opportunities for perpetrators. In addition, Reykjavík City Council has an Action Plan against violence, which focuses mainly on domestic violence. It includes actions and support for survivors, perpetrators, and children living in homes where domestic violence occurs. Regarding policies targeted to IPV, the National Health Service has official instructions for health care workers on first response to IPV, aiming at guiding nurses and midwives on the identification and support provision to IPV survivors.

Over the last years, the Greek government has prioritised actions to prevent and combat IPV, domestic violence (sexual violence and marital rape included),

sexual harassment and violence against women and girls. GSFPGE operates under the Ministry of Labour and Social Affairs, is part of the National Mechanism for Gender Equality, and holds the responsibility for the planning, implementation and monitoring of policies regarding gender equality (GSFPGE, 2020b). Since 2010, GSFPGE is implementing the first comprehensive and coherent national Action Plan against gender-based violence in Greece, entitled "*National Programme on Preventing and Combating Violence against Women*" (GSFPGE, 2020c). In terms of this action plan, a network of 63 structures was established, addressing women victims of gender-based violence. This network also includes 42 Counselling Centres and 20 shelters scattered all over Greece, a bilingual SOS telephone helpline (15900) and e-mail communication. Through this network, women victims of gender-based violence have access to psychosocial support, legal counselling and aid, counselling on labour issues and emergency shelters. Networking with local agencies and relevant associations for mutual communication and public awareness programmes is also implemented.

3.2 Policies about people with Problematic Substance Use issues

In Estonia there are several policies regarding PSU, such as the National Plan for Combating Alcoholism and Drug Addiction; the Drug Prevention Strategy; Estonia's Drug Prevention Policy: White Paper; the National Health Plan; a draft Health Population Plan for 2020-2030; Green Papers on Alcohol and Tobacco Policy and the Action Plan for the implementation of "*Estonia 2020*" for 2018–2020. The leading organisations carrying out prevention activities fall under the Ministry of Social Affairs, Interior, and Education and Research control. The Minister of Social Affairs holds overall responsibility for the National Health Plan 2009-20. The Interior Minister is responsible for drugs issues within the plan and its action plans. The Minister of the Interior chairs the committee, which has members from all relevant ministries. In addition, a group of experts and representatives from relevant ministries, agencies, and service providers in the PSU field meet regularly with the Minister of Interior and play an important role

in implementing PSU policy. The Minister of Social Affairs informs the government on the progress made in implementing the national drugs strategy. The National Health Plan 2020-2030 defines the main objectives in the area of PSU treatment. In 2018, a new pilot programme, entitled "*SÜTIK*" was initiated by the National Institute for Health Development (TAI) and the Police and Border Guard Board (PPA). The programme gives police officers the option to refer arrested addicts for the abuse or possession of small amounts of illegal drugs to the support programme SÜTIK. Estonian PSU policies provide a particular emphasis on the rehabilitation of people with PSU issues, and more specifically social and work rehabilitation. Work rehabilitation services operate under the Estonian Unemployment Insurance Fund, where people, including those with PSU issues, get prepared for working life and are offered support regarding starting or maintaining employment; peer support is also provided. Work rehabilitation activities occur individually or in a group, depending on the needs of people with PSU issues. A case manager from the Unemployment Insurance Fund assesses the service needs. However, according to the White Paper on Drugs for the year 2014, the systems for prevention, treatment, rehabilitation, social reintegration, and harm reduction of drug abuse were underdeveloped, as although there were separate services, many vital services were either lacking altogether or were of less than satisfactory quality or coverage (Ministry of Interior, 2014a; 2014b).

Similarly, in Iceland, multiple policies regarding PSU have been implemented. Iceland's Alcohol and drug policy *"Drug and Alcohol Prevention until 2020"* aimed at restricting access to alcohol and other drugs; protecting sensitive groups against harmful effects of PSU; preventing young adolescents from initiating PSU; reducing harmful PSU; securing access of people with PSU issues to continuous and integrated services (built on best knowledge/practices and high quality); reducing harm and preventing deaths caused by one's own, or others' PSU. However, whereupon, this policy was modified towards a more harm-reduction direction (Icelandic Parliament, 2016). In addition, Reykjavík City Council has taken up the ETHOS typology on housing and homelessness,

resulting in making women much more visible in the system and assisting them in finding secure or temporary housing, such as women shelters (FEANTSA, 2020). Finally, Reykjavík City Council's new policy "*Policy regarding homelessness and people with complex needs 2019-2025*" aims at intervening at four different levels: a) Ideology/ methodology (namely Harm-reduction and Housing first); b) Users (namely Human dignity, professionalism, empowerment, and active participation of those receiving services); c) Staff (namely Aspect, knowledge, experience, and job satisfaction of staff affects the quality of services) and d) Community (cooperation and constant development: Using opportunities in the environment and co-operation with other agencies and NGOs and Monitoring of the situation of users). This policy focuses strongly on the lack of services for women and the need for acknowledging the unique needs of women with long histories of PSU and trauma. Since 2013, the Root (Rótin) Association on Women, Trauma and Substance Use, puts pressure on more focus on gender-related issues in policymaking and treatment provision (Root, 2020).

In Greece, policy regarding PSU includes the provision of specialised services such as substitute and non-substitute PSU treatment programmes, and harm reduction programmes. Harm reduction services offer to drug users access to treatment for all consequences of drug use (e.g. HIV, Hepatitis etc.). At the same time promote strategies to reduce the health, economic, social and legal consequences of drug use (Pompidou Group, Council of Europe, 2020). Participating in the worldwide programme "*Partnership for Healthy Cities*", the Municipality of Athens aims to prevent overdose and related deaths by training drug users, their families, health professionals, and other relevant parties on naloxone provision to active drug users (Partnership for Healthy Cities, 2020). In 2020, the Municipality of Athens implemented, in cooperation with OKANA, KETHEA, and NGOs related to addictions, the first Hosting Structure for drug users (OKANA, 2020). Systematic data collection is a significant priority of Greek PSU policies as it fosters the right of professionals and society in general, to have access to relevant PSU information. To this end, research funding is provided by

several government sources to university departments and KETHEA (Pompidou Group, Council of Europe, 2020).

Although in all three participating countries, specific policies for gender-based violence exist in all three participating countries, IPV policies seem to be fragmented. In most cases, they constitute policies of specific services and organisations or partially address IPV (e.g. only prevention of IPV, only first response to IPV etc.). As a result, and according to IPV professionals who participated in the focus groups, there is a need for national, comprehensive, and all-embracing policies that would refer to all services and professionals working with survivors of IPV and would encompass all aspects of IPV. Finally, relevant literature and research, and research conducted in terms of the MARISSA project, highlighted a need for policies that would explicitly target and focus on survivors, especially women survivors, of IPV with PSU issues. The absence of such policies put those women at higher risk and lead to failure of IPV and/PSU service and treatment provision. The issues that these policies should include and address are presented and analysed in the following chapters.

4. Available Services for survivors of Intimate Partner Violence & people with Problematic Substance Use issues

The available services for both IPV and PSU, in Estonia, Iceland, and Greece, seem to have many similarities. In their majority, these services are public, operating under national or local umbrellas. 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.

4.1 Available Services for Women Survivors of Intimate Partner Violence

In Estonia, specific policies have been established to guarantee support for women survivors of gender-based and domestic violence, enacting the establishment of victim support services. Victim support services are public, aiming at maintaining or enhancing the coping abilities of survivors of criminal offences; negligence or mistreatment; and physical, mental, or sexual abuse. The provision of victim support services includes counselling and assistance to survivors in communicating with state and local government authorities and legal persons. In addition, 24/7 crisis helpline 116006, women's support centres and shelters are also available in every country.

In Iceland, the national health care system is one among other services for women survivors of IPV, whereas some health care centres screen for IPV during maternal health appointments and provide counselling. The National Hospital has an emergency reception for survivors of sexual violence providing access to physical checks (after rape), psychiatric support, and legal advice. The National Hospital also has a trauma centre where counselling to survivors is offered. The Red Cross has a hotline, providing guidance to survivors, via phone calls or chatting on the internet. At the same time, the local councils provide various services to survivors. Reykjavík city council offers counselling and follows up in cases where the police have been called due to domestic violence. Multiple sections of the city council have independent projects focusing on survivor support. There are also two women's shelters, one in Akureyri and one in Reykjavík. Reykjavik's shelter also has facilities to cater for women with disabilities. Additional services that offer counselling, support, and educational material to survivors are Aflið and Bjarmahlíð in Akureyri (northern Iceland) and Stígamót, Bjarkahlíð and Drekaslóð in Reykjavík and in Selfoss (south Iceland). Sigurhæðir has recently opened its doors. Bjarkarhlíð, Barmahlíð and Sigurhæðir are operated after Family Justice Center model for survivors of violence. Women living outside Reykjavík, Akureyri and Selfoss could use phone

services of any of the service centres available, but many would have to travel long distances to receive other services.

