

Safety and Sobriety:

**Best Practices in
Domestic Violence and Substance Abuse**

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**Domestic Violence/Substance Abuse
Interdisciplinary Task Force
Of the
Illinois Department of Human Services**

Task Force Chairs: Larry Bennett and Margee Morrison
Editor, Best Practices Document: Debi Edmund

Domestic Violence/Substance Abuse Interdisciplinary Task Force Members

Lynn Ange, Violence Prevention Center of SW Illinois
Larry Bennett, University of Illinois Chicago, Jane Addams College of Social Work
Vernie Beorkrem, IFVCC
Carol Brigman, IDHS, Bureau of Domestic and Sexual Violence Prevention
Dawn Bushma, United States Probation Office, Northern District of Illinois
Robert Campbell
Mary Coleman, IDHS, Bureau of Domestic and Sexual Violence Prevention
Reshma Desai, Rainbow House
Bharti Dev, Apna Ghar
Steve Doherty, Provident Counseling
Debi Edmund, Positive Options, Referrals and Alternatives (P.O.R.A.)
Mike Feinerman, Christine Call and Associates
Pamela Frazier, N' The Spirit Transformational Living
Suja George, IDHS, Bureau of Domestic and Sexual Violence Prevention
Karen Gill, IDHS, Bureau of Domestic and Sexual Violence Prevention
Daphne Glanton, Heartland Alliance Women's Program
Ruben Gonzalez, Resurrection Health Care/ProCare Centers
Julia Green, Gateway Foundation
Jeanné Hansen, IDHS, Division of Alcoholism and Substance Abuse
Jessica Hayes, IAODAPCA
Marco Jacome, Healthcare Alternative Systems
Robert Jenkins, Gateway Foundation
Bridget Kelly, Treatment Alternatives for Safe Communities
Janet Knappen, IDHS, Bureau of Domestic and Sexual Violence Prevention
Jeb Kresge, PHASE/WAVE
Amy Lehrner, University of Illinois at Urbana-Champaign
Barbara Cray Lokaitis, IAODAPCA
Kenneth Martin-Ocasio, Lifelink Latino Family Services
Margee Morrison, ADV and SAS
Erica Oliver, Gateway Foundation
Jennifer Orban, IAODAPCA
Charles Parker, IDHS, Division of Alcoholism and Substance Abuse
Mary Jo Peavy, IADDA
Susan Peters, Safe Passage
Judy Petit, PHASE/WAVE
Allison Popowski, Family Shelter Service
Lynn Siegel, Pillars - Constance Morris House
Pam Stewart, IDHS, Bureau of Domestic and Sexual Violence Prevention
K. Sujata, Apna Ghar
Pam Thompson, NICASA
Randall Webber, Chestnut Health Systems/Lighthouse
Deborah Williams, A Woman's Place Domestic Violence Program
Pam Wiseman, Safe Passage

Field Reviewers for Best Practices Document

Patricia Bland, Alaska Network on Domestic Violence and Sexual Assault

Janice DiGirolamo, Illinois Family Violence Coordinating Council

Maya Hennessey, IDHS, Division of Alcoholism and Substance Abuse

Catherine McNeilly, Illinois MISA Institute

Patricia O'Brien, University of Illinois at Chicago

William L. White, Lighthouse Institute/Chestnut Health Systems

Dedication

This document is dedicated to the thousands of victims, addicts and children who daily seek safety, sobriety and justice.

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Note: Information regarding Illinois Department of Human Service funded domestic violence providers and substance abuse treatment providers can be obtained at <http://www.dhs.state.il.us/> .

Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse

Introduction: 2000 Edition

In December 1997, the Bureau of Domestic Violence Prevention & Intervention of the Illinois Department of Human Services convened an advisory group to discuss the frequently co-occurring problems of domestic violence and substance abuse. The 30 members of the Domestic Violence-Substance Abuse Interdisciplinary Task Force were drawn from the domestic violence and substance abuse practice and policy communities, academia, and government, including the DHS Office of Alcoholism and Substance Abuse.

In conjunction with the Illinois Family Violence Coordinating Council, and with the support of the Illinois Violence Prevention Authority, Illinois Department of Human Services, Illinois Coalition Against Domestic Violence, Illinois Alcohol and Other Drug Abuse Professional Certification Association, and a number of private sponsors, the first Better Practices in Substance Abuse and Domestic Violence conference convened in Bloomington in May 1998. This conference succeeded beyond anyone's expectations, drawing nearly 400 participants from across the spectrum of service providers and policy makers in the state. In June 1999, the second Best Practices conference was held in Springfield. The theme of that conference, and the title of this manual – Safety and Sobriety – was drawn from a keynote address by Theresa Zubretsky.

The task force has met for the past two years. While there are few areas where the task force could reach a true consensus, there are some key points about which we do agree:

- Substance abuse problems and domestic violence overlap and they often co-occur. However, substance abuse and domestic violence are different problems, and they require different interventions.
- There are multiple causes for both substance abuse and domestic violence. There is little evidence that either problem causes the other.
- Active substance abuse by the perpetrator of domestic violence or active substance abuse by the victim of domestic violence threatens the safety of the victim.
- Domestic violence impairs the opportunity for addiction recovery and threatens sobriety.
- Regardless of setting, workers in all fields will be more effective if they consider the perspectives of safety, sobriety, and justice for the people with whom they work.

One of the tasks this group agreed to undertake is development of a best practices document which reflects the state of the art in substance abuse/domestic violence practice. The document is grounded in the 1997 booklet Substance Abuse Treatment and Domestic Violence published by the Center for Substance Abuse Treatment and distributed to participants at the 1998 conference.

The document you are reading was conceptualized as a brief, hands-on, Illinois-specific tool for use by substance abuse professionals, the domestic violence community, and workers in other areas such as criminal justice, child welfare, and public assistance. The core sections of the document target four populations defined by the settings where they would first be encountered: (1) men in batterers' programs, (2) men in substance abuse treatment programs, (3) women in domestic violence victim programs, and (4) women in substance abuse treatment. The task force believes these four settings – in addition to criminal justice, child protection, and public assistance – are the settings where the confluence between substance abuse and domestic violence can be most effectively addressed. Sections are added to address populations (cultural minorities, gays, and lesbians) and settings (child welfare, public assistance, and criminal justice) that could not be adequately addressed in the main sections.

This is only one of many ways to organize a document such as this, and we make no claim to it being the best way. Each of the four sections is designed for staff working in one of those settings. For example, the section on women in substance abuse programs targets addiction counselors working with women's treatment programs. The section assumes that addiction counselors do not need education in addictions, but are likely to need information about domestic violence. Specifically, they may need to learn about domestic violence as it affects practice with women currently receiving addiction treatment. The other three sections follow a similar pattern, targeting staff in batterers' intervention programs, addiction counselors in men's treatment programs, and domestic violence advocates.

There are a few things the reader should know about this document. First, it is not designed to be read cover-to-cover like a book. We believe the best way to use the document is to select the section best corresponding to the type of setting in which you work, then to read the other sections as interests direct. Second, the document was developed by individuals working in a committee. Consequently, it has all the advantages and disadvantages of committee products. On the one hand, it lacks a single voice and may at times appear uneven or disjointed. On the other hand, it reflects a much broader base of opinion than most material you can read in this area. There are parts of the document which contradict other parts of the document. These contradictions reflect the disagreements between knowledgeable practitioners within and between their respective fields. Finally, where research exists to support a perspective, it is reflected in the document. However, there is little actual research to support practice in this area, so we depend heavily on the experience of practitioners to fill the knowledge gaps.

On behalf of the Domestic Violence-Substance Abuse Interdisciplinary Task Force, I welcome readers to join and contribute to the movement to link the domestic violence and substance abuse fields in a way that will enhance the safety and sobriety of the people who look to us for help.

Larry W. Bennett, Ph.D.
University of Illinois at Chicago

Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse

Introduction: 2005 Edition

The Domestic Violence-Substance Abuse Task Force has continued to meet since the publication of the first Best Practices Manual in 2000. This group of individuals remains dedicated to the philosophy that victim safety is paramount. They have not wavered from this in their work. The task force has evolved from looking at why domestic violence and substance should be addressed as co-occurring issues to how the issues can be addressed in a variety of programs. Over the last five years, the members of the task force have dedicated their time, talents, and resources to enhancing services to those in need.

With a great deal of support and coordination by the Illinois Department of Human Services (Bureau of Domestic Violence Prevention and Intervention and the Division of Alcohol and Substance Abuse), the Task Force hosted Safety and Sobriety Conferences in 2000 and 2001. The conferences again brought together a cross-section of providers from throughout both the domestic violence and substance abuse treatment fields. These professionals came together to share their insights, their successes, and their tribulations. Counselors, therapists, advocates, and others came to learn from one another on how to best meet the needs of individuals whose lives are affected by both substance abuse and domestic violence. They learned from one another and found others in related fields who shared their concerns and aspirations.

Another result of the work of the task force and the Illinois Department of Human Services was the Substance Abuse/Domestic Violence Pilot Initiative. Illinois recognized the need for integrated services for women. A later chapter in this manual provides an overview of the pilots, a review of the literature on the topic of the co-occurrence of domestic violence and substance abuse, and an examination of project evaluations and its findings.

In 2002, the task force, under the direction of Larry Bennett, Chair, undertook the monumental task of updating the Best Practices Manual. The task force was assisted by Karen Gill, DHS staff, and Jeanné Hansen, DASA staff. Their dedication and commitment to the project was exceptional. The Best Practices Manual is the product of a great deal of research, study, and sweat of many members of the task force. Along with revising the manual, DHS staff undertook the development of training materials on domestic violence and substance abuse. These materials provide another means of getting information to those in the field who need basic information on the issues confronted by professionals in both arenas. The training materials are invaluable resource in conjunction with the Best Practices Manual.

Margaret M. Morrison, M.S. Ed., J.D.
ADV & SAS, Streator, Illinois

Note: The opinions expressed in this document are those of the Illinois Domestic Violence-Substance Abuse Interdisciplinary Task Force and do not necessarily reflect the opinions of the Illinois Department of Human Services or any of its constituent offices, bureaus, or programs. This document is not intended as legal advice and programs should consult with their own attorneys on all such matters.

Definitions

Domestic Violence

Domestic violence as defined by the American Psychological Association (APA, 1996) is: “a pattern of abusive behaviors including a wide range of physical, sexual, and psychological maltreatment used by one person in an intimate relationship against another to gain power unfairly or maintain that person’s misuse of power, control and authority.” Domestic violence, simply stated, is an attempt to control the behavior of an intimate partner. Abuse is a misuse of power that uses the bond of intimacy, trust, and dependency to make an intimate partner, man or woman, feel unequal, powerless and unsafe. Domestic violence is a crime under the Illinois Domestic Violence Act (725 ILCS 5/112A-1)(750 ILCS 60/102).

Substance Abuse and Addiction

Substance abuse is a destructive pattern of use of drugs including alcohol, which leads to clinically significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of the substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of the substance), it is likely that the person has progressed from abuse to dependence, or addiction. Addiction is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with drugs or alcohol, use of drugs or alcohol despite adverse consequences, and distortions in thinking, most notably denial. Addiction is a treatable disease and long-term recovery is possible. — *Adapted from definitions developed by the American Psychiatric Association and the American Society for Addiction Medicine*

Coordinated services

In this document, “coordinated” describes a situation where AODA and DV services are provided by different agencies. The services may be provided at the cross agency (i.e. AODA services provided to DV clients at the AODA agency) or in-house (i.e. AODA services provided to DV clients at the DV agency by the AODA agency), but in either situation, there is active case management between the AODA agency and the DV agency. In some large agencies with separate AODA and DV programs in different settings and no shared staff, we could also use the term “coordinated” to describe the services.

Integrated services

In this document, “integrated” describes a situation where AODA and DV services are provided by the same agency, and there is some sharing of staff. The programs may be theoretically integrated (i.e. both AODA and DV services are based on a common perspective or practice model, such as gender-based power or cognitive behavioral treatment) or just physically integrated (i.e. offered at the same setting with some staff overlap and consulting). In some large agencies with separate AODA and DV programs in different settings and no shared staff, “coordinated” is a better description of the services.

Lessons from the Illinois Substance Abuse/Domestic Violence Pilot Initiative

At the time the first edition of this manual was produced and distributed by the Domestic Violence/Substance Abuse Interdisciplinary Task Force, the idea of working with women toward safety and sobriety was conceptually rich but empirically untested. The “best practices” manual and the discussions it provoked over the course of three summer conferences led to the state of Illinois funding the Substance Abuse/Domestic Violence Pilot Initiative to implement integrated services for women. The pilot project was a joint effort of the Office of Alcohol and Substance Abuse (OASA) and the Bureau of Violence Prevention and Intervention. The project included the development of treatment/services for women by four collaborations covering six agencies and an evaluation of the Initiative by the University of Illinois at Chicago/Jane Addams College of Social Work. This chapter provides some of the literature on the co-occurrence of substance abuse and domestic violence and describes the evaluation and its findings with some recommendations for further development and study.

Co-occurrence of substance abuse and domestic violence

One million episodes of intimate partner violence are documented each year (Bachman & Saltzman, 1995), and this figure probably underestimates the extent of the problem. About 5% of women over age 18 use illegal drugs and 40% have used alcohol in the past 30 days (SAMHSA, 2001). The lifetime prevalence of substance abuse and domestic violence among women in community samples is 18% and 34% respectively (Miller & Downs, 1993).

Among substance abusing women, the prevalence of intimate partner violence has been estimated between 40% and 80% (Bennett & Lawson, 1994; Miller, Downs, & Gondoli, 1989; Stark & Flitcraft, 1996). Downs (2001) found that a majority of women in substance abuse treatment had been the victim of intimate partner violence. Links between adult female substance abuse have been established for both violence in the family of origin (Miller & Downs, 1993) as well as intimate partner violence (Miller, Downs, & Gondoli, 1989). Our best evidence-based perspective is that substance abuse by women and domestic violence toward women have a reciprocal relationship: either one increases the risk for the other (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997) and likely a reduction in either one leads to a reduction in the other.

*This summary is excerpted from *Lessons from the Illinois Substance Abuse/Domestic Violence Pilot: Results of the Implementation and Outcome Evaluation*, by Patricia O'Brien, University of Illinois at Chicago, Jane Addams College of Social Work. The study was supported by State of Illinois General Revenue Funds and made possible by a grant from the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse, Melanie Whitter, Associate Director.*

Explanations for the role of substance abuse in the abuse of women by intimate partners are fraught with difficulty, in part because these explanations suggest, directly or indirectly, that a woman's abuse of alcohol or drugs plays a causal role in her victimization. The general population believes that women who are drinking are more responsible for their own victimization than women who are not drinking (Richardson & Campbell, 1982). In an emergent traumatological perspective on domestic violence and substance abuse, women are seen abusing alcohol or drugs as a means of coping with earlier trauma (Harris & Fallo, 2001). Such perspectives do not usually address resiliency, the strengths of battered women, or the social etiology of men's abuse of women. Nor is this perspective unequivocally supported in clinical samples. In one recent study of 125 primarily African-American women in substance abuse treatment, there was no direct link between violence in their family of origin and adult substance abuse (Call, 2002). Self-silencing beliefs and subjective distress combined with male partner abuse offered the best picture of women's current substance abuse.

In addition to the woman's own use of drugs and alcohol, living with someone who has drug or alcohol problems also increases her risk of partner violence (El-Bassel, Gilbert, Schilling, & Wada, 2000). Substance abusing women are more likely than non-substance abusers to live with men who are substance abusers, and they are more likely to use physical violence to retaliate for being battered, which in turn increases their risk of more serious injury. Substance abusing women may also be less likely to have the social and financial means to escape from their batterer, and so may remain in a relationship longer. While some women may use alcohol or drugs to self-medicate physical and emotional pain, feminists suggest the key dynamic in the link between substance abuse and domestic violence is power motivation by male abusers and indirect cultural support for men abusing both substances and women as mechanisms of male dominance (Gondolf, 1995).

Pilot description

From July 2000 to June 2001, all women who requested domestic violence or substance abuse services from the six pilot agencies were screened on an 8-item survey regarding the cross-issue. If the screen identified a need for the cross-service, or if women in conversation with a staff member indicated a need for the cross-service, they were invited to participate in the pilot evaluation and admitted to the specialized services which, depending on the program, could be in the same building, down the street, or several miles away. Table 1 presents the community locations across Illinois and the population served in their project. As defined by the Office of Alcoholism and Substance Abuse, in the coordinated model, the DV and SA agencies collaborated to provide services to mutual clients. In the integrated model, the same agency provided both DV and SA services to their clients.

Table 1 Description of 4 pilot projects

Project	Type of project	Community	Sample in the study
A	Integrated (23% of sample)	Large town	Mostly white
B	Integrated (8% of sample)	Suburban	Mostly white
C	Coordinated (49% of sample)	Urban	African American & Spanish Speaking
D	Coordinated (20% of sample)	Urban	African-American

All of the pilot agencies had a similar mix of treatment/services for the women who had been identified as eligible for the enhanced services. These services included crisis intervention to assist women to get into emergency shelter, case management services, counseling, and advocacy, and assessment, planning, and referral for substance abuse treatment and aftercare.

Study Methods

The evaluation recruited 255 participants at program entry and conducted follow-up interviews with 128 participants (50% of the total). The study examined women's substance use, perceived vulnerability to abuse, and perceived self-efficacy over a four to six month period. A series of repeated interviews of a total of 23 pilot staff at three different points of implementation elicited their perceptions of the collaborative development of services and satisfaction with the outcomes. Focus groups with 50 pilot participants assessed their satisfaction with the services and recommendations for additional services.

Findings

Though each pilot project served different constituencies located in different parts of the state, demographics are presented in Table 2 as a total of all participants in the pilot agencies.

Table 2--Participant demographics and other participant data (total number = 255)

Average age:	35.2 years
Race/Ethnicity	
African American	44%
White	38%
Latina	12%
Education	
Less than 12 th grade	36%
HS diploma/GED	39%
Some college/BA	25%
Having minor children	71%

Mandated to attend treatment	58%
Living with a spouse/partner	38%
Living with someone with SA problem	37%
On probation or parole at admission	33%
Taking psychotropic medication at admission	20%
Substance use in past 30 days	
Multiple substances	68%
Crack/cocaine	34%
Alcohol	33%
Heroin/Marijuana	15/14%

Participant Outcomes

At follow-up, almost 80% of the 128 women had received more than 20 sessions of individual or group counseling, and 32% were still receiving treatment or services from the pilot.

- Drug and alcohol abuse decreased markedly from baseline to follow-up. The number of days that women reported using a substance in the past 30 days declined significantly, from 6.36 to .94. The percentage of women reporting that they had not used in the past 30 days increased from 57% to 87%.
- Women reported increases in the average number of days they had attended a 12-step meeting in the past 30 days, from 4.84 to 7 days.
- The percentage of women who reported they were currently in an abusive situation declined from 21% to 11%.
- The percentage of women reporting that they had not been arrested in the past six months increased from 66.7% to 96.9%.
- Women's degree of self-efficacy, as demonstrated by the Domestic Violence Self-Efficacy (DVSE) scale (Riger, Bennett, Schewe, Campbell, & Frohmann, 2002), increased from 28.5 to 32.3. This indicated a greater degree of confidence in managing life situations (and indirectly, in making choices about their sobriety and safety).
- The women's scores on the Women's Experience of Battering scale (Smith, Tessaro, & Earp, 1993) showed a reduction of 28.4 to 25.4 from baseline to follow-up indicating a perceived reduction in their vulnerability to domestic violence.
- Women participating in the pilot indicated a high degree of satisfaction with the services they received. 89.3% of the women said they would recommend the program to someone they knew was experiencing domestic violence or had substance abuse problems. The average score on the Client Satisfaction scale was 70.22 (the range was 64-71.6), indicating a positive opinion of services provided by the pilot programs.

Discussion

Based on the results of the pilot evaluation study, women participating in enhanced services in Illinois experienced reductions in their alcohol and other drug use, as well as increases in their ability to manage their lives (as reflected in increased scores on the DVSE scale) and a lessening of their perceived threat of violence (as reflected in lowered scores on the WEB). Women also experienced improvements in employment and physical and mental health, and were arrested fewer times. Clients were highly satisfied with the services, as indicated by their scores on the CS scale and their comments during the follow-up interviews and focus groups. Each agency's services resulted in *some* improvement to participants in the pilot. There was no difference in this overall finding between those that were located in more rural areas of the state as compared to the urban-located agencies; there was no difference between the coordinated agencies versus the integrated agencies. Participants in the focus groups articulated a sense of relief for the opportunity to discuss both substance abuse and domestic violence in the same program. As one participant said, "They go hand-in-hand." Women mentioned minor gaps in service delivery including transportation for getting to individual or group sessions and inconsistencies in child care availability. A major overarching strength that participants identified was the caring and compassion demonstrated by staff members, a hallmark of empowering practice with women.

Providers were also satisfied with their involvement in the pilot project, though they recognized the multiple challenges in creating the coordinated services that their clients need. If practitioners in both the disciplines of domestic violence and substance abuse treatment have trouble understanding and accepting one another's worldviews, this clearly affects the effectiveness of services. By the conclusion of the implementation of the pilot, all of the pilot staff recognized that participants were "better off" as a result of the pilot, even though most still articulated continuing frustration with differences in practice approach, treatment approach, or even work style. The outcomes for participants however, outweighed the procedural issues.

The small sample for this cross-sectional study with one follow-up point with half the baseline sample indicates a need for further study with a larger sample with a longer follow-up period. We also don't know if the changes demonstrated by the women might have happened without engagement in the enhanced services the pilot projects provided since there was no control or non-treatment group. A strategy that bolsters the credibility of this study was the use of multiple methods for data collection and analysis. The quantitative study of outcomes was consistent with findings from the qualitative study of implementation.

