



SUBSTANCE ABUSE RECOVERY AND DOMESTIC VIOLENCE: A GREAT LAKES ATTC INITIATIVE

Interim Project Report
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Several years ago, GREAT LAKES ATTC convened a group of experts on the co-occurrence of substance use disorder (SUD) and domestic partner violence (DV). The goal at that time was to produce a GREAT LAKES ATTC product to be used in training SUD staff in case-management/treatment of DV among their consumers. In particular, this product was to target more rural programs in the 3-state (now 4-state) region who are often less able to attend training. A key findings in GREAT LAKES ATTC's 1999 Illinois key informant needs assessment was that less urban SUD programs were having a difficult time getting staff trained due to budget and time restrictions at their center. Budget and time restrictions have worsened, and these same restrictions now apply to both urban and rural programs. Despite well established research documenting that well over half of consumers with whom SUD providers have contact are victims or perpetrators of DV, and that DV is a serious health risk which prevents engagement of men and women in SUD treatment and greatly elevates the risk of relapse and complicates the maintenance of recovery, all available findings suggest SUD providers are not properly trained in screening, assessment, or intervention in situations where DV and SUD co-occur. This presents an even more acute situation during times of war and economic downturn, both of which face the nation at this time. It was also found that DV providers are usually not properly trained in screening, assessment, or case management in situations where DV and SUD co-occur.

DV and Recovery-oriented Systems of Care. According to *Substance Abuse Treatment and Domestic Violence* (SAMHSA, 1997) and *Safety and Sobriety* (Illinois Department of Human Services, 2005), domestic violence—and similar intimate trauma such as sexual assault—impairs the opportunity for addiction recovery and threatens sobriety. As such, domestic violence awareness, screening, assessment, intervention, and community change fit into an emergent recovery management (RM) paradigm, with a continuum of support ranging from pre-recovery to recovery maintenance. Whether we are talking about the acute effects of alcohol on DV, the role of DV as precipitant or retardant of continued recovery, the chronic and disabling impact of SUD on the self and its victims, or the working links between DV and SUD co-providers, DV is a critical element for the SUD staff.

In our own research here in Illinois, we found that women in early recovery who were also victims of DV improved their self-efficacy and reduced their use of drugs and alcohol six months after admission to coordinated or integrated treatment programs, but they also increased in their level of fear about the effects of DV in their lives. In another project, this time with men, we found that men in a SUD treatment facility reported the same frequency of DV as men in court-ordered batterer intervention programs. These results, along with other recent studies of the DV-SUD link, have convinced us of the critical importance of DV in the knowledge, attitude, and behavior of SUD professionals. As the field gears up to shifting from an acute treatment to a recovery perspective, adding DV knowledge and skills to the toolkit of SUD professionals will support the effectiveness of practice. The challenge to Great Lakes ATTC is to put a vehicle for those knowledge and skills in a useful package that will be affordable, useful, and rewarding.

The GREAT LAKES ATTC SARDV Initiative. We have proposed the GREAT LAKES ATTC Substance Abuse Recovery and Domestic Violence (SARDV) Initiative. When fully funded, the GREAT LAKES ATTC SARDV Initiative will result in a web-based educational product which will be:

- Based on the latest research and fully advised by practitioners and experts (SUD providers, academics, policy makers, and DV advocates)
- Developed with collaboration from the UIC Interdisciplinary Center for Research on Violence
- Focused on screening and case management skills with both DV victims and DV perpetrators
- Available in a web-based, self-study package to reduce training costs
- Highly affordable
- Available for continuing education credit.

The GLATTV SAR-DV Project has completed the first two steps in its development. A preliminary literature review has been completed and will continue to be updated throughout the project. A Local Advisory Panel was convened March 12, 2007 and a Regional Advisory Panel was convened March 27, 2007 in conjunction with the First Midwest Recovery Management Symposium for Policy Makers.