In Greece, the available services for survivors of IPV pertain to GSFPGE or are NGOs, which are activate on the field. GSFPGE provides a 24-hour SOS 15900 helpline; 42 Counselling Centres at the capitals of the Regions of the country and 20 Safe shelters for Abused Women, with a total hosting capacity of approximately 400 women survivors or women at increased risk of violence and their children (GSFPGE, 2020b). The Union of Women Associations of Heraklion Prefecture (UWAH, 2020) is an NGO, established in 2001, that belongs to the Voluntary Non-Governmental Organisations, operating at Heraklion Municipality, Crete. UWAH is active in the promotion and protection of women's and children rights. At the same time, it also engages with raising awareness and advocating for human rights, including the promotion, implementation and supervision of the application of the Istanbul Convention. UWAH provides support services to victims of domestic, gender-based violence, and IPV and operates a 24/7 emergency help line, a Shelter and a Counselling Centre for women survivors. Additional organisations and services, either privately or publicly funded, providing services to survivors are the National Centre for Social Solidarity (EKKA) and Diotima. Diotima (2020) is a Non- Profit NGO that operates as a specialised centre for research on gender issues; aiming at highlighting all aspects of discriminations against women, including violence. EKKA (2020) provides counselling and sheltering services to women, children, and families originating from vulnerable groups and counselling for perpetrators. Finally, the National Reporting Mechanism aims at identifying and protecting victims of trafficking.

4.2 Available Services for People with Problematic Substance Use issues

The country reports and the focus groups of Estonia, Iceland and Greece, revealed many similarities regarding the operation of the available PSU services (e.g. governmental and local funding and NGO's; provision of both individual and

group therapy; availability of inpatient and outpatient treatment; harm reduction services). On the other hand, differences were found in the models and approaches being used in the field. For instance, in Iceland, PSU treatment mainly follows the 12-step approach, defining addiction as a brain disease and thus, giving minimal focus on social and/or psychological factors. On the contrary, in Greece, PSU treatment follows a psychosocial oriented approach; although quite widespread is also the medical model.

In Estonia, PSU treatment is provided through hospitals and is primarily offered in outpatient treatment units, while inpatient treatment services remain limited. At the local level, health coordination committees, throughout Estonia, address PSU-related issues as part of their work (Libertas, 2020). Public sector's PSU treatment is funded by the state budget, allocated by the Ministry of Social Affairs. Almost half of the budget funds are dispensed to opioids substitution treatment (OST), and the rest to detoxification and drug-free programmes. Some larger municipalities also fund PSU treatment. NGO Libertas (2020) has experience with the Minnesota model of 12-step treatment and offers three approaches to outpatient treatment: individual counselling, intensive outpatient programme, and continuing care programme. Intensive outpatient programme is medically and evidenced-based and includes group therapy, substance use disorder education, weekly family participation sessions and weekly drug screens. Clients come to Libertas voluntarily (on a self-funding basis), while some probationers are also referred to this programme. There are other PSU organisations as well, which are also using the Minnesota model of 12-step programme. These organisations usually offer follow-up programmes (on average nine months) as well, and participation once a week is free for clients who have finished the basic programme. The support programme SÜTIK refers to people with fentanyl and amphetamine PSU, and participation is voluntary and free of charge. A support person is assigned to each client, being responsible for assisting clients to deal with problems caused by PSU as well as find the necessary services for them (e.g. a place to live, gainful employment, advice from

a therapist, help with debt management, and medical care to back them up in their fight against PSU). A competent and skillful support person has a crucial role in this programme. In terms of effective treatment provision and outcomes, the Estonian PSU policy lays special emphasis to rehabilitation of people with PSU issues, and more specifically to social and work rehabilitation. Work rehabilitation services operate under the Estonian Unemployment Insurance Fund, where people, including those with PSU issues, get prepared for working life and are offered support regarding starting or maintaining employment; while peer support is also provided. Work rehabilitation activities occur individually or in a group, depending on the needs of people with PSU issues. Social rehabilitation programme is available through the Social Insurance Board, which runs procurement for getting services and has many partners. Harm reduction programmes are also available in Estonia, co-operating with probation services, rehabilitation centres, and local governments, in terms of holistic interventions. Regarding harm reduction, the government funds needle and syringe programmes (NSPs) that also provide clean injecting equipment and condoms**.** In 2017, around 2 million syringes were distributed, harm reduction services admitted around 5.500 people and more than 110.000 service contacts were registered across the country (NIHD, 2018). The Ministry of Justice is responsible for administering healthcare and social services in Estonian prisons. Drug treatment in prisons includes detoxification, opioids substitution programmes (OST), and social programmes. Rehabilitation and re-entry programmes, peer support, counselling and social accommodation are also offered to prisoners with PSU issues. Long-term inpatient rehabilitation services are provided for Viljandi Hospital adults in two departments, located in Viljandi and Sillamäe, where patients from all areas of Estonia could be treated. The PSU service provided is not substance-specific, and refers to both men and women, and their families as well. On average, rehabilitation lasts nine months and includes follow-up services in order to prevent relapse and support clients' social adaptation. The service is provided on a case-by-case basis and includes outpatient individual or group psychological counselling, social counselling, and

peer counselling. The service is available in various parts of Estonia (Tallinn, Jõhvi, Narva and Viljandi). NGO Peaasjad was established in 2009 by mental health specialists working for the Psychiatry Clinic of North Estonia Medical Centre and the team now consists of qualified mental health specialists, youth workers, ICT specialists etc. NGO Peaasjad is involved with a project VALIK (Choice) for young people with light cannabis use (low dose, beginners) and targets behavioural change. The website peaasi.ee provides information and online consultations. Corrigo offers outpatient rehabilitation services for 14- to 18-year-olds with PSU issues. The rehabilitation process focuses on restoring the healthy state, physical condition, and social coping skills of the youths. The primary treatment for opioids addiction is psychosocial help combined with substitute medication's daily administration (methadone). Based on clients' individual needs, treatment could last from nine to twelve months. Regarding harm reduction, the National Institute of Health Development funds provision of low-threshold harm reduction services to drug users, mainly under the operation of several non-governmental organisations.

Since the 20th century, Iceland's PSU policy and treatment could be characterised as abstinence-based, focusing on the reduction of supply. Although funded by the state, PSU treatment is operated by NGO's. The National University Hospital of Iceland (LSH) services people with dual diagnoses, such as severe mental health symptoms and addiction. Apart from SÁÁ, the largest rehabilitation centre in the country, and the National Hospital, there are a few organisations offering PSU treatment, founded on either Lutheran belief or the 12-step model, or both. The Minnesota model (abstinence model using the 12-step programme and the philosophy of Alcoholics Anonymous), or what has been called the "*Icelandic model*", has dominated PSU treatment in Iceland since the foundation of SÁÁ. Consequently, the influence of the 12-step model led to defining addiction as a brain disease, eliminating at the same time the focus on social or psychological factors and embedding a diverse offer of PSU therapy and treatment. At the same time, the City of Reykjavík is one of the largest service

providers for marginalised people and people using substances in a harmful way. Worth mentioning that, in recent years, the services of the city are undergoing important changes with more focus being brought on gender-related issues and harm-reduction interventions.

In Greece, PSU policy encompasses the provision of specialised research-based PSU services, which are based on specific guidelines regarding their structure and operation and follow the existing good practices (Pompidou Group, Council of Europe, 2020). In this line, PSU treatment is available in almost every region and is easily accessible and affordable (the service provision is free of charge) (National Centre for Documentation and Information on Drugs, 2020). The main types for dealing and treating PSU are drug-free PSU treatment offered by KETHEA and Detoxification Unit 18 ABOVE, opioids substitution treatment offered by the Integrated Treatment Units for Addiction and Intensive Psychosocial Support Units of OKANA and physical detoxification. Drug-free PSU treatment is based on psychosocial-oriented interventions, treating the person as a whole; while opioids substitution treatment is based on the medical model according to which, addiction is defined, treated, and perceived as a chronic recurrent brain disease. The officially recognised bodies that provide PSU treatment are more than twelve[5] and in 2018, 116 treatment structures and 47 PSU counselling centres were operating in Greece, under these bodies (National Centre for Documentation and Information on Drugs, 2020). In addition to the therapeutic interventions, PSU services encompass counselling centres/stations/reception centres along with information and admission centres. These centres constitute the first interface of those seeking help for PSU issues, and thus have a crucial role in addressing PSU issues. Furthermore, counselling centres function as a stage of clients' preparation and integration into the therapeutic process, where information; assessment of the situation;