Models that focus on empowerment and validation for each woman's historical efforts to help herself and manage her relationships, combined with advocacy and safety planning hold the most promise. To be successful, these approaches require the development of ongoing and collaborative partnerships by addiction treatment professionals and battered women's advocates. There was no difference in this

study whether services were provided by two collaborating agencies (coordinated) or by the same agency providing DV and SA services (integrated). Comprehensive training about domestic violence, its effect on women's health and the social and political issues that perpetuate its prevalence should be available to all providers of addiction treatment. Cross-training for staff of battered women's shelters, rape crisis centers, and child protection agencies about addiction and the process of recovery is needed to help all these systems work together effectively. Cultural competence in treatment and service approaches should reflect the diversity among women in class, race, ethnicity, age, disability, and sexual orientation, as each woman's cultural identity and history can be a central source for her healing and recovery.

Given the high percentage of women in this study who were mandated to drug abuse treatment (58%), and who were also addressing the effects of abuse, it is important to discuss how mandates for treatment have an impact on agencies' capacity to deliver collaborative and confidential services. Evaluation of partnerships between systems once working in opposition to provide integrated programs that serve women in a holistic manner can inform future efforts that respond to the profound impact domestic violence and substance abuse has on the lives of many women. Clients and providers alike recognize the value of integrated services. More integrated treatment and increased cooperation among providers will reduce service delivery gaps and help more women finish treatment successfully. One of the notable benefits of this pilot initiative was a statewide investment in the pilot projects and a "buy-in" from agency administrators and line staff to implement the integrated and coordinated services. Such a commitment bodes well for future planning efforts for moving women to safety and sobriety.

Lessons Learned From Successful Collaborations

The purpose of this section is to provide an overview of successful collaborations between substance abuse and domestic violence programs. These collaborations target services for women with substance abuse problems who are also victims of domestic violence. The guiding assumptions, key program components, challenges, and lessons learned are briefly discussed.

The information in this section is based on staff interviews at eight Illinois collaborations between domestic violence and substance abuse service providers. Some of the collaborations are between different programs within a single agency, but most are the product of interagency agreements. The interviews were conducted in 2001 and 2002 by DHS staff. Four of the collaborations are DHS-funded pilot projects that have been formally evaluated¹ and four collaborations are independent, community-based efforts. The agencies participating in the interviews were: (1) Constance Morris House, and Pillars, Summit; (2) Phase/WAVE, Rockford; (3) Gateway, and Violence Prevention Center, Belleville; (4) Healthcare Alternative Systems, and Rainbow House, Chicago; (5) Leyden Family Service and Mental Health Center and The Share Program, Hoffman Estates, Family Shelter Services, Wheaton, and Prevent Child Abuse Illinois; (6) Ben Gordon Mental Health Center, and Safe Passage, DeKalb; (7) South Suburban Council on Alcoholism and Substance Abuse, East Hazel Crest, and South Suburban Family Shelter, Homewood; (8) Haymarket Center, Chicago Abused Women Coalition, and West Side Domestic Abuse Program, Chicago.

Guiding Assumptions Behind Collaborations

Successful collaborations share a number of assumptions which are summarized below:

Women with co-occurring issues need both substance abuse treatment and domestic violence advocacy services. Providers articulate that substance abuse and domestic violence are two distinct but interrelated problems which need both substance abuse and domestic violence services. Neither service is an add-on to the other, and addressing only one problem is not viewed as sufficient. Furthermore, services are offered concurrently rather than sequentially.

Safety is prioritized. Whether in domestic violence or substance abuse treatment services, a woman's safety is paramount. Safety is incorporated into the substance abuse treatment plan, and is considered in how all services are provided.

¹ The results of the evaluation by Dr. Patricia O'Brien are in the previous chapter

Interagency collaboration is the norm. Agencies promote interagency collaboration when possible because each agency brings a full range of services and resources (e.g., treatment, advocacy, children's programs, ancillary services) to bear on its problem focus. Collaboration ensures a balanced focus built on the expertise of both fields. Collaboration allows women to be identified and served at their agency of choice or at the agency from which they first seek services. Grounded in the principle of empowerment, women decide what services they want and when they are ready to utilize them.

Services may be integrated or coordinated. Collaborative models differ, and agencies/services may be either coordinated or integrated, rather than sequenced. Sequenced services traditionally require the client to complete one service before receiving the other. For example, domestic violence shelters have traditionally required women to be clean and sober before entering shelter. Coordinated services are parallel services offered in tandem, but are independent in content. These services are coordinated so that the client can attend both. Each service may be offered at the host agency. Integrated services bring the services together to the client, with programs that have been designed specifically to address both domestic violence and substance abuse issues. Integrated services are not simply blended services, but a mixture of joint services complemented by the full range of resources and programs offered by both domestic violence and substance abuse agencies. Integrated services enhance consistency of message, a holistic approach, and a focus on both safety and sobriety across services.

Key Services in Collaborations

Ongoing Domestic Violence and Substance Abuse Screening. The traditional approach to addressing the co-occurrence of domestic violence and substance abuse has been to refer women with the cross issue, when that issue surfaces, to an agency with whom the host agency has a linkage agreement. Concerns about that approach include:

- Without universal screening, staff will probably not identify the majority of cases. Staff only identify those cases in the most extreme crisis situations;
- Referrals are often not followed by clients, who may be overwhelmed, or may not recognize the connection between the violence and abuse and their substance use;
- Lack of service coordination makes attendance difficult, setting up clients for failure;
- Lack of staff education and cross-training leads to a fragmented approach at best, and a conflicting approach at worst.

The most likely result of this traditional approach is service failure, which may include relapse, being asked to leave shelter, or revictimization.

The initial plan of most collaborating partners, therefore, was to implement a universal screening at intake or soon after intake. If a woman screened positive for the cross issue, she was referred to another agency. However, it became clear that many women do not disclose the cross issue at intake, for a multitude of reasons. These reasons may include shame, fear of stigma, lack of a culturally supportive service approach, fear of being rejected for service, fear of DCFS or other sanction, denial or minimization, or simply a lack of trust in the service provider. Often, however, as the issue was raised throughout services, women would self-disclose. This led collaborating partners to recognize the need for ongoing screening. This approach suggests that screening is never complete. Staff are always alert for signs and disclosure, integrating issues of domestic violence and substance abuse into their programs. The need for ongoing screening also led to the development of an early intervention/education component.

Early Intervention/Education. Called *early intervention* by substance abuse providers and *domestic violence education* by domestic violence advocates, this group-based service approach is provided by each agency for all clients at the partner agency. Women do not have to screen positive to be in this group, which uses an educational approach to deliver information about, for example, the cycle of violence, power and control tactics of abusers, and the continuum from use to addiction. These groups not only educate all clients, but they serve as a de facto screening process, with many women subsequently identifying a need for services.

Co-location of Staff. Even with enhanced screening and early intervention/education, many women do not make the connection to the partner agency for services. Out of this common experience, projects often realized that the solution lay in co-located services; in other words, bring the services to the client. Staff from one agency are based at the partner site, either full or part time. Women tend to be most comfortable at the agency they initially chose for services and their chance of receiving the cross-service is greater if that service is provided at the agency they have selected. Co-located staff increase buy-in of all staff, raise awareness, provide educational opportunities for all staff, build relationships across agencies, and reduce turf issues. Co-located staff lead to truly coordinated services where both agencies feel a joint responsibility to the client.

Individual and Group Services. The range of services offered through co-located collaborations include assessment, counseling, safety planning, and substance abuse treatment. Services usually include both individual and group programs. Both substance abuse treatment and domestic violence services traditionally emphasize group-based assistance, but pilot projects found that many women preferred individual services for a variety of reasons, so that became part of the pilot program. Individual counseling allows confidentiality for both issues, reduces stigma and discomfort, and builds a relationship with a personal counselor. Groups are co-facilitated by a

domestic violence advocate/counselor and a substance abuse counselor. The group integrates the two issues; this is not a single-issue group with a guest speaker.

Case Management. Case management is an approach to human services which emphasizes the use of individualized assessment, matching assessment to service, advocacy for needed services, provision of both counseling and concrete services as needed, and ongoing evaluation of both process and outcome. Case management is a core service of most domestic violence agencies and a required service in most substance abuse settings. Case management is a wonderful resource for collaborating projects. The more complex the client's issues, the more necessary case management becomes. This is especially true for women who are receiving services at both agencies.

Consultation. As individual relationships develop among staff at both agencies, case consultation develops naturally. Staff have a cross-problem contact person to call with questions or for feedback. This has been especially helpful in crisis situations. An example of how relationships facilitate consultation and support was observed at a shelter working with an addicted woman. The woman overdosed one night, and the shelter staff were understandably terrified. After calling an ambulance, they called their substance abuse treatment partner, who told them exactly what to do, what was happening, and what to expect. She drove straight to the shelter, and stayed with the staff and woman, riding in the ambulance to the hospital with the woman. Shelter staff reported a profound sense of relief and comfort in the assistance provided by the partnering agency's counselor.

Key Program Supports

Training. Training and education of staff is crucial for program implementation and staff support. Collaborating partners find that training is an ongoing effort. Training may include both in-house and cross training programs, and it may be either informal or structured. Initial "101" training often helps staff recognize their own belief systems and become familiar with the other system's culture. Training and discussion address unspoken expectations of what each partner can and cannot do, and begin to address myths and provide basic education.

Joint Staffing. Joint staffing is critical to coordinating services. Both staff are in the room talking about the same woman. This allows them to serve women better and more consistently. Often, each side has a very different picture of the woman. Also, joint staffing builds relationships among staff; as they learn to appreciate each other's expertise, mutual trust and respect begin to develop. Teachable moments provide informal training opportunities. Collaboration is a big-time commitment, and the payoff is equally big. Collaborating agencies comment that there is no shortcut to developing trust and building relationships.

Coordinated Administration. Coordinated project administration is needed to address issues of confidentiality, policy changes, staff roles and responsibilities,

information sharing, record keeping, and program management. Time must be devoted to developing a program plan that encompasses all these issues, in addition to service content.

Monitoring Performance. One program manager found that staff implemented new screening tools for about a week, then stopped using them. She stresses the importance of supervision and monitoring of program implementation. When staff were assured that management was committed to the collaboration, and that staff would be evaluated and recognized for implementing the new tools, then the new project became firmly institutionalized within the agency.

Supervision. Staff supervision, both programmatic and clinical, is needed to ensure quality services. Domestic violence and substance abuse collaborations open new territory for most staff, and often raise personal issues that need to be addressed. Issues may be related to the staff members' personal or family experience, beliefs and attitudes toward cross-problem populations or cross-problem agencies, clinical issues which emerge during assessment and intervention, or resource management.

Common Challenges

A number of barriers to collaboration were noted in our interviews and these barriers are noted elsewhere in this manual. Issues of conflicting philosophy (e.g. medical model v. social justice perspective, personal choice v. abusive control, treatment v. advocacy), language (e.g. powerless v. empowering, enabling v. being coerced), and misunderstanding (e.g., addiction and abuse, funding, and confidentiality). Barriers to collaboration such as these are not ignored by partnered agency staff. Experience demonstrates that, as staff talk to and educate one other, they identify more common ground and common goals than common conflicts. Such identification motivates staff to develop joint programming.

Keys to Success

A number of elements emerged in the interviews which appear to be associated with more successful collaborations.

Program Champions. Successful programs often have program champions. The program champion is a staff person who sees the big picture, who will push to make the collaboration happen, who is open-minded and willing to listen, and who is willing to adapt the approach. The program champion is deeply committed to addressing both issues, and inspires others to see the connections and the essential need for the collaboration.

Vision, Commitment, Common Goal. Successful collaborations are characterized by the ability of program partners to recognize their common goals, which engenders a commitment to keep working at the collaboration when challenges arise. They have a sense of purpose about what they are doing, and a feeling of unity and teamwork

among program staff. Many projects have developed their own name, adding to their sense of cohesion. Out of the common purpose and common goals, trust develops among partners.

Openness to Flexibility, Learning, and Changing the Model. Collaboration transforms participants. No collaborative project looks the same at the end as it did at the beginning. Successful collaborations are characterized by a high level of flexibility and openness to solving problems as they arose. Each had an initial program plan and vision of how the collaboration would work, and each evolved and changed with experience. Successful collaborations all required patience, openness and time commitment to develop the program plan and to build relationships. Open and frequent communication is essential.

Co-located Services. Co-location means that an agency's services are offered not only at the host agency, but at the cross-problem agency as well. Every collaboration found its way to co-located services, which are seen to be the foundation of a strong program.

Empowerment Models and Women-Specific Treatment. Domestic violence agencies are characterized by their use of an empowerment approach. Substance abuse treatment, however, has a range of models and approaches. It appears that substance abuse treatment agencies with women-specific treatment models are the most appropriate partners for this type of collaboration. Women-specific substance abuse treatment staff are more likely to be nonconfrontational, and usually recognize the significant impact of violence and abuse on their clients' lives. These agencies are developmentally and temperamentally in the best position to develop a collaborative project with domestic violence agencies.

Resources Dedicated to the Project. In an ever-changing climate of staff, clients, and organizations, sustainability of collaboration is key. As both a sign of management's investment in the project and as necessary concrete support, resources must be dedicated to the project and sustained over time. Resources include staff time, staff supervision, training, program management, and program materials. Project oversight and accountability are key to success. Collaborations of this nature do not run themselves; they require management and ongoing monitoring.

Conclusion: Co-location, Cross-Training, and Commitment

Collaboration between community-based substance abuse agencies and domestic violence agencies are underway, and are expected to increase in number. The advantages of these coordinated efforts far outweigh the inevitable differences between staff and philosophies. Participating staff and participating clients notice the difference. Moreover, preliminary program evaluation increases our confidence in coordination, co-location, cross-training, and commitment.

While we have learned much from the eight collaborations described here, there is much more to learn. We do not know, for example, whether the highly overseen pilot projects performed better than, the same as, or poorer than the autonomous collaborations. It is not clear how much collaborations cost, nor exactly what their benefits might be. We do not know whether integrated or coordinated programs work best, or for whom they work best. Despite this lack of knowledge, we are increasingly confident that, for women who are abused by their intimate partners and also abuse alcohol or drugs themselves, a woman-specific substance abuse program co-located with an empowerment-oriented domestic violence program offers the best opportunity for safety and sobriety.

Best Practices: Addressing Substance Abuse In Domestic Violence Agencies

Common Perspectives

A significant number of women seen in domestic violence agencies suffer from substance abuse problems. A study of Illinois shelter staff suggests that as many as 42 percent of their clients abuse alcohol or other drugs (Bennett & Lawson, 1994). There are a number of reasons for this:

- Victims may begin or increase their use of alcohol/other drugs in response to domestic violence or other trauma. Alcohol/other drugs may be used to medicate the physical and emotional pain of domestic violence or to cope with the fears of being battered.
- Alcohol/other drug use may be encouraged or even forced by the partner as a mechanism of control. Efforts at abstinence may be sabotaged.
- Outcomes of victimization may include diminished self-image, guilt, shame, powerlessness, depression, sexual dysfunction, and relationship dysfunction. All of these provide a foundation for the development of substance abuse.
- Victims may have the disease of chemical dependency, and this may have preceded their victimization.

A victim with a substance abuse problem is at increased risk because:

- Acute and chronic effects of alcohol/other drug use may prevent the victim from assessing the level of danger posed by the batterer.
- Under the influence, victims may feel a sense of increased power. Victims may erroneously believe in their ability to defend themselves against physical assaults, or their power to change the batterer.
- The abuse of alcohol/other drugs impairs judgment and thought processes so that victims may have difficulty with adequate safety planning. Alcohol/other drug use makes it more difficult for victims to leave violent relationships.
- Victims may be reluctant to contact police in violent situations for fear of their own arrest or referral to the Department of Children and Family Services.
- Use of alcohol/other drugs may increase involvement in other illegal activities.
- Victims may be denied access to shelters or other services due to substance abuse.

Another perspective to keep in mind when working with substance abusing domestic violence victims is that a significant number of substance abusing women are experiencing symptoms of Post Traumatic Stress Disorder (PTSD) as a result of various forms of victimization in their life experience.

Domestic violence advocates need to be aware of this and be prepared to recognize the potential for PTSD in their clients.

Response to Substance Abuse

Because there is a significant correlation between victimization and substance abuse, all domestic violence service providers need to address the issue of substance abuse. A formal screening for substance abuse should be included in the intake process. If victims are to remain free of violence, they should understand the impact substance abuse has on their safety. It is an empowering process for both client and staff to address safety and sobriety at the same time. By assisting a woman to become safer a staff member may also be helping to eliminate the very reason that the battered woman feels the need to use or improve her ability to access treatment.

When to do a Screen

Because sobriety greatly impacts a woman's ability to get and stay safe, a screening for alcohol and drug abuse should be done with every client, whether she is seeking shelter or non-residential services. It is important to remember when working with a victim that her substance abuse may be a very reasonable response to the trauma that she may be dealing with on a daily basis.

Screening is not a one-time occurrence but an ongoing process. The administration of a screening tool should happen early in the client's stay in shelter or by her second counseling appointment if she is not residing in

shelter. The use of a screening tool is intended to not only elicit responses specific to the client's use of drugs or alcohol but also to open the door to continued dialogue. In this way the screening process continues. Ongoing screening is done through observing the client's behavior and continuing to listen to information the client shares during individual and group counseling sessions.

If a client self discloses or indicates through her actions that she has as a drug or alcohol problem, staff may decide to re-administer the screening tool to try to get more accurate responses.

Many times a client will leave services only to seek those same services later. In that instance the question arises as to whether or not to do another formal screening. Although this is not an issue with definite answers here are some guidelines:

- In the case of a known alcohol/drug abuser, it may not be necessary to do another full screen. It may be more appropriate to simply have a discussion with her to discuss her most recent use/abuse issues.
- In the case of a repeat client, it is necessary to re-screen even if her services were recent. It is imperative that it be determined where the client is today. Remember, she has gotten services from you previously, so she may be more ready to discuss how alcohol and/or drugs have impacted her abuse history.

Signs of Alcohol or Drug Use

- Smell of alcohol
- Signs of IV drug use (tracks)
- Unusual or extreme behavior
- Nodding off
- Overly alert
- Slurred or rapid speech
- Staggering
- Tremors
- Glassy-eyed/pupils dilated or constricted
- Unable to sit still
- Disoriented or confused for no apparent reason
- Argumentative, defensive, or angry at questions about substance use

Substance Abuse Screening

A substance abuse screening is an opportunity to begin discussing how substance abuse impacts safety. It is a preliminary step that determines the *likelihood* that an alcohol or drug problem exists. Screening for substance abuse involves honest and nonjudgmental discussions with individuals about their alcohol and drug use, observing their behavior, and looking for signs of use. A screening differs from an assessment. An assessment uses diagnostic instruments and processes to determine if the person is abusing, or is dependent on, alcohol or drugs. When screening for substance abuse, be sure to:

- Ask open-ended questions. This allows the woman to share and offer more information than closed-ended questions. She may find it easier to discuss her partner's use rather than her own. If this is the case, follow-up with questions about her use.

- Ensure privacy. The first step in screening is to insure that it occurs in private. Take the client to a private office or room where she is able to feel comfortable and safe. *Children should not be present because they may repeat what they hear.*
- Communicate respect and trust. It is important to establish a respectful and trusting relationship. Assure victims that, except for safety concerns, anything discussed will be held in strictest confidence unless she permits otherwise. Ensure that her honest and candid answers will not jeopardize her ability to receive domestic violence services for her or her children. You may want to encourage her disclosure and give her permission to disclose by stating that it is very common to respond to trauma by using alcohol and/or drugs. Painting the substance abuse as expected or functional normalizes her behavior. In fact, her use may be keeping her safer. Remind her that this is a safety issue and will better allow staff to help keep her and her children safer.
- Observe behavior. Using the symptoms in the box (see "Signs of Alcohol or Drug Use"), observe the client's behavior, looking for signs of drug or alcohol use.
- Ask questions. There are several recognized screening tools for alcohol or drug use included in the Appendix, including the tool used by the Illinois Department of Human Services pilot sites. Also in the Appendices you will find a set of guidelines for the use of the screening tools from the pilot sites.

- Deal with denial. Denial can take two forms: knowing but withholding information; or not knowing the truth herself (i.e., the extent of substance abuse or the extent of domestic violence is suppressed, so she does not know it all, or it is minimized in her mind). Denial is the most frequent response to questions about alcohol/other drug use. This is especially true for women not only because they are ashamed of their behavior, but also because they fear losing their children. They also fear being denied services. It is important to give the client the support and time necessary to share her history with staff.

Intervention

What should come first: domestic violence counseling or substance abuse treatment? It is not a question of either safety or sobriety first, but rather safety *and* sobriety, since one is less likely without the other. The presence or threat of abuse often interferes with a victim's ability to achieve abstinence. Continued use of substances interferes with safety. If screening leads you to suspect that a person has an alcohol or drug problem, refer or arrange for an on-site assessment.

Linking persons to substance abuse programs requires the domestic violence staff to:

- Be informed about treatment options/providers available in their community. Refer clients only to Illinois licensed treatment providers.

- Do cross-training with substance abuse programs to increase the awareness of both issues.
- Continue open dialogue and collaboration between agencies.
- Be willing to provide service options for victims who are substance dependent, whether they are in treatment or not.

Ideally, victims should be referred to a treatment provider sensitive to the issues of domestic violence. If the batterer is in treatment, avoid referring the victim to the same program. In rural areas, this may not be feasible, and advocates will have to be sure that the substance abuse provider understands that violence is an issue. (See section on confidentiality in the Appendix.)

By assisting a woman to become safer the advocate may also be helping to eliminate the very reason that the battered woman feels the need to use or improve her ability to access treatment.