This report summarizes the results of the SAR-DV needs assessment conducted with an on-line survey during late Fall 2008. The survey was facilitated by the active collaboration and assistance of the GREAT LAKES ATTC Advisory Board, the SAR-DV Local and Regional Advisory Panels, the Division of Alcoholism and Substance Abuse of the Illinois Department of Human Services, the Office of Drug Control Policy of the Michigan Department of Community Health, the Office of Addiction and Emergency Services of the Division of Mental Health and Addiction of the Indiana Family and Social Services Administration, and the Ohio Department of Alcohol and Drug Addiction. The overall goals of this survey were to identify the SAR-DV initiative to the region, to generate information on state-specific training needs of addiction counselors and administrators, to empirically describe the need the web-based course in the 4-state region, and to estimate an acceptable level cost for potential participants.

Before summarizing the survey findings, we must offer several words of caution. This report is based on data from a convenience sample collected on the internet. As such, the numbers should

be considered a broad-brush picture of the field rather than a point estimate with a specified level of confidence in the results. The numbers often varied more between states than between individuals, suggesting that system-level factors at work may be as important as individual training and experience. Finally, the data suggest that supervisors and administrators are over-represented in the sample, particularly in Ohio and Illinois. It is likely that administrators and supervisors were contacted about dissemination of the survey and decided that they could provide a better accounting on agency practice than could line staff. This resulted in substantially fewer responses than we expected, but may have had an unintended consequence of providing higher quality information.

SUMMARY OF KEY SURVEY RESULTS¹

In this section we summarize the primary findings of the needs assessment. Following this summary section are a table of quantitative results (Appendix 1), a summary of qualitative results (Appendix 2), and a paper copy of the electronic survey (Appendix 3).

1. Although the survey was accessed by 405 people, a total of 294 (72.6%) respondents (Rs) completed all sections of the survey. The demographic characteristics of the Rs reflect the general demographics of the SUD field: an average age of 49, 69% women, 13% African American, 80% Caucasian, 4% Latino, 73% with a graduate degree, an average of 4.7 years in the field, 43% urban, 25% suburban, and 30% rural or small town.
2. Only a third of the Rs work in a setting which serves a large number of women, so screening for DV usually means screening men for DV. It also means that there will a large number of DV perpetrators being screened for DV. Whenever perpetrators are asked about DV, screeners need to be aware that perpetrators may believe that the reason they are being asked about DV is because their partner(s) have informed the agency about their violence. This situation presents an increased risk to the victim and requires special training, practice skills, and agency policy.
3. Most (66%) Rs work in a setting with a substantial (more than 25%) number of people who are mandated to treatment by the criminal justice system a condition which will be associated with a substantially elevated number of DV perpetrators.
4. More Rs screen for DV victimization (59%) than for DV perpetration (46%), but these screening levels are substantially higher than levels reported in earlier studies. Even more encouraging is that half (48%) of Rs report relationships with DV providers, which suggests that the building blocks for collaboration and coordination are already in place in many places. A substantial number (40%) report that their agency already has a linkage agreement with a DV agency and 38% report that, in their agency, there is an individual identified as a specialist in DV.
5. Similar to other reports, our survey finds that Rs are more comfortable asking SUD clients about childhood abuse (70%) than about current abuse (59%).
6. One of our more important findings is that SUD counselors in this study are far more willing to refer to and collaborate with DV agencies than in the past. While the PI's 1994 study found a hardcore 25% of SUD staff refused to refer to DV programs under any circumstances due to reservations about philosophical and professional differences

¹ An electronic copy of the full report including the survey tool and item-by-item statistics by state is available from Larry Bennett at lwbenn@uic.edu

with DV staff, most Rs in the 2007 survey indicate they would refer to DV victim agencies (83%) or batterer programs (82%). The vast majority (87%) agree that their clients would benefit from increased cooperation between DV and SUD agencies. The field has changed, although the reasons for the change are unknown. We would like to think that efforts like SAMHSA's TIP 25 and the wide dissemination of Illinois' Best Practice Manual are part of the reason.