[5] OKANA, KETHEA, Detoxification Unit 18 ABOVE, the Psychiatric Hospital of Attica (PSNA), the Psychiatric Hospital of Thessaloniki (PST), the General Hospital of Ioannina, the General Hospital of Corfu, the Psychiatric Clinic of the University of Athens, general public hospitals (in collaboration with OKANA), the independent association THESEAS within the Municipality of Kallithea and the Ministry of Justice, Transparency and Human Rights (Eleonas prison)

individual and group counselling; support; health care services and family support services are being provided. In parallel, specialised PSU services and relevant programmes are available so as to address the special treatment needs of the most vulnerable groups among the PSU population, such as prisoners, sex workers, pregnant women, migrants, refugees, elderly, minors, young offenders, disabled children, children originated from dysfunctional environments, children living in care institutions and at-risk families (Pompidou Group, Council of Europe, 2020). In 2020, the first Hosting Structure for drug users was implemented in Athens, filling a critical gap, since people with PSU issues are not admitted to shelters for homeless people. This structure provides housing, personal care and hygiene services, inclusion in Therapeutic Dependence Programmes and connection with other relevant services, and could accommodate 70 persons (OKANA, 2020). Harm reduction services address people's with PSU issues needs that derive from the consequences of drug use (e.g. HIV, Hepatitis etc.) and include interventions such as needle and syringe programmes (NSPs) and programmes for the provision of clean injecting equipment and condoms. Furthermore, harm reduction services participate in the worldwide programme "*Partnership for Healthy Cities*", aiming to prevent overdose and corresponding deaths through training drug users, their families, health professionals, and other relevant parties on naloxone provision to active drug users (Partnership for Healthy Cities, 2020). Additionally, harm reduction services fight against the stigmatisation of people with PSU issues and aim to raise awareness on both individual and social levels (Pompidou Group, Council of Europe, 2020).

4.3 Specialised Services for Women with Problematic Substance Use issues

In Iceland, The Root (Rótin), based on trauma-informed and gender responsive evidence-based approaches, provides services for women focusing on the link between trauma and PSU. The Root (Rótin) offers group-counselling, courses,

support groups and individual specialised counselling. It is also collaborating with the Women's shelter, offering training for staff and support for the women in the shelter. In 2021, Root (Rótin) has also offerd training and group counselling in Hlaðgerðarkot, which is the second largest residential treatment centre in Iceland as well as psychosocial groups for both women and men. According to the focus groups, in Iceland, three organisations act as one-stop shops for women survivors; where women with PSU issues are also welcome and get benefits. In Bjarkarhlíð, there are no specialised services for PSU and women are referred to PSU services, and especially to Root, with which there is an active cooperation. Konukot is an emergency shelter for women, and all homeless women are welcome; while referrals to emergency rooms, police, and IPV services are undertaken. Konukot admits all homeless women but does not offer treatment of any kind. Hringbraut 79, Reykavíkurborg, admits women with complex needs, including PSU and IPV. According to the country report, although SÁÁ has offered some form of gender specific treatment since 1995, it could be argued that the treatment system in Iceland has been characterised by gender blindness.

In Greece, there is only one specialised service for women with PSU issues, offered by Detoxification Unit 18 ABOVE. This PSU service provides a Reception/ Counselling Centre for Addicted Women, a specialised Women's Treatment Programme (of internal residence), and a Social Rehabilitation Programme for Addicted Women and Mothers. Through these PSU programmes that refer to different therapeutic stages, women are assisted in realising the reasons that led them to PSU, coping with trauma, and seeking new ways of life through various psychotherapeutic procedures, such as individual psychotherapy, group psychotherapy, drama therapy, and Art therapy.

In all three participating countries, there are many and various services available for the treatment of IPV and PSU. 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; agreeing with the relevant literature, which also underlines PSU services that would explicitly refer to women as a basic and essential need of the field (O'Neil & Lucas, 2015; UNODC, 2016).

5. Treatment of Women Survivors of Intimate Partner Violence with Substance Abuse issues

According to the relevant literature and research, the co-occurrence of IPV and/or PTSD and PSU affect any level of women's lives, namely the physical, psychological, and social level (Lipsky et al., 2010; Mason & O'Rinn, 2014; Schäfer & Najavits, 2007). Regarding the consequences of violent experiences on PSU, survivors tend to start earlier the experimentation with drugs and/or alcohol. In contrast, PSU in this population tends to be more long-term and severe, including poly-substance use (Schäfer & Najavits, 2007). Co-occurrence of IPV and PSU poses at women survivors more severe challenges and difficulties regarding the seeking, the commitment, and the outcome of the treatment (Berenz & Coffey, 2012; Lipsky et al., 2010; Mason & O'Rinn, 2014). Survivors of IPV with PSU issues present higher rates of dropout and lower rates of treatment completeness for both IPV and PSU treatment (Berenz & Coffey, 2012; Lipsky et al., 2010; Schäfer & Najavits, 2007; van Dam et al., 2012). Considering that these characteristics add additional challenges to clients and IPV and PSU professionals working in the field, these professionals should be aware of the phenomenon and possess the knowledge and the capacity to recognise and deal with co-occurring IPV and PSU.

5.1 Screening for Intimate Partner Violence and/or Problematic Substance Use

Screening for IPV in PSU services and vice versa, constitutes an essential requirement for adequate service provision to women survivors of IPV with PSU issues, as inadequate and/or inaccurate screening would possibly lead to neglect of those women's therapeutic needs.

According to Estonian, Icelandic, and Greek country reports and focus groups, there are not enacted and institutionalised, universal and shared protocols regarding the screening for IPV and PSU, in PSU and IPV services, respectfully. Given this absence, according to all professionals who participated in the focus groups, screening for IPV and/or PSU mainly lies upon each service's and professional's guidelines, principles, and philosophy.

In Estonia, IPV professionals who work at women support services and shelters admitted facing problems with PSU recognition; and PSU professionals revealed that often they could not recognise IPV signs. According to the Estonian country report, survivors of IPV with PSU issues are supposed to be scarce, especially in shelters, probably due to inadequate screening.

The situation in Iceland is similar, where screening for both IPV and PSU in PSU and IPV services, respectively, is in general terms adequate, and varies between service providers. In some IPV services, screening of PSU does take place; however, in these services, PSU does not constitute an exclusion criterion. Interestingly, although some IPV services, and especially shelters, do not allow substance use on the premises, they do not screen for it. In like manner, according to the Icelandic focus groups, PSU services do not screen for IPV or other traumatic violent experiences in general. A report was submitted to the parliament in 2011 by the Minister of Welfare, being in accordance with the action plan of the government against men's violence against women in intimate relationships. The report sets forth measures to prevent violence against women and improve resources for women who have suffered IPV, as well as to help men

to end violent behavior. A part of the proposed measures was screening in treatment centers:

"At treatment clinics for alcohol or drug abuse, screening should be carried out to identify men who have subjected their partners to violence, and that should inform their treatment programme. Screening should also be carried out to identify women who have experienced violence in intimate relationships, and such trauma should be taken into account in their treatment" (Ministry of Welfare, 2012).

After the report came out screening was implemented at the biggest treatment center but the results have not been published and the instructions of treating IPV and PSU together was not carried out.

Similarly, neither in Greece, there is an enacted protocol regarding screening for IPV nor PSU, in PSU and IPV services, respectfully. According to the country report and the focus groups, screening for IPV and/or PSU usually takes place during the first interview with the client, where the social history is taken. While screening for PSU, IPV professionals ask for any kind of PSU, its frequency and the specific substance being used. However, as there is no institutionalised protocol, there are no official data available regarding the procedure followed and the respective outcomes, even in cases that screening and referrals do occur. It is mainly dependent on the tool being used for the first overall assessment during the intake regarding screening for IPV in PSU services. Finally, according to Greek and Estonian research results, given the fact that screening for IPV is not mandatory, and thus, does not always take place, it is quite usual for IPV to arise as a topic during PSU therapy.

5.2 Dealing with Intimate Partner Violence and/or Problematic Substance Use

According to the relevant literature and the research conducted in terms of the MARISSA project, there are many gaps in the screening and the management of co-occurring IPV and PSU (Benoit & Jauffret-Roustide, 2015; Schäfer & Lotzin, 2018; NICE, 2014). Most professionals, who participated in the focus groups,

admitted that they do not have the appropriate knowledge and skills for dealing with survivors –and especially women survivors- of IPV with PSU issues.

As it has been previously discussed, the disclosure of IPV or other violent and abusive experiences, usually takes place during the counselling/ therapeutic process. Consequently, and due to the absence of institutionalised policies and protocols delineating the guidelines that should be followed in such cases, professionals have the "freedom" to choose the approach they will follow.