Referral

- When referring an individual to a treatment provider for an assessment, the first concern should be safety. Will an assessment interview place the client or children at risk for further harm? What strategies can be employed to ensure safety?
- What assurance does the person need to follow through with the

referral? Victims who have suffered from physical and/or sexual abuse and intimidation may be traumatized by the prospect of talking with a stranger about their use of illegal drugs or fear a drug test. What concerns does the person have about substance abuse treatment and how can they be addressed?

- What information does the person need to follow through with the referral? If the individual is referred to an off-site location, be sure she understands where to go, who she will see, and how to get there. Inform her of the costs of programs. Provide her with a letter to give to the treatment provider when she attends her intake at the treatment program. This letter could state the reason for the referral and any identified initial needs or screening findings.
- Another concern is what support the individual needs to keep the appointment. Are transportation or child care needed? Are there other barriers? The referral process necessitates developing a good working relationship with a treatment agency to jointly address the individual's needs.
- Victims of domestic violence should not be referred to programs that require conjoint or family counseling as part of substance abuse treatment.
- Many treatment providers do outreach; that is, they will attempt to visit the person at their home to engage them in treatment. If outreach will place the person or treatment provider staff at risk, it is

important to convey that information to the provider.

Substance Abuse Assessment

When a person is referred to a substance abuse treatment provider, a counselor will use assessment techniques to characterize the problem and to develop a treatment plan. The Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA) evaluates counselor competency and grants recognition to those counselors who meet specified minimum standards. All treatment programs licensed by the Department of Human Services must have credentialed staff.

Assessment involves five important tasks:

- Aid in *diagnosis* of the problem.
- Establish the *severity* of the problem.
- Develop a *treatment* plan.
- Define a *baseline*, which can be used to evaluate an individual's progress in treatment.
- Increase the individual's *motivation* to attend treatment.

A variety of methods may be used in assessing the individual, including medical examinations, clinical interviews, and formal instruments such as questionnaires. During an assessment, information is gathered to determine which aspects of the individual's life are affected by alcohol/other drug use. Areas of assessment include alcohol and drug

use, social and family relationships, psychological functioning, legal status, medical conditions, and employment and educational status. The goal is to determine if treatment is needed, and if so, the appropriate level of care. If the individual is given a DSM IV (or ICD-9) diagnosis (alcohol abuse, alcohol dependence, etc.), treatment is generally recommended.

In some settings, urinalysis may be required. For domestic violence victims who have been sexually abused, the prospect of a urine drug test may be especially threatening. Urinalysis is most commonly done to monitor treatment compliance rather than as part of the assessment.

Treatment

Treatment follows after the assessment process; the purpose is to address the substance abuse issue identified, dependence or abuse, and how it is exhibited in that particular person. Historically the focus of substance abuse treatment has been initial achievement of sobriety and then challenging the addicted individual to work towards a life of recovery. Recent changes within the field have lead substance abuse providers to start using Motivational Enhancement techniques and Stage of Change concepts. These are used in different levels of care to guide treatment, depending on the person's acceptance and desire to change. Licensed treatment providers use the ASAM PPC-2R (American Society of Addiction Medicine Patient Placement Criteria) to determine the most appropriate level of care to address the person's substance abuse problem.

The level of care is also dependent on a person's level of functioning. The criterion used matches a person to the different levels of care and increases the possibility of a successful outcome. The ASAM criteria are divided into six categories that represent different facets of a person's functioning. These are evaluated to determine the severity of the problem and the appropriate intensity of treatment needed. The six criteria from the ASAM PPC-2R are:

- Intoxication/Withdrawal Potential
- Biomedical Conditions
- Emotional/Behavioral Conditions That Can Detract From Treatment
- Readiness to Change (formerly Treatment Acceptance/Resistance)
- Relapse/Continued Use Potential
- Recovery Environment

The level of care determines the therapeutic techniques used but most levels of care will have core elements that change in depth according to the person's understanding of their substance abuse problem. Counseling techniques usually are cognitive/behaviorally based and may include different formats of therapy such as group therapy, individual therapy, family therapy, education, relapse prevention, skills training and support/self help groups. Medications may be used during the withdrawal process and/or as conjunct therapy. Levels of care available for a person with a substance abuse problem include:

- Detoxification (Level IV)
- Residential Rehabilitation (Level III.5)
- Intensive Outpatient (Level II)
- Outpatient (Level I)
- OMT (Opioid Maintenance Therapy- for those addicted to heroin using Methadone)
- Early Intervention (Level .5)

There are other treatment levels of care not indicated that are different intensities of those listed above. Each level has its purpose and its focus depending on the needs of the person in treatment. Detoxification can be separated into medical and social setting intensities with medical detoxification being the most intense due to possible life and/or health threatening withdrawals as well as possible self-harm.

Residential treatment programs provide primarily short term, one to three months, intensive treatment where a person can focus on their substance abuse problem without the influence of their living environment. This level of care is mainly for persons who cannot stop their drug use without complete separation from their environment. Residential treatment attempts to provide the structure that may have been lost due to the substance abuse problem.

Intensive Outpatient treatment consists of nine or more hours per week of direct contact with the person and helps them by initiating the process of recovery while the person remains in their

environment. This level of intensity is usually necessary when the substance abusing person has no experience with treatment, has poor or no skills to cope with problems without using substances, has other issues that can easily distract them from treatment, needs large amounts of support and motivation to remain sober, or may have medical issues that are directly related to or exacerbated by their use of substances.

Outpatient treatment's focus tends to be on skill acquisition/practice and maintaining motivation to start or maintain a recovery process or not use substances. This level of care is appropriate for the person whose substance abuse issue is not as severe such as mild to moderate dependence or abuse.

Early intervention is usually used for educational purposes when a person is identified as a substance user but does not have a substance abuse diagnosis. This level of care has also been used as a stepping stone for individuals who may have a substance abuse issue but are not motivated and/or have not considered themselves to have a problem.

For the purpose of visualizing the ASAM criteria the following concept is suggested:

**SI=IS
SEVERITY OF
ILLNESS=INTENSITY OF
SERVICE**

Once the appropriate level of care is determined, an individualized treatment plan is developed that will guide the treatment process and clearly indicate

what issues will be explored during treatment. The treatment plan is developed with the person seeking services so there is mutual agreement on the issues that will be explored. There are also clear goals and objectives identified regarding the problems identified. The treatment plan should also address barriers to treatment and resolution of these issues such as transportation to treatment, childcare arrangements, transportation to childcare, advocacy and placement. A limited number of substance abuse treatment providers are also integrating mental health services within the same agencies. This has been accomplished by providing psychiatric evaluations and follow-up as well as preparing counseling staff to provide mental health counseling in conjunction with substance abuse counseling.

In the case of a female domestic violence victim residing in a domestic violence shelter, the appropriate level of care may need to be a less or more intense level of care than the ASAM placement criteria indicate because of the other immediate psychosocial stressors, namely their domestic violence crisis. For example, often, the women who are actively abusing drugs meet the criteria for Level II (IOP), which requires a minimum of nine hours of treatment per week. It may be unrealistic and counterproductive to place them at that level. Instead, they may need to be placed in Level I (OP), which is a less intense level that only requires one hour of treatment per week. This may be much more realistic considering all of the other stressors and business that they need to attend to while in shelter. They may be more receptive to accepting treatment and not

feel that too much is being required of them. This treatment could be provided in both individual and/or group sessions with varying intensity. For example, some women may need to agree to three or four hours of treatment per week (up to eight hours is permitted at this level). The substance abuse treatment provider could structure a model conducive to this, such as a two hour group and a one hour individual session per week, totaling three hours of treatment per week. It is also highly recommended that this treatment be provided at the shelter in order to facilitate the engagement process. It would be important to document the reasons for a less intense level of treatment despite what the ASAM criteria indicate, which are the immediate factors associated with the domestic violence crisis.

Performing Urinalysis

Performing urinalysis for the detection of drugs of abuse in a domestic violence setting is a very contentious issue. Urinalysis should not be undertaken in the domestic violence setting without first examining the motivation(s) behind such actions. If urinalysis is done, it should be done by substance abuse staff rather than by domestic violence advocates. If the agency does not have a good collaboration with a substance abuse agency, performing urinalysis is not advisable.

Reasons to not consider urinalysis in a domestic violence victim service program:

- Domestic violence staff members may feel that a client is using drugs and feel compelled to “catch” this

client in lying about her drug use, thus validating the suspicions. Supervisors must teach staff members to understand the dynamics of drug and alcohol abuse because many clients may not be ready to quit their drug of choice or they may have relapsed. In addition, the agency's substance abuse policy should allow for these dynamics to take place. For example, terminating services of a chronic crack addict because she relapsed does not create the supportive environment necessary for recovery, let alone safety from abuse. Staff needing to be correct in their suspicions should examine their own power and control issues.

- Urinalysis may be desired to settle disputes between clients or confirm rumors that a client is using substances.
- Urinalysis results which demonstrate recent drug use may be the means by which staff are able to detach from difficult clients, even to the point of termination of services. Training and supervision should stress that behaviors are the issue to be addressed, not necessarily recent substance use which may be a means of survival.
- Urinalysis is only conclusive for a specific point in time. It does not indicate use before or after a specific window of time.

Reason to consider urinalysis:

- To use as a therapeutic tool with the client to monitor her sobriety in conjunction with her participation in substance abuse treatment. If the

urinalysis demonstrates no drug use, it may empower her and validate her recovery work. If urinalysis demonstrates recent drug use, the staff member and client have an opportunity to address the need for more supportive services and safety concerns that may be impeding her recovery. It also holds the client accountable for her actions.

Domestic violence staff should not be performing the urinalysis because it highlights the power differential between staff and client. Even the trained substance abuse staff member collecting the urine sample should be aware of the power and control issues that this procedure can elicit. The staff member should be fully trained on domestic violence issues in order to sensitively proceed. Understandably, the client may feel she will be punished or judged as a result of either the test results or producing the sample observed by her advocate. Many clients have experienced trauma in the past (i.e. adult or childhood sexual and physical abuse). The abuser may have controlled and monitored most of the client's behaviors. For example, when making a phone call the abuser listens on the other line or demands to watch her dress, shower and use the bathroom. Observing the production of a urine sample may decrease the client's feelings of safety and invoke past traumas. Clients should be advised of how a sample is obtained, how the results are used and any benefits or consequences. And help the client to process the feelings evoked by urinalysis, as this can help alleviate feelings of victimization.

Most often a urine sample is either tested by a dip stick on site or sent to a laboratory for testing. Dip stick tests result in nearly immediate results but are costly and less accurate.

Laboratory testing is more accurate, less costly and less immediate—up to seven (7) days for results. With any kind of testing there is a margin of erroneous results.

The length of time a drug stays in a body system varies based on many different factors such as frequency or duration of use and solubility of the substance. The table below estimates the length of time drugs can be detected by urinalysis, however; many other variables alter the estimates.

Drug Name	Detectable in Urine
Amphetamine	1-2 days
Cocaine	12 to 48 hours
Marijuana	Occasional Use: 1-7 days Chronic Use: 1-4 weeks
Opiates	1-3 days
Phencyclidine	Occasional Use: 1-8 days Chronic Use: Up to 30 days
Barbiturate	Pentobarbital: 1-3 days Phenobarbital: 1-3 weeks
Benzodiazepine	1-14 days
Methadone	1-3 days
Methaqualone	1-7 days
Propoxyphene	1-3 days

Despite the use of herbal supplements or consuming massive quantities of liquid, only time can remove drugs from detection by urinalysis, provided all the levels of testing are exhausted, including testing for Ph levels.

Biohazard/Chain of Custody policies detail how specimens are collected, stored and transported. Unless staff are trained in universal precautions regarding biohazards, like substance abuse staff, prudence would dictate not exposing staff to work related exposure. Local health departments are a good source of information regarding biohazards and universal precautions.

Supporting Sobriety

Domestic violence agencies can support victims struggling with the issues of substance abuse in the following ways:

- Assist staff in dealing with their own beliefs, feelings, and prejudices about substance abuse. Provide ongoing training to enable staff to recognize the characteristics of substance abuse and to make appropriate referrals.
- Minimize blame and moral reprobation for use or relapse, which may further disempower the victim and empower the batterer.
- Inform/advise the victim and treatment provider of the risks of conjoint couples counseling sessions.
- While providing advocacy-based counseling for substance-abusing victims, help them recognize the role substance abuse plays. It can keep them tied to the abusive relationship, increase their risk of harm and impair their safety planning ability.
- Be flexible with shelter programming to allow clients to attend out-patient treatment and/or support groups.

- Assist victims by helping them find an alternate means of empowerment as replacement for the sense of power induced by substances.
 - Include plans for continued sobriety as part of the safety plan. Help the victim understand the ways the batterer may attempt to undermine sobriety before the victim exits the shelter or completes advocacy-based services.
 - Encourage and facilitate linkage with substance abuse treatment resources and abstinence-based support groups.
 - Remain cognizant of which local substance abuse programs and support groups (Alcoholics Anonymous, Narcotics Anonymous, Women For Sobriety, church groups, etc.) provide the highest degree of physical and psychological safety for victims.
 - Review agency policies regarding substance abusing clients and re-visit the policy if necessary.
 - The probability that a victim will engage in treatment decreases if doing so will anger her perpetrator (Miller, Wilsnack, & Cunradi, 2000). The more domestic violence staff work toward the victim's safety the more likely she will be safe enough to access treatment.
 - It is also empowering for the victim to realize that the abuser wants her to be active in her addiction and to plan for his interference with treatment.
- Each victim presents unique experiences and abilities which either motivate or discourage engagement in substance abuse treatment. As her advocate, the domestic violence staff member can help the substance abuse counselor realize that allowing her to choose what interventions are best for her is best practice.

Confidentiality

Unique confidentiality laws apply to almost all substance abuse treatment programs. The law prohibits the disclosure of any information that would identify a person as having applied for, or having received treatment at federally assisted program for an alcohol or drug problem without the person's written consent. There are exceptions for mandated reports of child abuse, in certain medical emergencies or for court orders. A court may authorize a treatment program to disclose confidential patient information following a hearing at which good cause has been established and at which the patient and the treatment program have been represented. A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not sufficient, by itself, to require or permit a program to release patient information.

Information protected by federal confidentiality laws may be disclosed if the client has signed a proper consent form. To be valid, the consent must be in writing and must specify:

- The client's name.
- The name of the program making the disclosure.

- The purpose of the disclosure.
- The name of the person/program that will receive the information.
- How much and what kind of information will be disclosed.
- A statement that the client may revoke the consent at any time, except to the extent that the program has already acted on it.
- The date, event or condition on which the consent expires.
- The signature of the client and the date of the signature.

Because the potential exists for a judge to order release of the content of a substance abuse treatment file and because it may contain information that reflects negatively on the victim, special care should be taken to minimize file entries which may further victimize her. And while substance abuse treatment programs are legally hindered from re-releasing information received from programs governed by §§ 290dd-2,42 C.F.R. Part 2, information received from a domestic violence program may not apply to that statute and may be recoverable by a source harmful to the victim. Subtle and selective documentation may be the best practice.

Victims should always be advised of any potential for adverse consequences when consenting to release of information.

Domestic violence programs require that victims hold confidential any information seen or heard from other victims when

attending services. Violations of this expectation of confidentiality impact the safety and sobriety of the substance abusing victim. Both programs are encouraged to support and remain vigilant of the victim's need for confidentiality.

Other Confidentiality Considerations

Particular care should be taken to avoid victim file documentation of substance abuse related information that may reflect negatively on the victim. Although the Illinois Domestic Violence Act provides protection for this information, the best protection requires subtle and selective documentation of any negative factors. Because substance abuse and addiction are legitimate health care concerns, documenting that she is addressing needs in those areas may be preferred. Documentation of referrals to recovery groups or substance abuse treatment is less harmful in that it could be argued that those organizations also serve the needs of families concerned about another's substance abuse. Each agency must weigh the value of documenting substance abuse recovery successes in victim files against the risk of stigmatizing the victim.

Special care should be taken when releasing any damaging information about the victim to the substance abuse treatment program because their files are not protected in the same way as domestic violence files. Under certain circumstances a judge may order the substance abuse treatment file released whereas the IDVA is less liberal on exceptions. Victims should always be advised of any potential for adverse

consequences when consenting to release of information.

Should the domestic violence program release information to the substance abuse program the substance abuse treatment program is NOT legally forbidden to re-release information.

Substance abuse treatment programs require that patients hold confidential all information seen or heard from other patients when attending services. Violations of this expectation of confidentiality impact the safety and sobriety of the substance-abusing victim. Both programs are encouraged to support and to remain vigilant of the victim's need for confidentiality.

“If you take away substances and don’t deal with the trauma and pain underneath, then you leave them completely bare and exposed, with no anesthesia.”

Angela Browne speaking at the Faces of Family Violence and Trauma conference, New Haven CT, May 12, 2000.

Best Practices: Addressing Domestic Violence In Substance Abuse Treatment for Women

Common Perspectives

The importance of addressing domestic violence in substance abuse treatment for women becomes evident when one reviews the research. Women who abuse substances are more likely to experience domestic violence in relationships (Miller, Downs, & Gondoli, 1989). One study found that of women in a drug treatment center, 90 percent had been physically assaulted and 95 percent had been raped (Stevens & Arbiter, 1995). Women who experience domestic violence are more likely to misuse prescription drugs as well as alcohol (Stark & Flitcraft, 1988).

To produce successful outcomes, both issues must be treated together. Otherwise, a vicious cycle of victimization, chemical use, retardation of emotional development, limited stress resolution, more chemical use, and heightened vulnerability to further victimization results (C. Steele, 2000).

Substance-abusing women and women who have experienced domestic violence report similar experiences. Both may demonstrate:

- Isolation, shame, and guilt.
- Behaviors that others describe as bizarre or dysfunctional.
- Traumatization.
- Initial denial of the problem.

- Loss of support systems and fear of losing children as a result of admitting their problem.
- Low ego strengths.
- Magical thinking (a client's belief that the problem will simply go away as if by magic).
- Impairment of their ability to make logical decisions.
- Involvement in the criminal justice system, either as a victim or offender.
- Often seeking services only when in crisis.
- Several returns to the substance, or to a relationship where battering continues, before making a lasting change.

Interview Tips

Because of the incidence and prevalence of domestic abuse in the population of substance abusing women, it is recommended that all women served in the substance abuse treatment setting be screened for domestic abuse. When interviewing a client:

- Use caution and tact. Don't initially refer to the partner's behavior as domestic violence. Instead use language such as *inappropriate behavior*, *unhealthy behavior*,

behavior that is unsafe, and possibly abuse.

- A woman might not feel safe disclosing information to you. She may disclose more about herself when she gains confidence and begins to trust you. “When a woman does disclose, it is important to emphasize that the battering is not her fault; educate her about domestic violence and substance abuse; reduce the stigma; and perhaps most importantly, ASK HER how you can best be of assistance” (Hill, 1996).
- Proceed sequentially from the least sensitive to the most sensitive topics. Use the early (least sensitive) part of the interview for relationship-building and the establishment of trust.
- Be careful about criticizing the partner. Battered women may care for their partners and may become defensive or shut down if the partner is criticized.
- Avoid labeling survival strategies or other behaviors as co-dependent.
- Get factual information. Often a woman will give vague answers to questions. Ask her to clarify her responses. For example, ask her to talk more about her experiences in relationships.
- Avoid discounting her evaluation of her safeness. She is the expert regarding her safety.

Domestic Violence Screening

While there are formal domestic violence screening tools in the Appendix of this document, screening for domestic violence is a process which continues throughout your interactions with the woman. Also, be sure to listen for subtle disclosures of any misuse of power and control in the relationship, not simply physical abuse. Key questions which might lead to a formal screening include:

- What happens when you argue with your partner?
- How safe do you feel with your partner?
- How safe do you feel when you leave here?
- Can you tell me about a situation with your partner when yelling and screaming occurred?
- Can you tell me about a situation with your partner when things were destroyed?
- Can you tell me about a situation when your partner pushed, slapped, or hit you?
- How does your partner show respect to you?
- How does your partner attempt to control your alcohol or other drug use?
- Have your efforts to get clean and sober been sabotaged by your partner?

In addition to formal screening, counselors may observe and should note:

- Bruises or other untreated physical injuries.
- Inconsistencies or evasiveness.
- Frequently missed appointments or partner waiting for her during counseling sessions.
- Reports that partner isolates her, prevents her from attending counseling or support groups, threatens her, or forces her to do things she does not want to do.
- Evidence or reports of child abuse.
- Reports of jealousy or statements beginning with "my partner won't let me."

While clinicians once thought it best to wait until a client had achieved a reasonable period of abstinence before addressing her abuse or trauma issues, most programs now routinely ask clients detailed questions about their abuse histories in the intake interview. Ann Uhler and Olga Parker (2002) offer some guidance. Counselors should:

- Convey to every client during initial assessment that the counselor understands about abuse and trauma issues.
- Explain how the program can help with these issues.
- Determine whether the client is in a crisis related to ongoing abuse or

recent trauma that calls for immediate attention.

- Obtain the information necessary for a preliminary treatment plan, but reserve further probing for therapy rather than during assessment.

Referral

If the screening indicates a probability of abuse, you may first want to assure the client that the abuse is not her fault and declare that she doesn't deserve to be abused while you encourage her to consider either a shelter or a provider who deals with domestic violence issues. The more you know about the provider the more she will be able to determine if it is safe for her to access services.

If she chooses to not accept those services you may want to continue to encourage her while stressing the value and connectedness of both her safety and her sobriety. At a minimum, determine if there is anything about her treatment participation which places her at greater risk. Consideration for her safety should impact her level of care.