7. Many Rs hold beliefs which are at odds with prevailing "wisdom" in the DV field. For example, almost half (43%) believe that DV is usually the result of drinking or drugging; 61% disagree that SUD and DV are separate problems requiring separate interventions; 83% think there is little difference between a person who batters and a person who abuses alcohol or drugs; 67% believe that most men in batterer programs are the victims of childhood abuse; and perhaps most concerning of all, 66% believe that battered women are co-dependent.
8. Estimates of the prevalence of batterers and victims at the Rs agency, as well as among men and women with SUD in the general population are consistent with estimates from other studies. For example, Rs estimate that 40% of the men and 30% of the women at their agency have battered a partner, and 30% of the men and 60% of the women have been battered.
9. Most Rs (57%) believe that staff at their agency do not have adequate training to manage domestic violence cases but only 20% believe the agency prevents staff from doing adequate work with domestic violence cases. The vast majority (71%) believe staff at their agency would benefit from DV training.
10. One in five Rs say they would definitely pay for an online DV and SUD course. The mean dollar amount they would pay for such a course is \$38.80 (2007 dollars), a number which is most likely a reflection of relatively low pay and economic uncertainty rather than a valuation of training.
11. Qualitative data yielded the following themes:
 - a. While Rs have an intention to screen and refer cases, the actual mechanics and logistics of such screening and referral are usually left to others and left to chance.
 - b. Rs believe DV victims should be counseled to leave their abusers, a potentially risky position, often at odds with the wishes of victims. Rs often believe that DV victims. Even more concerning were suggestions by several Rs that they would notify child protection agencies if they knew a SUD client was a DV victim.
 - c. Attention to DV was often mentioned as an inclusion in treatment/recovery plans, regardless of whether the SUD counselor provided any services for DV.
 - d. Many Rs referred to the importance of providing couple or family counseling in DV cases, a practice which is controversial and considered potentially dangerous for victims. Likewise, anger management was often referred to as a preferred intervention with DV perpetrators, a position at odds with many state standards for DV programs.
 - e. A large number of respondents identify lack of resources as the major obstacle to routine screening and referral of DV cases at SUD agencies, including lack of resources at DV agencies, distance and transportation issues, and consumer lack of resources . . . including time.

- f. As in earlier studies, Rs cited philosophical and professional differences with DV agencies. This was epitomized by one R who was a DV liaison in an SA agency and remarked about the *willful ignorance* of SA providers toward DV. The gender differences in DV and SA may contribute to this conflict according to several Rs. SA's historical grounding in men's experience and DV's historical grounding in women's experience cannot be ignored, regardless of the current gender configuration of practitioners. A few Rs mentioned as a barrier to collaboration the conventional bias that women are victims and men are perpetrators of DV. A number of Rs also thought that DV providers were largely ignorant of SUD as a disease process, mistakenly believing SUD was merely an excuse for violence. Finally, difference in treatment styles (e.g. confrontation v. support) also presented problems.
- g. A *silo mindset* and *turf wars* were also seen as barriers to cooperation between DV and SUD agencies. Similar issues were mentioned with mental health agencies.
- h. Confidentiality issues, different for both DV and SUD agencies, were frequently cited as barriers.

CONCLUSION AND NEXT STEPS

This needs assessment yielded some concerns but much more optimism about the next steps in the GREAT LAKES ATTC SARVDV initiative. This survey has documented a need for low-cost training in DV for SUD professionals. The high documented need coupled with the dollar amount SUD professionals will pay is an indicator that traditional training vehicles (workshops and classes) are not practical. Likewise, a focus on merely screening women for DV victimization—even if it were done, which it is usually not—will miss most opportunities for intervention, but screening men presents a situation for which most SUD professionals are ill-prepared and an elevated risk with which they are unfamiliar. We have also documented that training alone may not be adequate without systemic support.

