

Best Practices: Addressing Substance Abuse In Domestic Violence Agencies

Common Perspectives

A significant number of women and children seen in domestic violence agencies suffer from substance abuse problems. A study of Illinois shelters reveals 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. 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.
- Factors related to victimization are low self-esteem, guilt, shame, powerlessness, depression, sexual dysfunction, and relationship dysfunction. All of these provide a foundation for the development of substance abuse.

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 judgement 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.

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.

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 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 insure that it occurs in private. *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 and will not jeopardize their ability to receive appropriate services.
- Observe behavior. Look for signs of alcohol or drug use.

Signs of Alcohol or Drug Use
<ul style="list-style-type: none"> • Smell of alcohol • Signs of IV drug use (tracks) • Unusual or extreme behavior <ul style="list-style-type: none"> • 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

- Ask questions. There are several recognized screening tools for alcohol or drug use included in the Appendix.

- Deal with denial. 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. When talking with a victim about alcohol/other drug use, ask open-ended questions. A victim may also find it easier to talk about their partner's use rather than their own. If this is the case, follow up with questions about the victim's use.

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.
- 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.)

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 the person understands where to go, who they will see, and how to get there.
- Another concern is what support the individual needs to keep the appointment. Is 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 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. The system identifies the functions, responsibilities, knowledge, and skill bases required by counselors in the performance of their jobs.

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, treatment is generally recommended.

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

Treatment

While abstinence may be a long-term goal for addiction programs, the immediate goals are to reduce use, improve the person's ability to function and minimize the effects of abuse on health and social functioning. Matching the person with the appropriate level of care ensures that the person receives the type of treatment corresponding to the person's use and their current level of functioning. Licensed treatment agencies in Illinois use ASAM (American Society of Addiction

Medicine) criteria to determine which treatment options and level of intensity are appropriate. In developing a treatment plan, the counselor evaluates:

- The person's level of intoxication, withdrawal potential and need for medication.
- The person's physical health.
- The person's emotional health and

functioning.

- The person's acceptance or resistance to treatment.
- The potential for relapse and the recovery environment.

Treatment options vary and may include behavioral therapies such as counseling, psychotherapy, support groups or family therapy. Sometimes medications are given to suppress the withdrawal syndrome and drug craving or to block the effects of drugs. Treatment may include:

- Outpatient services (Level I).
- Intensive outpatient services, a structured program offered a minimum of 9 hours per week (Level II).
- Residential detoxification services (Level III.2).
- Residential rehabilitation (Level III.5).
- After-care programs.
- Referral to support groups such as Women for Sobriety, Alcoholics Anonymous, or Narcotics Anonymous.

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 been referred for, or having received treatment 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.

Federal regulations also prohibit redisclosure of information; therefore, a domestic violence program may not disclose information received from a treatment agency without the person's consent. Federal regulations allow substance abuse treatment programs to disclose information to outside agencies that provide services to the treatment program — for example, laboratories, accountants or other professional services. When communication needs to take place on a regular basis, the treatment program enters into a *qualified service agreement*. The agreement specifies that the person or agency providing the service will abide by the federal confidentiality law. (See the Appendix for a more detailed discussion of confidentiality requirements.) A program should always consult its own attorney regarding the possible use of such an agreement.

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.
- 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 provide the highest degree of physical and psychological safety for victims.

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 sees the research. Women who abuse substances are more likely to experience domestic violence in relationships (Miller, Downs, & Gondoli, 1989). Women who experience domestic violence are more likely to misuse prescription drugs as well as alcohol (Stark & Flitcraft, 1988). 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).

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

All women in substance abuse treatment should be screened for domestic violence. 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.
- 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 labelling 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.

Domestic Violence Screening

There are formal domestic violence screening tools in the Appendix of this document. 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 notice:

- 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.”

Referral

If the screening indicates a probability of violence, refer the woman either to a shelter or to a provider who deals with domestic violence issues. (A list of domestic violence service

providers is included in the Appendix.)