In Greece, MSc active and graduate students who participated in the focus groups reported that during their 10-month practice, they observed that most of the PSU counsellors/therapists did not directly ask about present or even past experiences of IPV or any other kind of victimisation. In fact, in many cases, although suspecting IPV, professionals did not "open" this topic, unless the client did. According to participants, this tendency may be related to professionals' lack of knowledge and capacity of dealing with IPV.

Similarly, in Estonia, although PSU services have quite a wide range of different specialised professionals that would possibly identify IPV, there is no institutionalised procedure on how to tackle this issue.

On the contrary, some professionals participating in Icelandic focus groups underlined a significant improvement in the way professionals, especially nurses, treat their clients and support them according to their code of ethics. In PSU services, improvements have taken place regarding the recognition of trauma in the lives of people with PSU. However, it should be noted that, according to some PSU professionals, although discussing traumatic events is sometimes encouraged during group therapies, it does not seem to be followed up with the appropriate counselling.

Overall, many similarities were indentified between Estonia, Iceland, and Greece, regarding screening and dealing with PSU in IPV services, and vice versa. In none

of these three countries, there is a clear protocol for cases of co-occurring IPV and PSU, while procedures and interventions regarding dealing with this phenomenon, vary not only between countries but also between same service providers. These gaps, and thus needs, are related to further –mainly practical- training and frequent exchanges of knowledge, experiences and suggestions, and co-operation with experts from the other field in order to deal more efficiently with co-occurring IPV and PSU. Given this lack, professionals expressed a need for further knowledge, training and provision of tools that would assist them in screening and dealing with women survivors of IPV with PSU issues. It is worth mentioning, that this need was expressed by Icelandic professionals as well, despite the improvements accomplished towards this direction.

5.3 Approaches for Women Survivors of Intimate Partner Violence with Substance Abuse issues

As mentioned in the previous chapter, research conducted in terms of the MARISSA project confirms the relevant literature and research, regarding the fact that IPV services usually do not take into consideration PSU issues; whereas PSU services lack sensitivity towards gender-related issues and trauma (UNODC, 2016). In the U.S.A. only 38.4% of PSU facilities offer IPV-related services, with the provided IPV-related services being quite unclear (e.g. assessments only, referrals or more intensive in-house services) (Capezza et al., 2015). Regarding the situation in the countries that participate in the MARISSA project, Icelandic PSU services, despite the previous gender blindness, over the last years have mainly focused on gender dimensions of PSU and they are currently following trauma-informed and gender responsive approaches. On the other hand, the few Greek PSU services that deal with trauma, address those experiences in the context of their psychotherapeutic approach and therapy, lacking though gender-sensitivity.

At present, service provision to women survivors of IPV with PSU issues falls into "treatment-as-usual"; namely the standard substance-abuse treatment;

referral to domestic violence intervention programmes; conjoint therapy (couple-based interventions for IPV, behavioural couple-therapy for substance abuse) and individually-based PSU and IPV interventions (Fals-Stewart & Kennedy, 2005; Klostermann et al., 2010). However, through "treatment-as-usual" provision, women's access and uptake to health-care services, and the diagnostic and treatment pathways, are negatively affected by gender norms, gendered patterns of employment and work and gendered stereotyping by health-care providers (Manandhar et al., 2018). Health systems, mainly designed by men for men, usually do not take into consideration the ways unequal gender norms, roles and relations affect health and discriminate women within health-care settings; leading in this way to gaps in coverage and failure of therapy provided to those women (Covington, 2019; Manandhar et al., 2018).

The most prevalent gender-related barriers for women survivors of IPV with PSU issues are stereotypes, social stigma, shame, and guilt, which are closely related to their gender, IPV experiences, and PSU identity (Schamp, 2019). Additional barriers related to gender are poverty, accessibility and affordability of IPV and/or PSU services, the absence of childcare services, and the fear of losing custody of their children (Schamp, 2019). As a result, gender-related issues and discriminations magnify the dangers and risks those women face and deteriorate their position by preventing access to IPV and/or PSU services (Covington, 2019).

Provided all these obstacles in service provision, according to relevant literature and research, to be effective, IPV and especially PSU services, should tailor and take into consideration different types of IPV and PSU, as well as gender-related issues, focusing more on women (AVA, 2013; Manandhar et al., 2018; Stella Project, 2007; UNODC, 2016).

5.3.1 Gender-sensitive and feminist approaches

Through meeting the need for gender-sensitive approaches, structural violence, the already existing stigmatisation; victimisation; marginalisation and disempowerment of women survivors of IPV with PSU would be prevented

and/or tackled (UNODC, 2016). In this way, gender-sensitive and feminist approaches would assist professionals in recognising and intervening in sex and gender-related influences of IPV on PSU and vice versa; recognising at the same time how social and gender inequalities affect women's vulnerability to PSU and/or IPV (Benoit & Jauffret-Roustide, 2015; Ettorre, 2019; Poole, 2019; UNODC, 2016). They would also be assisted to understand that neither PSU nor IPV constitute women's choice and thus, that survivors of IPV with PSU issues are not to be blamed. On the contrary, women's capacity for change would be recognised and empowered. As a result, stigmatising attitudes and beliefs towards women survivors of IPV with PSU issues, such as the corresponding unemployment, homelessness, sex work and vulnerable youth (e.g. young survivors of family abuse and violence), would be eliminated.

In a similar vein, the adoption of sex and gender-informed evidence, such as gender-transformative approaches, would assist professionals in promoting the active examination, questioning and changing of negative gender stereotypes and norms; redressing at the same time the imbalances of power and leading (Greaves et al., 2020; Manandhar et al., 2018; Schmidt et al., 2018). As a result, gender equity would be fostered and positive health outcomes and improvements would be integrated into IPV and/or PSU treatment (Schmidt et al., 2018).

5.3.2 Trauma – informed approaches

Except for gender-sensitive approaches, sex and gender informed evidence such as trauma-informed approaches should also be adopted, especially in PSU services, due to the high prevalence of trauma –including trauma deriving from IPV- (Covington, 2019; Poole, 2019). Trauma-informed approaches would help professionals identify and foster women's physical and emotional safety; need for self-determination; need to make their own choices and need to regain control of their lives (Anyikwa, 2016; Covington; 2019; Schmidt et al., 2018; Poole, 2019). Through trauma-awareness, women's re-traumatisation would be prevented, as trauma triggers are being avoided leading women to benefit from

the provided IPV and/or PSU services (Schmidt et al., 2018). The main advantage of trauma-informed approaches is that the deriving from IPV trauma is taken into account. In these approaches, disclosure is not essential (Covington, 2019), as especially in PSU settings or during group therapy, the disclosure of IPV may be extremely difficult or dangerous. Moreover, through these approaches, PSU is related to past and current experiences of violence and trauma, while embodied experiences of IPV are being inclined (Ettorre, 2019; Poole, 2019). Indicatively, trauma-informed approaches could include Cognitive-Behavioural Therapy, Guided Imagery, Relational Therapy, Mindfulness, Eye Movement Desensitisation, and Reprocessing (EMDR), Emotional Freedom Technique (EFT), and Expressive arts (Covington, 2019).

Whole-person strength-based approaches offer to professionals and by extension to women survivors of IPV with PSU issue, the opportunity to take into consideration, embrace and deal with all the strengths, difficulties and/or mental health issues they may face (Against Violence and Abuse/ AVA, 2013; Covington, 2019).

According to the literature, research and the results deriving from country reports and focus groups, most PSU services are characterised by gender-blindness, with Iceland being the only exception. Consequently, there is an urgent need for gender-sensitive, feminist, trauma-informed and whole-person strength-based approaches, especially in the PSU field (AVA, 2013; Manandhar et al., 2018; Stella Project, 2007; UNODC, 2016). Nevertheless, the implementation of such approaches reflects the needs of professionals and women survivors of IPV with PSU. According to an Icelandic survey in the PSU population, women with PSU issues who had IPV experiences would like their treatment to be trauma-informed, individualised, holistic, safe spacing, free from distractions and triggers and tailored to women only (Pálsdóttir, 2019).

Thus, the implementation of trauma-informed, gender-sensitive and gender-transformative approaches would foster health and social priorities, empowerment, women's strengths and sense of value, trustworthiness, confidence, self-efficacy, and collaboration (Covington, 2019; Poole, 2019).

