**IRIS Fellowship Research Project Title: Effect of a Survivor-Led Training about Intimate Partner Violence on Addictions Counselors in an Opioid Treatment Setting**

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## Introduction

There is a wealth of research that supports a relationship between opioid use and intimate partner violence (IPV), however there is little research on addiction counselors' readiness to address instances of IPV among their patients. Opioid use disorders (OUDs) have been found to be positively associated with IPV victimization, which may indicate that OUDs increase the likelihood of victimization for women, or that victimization is a risk factor for opioid use among women (Smith et al., 2012). A meta-analysis by Stone and Rothman (2019) concluded that between 36-94% of women who have used opioids are a survivor of IPV. The Centers for Disease Control (CDC) reports that about 1 in 3 women report experiencing IPV in their lifetime, meaning that the results from the meta-analysis support likelihood that women with OUD are experiencing IPV at similar or much higher rates (Centers for Disease Control, 2019). Among women receiving methadone, IPV has also been associated with recurrence of substance use (Martin et al., 2022). Lack of training about IPV can leave counselors unprepared to support patients with OUD properly through substance use treatment.

Patients with comorbid SUD and Post-Traumatic Stress Disorder (PTSD) have been shown to be more prone to relapse than patients without PTSD during traditional substance abuse treatment (Brown et al., 1996), meaning clients traumatized from IPV may be more likely to relapse than other patients. Lack of training can also put counselors at risk of early burnout and secondary traumatic stress. A study by Bride, Humble, and Hatcher (2009) found that among counselors who had caseloads with patients exhibiting PTSD, 75% had experienced at least one symptom of PTSD in the previous week, 56% met the criteria for at least one of the core symptom clusters, and 19% met the core criteria for a diagnosis of PTSD.

The purpose of this research project is to assess knowledge and perceived knowledge about IPV among addictions counselors in an opioid treatment setting, and to examine the benefits of using survivors with lived experience in educational roles during trainings about IPV. Through a survivor-led panel, this project seeks to educate addictions counselors on best practices for addressing IPV among patients.

The study therefore poses the following research question: Is participation in a training session co-led by survivors of IPV associated with improved readiness for addictions counselors within an opioid treatment setting to support clients who have experienced IPV?

## Methods

### Sample

There were 11 addictions counselors who agreed to participate in this study and who took the pre-assessment. All were employed at an opioid treatment facility in Baltimore, Maryland. Of the 11 addictions counselors, 8 (72%) were female, 8 (72%) were African American, and the mean age was 60.7 years old. The range of experience among the counselors was 2.5 years - 33.25 years working as an addiction counselor, the mean being 18.9 years. Of the 11 counselors enrolled, 8 (73%) attended the IPV training and took the post-assessment, and thus made up the final sample.

**Study Procedures**

This project used the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS; Short et al, 2006) as its key measurement tool. PREMIS is an evidence-based instrument used to assess knowledge about IPV and was used in this study as a pre-assessment for counselors before they attended a training about IPV. Survivors and the study coordinator co-led a training that addressed the gaps in knowledge assessed in the PREMIS and discussed the importance of lived experience in IPV education. Counselors then completed a post assessment using the PREMIS to see how their perceived knowledge, actual knowledge, and opinions about intimate partner violence have changed.

***Phase 1: Pre-Assessment Using PREMIS and Willingness to Attend Training Survey***

Counselors were asked to complete the PREMIS, which consists of five sections that are used to assess the readiness of providers to support clients who have experienced IPV:

1. Profile: *Collected demographic and experience information*
2. Background: *Addressed amount and kinds of trainings previously taken and used Likert scale questions to assess preparedness and perceived knowledge.*
3. Actual Knowledge: *Tested on IPV knowledge using 8 questions and 37-point assessment that has multiple choice and true/false questions.*
4. Opinions: *Consisted of 32 Likert Scale questions asking how much the assessment taker agrees with the statements about IPV provided*
5. Practice Issues: *Asked how many instances of IPV the assessment taker has reported in the past 6 months, and how much they know about IPV protocol in their workplace.*

Counselors were also asked to complete a short survey which asked them about preferences for the training being virtual or in-person, before or after work hours, and willingness to participate in the training. Counselors were paid $15 for completing the pre-assessment and training survey.