In collaboration with our partners, GREAT LAKES ATTC will now initiate the development of a curriculum to support approximately 4 credit hours of web-based self-paced training provisionally titled *The Great Lakes ATTC Program for Screening, Referring, and Managing Co-Occurring Substance Use Disorders and Domestic Violence*. The next steps, in broad strokes, will be:

1. Obtaining financial support for developing and testing a curriculum
2. Write the curriculum
3. Curriculum review and approval by key elements in both the SUD and DV practice community.
4. Pilot the curriculum with a sample of SUD professionals
5. Revise the curriculum based on pilot results
6. Transfer the revised curriculum to a web-based product
7. Pilot the web-based product
8. Work out logistics (cost, credit, evaluation) of the product
9. Design an impact evaluation for the product
10. Product roll-out

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APPENDIX 1: QUANTITATIVE RESULTS

Consenting Participants

ITEM	IL	IN	MI	OH	All
Total Number of Participants	83	60	111	38	294

Setting

[All numbers are percentages]

At my agency (%) ...	IL	IN	MI	OH	All
More Than 50% of clients are female	23	30	43	29	33
More Than 25% of clients are minority	61	48	41	31	47
More Than 25% of clients are mandated by criminal justice system	68	69	56	87	66
More Than 25% of clients are mandated by child welfare system	16	12	11	24	15
More Than 50% of clients have co-occurring mental disorders	35	34	53	45	43
Respondent always screens for HIV/AIDS	56	45	61	61	56
Agency provides HIV testing	42	35	16	34	30

Domestic Violence Screening--Personal

[All numbers are percentages]

I ...	IL	IN	MI	OH	All
Always screen for DV victimization	71	50	51	70	59
Always screen for DV perpetration	59	37	36	58	46
At least sometimes meet with DV service providers	45	40	44	73	48
Always asks about childhood abuse/trauma	76	70	64	76	70

Domestic Violence Screening--Agency

[All numbers are percentages]

My agency ...	IL	IN	MI	OH	All
Definitely has a screening procedure for childhood physical abuse, neglect, or trauma	70	73	66	63	68
Definitely has a service agreement, memorandum of understanding, or other formal linkage agreement with a local DV agency	45	33	31	61	40
Definitely or probably has a person on staff identified as a specialist in DV	45	40	28	54	38
Definitely follows a standard format or has a regular set of questions for assessment of					

My agency . . .	IL	IN	MI	OH	All
DV	59	46	36	45	46
Definitely or probably has guidelines for how staff should screen for DV or manage situations when DV has occurred	66	62	50	58	58

Personal Knowledge, Beliefs, & Attitudes

[All numbers are percentages]

	IL	IN	MI	OH	All
Somewhat or very knowledgeable about the domestic violence laws in the state	71	62	61	63	64
There is definitely a batterer intervention program in the area	72	73	74	84	75
I would be very likely to refer to a batterer program if one were available	91	85	75	81	82
I would be very likely to refer to a victim service program if one were available	86	83	83	82	83
I agree: My agency and our clients would benefit from increased cooperation with domestic violence agencies.	89	90	87	76	87
I agree: Substance abuse and domestic violence are separate problems requiring separate interventions	49	38	33	34	39
I agree: Most of the time, domestic violence is the result of drinking or drugging	41	44	37	58	43
I agree: There isn't much difference between batterers and substance abusers	83	83	83	79	83
I agree: If a man quits drinking and drugging, he will usually stop battering his partner	7	3	5	5	5
I agree: Most women receiving help from DV agencies have mental disorders (other than substance use disorders)	28	25	23	40	27
I agree: Most men in batterer programs have mental disorders (other than substance use disorders)	27	27	27	58	31
I agree: Most women receiving help from DV agencies have substance abuse Problems	23	22	12	21	18
I agree: Most men in batterer programs have substance abuse problems	46	47	43	58	47

	IL	IN	MI	OH	All
I agree: Women are as violent as men	34	44	40	46	40
I agree: Most men in batterer programs are victims of childhood abuse	63	70	62	82	67
I agree: Most battered women are co-dependent	68	57	65	79	66