Concurrently, these approaches would induce multiple benefits through meeting additional needs, such as:

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

5.3.3 Integrated models

Apart from the approaches mentioned above, and in order to treat women survivors of IPV with PSU issues efficiently, a lot needs to be accomplished in this direction. In particular, according to relevant literature and research, the high prevalence of co-occurring IPV and PSU, the overlap and the complex interplay between these two phenomena create a need for a holistic, integrated model for treating IPV and PSU (Afifi et al., 2012; Cohen et al., 2013; Crane et al., 2014; Engstrom et al., 2012; Fals-Stewart & Kennedy, 2005; Fowler & Faulkner, 2011; Gilchrist & Hegarty, 2017; Macy & Goodbourn, 2012; Schumacher & Holt, 2012). In this line, according to professionals who participated in the Estonian focus groups, women survivors of IPV with PSU issues need a comprehensive, complex, and long-term treatment, as PSU often derives from emotional instability and in

most cases, from childhood trauma. Both scenarios seem to exist (i.e. PSU preceding the IPV incident, and vice versa). Even when individuals are being treated from PSU and/or physical violence is decreasing, psychological violence usually remains.

In this way, integrated models would offer professionals the opportunity to take into consideration and tailor different types (e.g. physical, emotional/ psychological and sexual IPV) and characteristics of IPV (e.g. typical behaviours, expected consequences) among women with PSU issues (Benoit & Jauffret-Roustide, 2015; Morton, 2019). By implementing such models, professionals working both at PSU treatment and harm reduction services could be benefited (Benoit & Jauffret-Roustide, 2015; Poole, 2019). Regarding PSU, these integrated models would offer IPV professionals the opportunity to consider and tailor different types and characteristics of PSU (e.g. specific substances being used, consequences and risks) among women survivors of IPV (Afifi et al., 2012; Crane et al., 2014).

Currently, a few available models coordinately and holistically address trauma and PSU, while their implementation is, in most cases, limited and fragmented. Despite this, integrated models demonstrate promising results in terms of effective treatment of IPV and PSU. The most prevalent integrated models are the "Women's Integrated Model" (Covington et al., 2008), "Seeking Safety" (Najavits, 2007), "Finding your Best Self: Recovery from Addiction, Trauma, or Both" (Najavits, 2019), and "Trauma Recovery and Empowerment" (Fallot & Harris, 2002). It is worth mentioning, though that, these models do not refer explicitly to IPV, but to trauma in general. "New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy" is a practical resource to implement gendered approach (Smith et al, 2018). Despite their similarities, traumatic experiences could be quite different, especially regarding the consequences they induce and how these consequences are being expressed and manifested. Thus, in order to effectively address IPV and PSU, professionals need integrated models and tools, which would be explicitly targeted to co-occurring IPV and PSU.

As the existing "treatment-as-usual" for IPV or PSU alone, may yield limited results, and as integrated programmes for survivors of IPV with PSU issues do not exist in none of the three countries, professionals who participated in the focus groups clearly expressed a need for holistic and integrated interventions. Both IPV and PSU professionals from Estonia, Iceland, and Greece highlighted their unawareness and lack of formal acquisition and training on integrated models to treat co-occurring trauma and PSU. Accordingly, there is a legible need to increase IPV and PSU professionals' knowledge and raise their awareness regarding integrated models. Furthermore, according to professionals' opinion, they should also be trained on the implementation of such models to understand how they could be applied. At the same time, professionals expressed the view that the understanding of integrated models' significance and benefits and the development of corresponding skills and capacity could motivate and commit them to adopt these models to treat women survivors of IPV with PSU issues.

6. Professionals' Training on co-occurring Intimate Partner Violence & Substance Abuse

As the MARISSA project's research illustrated, professionals working on IPV and PSU services have multiple training needs regarding dealing and treating women survivors of IPV with PSU issues. According to the country reports and the focus groups, the formal training of IPV professionals on PSU issues and vice versa, ranges from severely limited to totally absent. This lack of training was more intense among Greek and Estonian professionals working on the field, while officially implemented, such training was insubstantial and fragmented. Furthermore, professionals who participated in the focus groups reported that training on IPV and/or PSU mainly relies on professionals' personal interests, ethics, and development quest.

Iceland constitutes the only exception regarding training provision, as professionals from four different services reported that they have received

training on specific aspects of IPV and/or PSU. More specifically, professionals working in Hringbraut and Konukot were trained on harm reduction; while professionals from Hringbraut were trained on violence against people with disabilities. In Landspítali, professionals receive continuous training on IPV and PSU, alongside with a special information meeting focused on PSU. It is worth noting that, even trained professionals expressed the need for further and/or more specialised education and training regarding the co-occurrence of IPV and PSU and specific aspects of this phenomenon, such as screening, treatment, available approaches and referral pathways. According to these professionals, the view that PSU is a hindrance for work with trauma is still prevalent, and this needs to change. An interesting element, induced by Foreldrahús, was that there is higher availability of training on IPV in Iceland, in contrast with training on PSU, as there is a lack of general and specific education and training about IPV among PSU professionals. Confirming this gap and need, relevant assessments conducted in 2016 by the Directory of Health showed that rehabilitation treatment centres did not do well (Icelandic Directorate of Health 2016a; 2016b; 2016c). The task indicated by professionals as the most challenging and thus should be included in training was how to help women, who are stuck in violent relationships, escape from them.

Professionals who participated in the Greek focus group claimed that there had been some training within the last five years in IPV and PSU organisations regarding PSU and IPV, respectfully. However, all of them underlined that the training they received was very theoretical and did not provide further knowledge. They expressed a need to increase their knowledge, especially practice-oriented knowledge, as they acknowledged that they barren of capacities and skills related to the practical treatment of women survivors of IPV with PSU issues. Reinforcing this lack of training and expanding it to the academic field as well, active and post-graduate students of the Master Programme "*Clinical Interventions to Addictions*", highlighted that during their studies, they did not received any education or training regarding the co-occurrence of IPV, or violence and/or trauma in general. Provided that this

Master's Programme is explicitly focused on PSU and considering the high prevalence of traumatic experiences -including IPV- among the PSU population, students seemed to assess this lack as a huge gap in their studies.

At the same time, in Estonia, training programmes in IPV services operate under specific projects, and as a result, they depend on the topic on which those projects focus. In this line, most training programmes are addressing each topic/ case individually (e.g. focusing only on alcohol abuse, focusing only on drug abuse, focusing only on HIV prevention, focusing only on tackling violence against women etc.).

Since the so far provided training was perceived by almost all professionals as inadequate, the knowledge expansion and the further development and capacity building towards the effective treatment of women survivors of IPV with PSU issues, seems to depend mainly on professionals' personal interests; ethic; motivation and quest for development. As a result, motivated by their needs and deficiencies, professionals who participated in all countries' focus groups expressed the need and eagerness to be trained on specific aspects of IPV and PSU. The needs identified by professionals include increasing their knowledge, raising their awareness, and developing their skills regarding the characteristics and treatment of co-occurrent IPV and PSU. Lack of training leads to ineffective screening and treatment of women survivors of IPV with PSU issues, which leads to further stigmatisation, marginalisation and victimisation. These results comply with relevant literature and research highlighting the lack of sufficient and evidence-based training regarding the co-occurrence of IPV and PSU. In some cases, there is an absolute lack of training (Benoit & Jauffret-Roustide, 2015; Schäfer & Lotzin, 2018).

More specifically, the training of IPV professionals should offer/encompass:

- Knowledge of PSU: different kinds of drugs used; drug and alcohol's influence on clients' physical and mental health; their consequences at any level (e.g. personal, social etc.); typical behaviours; typical habits etc.
- Awareness of PSU signs and training on their recognition

- Awareness and training on screening tools for PSU
- Training material and practical tips about working with survivors of IPV with PSU issues and additional programmes to tackle cases where co-occurrence of IPV and PSU appears (including possible manipulation by persons with PSU issues)
- Knowledge of the existing evidence-based approaches and models for treating PSU
- Practical knowledge about how to deal with shelter work-related problems that may be related to PSU
- Skills about how to avoid PSU slips and relapses.

The training of PSU professionals should offer/encompass:

- Knowledge of IPV: various forms of violence; psychological profile of IPV survivors etc.
- Awareness of IPV signs and training on their recognition e.g. what is IPV; how it looks like
- Awareness and training on screening tools for IPV
- Adequate inventories and screening tools to be able to discover co-occurring problems -including IPV related issues-, whether the client is the victim or the perpetrator or both
- Knowledge of the existing evidence-based approaches and models of treating IPV
- Further understanding of survivors' needs
- Further training on gender-based stereotypes, especially as most of the PSU counsellors/ therapists are males
- Skills for helping people that are stuck in a violent relationship.

The training of both IPV and PSU professionals should offer/encompass:

- Knowledge of the phenomenon of co-occurring IPV and PSU

- Knowledge of the main characteristics of survivors of IPV with PSU issues e.g. typical behaviours and habits
- Practical training, combining IPV and PSU experiences
- Understanding of IPV and PSU screening in order to enable early identification
- Knowledge of and training on the prevention models for IPV and PSU
- Effective communication skills
- Problem-solving skills
- Skills about how to engage the client and increase her willingness to accept either IPV or PSU interventions
- Knowledge of integrated models for treating IPV and PSU and of the specificity of such interventions
- Knowledge of group therapy techniques for women
- Knowledge and skills regarding family interventions, as the general distortion of family values is quite evident in the increase and earlier start of both IPV and PSU
- Knowledge of the existing networks; IPV and PSU intervention programmes and available support services
- Knowledge of legal framework; legal counselling and Criminal Justice System's procedures
- Knowledge of and training on multi-agency cooperation and especially on ways of conducting referrals.