***Phase 2: Survivor-Led Training***

The study coordinator collaborated with speakers from a local community partner to create a panel of speakers with lived experience with IPV. The remainder of the training was created in collaboration with the treatment facility's on-staff psychologist and highlighted IPV protocols within the treatment facility, trauma-informed care information, the relationship between IPV and OUD, and Maryland specific IPV facts and mandated reporting laws. The training was held in-person at the counselors' workplace, after work hours. Counselors were paid $70 for attending the training. The speakers from the local community partner were compensated with a $150 honorarium per their policy.

The training consisted of two parts, a survivor panel and IPV information training. For the survivor panel, the survivors and research assistants agreed on questions ahead of the panel and agreed that survivors would have as much time as they needed to tell their story before addressing the panel questions. The panel questions consisted of: "What are some ways that

healthcare professionals can best support someone experiencing IPV?", "How can we best support survivors that are feeling shame and distrust?", and "How can counselors support clients who are not willing to leave their partner?"

In this IPV information section of the training, the study coordinator reviewed definitions of IPV, warning signs of IPV, the relationship between IPV and OUD, Maryland mandated reporting requirements, and Maryland specific IPV statistics. This section of the training also reviewed the facility-specific protocol for handling clients who report IPV or are suspected of experiencing IPV.

***Phase 3: Post-Assessment and Training Evaluation***

The study coordinator distributed the post assessment to counselors including the PREMIS and an optional qualitative self-report evaluation of the training assessing the counselors' satisfaction with the Survivor Panel and the remainder of the IPV training information. The evaluation asked counselors the following open-ended questions: "Describe what you liked about the training", "Describe what you did not like about the training", and "Describe some topics you want to explore in the future with IPV, or any additional comments". In addition to these open-ended questions, counselors were also asked to complete three multiple choice questions about their satisfaction with the speakers, the IPV presentation, and the overall training. Counselors were given $15 for completing the post assessment.

**Data Analysis**

Wilcoxon test was used for mean differences due to the small sample size for this project. A correlational analysis was run for the following variables: age, gender, number of hours of previous IPV training, years in practice as an addiction counselor, perceived knowledge, perceived preparation, opinion scaled scores, and total score of the actual knowledge section. A comparison was done at pre-assessment and post assessment between the two groups ("did not attend the training" and "attended the training"). There were no statistically significant differences found between the two groups at pre-assessment. However, at post assessment, analysis showed close to statistically significant differences in reported scores for perceived knowledge (p=0.052) and for scores of perceived preparedness (p=0.052). (Table 1)

Table 1: Comparison at Post Assessment

| | | Total | Not Attended | Attended | Comparison | | |
|---|---|---|---|---|---|---|---|
| Variable | Label | (N=11) | (N=3) | (N=8) | Test | Test Value | p |
| p_hrsprtrn | 2. Estimated total number of previous IPV training: | 8.6 ± 14.3 | 21.3 ± 24.4 | 3.9 ± 5.1 | Wilcoxon | 0.63 | 0.530 |
| p_Prep | Scores for Perceived Preparation | 4.7 ± 1.5 | 3.1 ± 1.0 | 5.3 ± 1.2 | Wilcoxon | -1.94 | 0.052 |
| p_FltKn | scores for Perceived Knowledge | 4.4 ± 1.4 | 3.0 ± 1.3 | 5.0 ± 1.0 | Wilcoxon | -1.94 | 0.052 |