Epidemiological Estimates

[All numbers are percentages]

Mean Estimated Percentages of . . .	IL	IN	MI	OH	All
Men who are clients at your agency who are, or have been, abusive toward a partner	37	40	40	43	40
Women who are clients at your agency who are, or have been, abusive toward a partner?	28	31	30	31	30
Women who are clients at your agency who are, or have been, abused by a partner	60	53	53	70	60
Men who are clients at your agency who are, or have been, abused by a partner	24	30	30	28	30
All substance-abusing men who are abusive of their partners, regardless of whether they have ever been in treatment.	50	46	48	50	50
All substance-abusing men who are abused by their partners, regardless of whether they have ever been in treatment.	27	32	30	27	29
All substance-abusing women who are abusive of their partners, regardless of whether they have ever been in treatment.	30	34	33	37	33
All substance-abusing women who are abused by their partner, regardless of whether they have ever been in treatment.	53	50	50	62	52

Agency Readiness

[All numbers are percentages]

	IL	IN	MI	OH	All
I agree: My agency has adequate policies in place to deal with DV	77	53	53	74	62
I agree: Most staff at my agency are unaware of DV practice procedures	76	53	53	74	62
I agree: Staff at my agency do not receive adequate training on how to deal with	51	55	63	53	57

	IL	IN	MI	OH	All
domestic violence					
I agree: Even if we wanted to do better work with victims and perpetrators of domestic violence, we would not be able to do it at my agency	20	22	23	8	20
I agree: I don't have a lot of confidence in the DV agencies around here	10	16	26	16	18
I agree: I don't think DV is as big an issue as people make it out to be	1	2	2	0	1
I agree: We already know how to deal with DV issues at my agency	57	43	47	61	51
To a large extent or completely, the staff of my agency would benefit in their work with issue of DV if they received training	71	76	68	68	71
Mean percent indicating staff would benefit from training on: Screening domestic violence among substance users	49	55	57	53	54
Mean percent indicating staff would benefit from training on better interviewing skills	85	78	78	76	80
Mean percent indicating staff would benefit from training on laws	59	58	59	55	58
Mean percent indicating staff would benefit from training on EVPs	52	63	57	55	57
Mean percent indicating staff would benefit from training on networking skills with IPV agencies	37	45	43	58	44

Documentation of Need

	IL	IN	MI	OH	All
I would definitely take this online course	25%	23%	18%	8%	20%
Mean (\$) fair charge for the course that you would pay for the course	38.80	39.80	37.90	41.10	38.80

Respondent Demographics

	IL	IN	MI	OH	All
Mean age	48	47	49	51	49
Percent women	70	63	77	58	69
Percent Latino	6	3	4	0	4
Percent African/Black	16	10	14	11	13
Percent Native/Indian	0	2	2	0	1
Percent Asian/Pacific Islander	1	3	1	0	3

	IL	IN	MI	OH	All
Percent Caucasian/White	77	80	79	87	80
Percent with Master's/Doctoral Degree	66	68	82	68	73
Mean years of experience as employee in substance abuse field	4.8	4.6	4.5	5.2	4.7
Percent directors or clinical supervisors	57	39	32	58	44
Mean years in current agency	3.7	3.3	3.5	3.9	3.6
Percent Urban	36	58	42	36	43
Percent Suburban	39	17	26	8	25
Percent Small Town/Rural	25	25	31	55	30

APPENDIX 2: QUALITATIVE RESULTS

As part of our survey of SUD counselors in Illinois, Indiana, Michigan, and Ohio, we asked survey respondents to expound on two topics of special interest: (1) What is the “typical” or “routine” *procedure* you or your agency follows once a person discloses or is identified as a victim (response rate 65%) or perpetrator (response rate 64%) of DV? and (2) What are the main *obstacles* to SUD agencies and DV agencies working collaboratively in the interest of clients with co-occurring issues? (response rate 65%)