In a similar vein, as described in the relevant literature and research, the training needs of professionals working with survivors of IPV with PSU issues should offer/encompass:

1. effective screening of IPV and PSU
2. sensitive response to the disclosure of IPV and PSU
3. provision of helpful advices (including advices for relevant services) and direct/refer clients to specialised services

4. asking the right questions regarding IPV and PSU (which presupposes the knowledge of epidemiology and effects of this specific phenomenon as well as the professionals' role in intervening safety)
5. the initial response that includes risk identification and assessment, safety planning and continued liaison with specialised support services
6. provision of expert advice and support
7. raising awareness of the phenomenon and tacking misconceptions and stereotypes regarding gender-related issues, IPV and PSU

(AVA, 2013; Macy & Goodbourn, 2012; National Institute for Health and Care Excellence/ NICE, 2014).

7. Co-operation between Intimate Partner Violence & Problematic Substance Use Services

Co-operation between related services in IPV and PSU co-occurrence cases is perceived by many scientists and professionals as obligatory (AVA, 2013; Macy & Goodbourn, 2012; Stella Project, 2007). This necessity is rendered because IPV and/or PSU centres offering integrated services that would address IPV and PSU holistically and simultaneously are not widespread; thus, not sufficient to meet women's survivors of IPV with PSU issues needs. Despite the urgency and necessity of co-operation between IPV and PSU services, in practice, such co-operation is not always applicable, mainly due to a lack of enacted, institutionalised protocols. According to the country reports and the focus groups results, in all three participating countries, and especially in Estonia and Greece, in many cases, there is an absence of formal collaboration between PSU and IPV services, such as agreements on bilateral protocols. In cases where informal co-operation exists, it is mainly based on professionals' personal enthusiasm, resources, and networks; acquaintances and relations formed in work-related events. As a result, the collaboration between IPV and PSU services faces various challenges, which are common among these three countries.

Indicatively, the main challenges IPV and PSU professionals face in the context of co-operation are:

- fragmented or absent policies;
- different angles of approaching the phenomenon;
- different philosophies;
- trust issues;
- professionals' ego;
- isolation and introversion of services;
- lack of effective communication
- lack of problem-solving skills, and
- lack of both general and specific training on IPV issues, mainly among PSU professionals.

In Estonia, PSU treatment, either inpatient or outpatient, is mainly provided through hospitals and the local government is responsible for several welfare services (social housing, peer support service etc). As a result, PSU services, including harm reduction programmes, co-operate with probation services, rehabilitation centres, and local governments. Co-operation also exists between the Estonian Unemployment Insurance Fund, Social Insurance Board, and PSU services in terms of rehabilitation. Women's support and intervention centres that deal with social rehabilitation, co-operate with the Social Insurance Board, and are involved in Multi-Agency Risk Assessment Conferences (MARACs) held on a national level. However, as professionals who participated in the focus groups reported, co-operation with the Unemployment Insurance Fund is missing.

On the contrary, the co-operation between PSU services and the Estonian Unemployment Insurance Fund was characterised as "excellent" by PSU professionals. In contrast, the co-operation with the Social Insurance Board, and sometimes with the local government specialists, was described as "not so good" due to the specialists' low interest or willingness. Furthermore, according to all professionals, smooth cooperation between IPV centres and PSU service

providers does not exist, and incidents with co-occurring IPV and PSU are solved case by case, depending on professionals' personal enthusiasm and resources.

According to the focus groups' results, clear referral pathways between IPV and PSU services do not exist in Estonia. According to professionals, IPV and PSU services have their own referral processes and service provision chain. As a result, every organisation has its 'own' partners. Women's shelter service professionals reported that they give advice to survivors, share information regarding PSU services, and try to refer women to PSU treatment centres directly through their network. However, there is no obligation to do so, and there are no available guidelines for support chain on a national level. As a result, since these procedures are neither formal nor institutionalised, they lack all-embracing and mandatory application.

In Iceland, focus groups' results also showed that, although some co-operation between IPV and PSU services exists, this cooperation is not officially determined. Additionally, there are not clear referral pathways neither a formal follow-up procedure. Referrals to other services depend on informal relationships with other service providers. Most cases are referred to the Emergency rooms to get injury notes. Root (Rótin) initiated a Forum of Women working with Women with Substance Use and Marginalised groups. However, this is a forum of individuals, not an organisational collaboration, and aims to create a space where dialogue and the sharing of experience and knowledge between individuals who work with this group of women could occur. The parties to the forum are women interested in improving the situation of marginalised women and women dealing with PSU, following human rights-centred harm reduction and strengths-based approaches. Currently, the forum has come to a standstill due to Covid-19. Landspítali co-operates with the VoR-team, Frú Ragnheiður (mobile harm reduction and needle changing unit), Bjarkarhlíð, the National Centre of Addiction Medicine, and the Addiction Psychiatry Clinic at the Landspítali. According to professionals who participated in the focus groups, Foreldrahús has good cooperation with children's services, health and welfare, and childcare services. For Bjarkarhlíð, Rótin and the VoR-

team have been of great help. Landspítali stated that more co-operations with PSU services and Foreldrahús are necessary.

In contrast, according to Bjarkarhlíð, more collaboration is needed with the Addiction Psychiatry Clinic and the Mental Health Clinic at Landspítali. On the other hand, the harm reduction service does not want to jeopardise clients' trust to close collaboration with other organisations and emphasise PSU users' focus and faith. Professionals from Landspítali mentioned that if survivors openly disclose IPV, they get in house support and are referred with their appropriate permission to Bjarkarhlíð, Emergency rooms, and IPV services such as Stígamót and Drekaslóð. However, in some cases, services are reluctant to co-operate, and professionals, mainly from Konukot, find it challenging to encourage clients to take responsibility for themselves when they face "closed doors" everywhere. According to professionals, apart from formal co-operation, additional obstacles prevent co-operation among IPV and PSU services. These obstacles include trust issues, different philosophies, and the healthcare system's prejudices. Moreover, the dominance of AA and the 12-step approach in the Icelandic PSU services could also be seen as problematic as it is in its essence very isolating and does not encourage support from other service providers. Finally, as professionals highlighted, this lack of referral and follow up protocols, complicates the situation and increases the challenges and obstacles both professionals and clients have to face, and especially in cases of inadequate services.

In Greece, the results from the two focus groups regarding co-operation between PSU and IPV services were conflicting, as the level and ways of co-operation between these services seem to vary. The aroused differences could be possibly attributed to the sample of each focus group. The first focus group consisted of IPV and PSU professionals working in both public organisations and NGOs, whereas in the second focus group, all professionals were working in public organisations, mainly from Heraklion, Crete. More specifically, according to professionals participating in the first focus group, co-operation between IPV and PSU services is mostly one-sided. IPV professionals refer women survivors

of IPV to PSU services in cases of co-existing PSU issues. In contrast, PSU professionals do not refer women survivors of IPV or violence in general. These PSU services follow the policy of incorporating IPV therapy as part of their holistic therapeutic approach, and as a result, they treat IPV within their services, perceiving IPV as a consequence or a cause of PSU. In the most severe abuse cases, they refer the women to an IPV centre, where they receive sessions with an IPV counsellor and the PSU therapist separately.

On the contrary, according to professionals participating in the second focus group, the co-operation between IPV and PSU services was characterised as "excellent" since they both refer women to the other when necessary. Despite differences in referrals, a common trend identified in both focus groups was that referrals are rare. Professionals from the first focus group claimed that referrals could occur twice a month or twice a year, depending on the IPV centre. For example, the National Centre for Social Solidarity refers more often as their services expand to a larger group of people and their offices being based in Athens, which populates around 5 million people. At the same time, the Shelter for Abused Women and the Counselling Centre for Women reported that over the last eight years that they have been operating in Heraklion, Crete, only a small number of women with co-occurring IPV and PSU were admitted and referred to PSU centres (less than 1 incident per year). However, it is worth mentioning that professionals from the second focus group reported that PSU centres refer to a slightly larger number of incidents, continuing their intervention independently.

In conclusion, IPV and PSU professionals from Estonia, Greece and Iceland clearly highlighted the lack of formal cooperation between IPV and PSU services and institutionalised protocols, with referral pathways and information sharing constituting the main challenges. Consequently, there is an urgent need for many changes and improvements regarding IPV and PSU services cooperation to treat women survivors of IPV with PSU issues adequately and efficiently in all three participating countries. According to them, the establishment of formal

cooperation and the implementation of corresponding protocols should include clear information regarding required actions; existing focal points; referral pathways and follow-up. Additionally, an expert team should be available to monitor the incidence, and professionals should be adequately trained on referral and other co-operative procedures.