It is important to coordinate services as much as possible with the domestic violence advocate. Explain confidentiality regulations to domestic violence advocates when coordinating services, as well as the meaning of American Society of Addiction Medicine (ASAM) criteria. Ask domestic violence advocates what legal remedies may be available to the client through the Illinois Domestic Violence Act (IDVA). Joint staffings and collaborative case management involving both service providers have been shown to be

particularly helpful in addressing her safety and sobriety. When serving a mutual client, it is also helpful for domestic violence and substance abuse providers to present a united effort when advocating with other systems (e.g., Department of Children and Family Services). Coordinate discharge planning, especially when discharging from a residential program. This coordination allows the woman to identify several options, such as staying at a shelter or staying with family or friends if it is unsafe to go home.

Intervention

As substance abuse professionals know, women often have treatment issues that are different from men's. When domestic violence is added, this difference is magnified. When providing services to women, keep these points in mind:

- Safety issues can seriously affect the woman's ability to maintain sobriety. ***Make safety as well as sobriety a top priority.*** Treatment should focus on *both issues*. Develop relapse prevention plans that include safety planning and ways to cope if her partner gets violent.
- When a woman is harmed, she may be more likely to use substances to cope. She may use alcohol or drugs to medicate physical and/or emotional pain. She may even be coerced into use by her partner — the abuser will often do whatever it takes to keep the woman under his control, including forcing use of substances and threatening her if she does not continue to use.
- Often a domestic violence victim's partner is using as well, and if she leaves to find a more sober support network, there is increased risk to her safety. *Be aware that the most dangerous time for women is when they leave their abusers.*
- Recognize that even though her relationship may be a trigger for continued use, it may also be unsafe for her to leave. Victims of domestic violence aren't so much choosing to stay in violent relationships as they are choosing when it is safe for them (and their children) to leave. For many victims, this may be never. Domestic violence advocates estimate that women make an average of eight attempts to leave violent relationships before they actually do so successfully, and that disclosure, contemplation and preparation (safety planning) are key elements of the process (Hill, 1996). Discuss these issues in terms of the dilemmas they create.
- When addressing issues of noncompliance, counselors should take into account the batterer's ability to sabotage substance abuse treatment through threats or fear.
- Couple or family counseling can be very dangerous for victims of domestic violence. **DO NOT** provide information to the partner. If the perpetrator finds out about disclosure of the violence or substance use, the woman may be punished. Residential substance abuse treatment programs with strong family components need to be sensitive to the victim's special needs for outside support

- *Domestic violence is not caused by substance abuse and is not merely a symptom of substance abuse.* Domestic violence is an issue of *power and control*, however often people identify anger as a symptom. Battered women often blame themselves for the beatings they have suffered. Victims often believe they are being abused because of their substance use and some substance abuse counselors believe this as well. Therefore, it is important to stress that abuse is not the victim's fault.
- Avoid language that implies there is something wrong with the victim or that she caused her own abuse. Some examples of words to avoid are *codependency*, *enabling*, and *powerlessness*. It is important to avoid *codependency* and *enabling* because these concepts do not hold the batterer fully accountable for his behavior. In the domestic violence community, *codependency* is a term for a woman's adherence to the socially sanctioned roles of women, and is always inappropriate when applied to domestic violence victims.
- Confrontational techniques are not appropriate for victims of domestic abuse. They can be interpreted by the woman as an extension of how the abuser treats her.
- Trauma survivors may be particularly sensitive to visually monitored urinalysis. When necessary, the observer should be well trained about domestic violence, so as not to revictimize the woman when interacting with her.
- Some 12 Step groups' concepts can pose problems for women. These include submission to a higher power referred to exclusively in male terms, emphasis on "character defects," limited emphasis on strengths, and discouragement from talking about the abuse that has happened to them. "Twelve-step programs rarely address the impact of post-traumatic stress disorder and fail to acknowledge the situational nature of substance use" (Hill, 1996).
- Whenever possible, domestic violence victims should be referred to gender-specific treatment and support groups. Mixed groups may involve descriptions of male aggression directed toward female partners. When planning interventions with the victim, her need for self-sufficiency and possibly childcare should be considered. Treatment programs which incorporate harm reduction strategies and a trauma sensitive environment are particularly suited to domestic violence victims.
- Some domestic violence victims experience a high degree of anger in the context of their survival. Some women are finally able to express their anger when they feel safe in a program. Staff should be trained to understand and facilitate expressions of anger, seeing it as a sign of healing for some women, and have the skills to balance a woman's need to release anger with the needs of other victims and survivors.
- Given the complex nature of surviving both substance abuse and domestic violence, treatment programs need to acknowledge that

treatment duration may be elongated.

- In one study, substance abusing victims reported that using substances allowed them to feel more powerful, more sexy and less fearful of being alone (Parisi-Dunne, (1992). Finding less harmful but more safe and sober ways to replace the benefit of the substance is a challenge.
- Victims respond best to gender-specific empowerment and self-discovery. They often desire and benefit from all-female support groups. They often feel there are not many options. Language focusing on empowerment may help them develop the tools to stay safe and sober. Emphasize strengths and healthy decision-making.
- Counselors may need to address domestic violence and substance abuse with different but integrated or coordinated interventions. Co-located services and substance abuse treatment which includes education about domestic violence co-facilitated by a domestic violence advocate have been shown to be particularly effective.

Make safety as well as sobriety a top priority.

- Consultation and review is advised to ensure efficacy of staff working with substance abusing victims. Support should be provided by staff experienced in dealing with both issues.

Domestic violence is not caused by substance abuse and is not merely a symptom of substance abuse.

Harm Reduction

Harm reduction strategies are promoted for active drug users who are seeking to end their dependency or addiction, and non-drug users who engage in a range of potentially risky behaviors or live in environments which pose a threat to their health and well-being (Hill, 1996). The philosophy of harm reduction requires health care/service providers to set aside their judgments in order to address problems and crises on the client's terms.

With its emphasis on establishing trusting supportive relationships between providers and clients and accepting the client at her/his own level, harm reduction can in many ways be viewed as a bridge between currently fragmented domestic violence and substance abuse treatment services, with safety as a key concern (Hill, 1996). Thus, the goals of treatment for women impacted by substance use and domestic violence are:

- To help the woman become more conscious of her risky behaviors and situations.
- To help her develop a plan for reducing the risk to her personal safety and the safety of her children.

Models of recovery from addictions and from trauma both have as a primary goal the attainment of safety through the

abstinence from chemicals and self-destructive behavior (Hill, 1996). In order to accomplish this, both models:

- Endorse behavior change and learning new ways to manage emotions.
- Address the cognitive distortions that come with living with addiction, or living with trauma.
- Have the creation of positive, consistent support systems as a component.
- Unlike in previous years, now support the careful use of appropriate psychotropic medications.
- While the stages or steps of change models have been studied relative to women with substance abuse problems and also victimization, the practitioner should acknowledge that motivation toward change does not ensure safety because it is the batterer who engages in the violent behavior. Perhaps readiness to explore additional safety options would be more apt to address the victim's choices.

Other Considerations

In its New York State Model Domestic Violence Policy for Counties (January 1998), the New York State Office for the Prevention of Domestic Violence suggests several accommodations that should be considered if a domestic violence victim chooses inpatient substance abuse treatment:

- If the client is a mother, "no contact" rules that often apply during the first

week of treatment should be waived to allow regular communication between the victim and her children while she is in treatment. This not only alleviates concerns that children might have about their mother, but also protects victims from charges of "abandonment" or "neglect" in custody cases.

- If a victim has initiated legal action for an order of protection, custody, and/or support, and it is not possible or advisable for her to obtain a continuance, allow her to meet with legal counsel, a court advocate, and/or district attorney, and to appear at all court hearings.
- Regardless of the treatment setting, inform all staff, with the client's consent, when a client has an order of protection and keep a copy of the order of protection in a confidential on-site location.

When a woman with these multiple issues makes the decision to accept help and enroll in substance abuse treatment, there are several questions that need to be investigated (Brown, Melchior, Panter, Slaughter, & Huba, 2000):

- Will such a woman enter drug treatment with these conflicting demands?
- Which of these needs and demands and risks takes priority as the woman decides to enter treatment?
- Will acute dangers of occurring or possible domestic violence propel such a woman toward or away from drug treatment?

- Is the readiness to make changes in various co-occurring problem areas a single disposition or a series of more independent ones?
- Is readiness to make changes in various problem areas related differentially to entry into different types of substance abuse treatment?

The Steps of Change Model is based on the woman's level of readiness and hypothesizes that women will wish to address the most immediately threatening issue first (and to seek help) before addressing significant problems that do not have the same degree of immediate threat (Brown, Melchior, Panter, Slaughter, & Huba, 2000). The Model covers four major areas in which women may seek to change their lives in order to enter a more stable and healthy lifestyle through entry into treatment:

- Readiness to change a domestic violence situation.
- Readiness to change sex risk behaviors.
- Readiness to change substance abuse behaviors.
- Readiness to deal with emotional problems.

Time urgency or immediacy appears to be an underlying issue of seeking help; that is, domestic violence is likely to be a more acute danger to the women than substance abuse. However, while a woman may feel the urgency to do something about her safety, she may also fear the loss of her children if she reports the violence in the home (Brown,

Melchior, Panter, Slaughter, & Huba, 2000). The client's perception of need or immediacy may differ from that of the therapist or provider. Also, individuals may be at different stages of recovery from substance abuse than the stage they are at in making choices about the violence in their lives.

Confidentiality

Because the potential exists for a judge to order release of the content of a substance abuse treatment file and because it may contain information that reflects negatively on the victim, special care should be taken to minimize file entries which may further victimize her. And while substance abuse treatment programs are legally hindered from re-releasing information received from programs governed by §§ 290dd-2,42 C.F.R. Part 2, information received from a domestic violence program may not apply to that statute and may be recoverable by a source harmful to the victim. Subtle and selective documentation may be the best practice.

Victims should always be advised of any potential for adverse consequences when consenting to release of information.

Domestic violence programs require that victims hold confidential any information seen or heard from other victims when participating in services. Violations of this expectation of confidentiality are particularly harmful to the substance-abusing victim. Both programs are encouraged to support and to remain vigilant of the victim's need for confidentiality.

Best Practices: Addressing Substance Abuse In Batterers' Programs

Overview

The prevalence of substance abuse among men entering batterers' programs has ranged between 40 percent and 92 percent, depending on the proportion of the men who were referred by the criminal justice system (Easton & Sinha, 2002). However, assessing whether a man abuses alcohol or drugs prior to the batterers' program is not enough. In one study of 840 men in batterers' programs in four U.S. cities, substance abuse *during the batterers' program* was the best predictor the man would abuse a partner in the future (Gondolf, 2002). This suggests that evaluation of substance abuse by men in batterers' programs needs to occur, not just at intake, but throughout his time in the program.

For most men who batter, alcohol or drug use does not directly cause their abusive behavior. However, for most men who batter, alcohol and drug use may:

- Increase the risk that he will misinterpret his partner's behavior.
- Increase his belief that violent behavior is due to alcohol or drugs.
- Make him think less clearly about the repercussions of his actions.
- Reduce his ability to tell when a victim is injured.
- Reduce the chance that he will

benefit from punishment, education, or treatment.

Recent Developments

Ongoing research is providing new perspectives on intervening with men who batter and have co-existing substance abuse problems. These developments are not necessarily endorsed as safe practices, but are offered here because they have established some empirical support. Motivational enhancement therapy (MET) has been shown to be useful in increasing readiness to change substance abuse behavior by men in batterers' programs (Easton, Swan, & Sinha, 2002). A number of well established batterer intervention programs (e.g. EMERGE in Denver) employ detailed professional assessment and intervention for substance abuse and new models are being developed to incorporate an alcohol component into batterer intervention programs (Conner & Ackerly, 1994).

Victim safety

While programs for men who batter may have several goals, including behavioral change and accountability, the most essential consideration is the safety of domestic violence victims. All interventions must account for the safety of victims whether they are in domestic violence programs or in substance abuse treatment.

Screening for Substance Abuse

Because so many batterers are also substance abusers, all batterers should be thoroughly screened for substance abuse problems. A substance abuse screening is an opportunity to begin discussing how substance abuse impacts a man's life. It is a preliminary step that determines the *likelihood* that an alcohol or drug problem exists. Screening for substance abuse involves honest talk with individuals about their alcohol and drug use, observing their behavior, and looking for signs of use. A screening differs from an assessment. An assessment uses diagnostic instruments and processes to determine if the person is abusing, or is dependent on, alcohol or drugs. When screening for substance abuse, be sure to:

- Ensure privacy. The first step in screening is to ensure that it occurs in private.
- Communicate respect and trust. It is important to establish a respectful and trusting relationship. Assure him that his honest and candid answers will not impact his ability to be in the program.
- Observe behavior. Using the symptoms in the box, observe client's behavior, looking for signs of drug or alcohol use.
- Ask questions. There are several recognized screening tools for alcohol or drug use included in the Appendix. Ask open-ended questions. This allows the man to share and offer more information than closed-ended questions. He may want to discuss his partner's

use of alcohol or drugs or the use of his peers, rather than his own. If this is the case, follow-up with questions about his use.

Screening is not a one-time only activity. Batterer intervention programs may screen for substance abuse through:

- Initial interviews. Program staff should ask established questions and be trained to interpret responses. In response to direct questioning about alcohol and drug use, substance abusers often deny the importance or effect of alcohol or drugs in their lives. (Examples of screening questions and formal screening tools are in the Appendix.)
- Observations of behavior and interactions during the batterers' program. Lateness, fatigue, aggression, or the smell of alcohol point toward the need for formal alcohol and other drug assessment. Look for signs of alcohol or drug use. (See box.) Interactions with recovering alcoholics and addicts in the batterers' program are usually revealing, because recovering men can often identify substance abuse patterns in others. Exposure of batterers who are substance abusers to recovering alcoholics and addicts is one of the more compelling reasons for not excluding active substance abusers from batterers' programs.
- Existing records. The contract signed between the batterer and the program should include access to criminal justice, mental health, and medical records.

If screening reveals the possibility of substance abuse, the batterer should be referred for formal assessment (unless the evaluator has appropriate training and certification). Formal assessment of substance abuse problems should be conducted by specialists qualified by the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA). The batterers' program should not regard the referral for assessment as a referral to another agency that will then assume responsibility for the case, since this has led to men "slipping between the cracks."

Signs of Alcohol or Drug Use

- Smell of alcohol
- Signs of IV drug use (tracks)
- Unusual or extreme behavior
- Nodding off
- Overly alert
- Slurred or rapid speech
- Staggering
- Tremors
- Glassy-eyed/pupils dilated or constricted
- Unable to sit still
- Disoriented or confused for no apparent reason
- Argumentative, defensive, or angry at questions about substance use

Substance Abuse Assessment

When a man from a batterers' program has been referred to a substance abuse treatment provider, a counselor will use assessment techniques to characterize the problem and to develop a treatment plan. IAODAPCA evaluates counselor competency and grants recognition to those counselors who meet specified

standards. All substance abuse treatment programs licensed by the Department of Human Services must have credentialed staff. The system identifies the functions, responsibilities, knowledge, and skill bases required by counselors in the performance of their jobs.

A variety of methods may be used in assessing the individual, including medical examinations, clinical interviews, and formal instruments such as questionnaires. During an assessment, information is gathered to determine which aspects of the man's life are affected by alcohol/other drug use. Areas of assessment include alcohol and drug use, social and family relationships, psychological functioning, legal status, medical conditions, and employment and educational status. The goal is to determine if treatment is needed, and if so, the appropriate level of care. If the individual is given a DSM IV (or ICD-9) diagnosis, treatment is generally recommended. In some settings, urinalysis may be required. Urinalysis is most commonly done to monitor treatment compliance rather than as part of the assessment.

Substance Abuse Treatment

Treatment follows from the assessment process with the purpose of addressing the substance abuse issue identified, dependence or abuse, and how it is exhibited in that particular person. Historically the focus of substance abuse treatment has been initial achievement of sobriety and then challenging the addicted individual to work towards a life of recovery. Recent changes within the field have lead substance abuse providers to start using

Motivational Enhancement techniques and Stage of Change concepts. These are used in different levels of care to guide treatment, depending on the person's acceptance and desire to change. Licensed treatment providers use the ASAM PPC-2R (American Society of Addiction Medicine Patient Placement Criteria) to determine the most appropriate level of care to address the person's substance abuse problem.

The level of care is also dependent on a person's level of functioning. ASAM criteria are used to match a person to the different levels of care and increase the possibility of a successful outcome. The ASAM criteria are divided into six categories that represent different facets of a person's functioning. These are evaluated to determine the severity of their problem and the appropriate intensity of treatment needed. The six criteria from the ASAM PPC-2R are:

- Intoxication/Withdrawal Potential
- Biomedical Conditions
- Emotional/Behavioral Conditions that can detract from treatment
- Readiness to Change (formerly Treatment acceptance/Resistance)
- Relapse/Continued Use Potential
- Recovery Environment

The level of care determines the therapeutic techniques used but most levels of care will have core elements that change in depth according to the person's understanding of their substance abuse problem. Counseling

techniques usually are cognitive/behaviorally based and may include different formats of therapy such as group therapy, individual therapy, family therapy, education, relapse prevention, skills training and support/self help groups. Medications may be used during the withdrawal process and/or as adjunct therapy. Levels of care available for a person with a substance abuse problem include:

- Detoxification (Level IV)
- Residential Rehabilitation (Level III.5)
- Intensive Outpatient (Level II)
- Outpatient (Level I)
- OMT (Opioid Maintenance Therapy- for those addicted to Heroin using Methadone)
- Early Intervention (Level .5)

There are other treatment levels of care not indicated that are different intensities of those listed above. Each level has its purpose and its focus depending on the needs of the person in treatment.

Detoxification can be separated into medical and social setting intensities with medical detoxification being the most intense due to possible life and/or health threatening withdrawals as well as possible self-harm.

Residential treatment programs provide primarily short term, one to three months, intensive treatment where a person can focus on their substance abuse problem without the influence of

their living environment. This level of care is mainly for persons who cannot stop their drug use without complete displacement from their environment. Residential treatment attempts to provide the structure that may have been lost due to the substance abuse problem.

Intensive outpatient treatment consists of nine or more hours per week of direct contact with the person and helps them by initiating the process of recovery while the person remains in their environment. This level of intensity is usually necessary when the substance abusing person has no experience with treatment, has poor or no skills to cope with problems without using substances, has other issues that can easily distract them from treatment, needs large amounts of support and motivation to remain sober, or has medical issues that are directly related to or exacerbated by their use of substances.

Outpatient treatment's focus tends to be on skill acquisition/practice and maintaining motivation to start or maintain a recovery process or not use substances. This level of care is appropriate for the person whose substance abuse issue is not as severe such as mild to moderate dependence or abuse. Outpatient can be from 1-8 hours, allowing the flexibility to step up or decrease support as needed.

Early intervention is usually used for educational purposes when a person is identified as a substance user but does not have a substance abuse diagnosis. This level of care has also been used as a stepping stone for individuals who may have a substance abuse issue but are not motivated and/or have not

considered themselves to have a problem. Many of the men seen in batterer intervention programs will fall into this category.

Once the appropriate level of care is determined, an individualized treatment plan is developed that will guide the treatment process and clearly indicate what issues will be explored during treatment. The treatment plan is developed with the person seeking services so there is mutual agreement on the issues that will be explored. There are also clear goals and objectives identified regarding the problems identified. The treatment plan should also address barriers to treatment and resolution of these issues such as transportation to treatment, childcare arrangements, transportation to childcare, advocacy and placement. A limited number of substance abuse treatment providers are also integrating mental health services within the same agencies. This has been accomplished by providing psychiatric evaluations and follow-up as well as preparing counseling staff to provide mental health counseling in conjunction with substance abuse counseling.

Substance Abuse Confidentiality

Unique confidentiality laws apply to almost all substance abuse treatment programs. Coordination between batterers' programs and substance abuse programs must accommodate the constraints of these laws to be successful. The law prohibits the disclosure of any information that would identify a person as having applied for, or having received treatment at federally assisted program for an alcohol or drug

problem without the person's written consent. There are exceptions for mandated reports of child abuse, in certain medical emergencies, or for court orders. A court may authorize a treatment program to disclose confidential patient information following a hearing at which good cause has been established and at which the patient and the treatment program have been represented. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, by itself, to require or permit a program to release patient information.

Information protected by federal confidentiality laws may be disclosed if the client has signed a proper consent form. To be valid, the consent must be in writing and must specify:

- The client's name
- The name of the program making the disclosure
- The purpose of the disclosure
- The name of the person/program that will receive the information
- How much and what kind of information will be disclosed
- A statement that the client may revoke the consent at any time, except to the extent that the program has already acted on it
- The date, event or condition on which the consent expires
- The signature of the client and the date of the signature.

Other Issues

- *Evaluate abstinent batterers.* Abstinent and recovering alcoholics and addicts will usually score positive on the Short Michigan Alcoholism Screening Test (SMAST), CAGE-D, and other screening tools. (Examples of such screening tools are in the Appendix of this document.) Abstinent batterers with no observable supports for staying sober should be considered at high risk for relapse, and consequently, a safety risk.
- *Case manage active substance abusing batterers who accept alcohol and other drug intervention.* Assertive case management by probation officers has been found to effectively increase community safety, hold batterers accountable, and increase batterers' coping skills (Johnson, 2001). Case management and service coordination for substance abusing batterers is likely to produce a similar effect. Men who are assessed as abusing, or dependent on, alcohol or other drugs require integrated or coordinated concurrent substance abuse and domestic violence programming. In cases where addiction impairs the man's ability to utilize the batterers' program, the batterer/addict may complete an initial phase of addiction treatment such as medical detoxification and engagement with a support program. He then continues in counseling and/or a support program while in the batterers' program. The batterers' program should receive regular reports from the substance abuse program about the man's

progress in substance abuse treatment. The substance abuse treatment provider may also be bound by further confidentiality constraints such as the Health Insurance Portability and Accountability Act of 1996 (HIPPA). It's best to have a frank discussion with the provider on how best to work together.