## Results

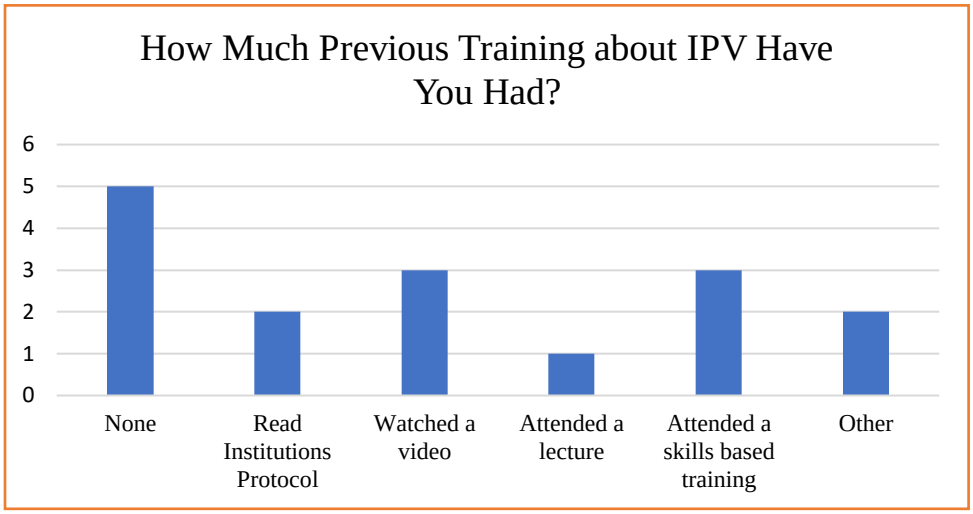
**<u>Pre-Assessment Phase</u>**

There were 11 counselors who consented to participate and took the pre-assessment PREMIS which measured actual knowledge, perceived knowledge, perceived preparedness to handle IPV situations.

**Background:**

Past Trainings: Of the 11 participants, 5 (45%) reported having no previous training about intimate partner violence, 2 (18%) reported having read their institutions protocol, 3 (27%) reported having watched a video about IPV, 1 (9%) reported having attended a lecture, 3 (27%) reported having attended a skills-based training, and 2 (18%) reported other training opportunities. (Figure 1)

Figure 1: How Much Previous IPV Training Have You Had?




Estimated total Hours of IPV Training: 5 (45%) counselors reported 0 hours of training, 4 (36%) reported 1-5 hours of training, 1 (9%) reported 6-10 hours of training, and 1 (9%) reported 45-50 hours of training.

Perceived Knowledge/Preparedness: The questions for preparedness are posed in a Likert scale (1- Not at all prepared to 7- Quite well prepared). The mean score for perceived preparedness among all 11 counselors was 3.9 (SD: 1.4), the mean for those who ended up attending the training was slightly higher at 4.2 (SD: 1.5) (Table 2). The questions for perceived knowledge are posed in a Likert scale (1- [Knows] Nothing to 7- [Knows] Very Much).The mean score for perceived knowledge among all 11 counselors was 3.7 (SD: 1.2), and slightly higher for the 8 counselors who attended the training at 3.8 (SD:1.4).

Table 2: Comparison at Pre-Assessment

| | | Total | Not Attended | Attended | Comparison | | |
|---|---|---|---|---|---|---|---|
| Variable | Label | (N=11) | (N=3) | (N=8) | Test | Test Value | p |
| i_hrsprtrn | 2. Estimated total number of previous IPV training: | 6.1 ± 14.1 | 17.3 ± 26.6 | 1.9 ± 2.3 | Wilcoxon | 0.86 | 0.391 |
| i_Prep | Scores for Perceived Preparation | 3.9 ± 1.4 | 3.2 ± 0.9 | 4.2 ± 1.5 | Wilcoxon | -1.03 | 0.304 |
| i_FltKn | scores for Perceived Knowledge | 3.7 ± 1.2 | 3.6 ± 0.8 | 3.8 ± 1.4 | Wilcoxon | 0.10 | 0.919 |

**Actual Knowledge:**

This assessment is scored out of 37 points for 8 questions. The questions include multiple choice, true/false, and “select all that apply” questions. The average (mean)

score for this section was a 21.8 out of 37 (59%), and the median score was a 21. The lowest score received on this section was 13 out of 37 (35%) and the highest score was 31 (83%). (Table 2)

There were 8 counselors who attended the survivor-led training, and the average score of the pre-assessment knowledge section for these 8 participants was 22.6 out of 37 (61.1%).