Both IPV and PSU professionals from the three participating countries are eager to co-operate and adhere to such protocols, as according to their experience, even in the few cases that co-operation among services and referrals was achieved, the outcome was positive. This success was attributed to the fact that both challenging aspects of survivors' lives were managed, as they were treated by specialised counsellors.

In agreement with professionals' opinions and experiences, relevant literature highlights that co-operation between IPV and PSU services would formulate a good practice, as resources would be used more efficiently (Macy & Goodbourn, 2012; Schäfer & Lotzin, 2018; Stella Project, 2007). At the same time, there are increased odds of successful outcome of both interventions as the presence of IPV would not be a barrier for the treatment of PSU and vice versa (Macy & Goodbourn, 2012; Schäfer & Lotzin, 2018; Stella Project, 2007).

Moreover, such a co-operation between professionals and their services could on the one hand intensify their feeling of being part of an alliance and on the other hand reduce their feeling of loneliness arising especially in such demanding and challenging fields as that of IPV and PSU (AVA, 2013). At the same time, professional deficiencies are being fulfilled through co-learning as professionals have the chance to learn from each other by exchanging knowledge and experiences that derive from the field they are specialised in (AVA, 2013). In this way, perspectives are being broadened, while innovation, flexibility and creativity are being inspired (AVA, 2013); fostering in turn personal as well as professional development and self-fulfillment.

Given the efficient treatment and adequate service provision to women survivors of IPV with PSU issues constitute professionals' ultimate goal, meeting

professionals' need for co-operation between IPV and PSU services could lead to meeting clients' needs too, due to its multiple benefits. As previously discussed, women survivors of IPV with PSU issues have to face discriminations and gender-related other problems, even during service/ therapy provision. Responding to these discriminations, concrete and collaborative actions, such as the cooperation between IPV and PSU services, could deliver equity in health facilities, enhance gender equality, empower women, foster their well-being, and, as a result, their recovery process (Manandhar et al., 2018). In this way, professionals would feel that they are part not only of a personal change but also of a more general change, which takes place at a community and social level.

However, to coherently address IPV and PSU professionals' needs regarding co-operation, existing or possible barriers, and challenges should be discussed.

According to relevant literature, the most prevalent obstacles that negatively affect or even prevent co-operation between IPV and PSU services are related to:

- differences in philosophy, language and terminology, priorities, way of working, interventions and models being used
- frequent staff changes that unsettle communication and professional relationships
- lack of personal, face-to-face contact of professionals to understand their approach, to know what they do and how they work
- reluctance or refusal to share information
- over-protection of clients
- feeling of threat
- limited financial resources
- fragmented governmental, legal, and policy systems

(AVA, 2013; Macy & Goodbourn, 2012; NICE, 2014).

Acknowledging the importance of co-operation between Victim Support and PSU services and meeting professionals and services relevant needs, many organisations and projects have released recommendations for practical co-

operation (AVA, 2013; NICE, 2014; Stella Project, 2007). According to these recommendations, Domestic Violence –including IPV- and PSU services should:

- participate in a local strategic multi-agency partnership to prevent domestic violence and abuse
- develop an integrated commissioning strategy
- create commission integrated care pathways
- adopt clear protocols and methods for information sharing
- identify and, where necessary, refer children and young people affected by domestic violence and abuse
- provide specialist advice, advocacy and support as part of a comprehensive referral pathway, and
- provide specific training for health and social care professionals in how to respond to domestic violence and PSU (NICE, 2014).

8. Existing Policies and Needs of Intimate Partner Violence & Problematic Substance Use Services

According to the relevant literature, the management of co-occurring IPV and PSU should be incorporated in national strategies and plans, securing at the same time sustainable funding (Benoit & Jauffret-Roustide, 2015). Confirming the above-mentioned statement, Estonian, Icelandic, and Greek focus groups' results indicated that treating women survivors of IPV with PSU issues constitutes a great challenge for both IPV and PSU professionals, mainly due to the lack of corresponding, inclusive policies. Since different ministries and agencies deal with different issues and approach the phenomenon from different angles, policies regarding co-occurring IPV and PSU are fragmented. In all three participating countries, IPV and PSU services do not often allocate specific protocols, guidelines, tools, and approaches regarding screening, dealing, and treating survivors -and especially women survivors- of IPV with PSU issues.

Furthermore, in broad terms, due to the absence of such policies, there is no formal collaboration between corresponding services in co-occurring IPV and PSU cases. Even in the few occasions that these policies exist, they seem to vary between not only these three countries but also both between and within IPV and PSU services of the same country.

According to the MARISSA project's research, new policies should be developed according to professionals' needs, extended in local and national level. These policies should be explicitly targeted to the needs and challenges of professionals who work with women survivors of IPV with PSU issues, addressing and respecting at the same time the needs and challenges of women as well.

Although in all three participating countries PSU services admit women survivors of IPV, in none of these countries women with PSU issues are being admitted in women's shelters; while their admittance at IPV counselling services varies among different services and countries. In Estonia, women's support services do not offer services to people with PSU or other psychological disorders. At a national level, there is a regulation on the Women shelter services description stating that "*Weapons, alcohol, drugs and other things dangerous to life and health may not be brought into the premises used for the provision of the service (shelter and counselling office), and should not behave in a way that disturbs or endangers other persons*". Furthermore, every shelter has "home rules", where is also stated that alcohol and substance use is prohibited and if necessary, service providers shall set out more specific security requirements in their house/internal rules.

In Iceland, women's shelters in Reykjavík and Akureyri, do not allow substance use. As a result, women with PSU issues face additional challenges and are in danger of being discharged. Some providers insist on their clients being sober for counselling sessions. If IPV survivors show up intoxicated, they are usually given another session later. If women are caught using substances within the shelter

premises, they are not discharged immediately, but rather the issue is discussed and a solution is sought. However, the rules are clear, and if women refrain from using substances within the shelter, they will be encouraged to leave. Women often leave themselves when they feel they cannot be free from substances since they are aware of the rules. It is also deemed likely that IPV survivors dealing with PSU do not prefer their admittance to the shelters in the first place since the rules are clear. At this point, shelters do not have the facilities to service these women. Thus, there is a need for more diverse and harm reducing services.

In Greece, some IPV shelters have strict protocols of not admitting women with PSU issues at all, as the consequences of PSU might endanger other cohabitants and their children's health and safety. At the same time, in other IPV shelters and IPV counselling centres, counselling and shelter provision to women with PSU issues could proceed with a certification of commitment and admission to the PSU centre, especially in cases where PSU is severe and interferes with the IPV counselling. These centres inform the survivors of the procedures and the prerequisites and refer them to the nearest PSU centre. The Counselling Centre of Heraklion, for instance, follows the policy of referring women survivors with PSU issues to the nearest PSU centre, but continues to provide IPV counselling independently. If women do not comply with the protocol, they are being discharged from the IPV centre in many cases. According to professionals, it is more frequent for women to dropout from IPV counselling by themselves rather than being discharged. The reason behind these dropouts is mainly those women's reluctance to participate in PSU treatment. At the other end of the spectrum, Greek PSU centres and shelters' policies, have no restrictions in admitting women survivors of IPV, since most women with PSU issues are also victims of IPV and thus, service provision cannot be refused. Professionals who participated in the focus groups indicated violent experiences as a vital factor affecting clients' outcome. The vast majority of participating professionals had no experience of incidents or cases where their services did not admit any PSU client who wished to commit to the programme, due to her IPV experiences.

Although admittance to the PSU programme is not forbidden due to IPV experiences, IPV or any other kind of violence perpetration is forbidden, especially inside the service's facilities; as in most PSU services, there are clear rules such as "*no drugs, no violence and no sex*". According to professionals, women follow those restrictions in most of the cases, especially if they are mothers who wish to keep their children's custody and not have them taken away by the authorities due to their PSU issues.

As a result, based on what most focus groups' participants highlighted, a key issue that needs to be addressed through policy making is the admittance of women with PSU issues to IPV services and especially shelters. It is well acknowledged by participating professionals that excluding them from IPV services, the most vulnerable women are being left unsupported and abandoned.