- *Intervene with active substance abusing batterers who refuse alcohol and other drug intervention.* When a batterer is also a substance abuser but does not understand or accept the situation, it is recommended that he should still be admitted into a batterers' program, with ongoing monitoring of substance use and effects. One goal for being in the batterers' program is successful referral to substance abuse treatment. Under the conditions of a court mandate, programs should communicate to probation officers or case managers that a man requires substance abuse treatment. The current or former partners of voluntary or non-court-referred batterers should be notified of his refusal to enter substance abuse treatment, along with the risk that such a refusal represents. Acceptance of an addiction treatment referral (including support group attendance) should be made a priority goal of the intervention program.
- *Integrate substance abuse and batterers' programs with caution.* An integrated program provides domestic violence and substance abuse services under the same program, with differing degrees of

integration. Integrated programs under substance abuse programs should actively utilize domestic violence programs as consultants and compensate them for their services. They should also actively participate in the community's coordinated domestic violence council. Integrated programs under domestic violence agencies should actively utilize addiction program staff as consultants and pay them for their services. Sharing certain staff members across agencies may be an alternative to an integrated program. Programs that are not integrated (i.e., batterers' program and substance abuse program are in different settings) should utilize networking, case management, joint staffing, or some other means of increasing continuity. Coordinating, collaborating programs may provide safer, more accountable interventions than integrated programs.

- *Recognize safety and sobriety are interconnected.* Lack of sobriety in batterers, increases the risk for further violence against victims. Lack of victim safety threatens the sobriety of the batterer. However, abstinence and sobriety are not sufficient conditions for safety.

Key Points

- *Victim safety must guide all assessment and intervention.*
- *Screen all batterers for substance abuse.*
- *Coordinated, concurrent programs are preferred.*
- *Batterers' programs should provide case management whenever possible.*
- *Do not terminate batterers who refuse substance abuse treatment.*

Best Practices: Addressing Domestic Violence In Substance Abuse Treatment for Men

Approximately half the men who batter their female partners have substance abuse problems. In one large treatment center in Chicago, which has been doing screening since 1997, a consistent pattern has emerged: 70 percent of funded clients (mostly indigent or below federal poverty-level incomes) and 92 percent of nonfunded male clients (mostly court-mandated for DUI or other non-domestic violence offenses) have used some level of violence in a primary relationship within the year prior to assessment (Haymarket Center, 1998). Counselors in addiction treatment programs for men may underestimate the number of men in their programs who use violence (Bennett & Lawson, 1994). Furthermore, the non-substance abusing female partner is often blamed for the actions of the substance abusing batterer. This practice includes labeling the woman as *co-dependent* or *an enabler*.

Domestic violence, like many other life problems, which affect chemically dependent persons, has traditionally been viewed within the substance abuse treatment field as a manifestation of the dysfunction resulting from long-term use of psychoactive chemicals including alcohol. Until recently most counselors may have expected that abstinence alone would reduce the incidence of violence, and that sobriety (understood as an ongoing connection to community support in addition to abstinence) would eliminate it. In discussions with counselors who are involved in providing intervention services to men

receiving alcohol and other drug addiction (substance abuse) treatment, the task force has been reminded of the importance of making treatment providers aware of the experience of women who are victims of domestic violence. Substance use is neither a necessary nor a sufficient cause of intimate partner violence (Leonard, 1999). Consequently, violence does not always stop or even diminish when the batterer becomes abstinent, and when it does, an increase in other abusive and controlling behavior may replace it.

Common Perspectives

Addict/abuser common features:

- Continuation of behavior despite negative consequences.
- Preoccupation/obsession.
- Adversely affect family members including across generational lines.
- Predisposition to relapse.
- Accountability for difficulties placed on others or external causes.
- Increased use (of substance and/or power/control) to maintain effect.
- Preoccupation, rituals, acting out, guilt/remorse.
- Late manifestation of involvement in workplace, further on the continuum of the disease or lethality.

- Adversely affect intimacy.
- Characterized by denial, minimization, and rationalization.
- Intervention or abandonment by family members exceptionally difficult. (Iron & Schneider, 1997)

Recent Developments

The link between substance abuse and intimate partner violence is becoming increasingly visible (Wekerle & Wall, 2002). Ongoing research is providing new perspectives on intervening with men who abuse alcohol or other drugs and also batter their female partner. These developments are not necessarily endorsed as safe practices, but are offered here because they have established some empirical support.

For:

- alcoholic men
- whose violence has been minimal
- who are not court referred
- and whose partners wish to maintain the relationship

behavioral couple therapy (BCT) has been shown to reduce the risk of domestic violence *for those men who discontinue drinking* (O'Farrell & Murphy, 2002).

A recent study of domestic violence screening in seven substance abuse treatment facilities (Schumacher, Fals-Stewart & Leonard, 2003) found, paradoxically, that prior criminal justice involvement by men seeking substance abuse treatment decreased rather than increased the odds they would be referred to batterer programs. The study also found that, even when referred, men in substance abuse treatment rarely followed through with

the referral. This finding supports the suggestions in the “lessons learned” chapter that integrated and coordinated programs are absolutely essential in preventing further violence by men in treatment for alcohol or drugs.

Tips for Safety and Sobriety

Screen substance abuse clients for domestic violence. Make it clear that *all* program participants are screened for violence. It is important for victim safety that the man not believe the evaluator has been “tipped off” by his partner. (See Appendix for examples of screening and assessment tools.) If you identify a man as having used violence, do the following:

- Refer him to a batterers’ intervention program as soon as possible. If you are doing his treatment plan, address violence in Dimensions 3, 5, and 6 (Emotional/Behavioral Issues, Relapse Potential, and Recovery Environment) of the current Client Placement Criteria of the American Society of Addiction Medicine (ASAM).
- Use separate facilities to provide services to the batterer and his female victim if at all possible — unless staff and clients in men’s and women’s programs are distinctly separate. If this is not possible, at least schedule appointments at times when the perpetrator and victim are not likely to be in the facility at the same time or on the same day.
- Even if both the batterer and victim consent that their treatment progress will be shared with their partner consider how doing so may

jeopardize the victim's safety.

- If the client is under court supervision, contact his probation officer to request that batterers' intervention programming be added as a condition of probation.
- Determine if anger management services are important to the treatment process but also determine how they may impact safety. (The differences between anger management and partner abuse intervention programs is further explained in the appendix.)
- Avoid group discussions and/or support groups that provide collusion among batterers. Instead, seek supports which hold the batterer accountable.
- Address how the batterer's abuse of power, control and substances have impacted exposed children.
- Reinforce how adults model mood regulation, substance abuse and equality for future generations.
- Recognize that the substance abusing batterer requires intensive case management to be successful in addressing both issues.
- Recognize that violence does not always stop or even diminish when the batterer becomes abstinent, and when it does, an increase in other abusive and controlling behavior often replaces it.
- Do not provide him with family sessions or conjoint therapy. The *Illinois Protocol for Partner Abuse*

Intervention Programs recommends the following criteria **be achieved before** conjoint intervention with batterers and victims:

- (a) The participant has been violence-free for six months.
- (b) A determination by the participant's counselor and abused women's advocates that it is appropriate — not automatic at a set time.
- (c) An affirmative desire by the victim, which must include provision for safety at the facility.
- (d) Separate screening of participant and victim.
- (e) A determination that the victim does not hold herself responsible for the abuse, and that she is aware of resources and knows how to use them.
- (f) An affirmative statement from the participant that he accepts full responsibility for his actions.
- (g) The joint arrangement must be able to be terminated at any time in the process. The person providing intervention must terminate any time it is determined to be unsafe to continue.
- (h) Victims must never be required to go for counseling as a condition of services for the participant. Services for men who abuse must never be contingent upon the victim receiving services there or at a domestic violence

victim services program.

In addition, talk with local courts and police regarding appropriate mandated sanctions for substance abuse clients who are found to be batterers. When courts mandate services, it empowers agencies to include batterer intervention as part of their treatment recommendations, even when the offense is not related to domestic violence (e.g., when a client is mandated to treatment for substance abuse after a DUI conviction).

Do not provide him with family sessions or conjoint therapy.

Raising Awareness on Domestic Violence

Assess your own agency's tolerance toward the equality of women:

- Are women included in the decision-making processes of your agency?
- What are your agency's recruitment and promotion policies?
- Is there an equal partnership between male and female group co-facilitators?
- Is your agency actively involved in community networks that confront violence against women?
- Do staff exhibit supportive attitudes and beliefs about women and domestic violence?

Talk with local domestic violence service providers to get linkages going which

include cross training of staff. This will increase awareness of the issues on both sides and help in providing services across both agencies.

Screening and Referral

The incidence of family violence perpetrated by substance abusing men is sufficiently high that universal screening is necessary and should become not only the norm but should be seen as an essential part of the screening and assessment.

- Screening tools (see Appendix for examples) should be implemented in consultation with domestic violence professionals.
- These tools should include a clear explanation of what constitutes abuse, rather than just asking a general question about violence or abuse.
- If you do not have on-site batterer intervention services, you will need to establish a relationship with local batterers' intervention services.
- Make a Mutual Service Agreement or another linkage agreement (see Appendix for example) which establishes regular communication between substance abuse treatment providers and local domestic violence programs. Linkage agreements should not be considered a substitute for regular direct communication between such programs.

Timing of Batterer Intervention

Some substance abuse counselors want

to wait 90 days or longer to put clients in batterers' intervention services. However, violence is a powerful relapse trigger which can sabotage recovery in its earliest stages. For this reason, many service providers recommend beginning batterer services well before a client is discharged from primary substance abuse treatment. Remember: *Sobriety without accountability is unlikely.*

There are other concerns regarding partner abuse intervention during treatment and early recovery. Some of them are:

- Clients may be very resistant to the whole concept of treatment, and may not react well to the traditionally confrontational format of some forms of batterers' intervention.
- Clients are likely to be suffering neurological complications of long-term use of psychoactive chemicals, which may have an impact on their ability to function in a highly confrontational group.
- Clients may have significant cognitive and educational deficits. These can have an impact on their ability to take responsibility for their violence, as well as on the ability of the program to screen for problems that might suggest that a client is inappropriate for partner abuse intervention.
- Denial is an active dynamic in both substance abuse and domestic violence. Clients must be individually assessed to determine readiness for partner abuse intervention groups. Carelessness in this area can easily foster bad outcomes by needlessly

increasing client resistance and noncompliance.

Remember: Sobriety without accountability is unlikely.

Batterer Intervention and Relapse Prevention

Clients may respond better if the batterers' intervention is tied to the idea of relapse prevention. The process of relapse tends to be cyclical. The phases of the cycle may be related to the phases of the cycle of violence. Compare the two, and ask clients to identify experiences where an event in one cycle triggered an event in the other cycle for them. Stress to clients that violence-free life and sobriety are linked in a number of ways:

- In the Twelve Steps of Alcoholics/Narcotics/Cocaine Anonymous, inventory steps require admitting "to God, to ourselves and to another human being the exact nature of our wrongs." The "amend" steps require making a "list of persons we have harmed," and becoming "ready to make direct amends to them all." Accountability and responsibility can be framed in terms of these concepts.
- The A-B-C cognitive-behavioral approach of Rational Recovery and Rational Emotive Therapy asks clients to identify a relationship between their thoughts, feelings, and behaviors. Belief systems which exaggerate male privilege and demean women can be challenged in this context.

- Most religious traditions embrace some version of the Golden Rule: “Do unto others as you would have others do unto you.” Stress the link between personal spirituality and relationships in ways which support equality and mutuality. Contrast concepts such as *serenity* and *centeredness* with violence, abuse, and chaotic family life. Relate *surrender* to giving up control of others’ lives.
- Use tools such as the Cycle of Violence illustration and the Power and Control Wheel as concepts in treatment and relapse prevention.
- Explore the correlation between domestic abuse, substance abuse and the need for personal power.
- Explore what role the use of substances has as a mood regulator.

Confidentiality and Other Legal Issues

Federal laws governing the confidentiality of client records and client-identifying information apply to alcohol and drug abuse treatment providers (see 42 CFR Part 2, and the similar Illinois rule in 77 Ill. Adm. Code 2060.319).

Under these laws and the regulations implementing them, no client-identifying information can be disclosed without the client’s written consent in a specific form. Exceptions are:

- Mandated reports of child abuse.
- Emergency medical care.
- Orders of a court of competent

jurisdiction following a hearing *in camera* (in the judge’s chambers) at which good cause has been established (and at which the client and the agency should be represented).

- Suicidal and homicidal threats.

See the relevant portion of the federal and state rule for specific language regarding the exceptions.

Potential problem areas include:

- *Caller ID and Star 69.* If your agency cannot place a total block on these services, you should block each call with *(Star) 67. If this is not possible, anonymous calls will have to be placed from phones which cannot be traced to the agency.
- *Safety checks with partners.* Agencies must carefully limit the amount of information they convey, even with consent, to that which is necessary to assure partner safety.
- *Tarasoff situation (e.g., where consent has been revoked by a client who leaves an intervention group prior to completion).* Safety checks to partners must, again, be as limited as possible while assuring the goal of partner safety. If consent has been effectively revoked, contact must be made anonymously or only in the name of the victim-service program. (“We have information which leads us to believe that you may be in danger from your partner.”)
- *Contracted providers of batterers’ services.* Using their own agency’s identity rather than the substance

abuse treatment provider's identity may avoid the problems specific to the substance abuse-related federal confidentiality regulations.

- *Programs in hospitals or other institutions which are not primarily alcohol and drug abuse treatment providers.* Using the name of the larger institution rather than the specific name of the substance abuse treatment program is also an option for exercising duty to warn.

Reverse Confidentiality

Full disclosure and discussion of treatment planning and ancillary services is the rule in substance abuse programs and reflects the need for transparency and genuineness in the therapeutic relationship. However, as a component of safety checks, programs may obtain reports from partners of men in treatment who are also receiving intervention services, and this information must remain confidential if the partner requests confidentiality. *Substance abuse providers need to be scrupulous about informing clients who are receiving batterers' intervention services of the fact that such reports will be accepted and will be kept in confidence if the victim requests it.*

Address how the batterer's abuse of power, control and substances have impacted exposed children.

Special Settings: Public Assistance (TANF)

Welfare Reform

In 1996 President Clinton signed the Personal Responsibility and Work Reconciliation Act which ushered in an era of welfare reform. The law ended the income entitlement program known as Aid to Families with Dependent Children or AFDC and replaced it with Temporary Assistance for Needy Families or TANF. The primary goals of welfare reform legislation were to promote work and marriage and to decrease welfare dependency and births to unmarried mothers. The legislation creating TANF shifted welfare policy from economic security to stressing work and self sufficiency. It establishes time limits and work requirements, and emphasizes personal responsibility.

Like most states, Illinois focused on moving families from welfare to work. The result was a dramatic decline in the TANF caseload. In July of 1994 there were 246,835 TANF cases compared to 38,234 in July of 2003 (Illinois Department of Human Services TANF Data). As caseloads have declined, a larger proportion of the caseload faces barriers to self-sufficiency. Persons who remain are more likely to confront barriers such as substance abuse, learning disabilities, domestic violence, and physical and mental health problems.

Prevalence of Substance Abuse and Domestic Violence

There is a wide range of estimates of the prevalence of substance abuse and domestic violence among TANF

families. Many studies lack common definitions resulting in a wide range of estimates

- Analyses of the National Household Survey of Drug Abuse data indicate that the prevalence of drug and alcohol abuse is higher among welfare clients than in the general population. Approximately 20 percent of the 1998 TANF caseload used illicit drugs, compared with 12.5 percent of those not receiving cash assistance; 4.5 percent of welfare clients were dependent on illicit drugs, compared with 2.1 percent of those not receiving cash assistance. Alcohol dependency among welfare clients was also slightly higher, but the difference was not statistically significant (Pollack et al., 2001).
- It is estimated that 50 percent to 60 percent of TANF clients have experienced domestic violence over their lifetimes and 20 percent to 30 percent are recent or current victims of abuse (Tolman and Raphael, 2000). Victims of domestic violence are more likely to be long-term welfare recipients and are more likely to cycle on and off welfare (Lyon 2000).
- In a study of Illinois TANF families, 13 percent reported severe physical domestic violence in the past year and 3 percent were found to be chemically dependent (Kirby, 2003).

The disparity between the estimates and actual reports may be attributed to several factors. It may reflect a woman's reluctance to acknowledge that she is living with a man who may or

may not be the father of her children. She may be reluctant to disclose for fear that financial and food stamp benefits will be reduced. She may also fear that disclosure may trigger child welfare involvement.

Illinois TANF Program

The Illinois Department of Human Services implemented the state's TANF program in July of 1997. The program was based on federal law and policies developed during the state's earlier experiments with welfare reform. Since 1997, Illinois' TANF plan has been modified several times. Among the notable changes are the addition of exemptions to the TANF 60-month time limit and the adoption of the Family Violence Option. It is likely that the TANF program will change again with the passage of the federal TANF Re-authorization legislation. The Bush Administration is supporting legislation that increases employment requirements, imposes strict sanctions and provides substantial funds to promote healthy marriage.

Implications for TANF Families in Illinois

Work Requirements

Welfare reform places an emphasis on engaging TANF clients in work as quickly as possible.

- A single parent who is able to work must work or participate in a work activity for at least 30 hours per week. Two-parent families are required to work 35 hours per week.
- The hours spent in programs for

substance abuse, domestic violence and mental health count toward meeting the work requirement.

Income Disregards

The Work Pays program disregards two-thirds of earned income when determining benefit levels. For example, if a parent earns \$300 per month the TANF grant is reduced by \$100.

Personal Responsibility

TANF stresses personal responsibility.

- Clients must cooperate in establishing paternity and obtaining child support. A woman may receive an exemption from establishing paternity or obtaining child support if doing so will place her or her children at risk of violence.
- Clients must cooperate in work and training activities, cooperate in referral and treatment for substance abuse and follow through on their service plan or face sanctions.
- Sanctions are imposed at three levels:
 1. At the first level, the cash benefit is reduced by 50%. Benefits are restored as soon as the client cooperates.
 2. At the second level, the cash benefit is reduced by 50% for three months. If by the fourth month the client has not cooperated, the entire cash benefit is stopped.
 3. At the third level, the entire cash

benefit is stopped for three months. The client must cooperate for benefits to be restored.

Time Limits

The focus of TANF is on transitional services. Cash benefits are limited to a maximum of five years in a lifetime. Cash benefits received in other states or in nonconsecutive months count toward the 60-month time limit.

What stops the time limit?

The time limit ("stopped clock" provision) stops for clients who:

- Work at least 30 hours per week and still qualify for cash assistance (30 hours for single-parent families and 35 hours for two-parent families);
- Are single-parents and attend a post-secondary education program full-time and maintain a cumulative 2.5 grade point average;
- Provide constant in-home care for a medically dependent child under 21;
- Provide care for a disabled child or spouse; or
- Are approved for a Domestic Violence Exclusion.

Exceptions to the 60-month limit

A family might be able to receive more than the 60 months of TANF benefits if the parent:

- Has a pending SSI application and is determined disabled by IDHS; or is

determined unable to work at least 30 hours per week due to a medical condition; or

- Is in an intensive program that prevents working at least 30 hours per week (includes DCFS, domestic violence, homeless services, mental health, substance abuse, and vocational rehabilitation programs); or
- Is in an approved education or training program that will be finished within 6 months after the end of the 60 months; or
- Is approved to care for a related child under 18 or spouse due to their medical condition; or
- Has a disabled child under 21 who is approved for a Home and Community-based Care waiver.

Domestic Violence Exclusion

The Domestic Violence Exclusion went into effect in Illinois on July 1, 2002. It provides needed relief to domestic violence victims and their families as they struggle to break out of the cycle of violence. A client who qualifies for a Domestic Violence Exclusion is not required to participate in work and training activities and the TANF 60-month counter stops.

To qualify:

- The client must experience difficulty participating in work and training activities for at least 30 hours a week due to domestic violence, or participation in work or training activities is unsafe.
- The client must request to be

excused from work and training activities because of a domestic violence problem (a written request is not required).

- The client must give proof* of being a current or past victim of domestic violence.
- The client's request must be approved by a team of staff and consultants (i.e., the multi-disciplinary staffing that always includes the caseworker and a domestic violence expert).
- A person does not have to be receiving services from a domestic violence service provider to qualify for the Domestic Violence Exclusion.

*Proof may include a written statement from another person (e.g., relative, friend) who has knowledge of the circumstances that support the claim; a police, government agency, or court record; a statement or documentation from a domestic or sexual violence program or rape crisis organization; documentation from a professional (e.g., doctor, lawyer, clergy); or any other credible evidence, including physical evidence, that supports the claim. If approved, the initial waiver lasts only two months. The client's Responsibility and Services Plan, or RSP, is amended to reflect what the client is doing to deal with the domestic violence (e.g., counseling, legal action, medical services). After two months, the waiver may be continued for as long as necessary, but the client is obligated to undergo a reassessment of her situation once a month.

Need for Collaboration

Helping families struggling with poverty and issues of domestic violence and/or substance abuse requires the coordinated efforts of TANF, domestic violence and substance abuse treatment agencies.

- The imposition of time limits on welfare receipt necessitates that service/treatment plans incorporate the goal of employment.
- The reality of sanctions necessitates that TANF offices are informed of any circumstance that would keep a client from complying with a program requirement. Agencies need to communicate and work together to develop coordinated rather than conflicting service plans.
- The complexity of multiple problems often requires joint intervention. TANF policy requiring cooperation with a substance abuse treatment plan may be used to motivate a client. Payment of supportive services such as child care and transportation are available to assist TANF clients with their service plan.