Table 2: Actual Knowledge Scores

| | **Scores in Ascending Order** |
|---|---|
| **Lowest Score** | 13 |
| | 15 |
| | 17 |
| | 18 |
| | 20 |
| **Median** | 21 |
| | 23 |
| | 26 |
| | 28 |
| | 28 |
| **Highest score** | 31 |
| | |
| **Mean** | 21.8 |
| | |

**Practice Issues:**

4 counselors (36%) reported identifying IPV among their patients in the previous six months. Each of these 4 counselors reported providing information about IPV resources, and counseling patients about their options with IPV. One participant reported helping develop a personal safety plan, and 1 reported conducting a safety assessment.

**Post-Assessment Phase**

Of the 11 counselors who agreed to take the pre-assessment, 8 (72%) attended the survivor-led training. Of the 8 counselors who attended the training, 5 (62.5%) were female, and 6 (75%) were African American. All 11 counselors were allowed to take the post-assessment PREMIS, but counselors who attended the training also had the opportunity to fill out an optional anonymous evaluation of the training. The post assessments were handed out 2 weeks after the training, and counselors had a week to complete.

**Background:**

Perceived Knowledge/Preparedness: Analysis showed close to statistically significant differences in reported scores for perceived preparedness (p=0.052) and for scores of perceived knowledge (p=0.052) between those who attended the

training, and those who did not. The mean for perceived preparedness among those who attended the training was 5.3 (SD:1.2) compared to the previous 4.2 mean in the pre-assessment. The mean score for perceived knowledge was 5.0 (SD:1.0), compared to the previous 3.8 in the pre-assessment.

**Actual Knowledge:**

Counselors who attended the training: 8 out of the 11 counselors (72%) attended the training. The average (mean) score of the post assessment PREMIS actual knowledge section was 27 out of 37 (72.9%), compared to the previous 22.6 (61.1%) averaged in the pre-assessment. None of the participants who attended the training had a lower post assessment score, but one participant's score did remain the same. The average change in score was +4.4 points, with a range of 0–14-point individual improvement in score. This was considered not statistically significant.

**Training Evaluation**

Four counselors turned in anonymous evaluations of the IPV training. Responses to the training were predominantly positive. Several reported enjoying both the speaker panel and the IPV presentation. When responding to what they did not like about the training, one person responded that they wished the training had stayed within the allotted hour (the training went 15 minutes over due to one of the speakers running late). And one person stated they would have preferred one speaker and more IPV presentation material. In the post-training evaluation, counselors requested the following topics to be explored in the future: an action plan within the clinic for patients seeking assistance, the best ways to support individuals that are experiencing IPV, protocols for documenting IPV, IPV from a male perspective, and extended resources for referrals. The results from the multiple-choice questions are displayed in figures 2-4 below.

Figure 2: How much would you say you learned from the Community Partner Speaker Panel?

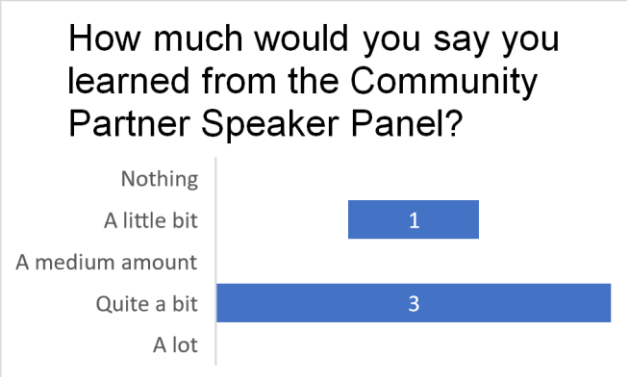



Figure 3: How much would you say you learned from the IPV Presentation?