According to literature, gendered institutional responses affect women's physical and mental health (Covington, 2019; Manandhar et al., 2018). To overcome this obstacle and increase women survivors of IPV with PSU issues access to services, policies that ensure and foster gender parity in decision-making positions and leadership in the health domain –including IPV and PSU field- should be developed (Manandhar et al., 2018). These policies should process beyond equating gender with women. Instead, they should perceive gender as a social and relational construct of power that amplifies inequities in health due to the different levels of power that influence roles, behaviours, activities, attributes and thus move forward and be more informed and inclusive (Manandhar et al., 2018). Social determinants and health-seeking behaviour, service provision and professionals and/or services' responses to co-occurring IPV and PSU should be simultaneously addressed through holistic approaches fostered by corresponding policies (Manandhar et al., 2018).

In a similar vein, policies for IPV and PSU co-occurrence should also include effective, evidence-based approaches, models, and good practices for the prevention and treatment of co-occurring IPV and PSU, as it has been mentioned

in previous chapters. Through the development of gender-sensitive policies, specific focus would be given to gender-sensitive and feminist approaches, eliminating in this way gender blindness and tackling discriminations against women. At the same time, trauma-informed approaches would enable women's emotional safety; need of self-determination, making their own choices, and having the control of their lives; health and social priorities; empowerment; strengths and sense of value; trustworthiness; confidence; self-efficacy, thus preventing re-traumatisation (Anyikwa, 2016; Covington; 2019; Schmidt et al., 2018; Poole, 2019). Apart from clients, through trauma-informed approaches, professionals would also benefit. In particular, trauma-informed approaches could improve staff retention; increase professionals' satisfaction with employment (e.g. less burnout or compassion fatigue, less vicarious or secondary trauma), and improve the system and programme planning (e.g. ability to respond to trends in substance use such as young women's high rates of heavy drinking) (Schmidt et al., 2018).

According to professionals' opinions, policies should also acknowledge the need to alter and improve the existing IPV and PSU interventions and services and create new services for the benefit of women survivors of IPV with PSU issues. In this context, policies should promote and assist the adoption of integrated models for treating co-occurring IPV and PSU and the establishment of PSU services, explicitly referring to women. These services would address women's needs, including the need for 24/7 emergency care for IPV and PSU cases.

Apart from implementing IPV and PSU integrated services, policies should also focus on multi-agency cooperation, including clear referral pathways. Such protocols and guidelines do not exist in any of the participating countries.

Furthermore, another issue that arose from Greek and Icelandic focus groups was the limited funding of IPV and PSU services. According to professionals, sufficient funding should be anticipated by related policies in order to enable efficient co-operation among services, adequate training, staffing and infrastructure.

Finally, according to Estonian professionals, staff shortage has led to less skilled professionals who have completed some form of training but are incapable of working with IPV survivors with PSU issues. Policies should implement specific criteria for candidates for personal assistants and peer support individuals to be more efficient.

Concluding remarks

According to the MARISSA project's literature review and research, IPV and PSU professionals working with IPV survivors with PSU issues have multiple needs. According to the country reports and the focus groups' results, these needs, in their vast majority, are common among the three participating countries.

Firstly, data regarding IPV and PSU population and data regarding women survivors of IPV with PSU issues seem to be fragmented, leading to a need for systematic and official data collection. It is suggested that data collection should include the prevalence of IPV and PSU co-occurrence in IPV and/or PSU and the general population and the special characteristics of women survivors of IPV with PSU issues their challenges, needs and strengths. In this way, professionals' need for an accurate picture of the totality of this specific phenomenon would be adequately met.

Secondly, to address those women's issues effectively, the existing legislation and policies about IPV and PSU need to change. More specifically, regarding legislation about IPV, additional laws, provisions, and regulations, specifically targeted to the prevention and tackling of IPV, are needed. Legislation about PSU also needs to change, adopting a more intervention and service-oriented approach, rather than fostering punishment and criminalisation of PSU. Through this legal arena, the role of IPV and PSU professionals and services would be empowered and validated, while at the same time, they would provide professionals safety and security. Policies about IPV are also needed, especially in Estonia and Greece, since, in contrast with policies regarding gender-based violence, IPV policies seem to be fragmented. Even in cases where IPV policies exist, they constitute specific services and organisations or partially address IPV (e.g. only prevention of IPV, only first response to IPV, etc.). As a result, professionals working in the field require comprehensive and all-embracing policies, explicitly targeted, not only to women survivors of IPV but also to women survivors of IPV with PSU issues.

Thirdly, although there are many IPV services available in all three participating countries, mainly referring to women, there is a lack of specialised PSU services for women. Consequently, confirming the relevant literature, focus groups' results highlighted that PSU services explicitly referring to women, with or without IPV experiences, constitute a basic and essential need for both clients and professionals.

Fourthly, according to the existing literature and research and the research conducted for the MARISSA project, there is a lack of relevant knowledge and corresponding skills and capacities among IPV and PSU professionals regarding treating PSU and IPV, as well as regarding treating co-occurring IPV and PSU. In this line, professionals from Estonia, Iceland, and Greece, clearly expressed a need for further knowledge, training, and provision of tools that would assist them, especially in screening and dealing with women survivors of IPV with PSU issues. Moreover, given the fact that there is an absence of a clear protocol for cases of co-occurring IPV and PSU, the procedures and interventions regarding dealing with this phenomenon vary not only between countries but also between the same service providers. This fact also points to the need for all-embracing protocols and guidelines. At this point, it is worth mentioning that this need was expressed by Icelandic professionals as well, even though improvements towards the recognition of trauma in the lives of people with PSU issues have been accomplished in this country.

Fifthly, both relevant literature and the MARISSA project's research results, underlined that there is an urgent need for gender-sensitive, feminist, and trauma-informed approaches, as IPV services usually do not take into consideration PSU issues, whereas PSU services lack sensitivity towards gender-related issues and trauma. This need is more intense among PSU services, as they are characterised by gender-blindness. Of all three participating countries, Iceland was the only exception. Over the last years, PSU services mainly focus on the gender dimensions of PSU, implementing trauma-informed and gender-responsive approaches.

Apart from gender-sensitive and trauma-informed approaches, the high prevalence of co-occurring IPV and PSU, the overlap and the complex interplay between these two phenomena pose additional challenges to the effective treatment of women survivors of IPV with PSU issues. Hence, IPV and PSU professionals from all three participating countries highlighted the need for holistic, comprehensive, and integrated models. Through such models, professionals would have the opportunity to consider and tailor different types and characteristics of both IPV and PSU. Moreover, most professionals admitted being unaware and lacking formal training on these models, expressing a need for increasing their awareness and knowledge, along with a need for developing through training on such models their complementary skills and capacities. Understanding integrated models' significance and benefits would promote their motivation and commitment to adopt these models while working with women survivors of IPV with PSU issues.

Sixthly, regarding IPV and PSU professionals' training needs, the relevant literature review and research conducted within the MARISSA project revealed that official training on dealing and treating women survivors of IPV with PSU issues is severely limited and fragmented, and it mainly relies upon professionals' personal interests, ethic, and the quest for development. As a result, professionals who participated in all countries' focus groups expressed the need and eagerness to be trained on specific aspects of co-occurrent IPV and PSU, such as the characteristics and effective treatment of women survivors of IPV with PSU issues.

Seventhly, according to country reports and focus groups results, in all three participating countries, and especially in Estonia and Greece, in most cases, there is an absence of formal collaboration between PSU and IPV services. Like training, co-operation among these services is mainly based on professionals' personal enthusiasm, resources and networks; acquaintances and relations formed in work-related events. Another similarity identified between Estonia, Iceland, and Greece, were the challenges of IPV and PSU services' collaboration. The most prevalent challenges were: fragmented or absent policies; different

angles of approaching the phenomenon; different philosophies; trust issues; isolation and introversion of services; lack of effective communication and problem-solving skills and lack of both general and specific training on IPV issues, mainly among PSU professionals. In agreement with relevant literature, the MARISSA project's research results underlined an urgent need for formal co-operation, which could defined by policies and institutionalised protocols. According to professionals, these protocols should include clear information regarding required actions, existing focal points, referral pathways and follow-up, implementing a shared understanding and standard procedures among IPV and PSU services.

Finally, relevant literature indicates that the management of co-occurring IPV and PSU should be incorporated into national strategies and plans. In accordance with this statement, Estonian, Icelandic, and Greek country reports and focus groups' results highlighted that the lack of corresponding, all-embracing policies pose additional challenges to IPV and PSU professionals regarding the effective treatment of women survivors of IPV with PSU issues. As a result, according to professionals' needs, new policies explicitly targeted to co-occurring IPV and PSU should be developed at a local and national level. These policies should include:

- data collection;
- acceptance of women survivors of IPV with PSU issues at IPV and PSU services, and vice versa;
- adequate training; altering and improving the already existing IPV and/or PSU interventions and services (e.g. through the adoption of gender-sensitive and trauma-informed approaches);
- creating new services (e.g. specialised PSU services for women, integrated services);
- co-operation between IPV and PSU services;
- provision of additional funding, and
- adequate staffing and infrastructure.

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