Special Settings: The Criminal Justice System

Common Perspectives

Although this best practice manual is targeted to direct service providers working in the substance abuse and/or domestic violence field, the collective authors of this manual concluded that the large number of domestic violence perpetrators involved in the criminal justice system necessitated the development of a separate chapter. This chapter is not sufficiently comprehensive to delineate all of the “best practices” within the intricacies of the criminal justice system; rather, it is intended to raise the general awareness of the system in its response to and treatment of the dual issues of domestic violence and substance abuse, and to encourage the system to undertake a more holistic approach to these dual issues.

An integrated systems approach is necessary to ensure that proper referrals are made, appropriate treatment is received, adequate support services are in place, and to improve communication between systems. It is important for service providers to understand the role of the criminal justice agents (law enforcement, courts, probation, etc.), since these agents can be their best resource in protecting the victim or getting the batterer to attend/participate in appropriate treatment.

A survey conducted by the American Correctional Association in 1990 found that more than half of female inmates report being victims of physical abuse and 36 percent report being victims of

sexual abuse (that often occurred when they were adolescents or children). Batterer intervention programs report that approximately 80 percent of their referrals were court mandates (Healey, Smith & O’Sullivan, 1998).

The Illinois compiled statutes (ILCS), Chapter 750, defines domestic violence/abuse as “physical abuse, harassment, intimidation of a dependent, interference with personal liberty or willful deprivation,” but does not include reasonable direction of a minor child by a parent or person in loco parentis. It also defines “family or household member” as inclusive of spouses, former spouses, parents, children, stepchildren and other persons related by blood or by present or prior marriage, persons who share or formerly shared a common dwelling, persons who have or allegedly have a child in common, persons who share or allegedly share a blood relationship through a child, persons who have or had a dating or engagement relationship, and persons with disabilities and their personal assistants.

Relationship Between Substance Use and the Crime of Domestic Violence

A National Institute of Justice study (1997), *Drugs, Alcohol, and Domestic Violence in Memphis*, indicates the following:

- 92 percent of domestic violence assailants had used drugs or alcohol during the day of the assault.
- 67 percent had used a combination

of cocaine and alcohol.

- 45 percent of assailants were described as using alcohol, drugs, or both daily to the point of intoxication during the past month.
- 9 percent of assailants were either in treatment or had previously received treatment for substance abuse.
- 89 percent of victims were repeat victims of current assailants.
- 67 percent of assailants were on probation or parole at the time of assault.
- 72 percent of victims were female; 78 percent of assailants were male.
- 42 percent of victims used alcohol or drugs the day of the assault — 15 percent had used cocaine; about one half using cocaine reported being forced to by the assailant.
- 68 percent of the assault episodes included use of a weapon, primarily blunt instruments such as hammers, baseball bats, etc.
- 85 percent of the assaults were witnessed by children under the age of 18.
- 15 percent of the victims in the survey were younger than 18 years and most were assaulted after witnessing assaults on their mother.

It is important to dispel the myth that substance use and/or abuse is the cause of domestic violence. Experts agree there is a connection between substance use disorders and domestic

violence; however, domestic violence is not caused by the use of alcohol or other drugs. Research supports that the use of alcohol or other drugs is one of several factors that influence the batterer's behavior. Substance use disorders may increase the frequency or severity of violent episodes over time (Bennett, 1995; Jillson & Scott, 1996).

Batterers' Services

In July 1998, NIJ published a research brief titled *Batterer Programs: What Criminal Justice Agencies Need to Know* (Healey & Smith). The highlights of the brief provide this information:

Batterer intervention programs were originally established in the late 1970s as feminists and others called attention to the victimization of women through domestic violence, grassroots programs sprang up, and service providers recognized that the offenders' behavior needed to be addressed. The requirement that batterers attend intervention programs as a condition of probation or as part of pretrial or diversion is fast becoming a part of the response to domestic violence in many jurisdictions. However, judges and probation officers often lack basic information about program goals and methods. This report, a summary of the full-length study, attempts to meet that need by

presenting information about batterer intervention programs operating throughout the country. The interventions described were selected to represent the range of programming available and include the established or “mainstream” programs as well as innovative approaches.

All programs are structurally similar, proceeding from intake through assessment, victim contact, group treatment, and completion; but each program is based on one of several theoretical approaches to domestic violence. Most of the pioneers in intervention use the feminist model, which attributes the problem to societal values that legitimate male control. This model, exemplified in the “Duluth Curriculum,” uses education and skills building to re-socialize batterers. The less common family systems interventions, based on the notion that violent behavior stems from dysfunctional family interactions, emphasize building communication skills within the family. Psychotherapeutic and cognitive-behavioral interventions are based on

the belief that domestic violence is related to the offender’s psychological problems and, as a result, emphasize therapy and counseling. The EMERGE and AMEND models represent a blend of the feminist educational approach with more in-depth and intensive group work.

Increased awareness of the diversity of the batterer population has given rise to the belief that more specialized approaches are needed. One trend reflects the idea that interventions should be based on various typologies or categories of batterers. Of these, the typologies that group offenders by their psychological factors may be less useful for criminal justice purposes than those that do so by degree of risk for dropping out or re-offending. Other specialized approaches are designed to enhance program retention of specific populations based on sociocultural characteristics such as poverty, race, ethnicity, nationality, gender, or sexual orientation.

Batterer intervention programs cannot deter domestic violence unless they are supported by the criminal justice system. Criminal justice responses to

domestic violence should be coordinated to support batterer intervention. For example, the integrated criminal justice responses studied for this report included coordination among agencies; use of victim advocates throughout the system; designation of special, dedicated batterer intervention units; and provision of training for agency personnel. Probation officers have a key role as the critical link between the justice system and batterer interventions.

In a recent study of 840 men and their partners in four longstanding U.S. batterer programs (Gondolf, 2002), the best predictors of re-assault were prior arrest for crimes other than domestic violence, severe psychopathology, severe levels of physical abuse, victim perception of her safety, and drunkenness during the program. Drunkenness during the program and prior arrest are both within the domain of criminal justice staff to identify.

Gondolf suggests that previous offenders and severe first-time assaulters need more intensive programs, meeting at least two times a week for the first two months. In their key roles, probation officers are in a position to implement such changes in how batterers are processed in the system. He further suggests that courts may consider providing pre-trial referral to batterer intervention programs for first time offenders whose violence is less severe, but impose swift and certain sanctions on offenders for noncompliance, drunkenness, and re-assault. Finally, as a result of this study, he recommends implementation of domestic violence courts similar to drug courts, with frequent reviews of program

compliance and status.

Victims' Perspective

Another NIJ study (Keilitz et. al., 1998), *Civil Protection Orders: Victims' Views on Effectiveness*, indicated the following:

- Effectiveness depends on how specific and comprehensive the orders are and how well they are enforced.
- Victims indicated that effectiveness depended on how accessible the courts are for victims and *how well established the links are between public and private services and support resources for victims.*
- Violations of the protection order increase and *reported effectiveness decreases as the criminal record of the abuser becomes more serious.*
- Victims reported that the orders protected them against repeated incidents of physical and psychological abuse and were valuable in helping them regain a sense of well-being.
- The study confirmed a strong correlation between the severity and duration of abuse — the longer women experience abuse, the more intense the behavior is likely to become and the more likely women are to be severely injured by their abusers.

Recent Legislation

The following legislation, which became effective in Illinois on Jan. 1, 1999,

enhances the criminal justice system's ability to respond to and deter further family violence:

- *First Degree Murder:* Amends the Criminal Code to state that a defendant, who is at least 18 years of age and who is guilty of first degree murder, is eligible for the death penalty when the victim had an order of protection against the defendant.
- *Domestic Battery and Violation of Order of Protection:* Enhances a domestic battery and violation of order of protection charge from a Class A misdemeanor to a Class 4 felony if the defendant has a prior conviction for domestic battery or violation of order of protection.
- *Insurance:* Forbids a company issuing property or casualty insurance from using the fact that an applicant incurred bodily harm as the result of domestic violence as the sole reason for a rating, underwriting, or claims handling decision.
- *Elder Abuse:* Amends the Elder Abuse and Neglect Act to include a requirement that certain individuals report suspected elder abuse or neglect when it is believed that the elder is unable to seek help on his or her own.

Best Practices

The previously mentioned NIJ studies suggest the following:

- Screen and/or test assailants at the time of arrest for alcohol or drug

intoxication.

- Detoxify arrested drug- or alcohol-dependent assailants prior to release from jail. Probation officers should ensure that batterers are regularly re-evaluated for both violence and substance abuse throughout the course of the program.
- Assess children who directly witness domestic violence to determine if services are needed.
- Allow domestic violence assault victims to swear out arrest warrants at the assault scene.
- Provide services for women whose self-esteem has been eroded by the manipulative and coercive behavior of a batterer.
- Safety planning must begin at the earliest point of contact with the victim and continue throughout the process.
- Accurate and complete information about the defendant (including previous arrests, substance abuse history, involvement with child protective services, and experience with batterer intervention) should be used to assist in making decisions concerning plea bargains, bail, and supervision and in fashioning the protection order.
- Reduce time between arrest and intervention program enrollment for batterers.
- Track participants more efficiently — practices currently involve referrals to a wide array of services.

- Centralized dockets created to handle domestic violence cases result in increased expertise, and access to all criminal justice system players and services.
- Opportunities for coordination by the criminal justice system include integrating batterer intervention with court-ordered substance abuse treatment.
- Program and sentencing options are needed for the full range of batterers, not just the low-risk male heterosexuals (the most common category).
- Further research is needed on the interactive aspects of domestic violence, such as use of criminal history information in crafting orders and counseling victims; effects and enforcement of specific terms of protection orders; and actions of police and prosecutors.
- Substance abuse treatment programs should screen to identify batterers and victims of domestic violence. The treatment provider needs to respond to the safety needs of a woman with a substance use disorder who is being battered before developing a treatment program to help her overcome her addiction. It is important to address the issues that affect an individual's pattern of substance use so that they can be addressed and don't interfere with treatment (CSAT, 1997).

Special Settings: Child Welfare

Domestic violence and substance abuse increase the risk of child abuse and neglect. Either problem alone has the potential to destroy families; but when the two are combined, this potential increases significantly.

Domestic Violence and Child Maltreatment

Ninety-five percent of injurious domestic violence is committed by men against women. These same men are also at high risk of physically abusing their children. Research has shown that children in homes where domestic violence occurs are at risk of becoming victims of violence themselves:

- Children whose mothers are battered are physically abused or neglected at a rate 15 times higher than the national average.
- Women and children are often victims of the same batterer. Studies have found that over half of the children of battered women have been physically or sexually abused by the same perpetrator as their battered mothers. Research on abused children similarly shows that nearly half of them have mothers who are battered.
- Lenore Walker's study of battered women found that one quarter had abused or neglected their children when they were being abused themselves. The same study also found that battered women were eight times more likely to hurt their

children when they were being battered themselves than when they were living safe from violence.

- Even if they are not intentionally targeted for abuse, children in homes where women are being battered are sometimes injured while trying to intervene on behalf of their mothers, or when they are nearby while objects are thrown. Young children are sometimes hurt when their mothers are attacked while holding them.
- Because domestic violence is a pattern of behavior that escalates over time, it becomes increasingly likely that child witnesses of battering will eventually become victims of the same perpetrator.
- Domestic violence is the single major precursor to deaths occurring as the result of child maltreatment.

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Child Witnessing

Even when children of battered women are not physically abused themselves, they still suffer the traumatic effects of witnessing violence between their parents or caretakers. It is estimated that at least 3.3 million children annually are exposed to episodes of domestic violence (Schewe, 2000). Children may

also be used as pawns by an abuser who uses them to gain control of the mother. While many of these children are seriously affected by their experience, others seem to be surprisingly resilient.

Research has shown that of children residing in domestic violence shelters, one-third show minimal problems, one-third have significant problems but are able to cope with them, and the remaining one-third suffer problems the severity of which puts them in the clinical range of symptomatology (Hughes & Luke, 1998). At least one other study, however, indicates that as many as 50% of child witnesses to domestic violence manifest significant problems of adjustment (Margolin, 1998). The gravity of the trauma experienced by such children and the nature of their reaction to the observed violence may depend on a number of factors, such as:

- The nature of the domestic violence.*
- The severity of the abuse.*
- Whether the child witnessed one act of abuse or multiple acts.*
- The length of time that episodes of abuse continued.
- The age of the child.*
- The existence of other family problems, such as substance abuse, mental illness and homelessness.*
- Whether the child told anyone outside the family about the abuse and, if so, what the result of

“breaking silence” was.

Schewe (2000) has suggested that another important factor influencing the child’s reaction to domestic violence is the nature of social supports available to the child. Recent research that has identified key factors that contribute to resilience and coping ability in children exposed to domestic violence has shown that chief among these factors is a strong relationship with a caring, competent and positive adult, most often a relative (Groves and Zuckerman, 1997).

Whether or not they experience any physical abuse themselves, children from violent homes are at risk for problems of adjustment:

- Children who witness domestic violence suffer effects similar to children who are themselves physically or sexually abused. In some cases, children who are exposed to violence display symptoms similar to post-traumatic stress disorder in adults, such as repeatedly reexperiencing the traumatic event, emotional numbing, avoidance and increased arousal (Bell, 1995).
- Children under the age of five may be at risk of serious development problems due to the heightened stress and the physical immaturity of their brains (Analytical Sciences, 2002).

*These factors appear in Schewe, P.A., et. al. (2000). *Interventions for Children Exposed to Domestic Violence*. Paper presented to the Illinois Department of Human Services by the author and the University of Illinois-Chicago Domestic Violence and Sexual Assault Evaluation Team

- The emotional effects of domestic violence on children include taking responsibility for the abuse, constant anxiety, guilt for not being able to stop the abuse, fear of abandonment, and lack of confidence.
- Children from violent homes may experience cognitive or language problems, developmental delay, stress-related physical ailments, hearing and speech problems, excessive irritability, sleep problems and fear of being alone (Zeanah & Scheeringa, 1996).
- Stress-related symptoms such as bed-wetting, hair pulling, frequent nightmares or night terrors are often present in children of battered women.
- Some children cope through regressive symptoms such as thumb-sucking or infantile temper tantrums, or display regression in toilet training or language (Zeanah & Scheeringa, 1996).
- Even infants can be visibly upset by arguments between their parents.

In addition to these negative effects, children of battered women also experience the effects of having violent role models. They learn that violence is an appropriate way to manage stress, one that has few consequences from society:

- Many children begin to act out the violence they have seen at home. A study found that 47 percent of boys and 36 percent of girls from violent homes fell within the clinical range of

behavior problems. Even when they are not physically abused themselves, child witnesses of domestic violence still show higher levels of behavior problems than children living in safe homes.

Research shows that children from violent homes are more likely than other children to be abusive toward brothers and sisters.

- When tested, children from violent homes were more likely than their peers from nonviolent homes to indicate that violence is an acceptable way to resolve conflicts, bring a quick end to an argument, get their way or express anger.

This modeling of violence continues into adulthood, and many children of battered women become batterers or victims themselves. Boys from violent homes are 15 times more likely than boys from non-violent homes to become abusers themselves. Research found that *witnessing* spouse abuse as a child was an even better predictor for becoming an abuser than experiencing physical abuse as a child. In this way, the cycle of violence continues.

They learn that violence is an appropriate way to manage stress, one that has few consequences from society.

Substance Abuse and Child Maltreatment

Substance abuse is closely linked to child abuse. At least 40 percent of child

maltreatment cases involve the use of alcohol or other drugs, and that percentage could be as high as 75 percent. Studies suggest that at least 10 million children live in homes where the primary caretaker is addicted to alcohol or other drugs, and up to 675,000 children per year suffer serious abuse or neglect as the result of that substance abuse.

- Among psychoactive drugs, methamphetamine, cocaine, and PCP are only three of the substances that are capable of increasing the risk for violence due to drug-related irritability, hostility, suspiciousness, and psychosis.
- Among psychoactive drugs, alcohol, methamphetamine, cocaine and PCP are the only three substances that are capable of increasing the risk of aggressiveness and violence due to drug-related irritability, hostility, suspiciousness, and psychosis. Alcohol, barbiturates, and tranquilizers, due to their disinhibiting effects, may also act as a risk factor for domestic abuse by sedating the portion of the brain that acts to recognize and suppress violent/antisocial behavior. In addition, the diminished consciousness produced by such drugs may produce an increased risk for child neglect as well as reduce the ability of a caretaker to protect the child from violence within the home.
- Opiate use (e.g., heroin) may contribute to child neglect, while withdrawal from opiates is more likely to increase the risk for abuse.

- The communities in which addicted women live with their children may also be a source of traumatic violence. In Illinois, some clients report that they live in what they perceive as a “war zone,” and may resort to sleeping with their children on the floor of their home in order to avoid stray bullets from drive-by shootings.

Whether or not they are physically abused, children of substance abusers experience the effects of the chronic stress of living with an addicted parent. Young children of substance abusers may believe they caused the addiction, and older children may feel anxiety and guilt for not being able to control or cure it. Like children of batterers, children of substance abusers often grow up to repeat the pattern, becoming substance abusers themselves.

Safety and Sobriety

A common assumption within substance abuse treatment programs is that if the offending parent’s alcohol or other drug use ceases, so will child maltreatment. This assumption, however, is based on the mistaken belief that the child abuse or neglect is entirely a product of substance abuse.

- *Child neglect appears to decrease when an addicted parent or caregiver achieves and maintains sobriety.* In some cases, child neglect is directly related to the effects of alcohol and other drugs and to the addict lifestyle, which is often chaotic and unpredictable.
- *Child abuse seems to decline minimally, if at all with sobriety.* The

parent's sobriety can not be taken as an indication that all child maltreatment will stop.

- *A personal history of child abuse is also a risk factor for continued or renewed substance abuse as a means of "self-medicating" the feelings associated with such trauma.* Of adults in substance abuse treatment, nearly 70 percent of women and 12 percent of men were sexually abused as children. Substance abuse may often serve as the "anesthetic" which numbs the pain of being an adult survivor of child abuse. When this anesthetic action ceases as the result of sobriety, the individual's pain may be magnified, increasing the risk of child abuse. For this reason, therapy or counseling outside the realm of chemical dependency treatment may be required in order to minimize the risk of continued child abuse.

- ***Child neglect appears to decrease when an addicted parent or caregiver achieves and maintains sobriety.***
- ***Child abuse seems to decline minimally, if at all with sobriety.***
- ***A personal history of child abuse is also a risk factor for continued or renewed substance abuse as a means of "self-medicating" the feelings associated with such trauma.***

Programmatic Responses to the Issue of Child Witnessing

Each year domestic violence programs funded by the Illinois Department of Human Services provide almost 150,000 hours of service to at least 25,000 children. A summary of these services can be found in Schewe (2000).

Systematic evaluation studies concerning the effectiveness of services to child witnesses of domestic violence are currently lacking. Some research has been conducted, but the results are mixed. Evidence accumulated more than 15 years ago has suggested that such interventions may be helpful (Jaffe, Wilson and Wolfe, 1986). The authors conducted interviews with both children and their mothers who had completed a 10-week program that used small group processes as the primary intervention, and reported the following results:

- Mothers said that their children enjoyed the group (93%), learned something from the group (62%) and changed their behavior as a result of the group (33%) (Jaffe, Wilson and Wolfe 1986).
- Children who participated in the group were more able to identify 1) three or more appropriate reactions to emergency situations (44% pre-intervention vs. 73% post) and 2) two or more positive things about themselves (53% vs. 85%) (Jaffe, Wilson and Wolfe 1986).

Two more recently conducted studies have also produced mixed results. Pepler, Catallo & Moore (2000)

examined a 10-session small group intervention for 6 to 13-year-old children who have been exposed to domestic violence. Reductions in depression and anxiety were noted, as well as an improvement in emotional and hyperactivity problems. On the other hand, no significant changes in the (negative) conduct of participants (as measured by the Child Behavior Checklist) were observed, nor changes in attitudes against violence (as measured by the Attitudes Toward Family Violence Questionnaire). In addition, there appeared to be no correlation between the mothers' participation in domestic violence counseling and their children's improvement (Pepler, Catallo & Moore, 2000).

Stein, Jaycox, et. al. (2003) evaluated the results of a school-based intervention designed to reduce children's symptoms of post-traumatic stress disorder (PTSD) and depression that had resulted from their exposure to violence. However, at the request of the schools involved, questions asking specifically about violence at home were removed from the project questionnaire. Thus, it is unknown how many of the subjects were suffering from violence observed in the community versus at home. Violent events that the subjects had observed in the media or that they had simply heard about rather than observed first hand were not included.

Stein, Jaycox and their colleagues also utilized a ten-session/ten-week intervention delivered in the schools by psychiatric social workers. After three months of participation in the intervention group, students who were

randomly assigned to the group had, compared to a group of similar students who received no treatment, lower scores on symptoms of PTSD, depression and psychosocial disruption. However, no significant differences between the two groups was found with regard to teacher-reported classroom problems in acting out, shyness/anxiousness, and learning. At 6 months, after both groups had participated in an intervention group, there were no statistically significant differences with regard to symptoms of PTSD, depression or teacher-reported classroom behavior.

When intervening with children exposed to domestic violence:

- The batterer should be referred to only protocol approved PAIPS and not anger management services.
- Separate service plans for the victim and batterer are best practice so that the batterer doesn't have the opportunity to jeopardize her custody of the child.
- Safety planning for the child and victim should occur especially if visitation with the batterer is allowed.
- Substance abuse and victim or abuser services should be concurrent.
- Services for the victim or batterer should be community based, licensed (substance abuse treatment), monitored (victim

services) and/or protocol approved (batterer).

- If interventions require that both the victim and batterer attend services at the same location, victim safety should be considered.

Ethics

The identified client within both domestic violence and substance treatment programs is the adult. However, such programs should take into account the importance of ensuring the safety of children within a home in which substance abuse and/or domestic violence is occurring. In fact, since both substance abuse and domestic violence intervention programs are mandated to report child abuse and/or neglect, such programs *must* report situations in which children are harmed as the result of substance abuse or domestic violence in their homes. However, the question of whether mandated reporters are required to report situations in which a child has witnessed repeated instances of domestic violence on a regular basis is debatable.