Procedures

Over three fourth of respondents reported that their first line of action was to assess and refer. The specific mechanisms for screening and assessment were vague, with only one respondent reporting use of a specific tool or screening instrument to screen for DV victims. One participant reported using the Addiction Severity Index . . . *which asks about the family and if they have ever felt abused emotionally, physically or sexually.* Another respondent indicated using the “power and control wheel” for discussing DV issues. It should be noted that neither the ASI nor the Duluth power and control wheel have any systematic mechanism for screening for DV, although the power and control wheel has eight different domains of physical and non-physical abuse which could guide such an assessment. A number of respondents suggested that women be screened for sequellae of abuse such as trauma symptoms and PTSD. This may reflect the influence of the SAMHSA’s well-publicized Women’s Co-Occurring Disorders and Violence Study (Jahn Moses, Reed, Mazelis, & Ambrosio, 2003) or it may reflect the participant’s own training and experience.

Assessment of victims also included understanding of triggers behind violent occurrences, current trauma, and PTSD assessment. Once a client was identified as a victim of DV, most respondents resorted to making referrals to local domestic violence agencies, shelters, group programs, legal aid or made in house referrals to psychiatrists. Several respondents reported their agencies had DV specialists on the staff. Some reported that they ensured that the clients being referred reached the DV shelter by accompanying them, while other reported “advocating” for the DV victim at the DV shelter/ agency; the details of such advocacy were not clear. Before making the referral respondents often reported they did safety planning to help victims make a plan for protecting themselves, the process of this planning as described included discussing ‘exit strategies’, giving clients a list of local resources, shelters and help lines to use, encouraging the

clients to use Protection Services, immediately leaving the situation, blocking the perpetrators phone no. or using a different phone number.

Many respondents say they worked collaboratively with the police to obtain an Order of Protection or chose to inform the Adult/child protective services if their assessment revealed that danger to the victim was imminent. Respondents provided no evidence that they had considered the effects on victims of reporting cases to protective services.

Whether the staff of SUD agencies participating in this survey provided direct services to the victims depended on the imminence of danger to the victim. The majority of participants reported they do offer services to DV victims if the danger was not imminent to the clients and if victimization was in the past. These respondents typically describe this process as, *First assess if the client is current or past victim. If current, offer the client assistance in linking with domestic violence shelter and agencies in town. Explore safety options with the client and make sure that the client is informed of the crises services* One area that was not reported by respondents was how to manage cases where the victim chose to remain with their batterer. *available. If past victimization, explore the impact of the victim is having on his/her lifer currently. Offer client with individual therapy to process issues surrounding abuse.*

Services There was a variation in the services that were offered by counselors. The most frequent response was “individual therapy” or counseling, but what therapy or counseling entailed was usually not described. Approaches utilized were described as client centered, motivational interviewing, cognitive behavior therapy, psycho-education, and group meetings for survivors. Other forms of service included educating clients about DV laws and rights of the victims, support services, legal advocacy, case management services, and education about medication for mental health problems. Almost all respondents reported including DV in their treatment plan along with SUD treatment, regardless of whether they provided services for DV.

Overall, the responses did not reflect an underlying treatment philosophy for DV. However a few respondents elaborated on what they believed, such as *We are staunch advocates of family involvement, and when safe, address the issue within that setting as well. Individual, marital, and family therapy is strongly encouraged for the stability of the family and resolution of the problem.* Another respondent alluded to working with the perpetrator to *Gather more history. Make a determination whether return to home is safe and advisable. Try to engage the perpetrator in treatment for his substance abuse and/or psychiatric treatment. Try to work with the couple on communication and conflict resolution skills. Encourage separation if danger likely. Always develop plan B for safety.* In general there was not much evidence that respondents were aware of safety issues in family-based services for domestic violence.