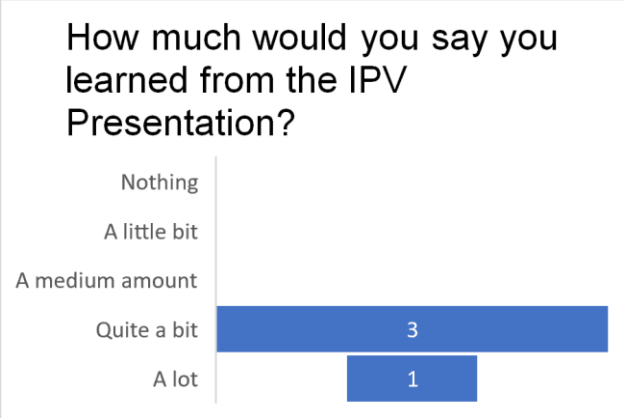
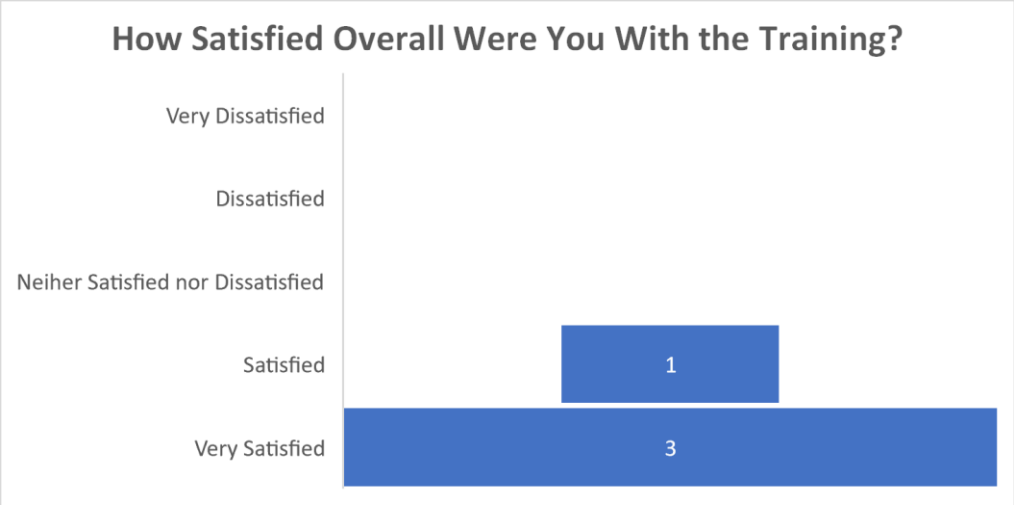


Figure 4: How satisfied were you overall with the training?




## Discussion

The scores from the actual knowledge section of the pre-assessment support that there is a gap in IPV knowledge among this sample of addictions counselors. Although there were technically no statistically significant results, there were individual results among counselors that showed engagement with material and improvement in IPV knowledge. The hope for this project was to provide further evidence that that survivor involvement in IPV training can be an effective tool for increasing readiness to address IPV, however that goal for this small sample may have been too ambitious.

There were several limitations within this study. The first was sample size. There were only 11 participants in this study, meaning that the data gathered from this sample is not necessarily generalizable. There was also only one measure used to assess knowledge and readiness to address IPV. The PREMIS has been used to assess IPV knowledge among physicians, nurses, pharmacists, administrators, and students; however future projects with a larger scope may consider using multiple measures, and more recent measures, to assess knowledge and perceived knowledge about IPV. Another limitation was that the project only included one 60-minute training and one post assessment provided two weeks after the intervention. Ongoing training and engagement with IPV advocates, survivors, and educators

will be paramount for continued confidence in assisting patients who disclose IPV. If the project were to continue, the addition of another post assessment would be ideal to measure long-term efficacy of the training. In a similar study conducted by Martin-Engel et al, (2021), a second follow-up assessment was conducted six months after the training to assess long-term efficacy of the training. Results from this study showed the "mean actual knowledge score trended toward improvement 1 month postintervention (P=.07), with improvement becoming statistically significant 6 months postintervention (P=.05)," (Martin-Engel et al, 2021).

Although the reach of this project was limited, and continued assessment of IPV knowledge among addiction counselors is needed at this treatment facility, participation in this project has ignited productive conversations about future policy and related assistance for staff members.

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