Schewe (2000) has suggested that if perpetrating domestic violence in the presence of a child or, more relevantly, "exposing" children to such acts is defined as child maltreatment, battered women may be discouraged from seeking help, fewer child and family service providers will screen for domestic violence, and even greater demands will be placed on the already overburdened child welfare system. At a minimum, though, children from homes in which domestic violence has occurred should receive a thorough

physical and psychological assessment, and, when appropriate, should be referred to a specialized support group such as those commonly found in domestic violence programs.

Training and Certification

At present, no agency within Illinois provides specific certification for child welfare professionals. The Illinois Alcohol and Other Drug Abuse Professionals Certification Association (IAODAPCA) provides a wide range of certificates and levels of certification for substance abuse counselors, preventionists, assessment and referral specialists, and MISA (mentally-ill substance abuse) workers. Currently, training in the areas of domestic violence and child welfare are not requirements for such certification. Illinois Certified Domestic Violence Professionals, Inc. is the organization in Illinois currently certifying domestic violence professionals. More information about this organization can be obtained at their Web site at www.ilcdvp.org.

- Currently, the best solution to the issue of dual certification appears to be to continue offering cross-training opportunities to various professions, and to encourage continued dialogue and service planning between the various fields.
- Individuals who are chemically dependent, as well as those who are victims of domestic violence and child maltreatment, are frequently seen in hospital emergency departments and physicians' offices. Doctors, nurses, and social workers should be targeted for training in the screening of patients for substance

abuse, domestic violence and child maltreatment.

- Colleges and universities should be encouraged to seek out opportunities for students majoring in human service fields to learn skills and gain experience in such diverse fields as addiction counseling, domestic violence intervention, and child welfare.

Special Populations: Racial and Ethnic Groups

Multicultural Sensitivity

Culture has been defined as “the shared values, norms, traditions, customs, art, history, folklore, and institutions of a group of people.” Culture is developed in relation to the changing social and political contexts. It is based on race, ethnicity, age, class, gender, sexual orientation, geographical location, immigration status, disability status, and within the historical context of oppression. Culture shapes an individual’s view of the world, their values, behavior, and way of life. It influences attitudes and affects how an individual responds to domestic violence and substance abuse services.

Culturally competent programs demonstrate sensitivity to and understanding of cultural differences. A culturally competent program:

- Understands the role of culture in shaping behaviors, values and institutions.
- Continually trains staff to recognize and confront their own prejudices.
- Recognizes that culture is a source of power.
- Recognizes that cultural differences exist and have an impact on service delivery.
- Recognizes that diversity exists among and within the same racial and ethnic groups.
- Respects the unique, culturally

defined needs of various client populations.

- Understands that people from different racial and ethnic groups and other cultural subgroups are usually best served by persons who are a part of or in tune with their culture.
- Trains staff to assess and respond to an individual’s communication style — for example, their preferred personal space, eye contact, language style, and the degree to which touching is appropriate.
- Provides written material in the appropriate languages.
- Develops linkages with support systems representing the client’s culture.

General Points to Consider

Here are some general points to consider in providing culturally competent services:

- Be aware of and respect the diversity among the multiple racial and ethnic groups. For instance, there are more than 60 Asian/Pacific Islander groups, each with their own culture, language and ethnic identity. Latino/as come from more than 20 different countries. The Native American population consists of approximately 450 different groups with varying customs and some 250 languages.
- Acknowledgment of the cultural and religious beliefs, values and

practices can empower and validate the client/survivor/victim.

- Be sensitive about touching and eye contact. Respect one's space during conversations. Some people consider touching by a counselor to be intrusive, insincere or even threatening.
- Questions of a personal nature, such as those related to sexual behavior, may be viewed as intrusive, taboo, and/or indicative of stereotypical thinking. Staff should be aware that it may take some time before a person is willing to share personal information.
- Be sensitive about asking for immigration status, social security number, or identification cards and about taking pictures of immigrant women or men.
- Use of children as interpreters should be avoided, if at all possible.

Women of Color

When working with women of color, consider these points:

- Assess the individual's communication style and avoid judging behavioral cues. Some women may avoid maintaining eye contact because it is perceived as challenging. Others may reject deferential behavior and may be perceived as disrespectful or hostile.
- Some women may be reluctant to report violence because of their community's negative experience with social service agencies,

government entities, and the police.

- Some women may be ostracized from their communities if they report abuse.
- Recognize the importance of family. Be aware that the concept of family is broader than parents and children, and generally includes blood relatives, relatives by marriage, close family friends, and neighbors. When abuse exists, women may be reluctant to leave because of commitment to the family and fear of isolation.
- Some immigrant women are vulnerable to domestic violence because of their immigration status and economic dependency. They may also be isolated because of language barriers and may face the added burden of racism.
- Some immigrant women may not know U.S. laws or may be misinformed by their batterer. The batterer may use the threat of deportation to control the woman. The Violence Against Women Act allows an immigrant woman to petition for legal residence. The provisions of the law are complicated, and professional assistance is recommended. Contact the Illinois Coalition Against Domestic Violence or the Poverty Law Center for assistance.

Men of Color

Facilitators working with men of color need to be sensitive to the following cultural issues. However, do not tolerate these conditions as an excuse

for abuse. No culture condones violence.

In groups composed primarily of European Americans, men of color may feel:

- Isolated — detached from familiar surroundings, culture, institutions and people.
- Uprooted — lacking familiarity with the system, dealing with hostility and messages of inferiority from the majority culture.
- Helpless — not functioning fully because of language barriers, lack of support systems, lack of education and skills.
- Powerless — lacking political and economic power, vulnerable because of immigration status and/or lack of documentation, experiences with racism. Studies have shown that men of color progress faster in treatment groups where they are the majority.

In partner abuse groups it is important to consider:

- Some men of color may argue that the society which disenfranchises them gives disproportionate power to women over men.
- The provider should be aware of the distinction between *acknowledgment* and *collusion* and take care to avoid the kind of negative bonding which can allow the man to internalize the message that his experiences justify his violence against women.

Be aware of and respect the diversity among the multiple racial and ethnic groups.

Special Populations: Lesbian, Gay, Bisexual, and Transgendered People

Addiction and the Lesbian, Gay, Bisexual, or Transgendered Individual

Research on alcohol and drug addiction in the gay, lesbian, bisexual, or transgendered (LGBT) community is limited by a number of factors. Early research tended to concentrate on samples drawn from almost exclusively male patients of psychoanalysts and psychotherapists. The focus of the studies was often directed less toward treatment of alcoholism or addiction than toward “curing” homosexuality. Subsequent studies have focused on samples of people who are identified as gay because they are patrons of gay bars (Fifield, 1975). The fact that in each of these groups rates of drug and alcohol use tended to be higher for what should have been obvious reasons skewed the resulting data.

A review of LGB incidence studies (Bickelhaupt, 1995) notes one ambitious 1991 study of 748 gay, lesbian and bisexual individuals in the San Francisco area using a lengthy survey tool, which included a 209-item AOD use survey over a two-month period. “Distribution,” the author notes, “was accomplished using a gay/lesbian monthly newspaper, bookstores, businesses, organizations, service agencies, personal networks of LAGSAP (Lesbian and Gay Substance Abuse Planning Group), and field workers. In addition, there were interviews with targeted populations, including people of color, youth, and

homeless or low-income people.” The study found that nearly one third (31%) of gay and bisexual men reported using alcohol and /or drugs at the highest risk level (suggesting dependency) and another 11% reported patterns of drinking/drug use labeled “problematic.”

Alcohol was recognized as the drug of choice for gay/bi men (75%) and lesbian/bi women (66%). Forty percent of male and 30 percent of female respondents indicated use of more than one drug, and twice as many men as women (10% vs. 5.5%) used alcohol daily (Kelly, 1991, cited in Bickelhaupt). This example illustrates a major methodological problem of studies like this in that a largely self-selected sample was used that included only men and women who were to at least some level “out,” or publicly identified as gay or lesbian. Useful as this information is, the fact remains that there has been little research that recognizes the fact that most gay men and lesbians historically have not publicly acknowledged their orientation; this voiceless majority consequently has been overlooked in most studies. No such extensive studies have been done of the transgendered population, and Bickelhaupt notes that in several studies, because of small sample size or apparent “mixed membership,” the bisexual component studied was either dropped or not reported in the final data.

“Bar Culture” in LGBT Communities

One of the factors complicating the

recognition and treatment of addiction in the LGBT community is the fact that bars do tend to be social centers in the community. For people who may be subject to hostility, violence, or arrest for making incorrect guesses or assumptions about another person's orientation, it is important to have a place where LGBT identity can safely be assumed. That place has usually been the gay and/or lesbian bar. In larger communities, this is less true now than it may have been previously, but it is still the case for many LGBT people. In some locales such venues are the only places where LGBT people can be relatively free of harassment and ridicule, although in some communities even these havens are subject to law enforcement and regulatory discrimination. It may be true for some people that the only gay men or lesbians they know are people whom they have met in gay or lesbian bars.

Several researchers, (notably Kus, 1988) have suggested that there is evidence that the etiology and incidence of alcoholism in gay men, at least, is unrelated to gay bars, noting that most gay alcoholics interviewed point out that they began drinking (and may have begun problematic drinking) before they ever patronized a gay bar. In larger communities, 12-step and other groups with a specific focus on gay men, lesbians, or the LGBT community in general have become well established alternatives for those recovering from addiction. In the Chicago area there are now two social organizations for recovering people that provide social and recreational activities in addition to self-help groups. Rural LGBT people in recovery may have less formal networks within AA, NA and other groups, but for

many LGBT people, bars will continue to be part of their social life in sobriety. Treatment centers that do not serve large numbers of LGBT clients may be ill-equipped to prepare them for dealing with this aspect of their recovery.

LGBT-Specific Treatment Options

Treatment options for the LGBT person have been less carefully thought out and less available than those from which heterosexual clients choose. In a recent edition of a directory published for the LGBT community in Illinois' largest city, there are 35 listings for "Counseling and Psychotherapy." Only two mention addiction specifically and one of those is a Chicago unit of an addiction treatment program specifically designed for LGBT people. A third program refers to "compulsive behaviors." (*Out!*, 2002-2003). Another guide offers a separate specific "Addiction Recovery" section; it fails to list the LGBT-specific program but does include information about contacting LGBT 12-step groups and organizations such as Rational Recovery™ (Alternative Phonebook, 2002-2003).

On the whole, people in the LGBT community tend to be wary of mental health and substance abuse treatment because of the homophobic assumptions and practices which have been characteristic in the past (and which continue to be a problem in some institutions and settings). Moreover, the "peer group" from whom LGBT people must seek support in treatment and in 12-Step and other self-help groups may reflect the generally homophobic attitudes of the larger culture, and may pose problems for the gay man or

lesbian who is seeking sobriety. The encouragement of self-acceptance, which generally characterizes addiction treatment, has often hit a snag when a client discloses same-sex sexual attraction.

While the incidence of LGBT alcoholism and drug addiction may have been overstated in some studies there is certainly no reason to believe that overall rates of addiction and substance abuse in the LGBT community are any lower than in the general community. Other research has shown that addiction to or abuse of substances “occurs over time and progresses — or not — according to an intricate process that involves the larger socio-cultural system; the individual’s age, life stage, and social role within that system; the demands and opportunities of the individual’s more immediate social environment; and the unique pattern of neurobiological vulnerability and protection that his or her genetic endowment provides” (National Institute on Alcohol and Alcoholism, 2000).

Even assuming a similar distribution in the LGBT community of whatever factors may predispose people to addiction for genetic or biological reasons, the use of alcohol and other drugs to medicate negative feeling states resulting from homophobia (both external and internalized) is likely to be higher in this population. Thus, it seems likely that those with such predisposing factors will be more likely to show symptoms of the disease, and to do so earlier.

Violence in Gay and Lesbian Relationships

Incidence

What we know about same-gender relationship violence is limited. According to a fact sheet distributed by the Wingspan Domestic Violence Project in Tucson, AZ, this is because:

- Same-gender relationships are often not considered to be viable partnerships or families.
- In many states (Illinois is an exception¹), domestic violence law only protects partners of the opposite sex. Other types of domestic violence legislation, such as mandatory arrest, no-drop clauses, state prosecution and mandates for abusers or victims to attend programs that address domestic violence, may not apply to same-gender relationships.
- Fear of continued victimization by law enforcement, criminal justice, and social service helpers keeps LGBT people from seeking assistance, support, and safety.
- Limited or non-existent officially sanctioned programs and resources further isolate same-gender victims and offer few intervention opportunities for perpetrators in domestic violence situations.
- Many LGBT people lead double lives in which it would be a threat to job, status, family role, safety, and security to be open about their sexual or gender identity. When help

¹IDVA [750 ILCS 60/103(6)] lists “persons who have or have had a dating or engagement relationship.” Illinois courts have interpreted this to include same sex partners.

is needed, fear of exposure may prevent them from taking action to stop the cycle of violence.

- With a few exceptions, the LGBT community generally avoids, denies, and ignores relationship violence. Victims and perpetrators are left without resources within their identified communities (Wingspan Domestic Violence Project).

There is evidence that battering occurs in gay and lesbian domestic partnerships at roughly the same rate as in heterosexual marriages or domestic relationships. One of the first studies of domestic violence in lesbian relationships found that 25 percent of those surveyed reported abuse in their committed relationships (Brand & Kidd). A 1990 study determined that 47 percent of lesbian couples had experienced repeated acts of violence. Of these couples, 10 percent to 20 percent experienced severe violence, defined as: two or more incidents of physical violence, including beating, strangulation, hitting, forced sex, mutilation or threats with a weapon (Coleman, 1990).

More recently, a study of gay and bisexual men indicated that 2 in 5 of these men who have sex with men experienced abuse in intimate partner relationships (Greenwood, 2002). The Gender, Violence and Resource Access survey of transgender and intersex (defined as those who “naturally, [that is, without any medical intervention] develop primary or secondary sex characteristics that do not fit neatly into society’s definitions of male or female”) individuals determined that half of respondents had been raped or

assaulted by a romantic partner. The study goes on to note that only a little less than 2/3 of transgendered or intersex individuals who reported rape or assault (or a bit less than 1/3 of the whole sample) described themselves as survivors of domestic violence (Courvant and Cook-Daniels, 1998).

Chicago-based Horizons Community Services is the only Illinois program reporting statistics on LGBT domestic violence to the National Coalition of Anti-Violence Programs, which publishes an annual report on LGBT domestic violence across the nation.

In the NCAVP’s report on LGBT domestic violence in 2002, Horizons reported 74 new cases. These reports break down as follows:

Horizons 2002 Report to NCAVP		
Gender	Number	Percent
Female	33	45%
Male	36	49%
Transg. M-F	1	1%
Unknown	4	5%
Total	74	100%
Orientation	Number	Percent
Lesbian/Gay	56	76%
Bisexual	4	5%
Heterosexual	6	8%
Questioning or Unsure	1	1%
Unknown	7	9%
Total	74	99%
Age	Number	Percent
Under 18	4	05%
18-22	5	07%
23-29	15	20%
30-44	19	26%
45-64	3	04%
Unknown	28	38%
Total	74	100%

Ethnicity	Number	Percent
African-American	12	16%
Asian/P.I.	1	1%
Latino/a	7	9%
Multi-racial	1	1%
White	26	35%
Unknown	27	36%
Total	74	100%

Months with the highest incidence were January (12), August (14) and December (10). Months with the fewest reports were February and September with two each, and April and May, with three each.¹ Clearly, these numbers cannot be considered fully representative of the incidence of domestic violence in Chicago, Illinois' largest LGBT community, as they do not include LGBT victims served by other agencies and governmental units or unreported incidents. It seems important to note the obvious: that when appropriate, LGBT-specific services are available, many LGBT victims use them.

Homophobia, Misogyny and Violence

Rigid conceptions of gender roles and attributes play a significant part in the dynamics of domestic violence. The expectation of male privilege is grounded in a belief that men are superior to women and that men have rights with regard to women which are not reciprocal. One of the effects of this attitude is to make male identity, and specifically heterosexual male identity, the norm. To be anything else is to be

¹ "Lesbian, Gay Bisexual and Transgender Violence in 2002: A Report of the National Coalition of Anti-Violence Programs (2002 Preliminary Edition) ©2003, Adapted from Appendix A (Data Chart).

"less than."

In a sexist society it is not surprising that boys who find themselves attracted to other males, and wish the attraction reciprocated, may begin to internalize the gender role expectations that surround them and assume characteristics that the social framework characterizes as "feminine." Similarly, girls who are attracted to women may take on characteristics that might be seen as "masculine." Misogyny's relationship to homophobia can be inferred from the fact that adults generally see a girl who is considered a "tomboy" as "cute" far longer than they do a boy who is considered a "sissy."

The threat to male privilege implied by homosexuality is that gender roles and their attendant privileges are not immutable ("if he can give his up, perhaps mine can be taken away"). If, as a man, I view women as sex objects in ways that depersonalize them, I am likely to respond with anger and fear to the thought that another man might regard me in the same way. If, as a man, I am defensive of male privilege, I may well feel threatened when confronted by another man who appears to have voluntarily surrendered that privilege. If I believe that being the object of a man's sexual interest is one of the things that defines the female and makes her "less than," then the attention of such a man is even more threatening to me.

Lesbians get less attention from the heterosexist position. The sexual attraction of one woman for another becomes useful in providing a label for women who reject or are indifferent to a particular man's advances. Whereas

male-male sex is seen as repulsive and shameful, female-female sexual activity is seen as titillating or merely strange. Thus lesbians tend to become less visible, and are discounted by being trivialized (Nelson, 1988).

Homophobia and Men Who Batter

In many kinds of behavioral intervention or therapy with men, it is necessary to address homophobia as an isolating factor. Men in substance abuse treatment, for example, often need to confront homophobia as a factor that makes it more difficult for them to self-disclose in groups of men or to confide fully in a sponsor. Many men come to realize that homophobia has made it difficult for them to seek and appreciate support from other men, including fathers and male siblings.

In intervention with men who batter, however, homophobia and its relationship to misogyny play a more crucial role, and confrontation of homophobia is often a difficult and volatile aspect of the intervention process. Placing gay men in intervention groups designed for heterosexual males makes them uniquely vulnerable. They may become targets for the fear, discomfort and hostility which men in the group often experience as men's assumptions about maleness and masculinity are challenged.

Transphobia

Perhaps related to homophobia is the antipathy or discomfort with transgendered people that is sometimes referred to as transphobia. During focus

groups, providers who serve the transgendered community pointed out that reporting of domestic violence among transgendered clients is frequent in private conversations but rare in official reports. One provider reported that a number of transgendered sex workers have reported frequent abuse by clients or procurers but state that reporting to the police has only resulted in ridicule or harassment. Additionally, they report confronting confusion or uncertainty when they approach some social service agencies for assistance.

The consistent message that transgendered people give when asked about what would help is that agencies and individuals in the helping professions should first respect the gender identity of the person seeking help, period. Service providers' "ifs, ands, and buts," as one person put it, that are often appended to offers of assistance make transgendered people feel both unsafe and unwelcome because they send a message that providers are not knowledgeable about or comfortable with them because they challenge the conventional understanding of gender. Service providers need to educate their staff about transgendered people, establish policies and procedures that respect the identity of transgendered people, and make appropriate and respectful accommodation when required. Providers must recognize that a transgendered individual who receives gender-inappropriate treatment may be likely to reject the treatment for the same reasons that would cause any other individual to resent or fail to identify with such treatment.

LGBT People of Color

Lesbians, gay men and transgendered individuals who are people of color experience what has been called "double trouble": they must deal with the effects not only of racism, but also of homophobia. For lesbians of color, this becomes a triple threat, as the effects of sexism must also be considered. People of color must deal with racism in the gay and lesbian community, whose emerging culture remains heavily dominated by white men and women. At the same time, in struggling against racism, they must deal with the fear of homophobic retaliation in addition to their other vulnerabilities. These factors increase the isolation of the lesbian of color particularly, but also of the gay or transgendered person of color. The person of color who embraces a lesbian, gay, bisexual or transgendered identity is subject not only to homophobic attack, as are whites, but also to racist attacks, which are not a concern for whites (Kanuha, 1990).

Intervention

Few resources are available for intervention in violent LGBT relationships. It is obvious that gay men would not be safe in an intervention group that was predominantly composed of heterosexual men. Of course, no woman should be included in a group for men who batter. In many communities, this makes group treatment of gay and lesbian batterers impossible, because it is unlikely that a sufficient number of gay men or lesbians to form an effective group would present for intervention at any one time. In Chicago, the largest social service agency that serves the lesbian and gay

community is currently referring identified perpetrators to individual therapy with selected psychotherapists. This is certainly not recognized as the intervention of choice.

One private practice in the Loop area is willing to provide group intervention but has not yet received enough referrals to begin a group. At this writing one agency is planning to begin a group intervention for gay and bi men in the fall of 2005 and for lesbians and bi women in early 2006 (West Side Domestic Abuse Project, Chicago). They are also engaged in discussions with other service providers who primarily serve the LGBT community in Chicago to assure the necessary matrix of ancillary services for an accountable intervention group. In discussing this issue with various service providers, the authors found that several partner abuse intervention groups for women in various areas of the state report that some lesbian perpetrators have been successfully integrated into women's intervention groups. Other counselors working with lesbians who have been identified as perpetrators have reported that some clients make it very clear that they would not be comfortable in groups of heterosexual women. To date, no groups specifically for lesbian perpetrators exist in the state, and no partner abuse intervention groups for bisexual or transgendered men or women are available.