Mandatory reporting/accessing protective services. Respondents often reported that they report DV to authorities if children are involved in situations of violence and abuse at home. Mandatory reporting was also used to seek safety, rescue and shelter for victims of DV, mainly women and children. Respondents reported encouraging women to obtain a Protection Order from police and often accompanied them. One respondent said that s/he hoped that the Probation Officers engage more in encouraging clients to attend and comply with DV services, as these clients complete SUD counseling, but do not comply with DV treatment.

Agency level policy on addressing DV. Respondents who reported any agency level policy to address DV said that they assessed for safety first and then decided to refer or treat (contingent upon what services the SUD agency could offer). 18 respondents said that their agency did not have any policy on addressing DV. Of these 18 respondents more than half typically responded similar to *It does not appear as though there is any “procedure” in my agency that I am aware of. It ends up being the responsibility of each worker to determine to what degree they will deal with or handle the situation.* Whereas another respondent reported not just lack of agency level policy, but also lack of sensitivity to the issue of DV in their setting: *Unfortunately, there is no typical procedure at the agency. DV is not seen as an important primary issue to be addressed. Supervisors may suggest referring someone to a local DV agency, but do not have a full understanding of the issue.*

Theme	Frequency of report
Assess and refer	96
Safety Planning	57
In house DV services	53
Use of screening tools	1
Duty to warn	20

When asked to describe the typical/routine procedure followed by their agency, once a person discloses or is identified as a perpetrator of DV, the responses were grouped in various themes that emerged.

Referral Themes Referring the perpetrator to a DV or a mental health agency was the most frequently occurring response. Among those who reported referral as the way to deal with perpetrators, *anger management* was the purpose for referral, thus indicating that these respondents consider ‘anger management’ as a possible treatment for perpetrators. These anger management referrals were for individual counseling as well as anger management groups. Similarly, anger management was reported to be conducted within the agency or at DV or mental health agencies. There was no evidence that respondents were aware of the debate over the appropriateness of anger management for batterers. The other purpose of referral was to get the perpetrators to attend ‘groups’, which emphasized education, counseling, or a Partner Abuse Intervention Program (PAIP). Other referral targets for perpetrators included in house psychiatrists, therapists, LCSW’s, or bringing disclosure of perpetration to the notice of the Probation Officer.

The second theme that emerged from the responses was that of services provided by the SUD providers/agencies. These can be understood at two levels: In house services- in house “typical” or routine services to the perpetrators typically included assessing the perpetrators intention to be violent again, which was then followed by notifying authorities if danger was imminent. If the danger was not imminent, various respondents gave varied answers depending on the services their agency could offer. Some participants reported continuing further assessment to understand the triggers of violence, issues of relationship, patterns of perpetration and coping strategies. Others mentioned developing a therapeutic relationship to educate the perpetrators about resources available to them and passing information about local DV agencies, start medication, obtain signed releases and urging them to attend a local DV agency. Some respondents reported consulting the clinical supervisor at the SUD agency to decide upon the further course of action,

whereas some respondents reported bringing up issues of perpetrators in staff meetings in order to strategize how to make a referral to the DV agency. Some specific techniques mentioned by the respondents were: anger management, use of Cognitive behavioral therapy, family therapy, couples therapy, motivational interviewing and use of psychiatric medication.

Responses suggest that the course of action of treatment for perpetrators of DV also depended upon the clients' involvement with the criminal justice system. If a perpetrator was mandated to SUD treatment, and during the SUD treatment DV perpetration was identified or disclosed, respondents would contact the Probation Officer or the case manager and would seek further direction or support from them to help the perpetrator comply with follow up at the DV agency as the respondents reported resistance of mandated clients to enter DV programs or services. Decision making based on clients' involvement with the Criminal Justice System is best illustrated by one respondent, *if law is involved, talk with probation and see what they recommended as a part of treatment and encourage clients to follow those goals. If legal system is not involved then discuss with the client and set treatment goals.*" One respondent reported collaborating with the Probation Officer to get compliance of the client to DV interventions, *Ask if they have participated in the 'RAP Group' at our county mental health agency. Refer them there; discuss the recommendation for participation in RAP with their PO. Most perpetrators will not participate without coercion from the court/DOC...* Again, there was a noticeable lack of deliberation about the potential effect of these actions on the DV victim.