It is important to coordinate services as much as possible with the domestic violence advocate. 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. Explain confidentiality regulations to domestic violence advocates when coordinating services, as well as the meaning of American Society of Addiction Medicine (ASAM) criteria. When serving a mutual client, it is also helpful for domestic violence and substance abuse service providers to present a united effort when advocating with other systems (e.g., Department of Children and Family Services).

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.

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 her partner is using as well, and if she leaves to find a

more sober support network, there is increased risk to her safety.

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.

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 of substance use, the woman may be punished.

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. Counselors may need to address domestic violence and substance abuse with different interventions.

Confrontational techniques are often not effective with victims of domestic abuse. They can be interpreted by the woman as an extension of how the abuser treats her. Also, avoid language that implies there is something wrong with the victim or that she caused her own abuse. Some examples of words to avoid

with these women 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.

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.

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.

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 her develop the tools to stay safe and sober. Emphasize strengths and healthy decision-making.

Best Practices: Addressing Substance Abuse

In Batterers' Programs

Overview

The incidence of substance abuse among men in batterers' programs is between 50 percent and 100 percent, depending on the proportion of the men who were referred by the criminal justice system (Bennett, 1995). Batterers referred through the courts are more likely to also be substance abusers than self-referred men. Men who are violent outside their families are more likely to have substance abuse problems than men who are violent only within their families. Alcohol or drug abuse does not *cause* the abusive behavior. However, for most batterers, 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.

Victim safety

The most essential consideration is the safety of domestic violence victims. The interventions must account for the safety of victims whether they are in domestic violence programs or in substance abuse treatment.

Batterer screening

Because so many batterers are also substance abusers, all batterers should be thoroughly screened for substance abuse problems. A screening for substance abuse is a preliminary step that determines the probability of an alcohol or drug problem. Batterers' intervention programs screen for substance abuse through:

- Initial interviews. Program staff should ask established questions and be trained to interpret responses. Direct questioning about alcohol and drug use often makes substance abusers 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.

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

Refer for assessment. 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. If a probation officer is not actively involved in monitoring the batterer's progress, the batterers' program should assume the role of *case manager* during substance abuse assessment. 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 batterers "slipping between the cracks."

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. Men who are assessed as abusing, or dependent on, alcohol or other drugs require integrated or parallel 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. This will require a Qualified Service Organization Agreement (see Appendix) or a two-way consent. Similarly, the batterers' program should also release to the substance abuse program (with the signed consent of the batterer) regular reports of attendance, participation, and compliance in the batterers' program.

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, he should still be admitted into a batterers' program. He can then be referred 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 pay 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) must utilize networking, case management, joint staffing, or some other means of ensuring continuity.

Safety and sobriety are interconnected.

Lack of sobriety, either in victims or in batterers, increases the risk for further violence against victims. Lack of victim safety threatens the sobriety of both victim and batterer. However, abstinence and sobriety are not sufficient conditions for safety.

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 labelling 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.

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.

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 American Society of Addiction Medicine's (ASAM) Client Placement Criteria.
- 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.
- If the client is under court supervision, contact his probation officer to request that batterers' intervention programming be added as a condition of probation.
- 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 for 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).

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 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.

Batterer Intervention and Relapse Prevention

Clients will 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.

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.

Qualified Service Organization Agreements

Qualified Service Organization Agreements (see Appendix for example) may be useful in communicating with a domestic violence program in some instances. In such an agreement, each agency states its understanding of and commitment to the protection of client information contained in the federal regulations and agrees to share such information as is necessary for the provision of the services in question. When such an agreement has been appropriately entered into, the program may share information with the Qualified Service Organization (QSO) as long as it pertains to the service which the QSO is providing. Further, the agency is not required to notify clients of the existence of the QSO Agreement. This may be a useful tool for agreements with victims’ services organizations regarding safety checks. Note that in ordinary situations, this is not intended to replace consents, and that the QSO should not receive any more information than is necessary for it to perform the service which it has agreed to provide to the substance abuse treatment agency. The QSO is of course prohibited from redisclosing any information it does get unless it obtains a consent to do so from the client in question.

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.*