Lesbian victims of domestic violence report a wide variety of responses from shelters and other domestic violence providers. A particular shelter's commitment to providing safe refuge for lesbian women may depend on the attitudes of individual staff members and

volunteers, and may change as personnel change. Focus groups of persons active in the LGBT shelter movement and the battered women's movement in Chicago described incidents of lesbians coming into shelter reporting that they had been denied shelter by staff at a local shelter who felt their presence would be "disruptive" to the milieu of the shelter. Most shelters in Illinois have no policy that would exclude a woman simply because she is lesbian, but staff sensitivity and willingness to confront homophobia on the part of other residents varies considerably.

Although an LGBT shelter movement has begun in Chicago, it has not yet progressed to the point where clients can be offered specific LGBT-friendly shelter. This movement hopes in the future to be able to offer shelter in homes, much like the early work of the battered women's movement, and eventually a brick-and-mortar shelter for LGBT victim-survivors of domestic violence. Several shelters around the state will provide emergency assistance (usually in the form of vouchers for hotel or motel accommodations) to gay male victims of domestic violence. At present, there are no active support groups for gay, lesbian, bisexual or transgendered victims of domestic violence in any agency in Chicago or elsewhere in the state. Several agencies have tried to develop these with limited success in the past.

Special concerns

Concerns specific to LGBT identity also reduce the willingness of people affected by the problem to seek help. Anecdotal evidence is strong that such

services, if they existed, would be used by only a small fraction of the LGBT community. Barriers to greater participation include the following:

- *Fears of being "outed" or exposed as homosexual.* In Illinois, it has only been since early 2005 that gay, lesbian, bisexual or transgendered persons are protected by law from being discharged from or refused employment, evicted from or refused housing, and denied any public accommodation simply because of the person's sexual orientation. In fact, such discrimination is also legal on the basis of *perceived or suspected* orientation. (This protection does not exist in all states.) Despite this new legal protection, there may be less-formal kinds of discrimination (ostracism by family, co-workers or religious community, for example) that may discourage the victim from acknowledging his or her abuse.
- *Low expectations of official response.* Many LGBT persons have experienced insults, harassment, and ridicule from police and other governmental authorities, and do not expect serious attention to their needs, including their needs for protection from violence. Many fear that taking action will result in retaliation by the perpetrator that will go unhindered by any official sanction.
- *Concerns about HIV status and about having that status revealed.* For those who are impacted by HIV, abusers may exploit fear that negative consequences from employers, family, friends and

acquaintances, landlords and others in the community may result from disclosure of that status.

- *Fear of other homophobic or heterosexual responses.* Both battered gay men and lesbians who batter challenge the assumptions that underlie the provision of services to both victims and perpetrators. Internalized homophobia leads many in the LGBT community to deny or minimize the existence of the problem, and disbelief, ridicule or rationalization often greets discussion of the problem.

Working With LGBT Domestic Violence Survivors (Adapted from a document prepared by Horizons Community Services, Chicago)

- Whether on the phone or in person, do not assume that every victim you come in contact with is heterosexual. Be sensitive to word choices (“lover” or “partner” or even “roommate” as opposed to “boyfriend/girlfriend” or “husband/wife.” Be aware of your own use of pronouns from the initial contact with any victim; do not assign a gender to their partner until they do. Practice use of non-gender-specific language.
- Do not pressure the victim to file a report or follow up on legal action. Know that this is a difficult and risky choice for the victim (to be involved in the legal system), especially if they/their partner are not “out.” If the victim does choose to take legal action, work with them on anticipating the reactions of family,

friends, employers, etc. Know what protections exist or do not exist for them.

- Take special care in finding out what support systems exist in a victim’s life. Acknowledge that some victims may not have the support of their original family members. Do not assume that a victim has an “LGBT community” to which they can turn for support. Acknowledge that many of their friends may align with the abuser and not want to get involved. Provide the victim with information and referrals and let them know that they are not alone and that they are welcome in your program.
- Respect their individuality and don’t expect them to conform to stereotypes or your ideas of what LGBT people are like. Don’t assume that just because they’re in a relationship with someone now that they’ve never been with other genders in the past. Don’t assume that they or their partners are childless. Don’t assume that they are politically active, a feminist, not a churchgoer, etc.
- Advocate for them in situations where others may be insensitive or unsupportive: police, doctors, landlords, etc.
- Know the counseling, medical and legal resources available in the LGBT community in order to make appropriate referrals, but don’t assume that just because they are LGBT that they will want an LGBT attorney, therapist or doctor.
- If an LGBT victim asks to speak to

an LGBT advocate and none are available, do your best to convey your knowledge and sensitivity to their needs and concerns, but do not automatically pass LGBT clients off to an LGBT counselor.

Working With LGBT Abusers

Most of the same things apply to working with abusers, but there are several other issues that partner abuse intervention professionals should keep in mind, whether they are starting a group for abusers or working with an abuser in individual sessions.

- Do not assume that size, perceived “masculinity” or “femininity,” “butch” or “femme” identification, or perceived body strength or weakness are determinant factors in who is the abuser. Consider other kinds of power differentials including class privilege, economic dominance, age and social status, job security, community ties, and HIV status (positive or negative). The abuser may be taking advantage of any of these.
- If it is not possible to offer the client a counselor or facilitator who is LGBT, or a counselor or facilitator who has had extensive training about and contact with LGBT individuals and their needs, consider referral to an agency or individual that can provide these options. If this is not an option, the counselor or facilitator will need to balance the need to listen to the client’s understanding of his/her situation with the need to obtain supervision or consultative assistance from professionals who are familiar with the community and

the needs of LGBT clients and their victims.

- If your agency or practice does victim safety checks, consider obtaining assistance from a victim’s service program that has experience providing services to LGBT victims.

Moving Forward

While there are no easy solutions to this complex group of problems, there are steps communities and institutions can take to continue the work that activists in the LGBT, domestic violence and substance abuse treatment communities have begun.

- Continue to name the problem. Community groups, publications, and institutions within the LGBT community must continue to acknowledge that gay men, lesbians, bisexuals and transgendered people batter their intimate partners.
- Make a commitment to a response. Complex problems such as the incidence of violence in same-gender relationships often lead to situations in which nothing is done because so much needs to be done. An individual, a single community, or one institution cannot provide all that is necessary to address this, but each can do something. Programs can examine their attitudes toward LGBT clients, and can provide training designed to increase staff sensitivity, awareness, and knowledge about the particular needs of this community and its members.
- Individual counselors and

intervention workers can become knowledgeable about the LGBT community in their area.

- Community organizations and networks that have done so much to begin a coordinated response to intimate partner violence in opposite-sex couples can examine the opportunities for outreach to LGBT people, including hiring LGBT staff, recruiting LGBT volunteers, and encouraging participation of LGBT people on their Boards of Directors.
- Encourage research. While there are few resources nationwide for this community, there are some. Further research is clearly needed to better understand the dynamics of same-sex domestic violence and the particular challenges it poses to intervention and safety planning efforts. Within programs, there are steps that counselors and advocates can take to increase the effectiveness of their interactions with LGBT clients.
- Service providers should be aware that there is not one monolithic “gay subculture” or “gay lifestyle.”
- As with any special population, an effort to be culturally sensitive begins with awareness of one’s own attitudes. Advocates and counselors may wish to ask themselves:
 - (a) Can I personally believe that gay is just as good as straight?
 - (b) Can I personally conceive of a homosexual person living a happy life?
 - (c) Do I conceal from myself attitudes of pity, condescension, and moral superiority toward LGBT people, attitudes that may cut me off from full communication with LGBT clients? (Schwartz, 1980).
- Become familiar with the resources available to LGBT clients in your community. For example, in Chicago, many LGBT persons may be unaware that more than 60 gay/lesbian or gay/lesbian-friendly religious organizations have services on a weekly or more frequent basis (*Out! 2002-2003*). Many LGBT organizations for civic, political, philanthropic, and community organizing activities exist, which are places to seek friendship and support among people who are not focused on drinking or drug use. Social, athletic, cultural and political organizations for LGBT people are becoming more numerous all the time. Many smaller communities may have some resources for LGBT clients of which the clients are unaware. Horizons in Chicago can serve as a resource, as can organizations such as Equality Illinois and the National Gay and Lesbian Task Force.
- Become familiar with referral sources for treatment such as the Pride Institute, Horizons Community Services and the Howard Brown Health Center, which may be able to suggest additional local resources. Obtain copies of the *Pink Pages* or *Out*, which are LGBT “yellow pages” publications issued on a semiannual basis.
- Be aware that there is a growing

network of sobriety-based support for LGBT people such as special-interest A.A. and N.A. groups.

In many states (Illinois is an exception), domestic violence law only protects partners of the opposite sex. Other types of domestic violence legislation, such as mandatory arrest, no-drop clauses, state prosecution and mandates for abusers or victims to attend programs that address domestic violence, may not apply to same-gender relationships.

Resources

Horizons Community Services

961 W. Montana

Chicago, IL 60614

(Social Service agency serving the LGBT community)

<http://www.horizonsonline.org/>

24 hour Anti-Violence Project Crisis Line: 773-871-CARE

(Domestic violence, hate crimes, police misconduct and discrimination)

6-10 PM Helpline: 773-929-HELP

Serves the LGBT community and anyone who has questions about LGBT issues or Horizons services.

Victim Advocacy Coordinator: 773-472-6469 ext. 244

Howard Brown Health Center

4025 N. Sheridan Road

Chicago, IL 60613

773-388-1600

(Comprehensive Health Care for the LGBT community)

<http://www.howardbrown.org/homepage.html>

Illinois Gender Advocates

47 W. Division Street

Chicago, IL 60610

312-489-5489

(Public Advocacy for Gender Variant and Transgender Community of Illinois)

<http://www.genderadvocates.org/>

Pride Institute

at Chicago Lakeshore Hospital

4840 North Marine Drive

Chicago, IL 60640

Contact Jennifer Beiner

800-888-0560

773-878-9700

(Addiction treatment for LGBT persons, including inpatient, outpatient and sober living)

The Survivor Project is a non-profit organization dedicated to addressing the needs of intersex and trans survivors of domestic and sexual violence through caring action, education and expanding access to resources and to opportunities for action. <http://www.survivorproject.org/>

The National Gay and Lesbian Task Force has worked to eliminate prejudice, violence and injustice against gay, lesbian, bisexual and transgender people at the local, state and national level since its inception in 1973.

<http://www.ngltf.org>

Equality Illinois works to secure, protect, and defend the basic civil rights of lesbian, gay, bisexual and transgender persons in the state of Illinois.

<http://www.equalityillinois.org/home.htm>

Special Populations: Children Dually Exposed to Batterers and Parental Substance Abuse

While a great deal of literature exists on children's exposure to domestic violence batterers and children's exposure to substance abuse, very little is written about the dual exposure, its impact and implication for intervention. From a review of the literature (Reid, Macchetto & Foster, 1999; Governor's Commission on Domestic Violence, 1995), three principals were cited most often:

- The best way to protect children is to support their mothers' efforts to attain safety and sobriety.
- Family violence and addiction take the mother away from her children both physically and emotionally.
- Protective/resiliency factors can decrease the harm caused by some risk factors and can prevent certain risk factors from developing.

Extent of the Problem

- 3.3 million-10 million children are at risk of exposure to family violence.
- 80-90% of these children are aware of the violence.
- Children in homes with domestic violence are abused or neglected at a rate 15 times higher than the national average.
- In 60-75% of families where a woman is battered the children are battered as well.

- 63% of youthful murderers kill their mother's abuser.
- Children older than 5 or 6 have a tendency to identify with the abuser and lose respect for the victim.
- The most serious cases of child abuse resulting in emergency room treatment are often "extensions of the battering rampages launched against the child's mother, with 70% of the serious injuries to children and 89% of the fatal injuries inflicted by men." (Governor's Commission on Domestic Violence, 1995).
- 50% of the time police respond to domestic violence calls, children are present.
- 71% of victims using a domestic violence shelter bring their children.
- The United States Conference of Mayors found nationally 75% of all homeless women and children are on the streets because of violence in the home.
- 67% of state child welfare workers said that AOD families are "much more likely" to re-enter the child welfare system over a 5-year period compared to non AOD-involved families.
- Alcohol is abused by more than 15 million American adults.
- Children whose parents abuse substances are almost 3 times more

likely to be abused and 4 times more likely to be neglected.

- At least 10 million children live in homes where the primary caretaker is addicted to alcohol or other drugs.
- Up to 675,000 children per year suffer serious abuse or neglect as a result of that substance abuse.
- 2 out of 3 cases of “child abuse” have a co-occurrence of domestic violence and substance abuse.

The best way to protect children is to support their mothers' efforts to attain safety and sobriety.

Effects of Domestic Violence on Children

Prior to birth

- Victims of domestic violence are at increased risk for miscarriage during pregnancy.

Infants and toddlers (birth-2 ½)

- Developmental delays — walking, talking, focusing.
- Failure to thrive — slowed growth and development.
- Emotional withdrawal — failure to bond/attach.
- Frequent illness.
- Intense fear of adults.
- Incessant screaming (resulting in

more family strain).

Preschool (ages 3-6)

All of the previously mentioned plus:

- Language delays.
- Decreased motor abilities — physical agility/coordination.
- Easily frustrated and intolerant.
- Acting out/aggressive behavior/violence as a form of communication.
- Increased startle response.
- Violence re-enacted in play.
- Low self esteem.

Elementary (ages 7-11)

All of the previously mentioned plus:

- Decreased verbal or cognitive skills.
- Behavior problems.
- Inability to empathize with others.
- Nightmares.
- Fearfulness.
- Withdrawn/depressed/despondent.
- Chronic physical complaints.
- Bullying.
- Taking on predator or prey roles.
- Violence re-enacted in play.

- Sleeping in class/truancy.
- Shame.
- Self-destructive behaviors.
- Higher risk for suicide.
- Isolation from peers.
- Perfectionistic thinking — attempts to fix situation, which reduces likelihood of identification.

Adolescents (ages 12-17)

All of the previously mentioned plus:

- Feelings of guilt.
- Delinquent behavior.
- Running away.
- Alcohol/drug use.
- Eating disorders (need to control).
- Among sexually active teens, males are more likely to be sexual offenders and females are more likely to be sexually assaulted.
- Re-enacting relationships — based on control/dominance and not respect/equality.
- Parental caretaking at personal cost.

Post Traumatic Stress Disorder

While not all children exposed to domestic violence batterers develop symptoms of Post Traumatic Stress Disorder (PTSD), 50 to 70% of exposed children suffer from PTSD. PTSD is an

anxiety disorder which can have an onset at any age following exposure to a psychologically traumatic event that would generally be considered outside the range of typical human experience.

Children suffering from PTSD are often misdiagnosed as having Attention Deficit Disorder (ADD) due to symptoms of difficulty concentrating and diminished interest or participation in school work and activities.

Beyond exposure risks

Beyond the risks associated with exposure or witnessing battering domestic violence, the child is also at increased risk of injury related to violence in the home:

- Thrown objects hit the child.
- Infant is dropped by the victim when the victim is being abused.
- The child is injured when intervening in violence.
- Intentional violence to the child intended to intimidate or control the victim.
- Abuser's displaced frustration toward the child results in injury.

Through the eyes of a child

Children exposed to domestic violence have a vantage to view the violence that is not available to either the victim or the abuser. Through the eyes of a child the violence occurs suddenly, allowing no opportunity to prepare; the event is unusual and unpredictable and outside of the child's experience; in the passive

role, the child is able to fully attend to the act; absorbing the attacker's aggression and the victim's suffering.

Children who observe domestic violence often report feeling:

- Shame for families.
- Powerlessness.
- Lack of trust.
- Feeling scared and unsafe.

Their efforts in normalizing their experience may result in the following beliefs:

- Violence is an act of love.
- Hurting others to control them is acceptable.
- Males are mean.
- Females are weak and powerless.
- Violence lacks consequences.

Through the eyes of a child the violence occurs suddenly, allowing no opportunity to prepare; the event is unusual and unpredictable and outside of the child's experience; in the passive role, the child is able to fully attend to the act; absorbing the attacker's aggression and the victim's suffering.

Resiliency factors

While many factors may determine how the child adjusts to exposure to domestic violence the following resiliency factors are most often cited:

- Child's age.
- Relationship to the abuser.
- Relationship with the victim.
- Social supports.
- Duration of the violence.

Effects of Parental Substance Abuse on Children

Prenatal exposure to illicit drugs

Use of illicit drugs during pregnancy can impact the health of the unborn in varying ways such as:

- The increased risk of stillbirth.
- Premature detachment of the placenta.
- Smaller than normal head size/low birth weight.
- Central nervous system damage-developmental delays.
- Risk of motor dysfunction.
- Link to neo-natal respiratory patterns.
- Link to Sudden Infant Death Syndrome (SIDS).

Prenatal exposure to alcohol

- Increased risk of spontaneous abortion or stillbirth.
- Shorter gestation periods.
- Reduced birth size and weight.
- Fetal Alcohol Effect (FAE).
- Fetal Alcohol Syndrome (FAS).

Unfortunately, it is difficult to predict the outcome because of the many variables such as the amount of drug used, purity of drug used, gestational age at exposure, coupled with other mitigating factors such as good prenatal care and nutrition.

While direct physical exposure to the substance can impact healthy births, many more children are affected by witnessing parental substance abuse.

Maladaptive responses

- Increased suicide risk.
- Eating disorders.
- 3-4 times more likely to become addicts.
- Less internal locus of control.
- Health problems — gastrointestinal disorders, migraines, asthma.
- Hyperactivity.
- Takes on role of parent/caretaker.

Academic effects

- Learning disabilities.
- Truancy.
- Repeating grades.
- Transferring schools.
- Expulsion.
- Inability to focus/concentrate.

Emotional effects

- Guilt.
- Feeling unloved.
- Depression.
- Anxiety.
- Feeling invisible.
- Insecurity.
- Confusion.
- Fearfulness.
- Embarrassment/shamefulness.

The substance abusing or addicted parent is less able to parent because the substance use impairs thought processes, judgement, the parent's ability to be available both physically and emotionally, and the parent's ability to keep the child safe and healthy in cases where there is exposure to criminal activity.

Children exposed to parental substance abuse are often:

- Unkempt.
- Sleepy/tardy for school.
- Preoccupied near end of school day.
- Sophisticated in their knowledge of substance use.
- Uncomfortable discussing substance use.
- Depressed/withdrawn.
- Acting out.
- Without parental involvement in the child's activities.

When Domestic Violence and Substance Abuse Occur Together

Parents experiencing both domestic violence and substance abuse are emotionally and physically unavailable, unable to provide secure attachments for the child.

Children exposed to both parental domestic violence battering and substance abuse may experience emotional, educational and mental health deficits, depression, anxiety, eating and substance abuse disorders. The child may be preoccupied, tired, embarrassed, guilty, and fearful but is willing to commit to parental care taking despite the personal cost. The children may feel a need to both fix the family problem and keep it a secret while lacking trust in other adults and authorities. Prolonged exposure to

domestic violence batterers and substance abuse may result in the belief that substance abuse and domestic violence are normal occurrences, domestic violence and substance abuse are a natural means to obtain desired feelings and that violence/use/abuse lack sufficient consequences, all of which may lead to replication of the dysfunction in future family relationships.

Strength based interventions with these children require acknowledging and strengthening the child's resiliency factors.

Personal factors

- Positive attitude.
- Ability to adapt to change.
- Belief in ability to handle things.

Family factors

- Close-knit family.
- Warmth.
- Consistent age-appropriate discipline.
- Parental supervision of children.

Environmental factors

- Close friends.
- Supportive extended family.
- Community resources.
- Family and communities that do not tolerate substance abuse.

Interventions with children exposed to both battering and substance abuse

Don't:

- Press the child to talk; she or he will talk when ready.
- Ask demanding questions (i.e., "Are you worried about school?")
- Make promises you can't keep (i.e., "This won't happen again." "No one will hurt you anymore.")
- Assume the mother's role, instead strengthen her ability to meet her child's needs.

Do:

- Intervene early.
- Assist the victim with her needs.
- Believe the child.
- Know appropriate resources for referral.
- Talk to child in a calm, focused manner.
- Keep talks short.
- Focus on child's strengths.
- Assist the child in creating a safety plan (if age-appropriate).
- Provide child with nurturing environment.
- Provide consistent, predictable pattern.

- Acknowledge child's feelings.
- Give child choices/sense of control.
- Always end on a positive note.
- Provide the child with support from other children so exposed.
- Provide opportunities for constructive mother/child interaction.

Things to say to a child:

- I am sorry you were hurt.
- It's not your fault.
- It's okay/safe to talk to me.
- I'll do everything I can to keep you safe.
- You have a right not to talk about it.
- I want you to be safe.

Ways to help:

- Comfort and reassure.
- Offer basic information about what happened.
- Tolerate regressive behavior.
- Respect the child's fears.
- Remind the child that at this moment s/he is safe.
- Talk about feelings.
- Provide opportunities and props for play.
- Expect some difficult behavior.

- Convey rules.
- Return to normal routine.
- Provide physical outlets.
- Focus on images of strength, competence and survival.
- Seek additional help/guidance if necessary.

Best Practice: Children Dually Exposed

Intervene with both the child and the adult(s):

- Empower victims.
- Hold perpetrators accountable.
- Develop recovery plans that address violence and safety plans that address recovery.
- Link safety, sobriety and child welfare needs.
- Coordinate among systems serving the family.
- Avoid conjoint counseling between perpetrators and victims.
- Avoid service plans that allow the perpetrator to control the mother.
- Call upon Prevention Resource Developers throughout the state who build partnerships among domestic violence, substance abuse and child welfare providers.

Prolonged exposure to domestic violence batterers and substance abuse may result in the belief that substance abuse and domestic violence are normal occurrences, domestic violence and substance abuse are a natural means to obtain desired feelings and that violence/use/abuse lack sufficient consequences, all of which may lead to replication of the dysfunction in future family relationships.

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