Legal Procedures. Responses also highlighted the extent to which SUD providers are involved in following legal procedures with regards to DV. Respondents reported that are mandated to report intent of homicide, child abuse and have a 'duty to warn'. They also mentioned notifying the 'safety committee' at their agency about issues of danger to victim and children. Most respondents reported their involvement with law related aspects as involving risk assessment of danger, notifying police and notifying potential victims.

Most respondents reported their intervention with perpetrators stemmed from their personal decision rather than an agency initiated procedure. As described earlier, most participants typically described their typical routine as *assess danger, if danger imminent refer notify authorities, if danger not imminent refer perpetrators local DV or mental health agency for treatment*. Few respondents reported treating the perpetrators in house, these included use of in house therapist, in house anger management groups, counseling, and referral to an in house psychiatrist. The most common agency policy/procedure mentioned was that of *referral*. Only one respondent mentioned the presence of a formal document: *...talk to the director and follow procedure outlined in our manual*, and another respondent reported using an *in house violence screening tool to determine safety*.

30 respondents reported *not having any policies at the agencies....being unaware of agency level procedures*. Whether the services were provided to perpetrators seemed to depend largely on the personal practice of the individual practitioners as illustrated by one response: *no set "procedure" at the agency, the workers are aware of the supports in the community and pass the information along. Unsure if they address the issue with the individual or not. A lot depends on if they have a degree or what their scope of practice allows them to do.*

Theme	Frequency of report
Assess and refer	60
Anger management	34
In house DV services	28
Use of screening tools	1
Duty to warn	25
Lack of agency policy	30

Obstacles

We asked about “the obstacles you/your agency face while working on issues of domestic violence?” Responses were grouped in various themes that emerged as follows:

Lack of resources/infrastructure. Many respondents reported lack of resources to be the main obstacle of working on issues of domestic violence. Lack of resources included fewer DV services available in the same area as the SUD agency, DV services too far away from the SUD agency, undue burden on the SUD agency to assist clients in reaching the DV agency. One respondent suggested *one of the difficult factors in this community is transportation and cost of such for participants to get to therapy*, while another said *DV agencies are 20 miles away... .* Other resource issues involved inadequate time, additional paperwork involved in collaboration, burnt out staff who have too much work for little pay, lack of personnel, and lack of training and knowledge about DV. The financial resources of the client also were an obstacle: *Clients often are involved in the courts and have a number of places to go to in order to fulfill the court requirements. Court costs and the cost of treatment create financial stress.*

Funding. Related to resources, the second most commonly reported obstacle was that of inadequate funding. Many respondents commented on the issues of funding cuts and that these affect their services. Another issue that was consistently pointed out with funding was that the funding for DV and SUD sometimes came from the same source and that created conflicts that hindered providers from SUD and DV agencies in working together—*Turf wars, who gets money. Sometimes they apply for the same dollars.* Problems with receiving funds were also linked with agency’s ability to pay for professionals. Lack of funds are also linked to issues of resources and infrastructure, like deciding on who funds the meeting with DV, phone calls, phone tags and follow up were seen a extra financial burden by the SUD providers and found it difficult to address DV.

Differences in views regarding SUD and DV. Differences in views regarding SA/DV were also cited as obstacles in working with DV. These differences ranged from differences in understanding the cause of DV or SUD as pointed by one respondent, *Several "mental health" providers still believe that substance abuse and mental health issues are separate.* One DV provider had to say this about SUD providers: *substance abuse agencies are willfully ignorant of DV issues, and don't want their cherished, ignorant theories challenged with the realities of DV.* Another remarked *Some substance abuse agencies believe the DV is caused by the alcohol/drugs. Lack of information on domestic violence.* Yet another respondent pointed to problems with attitudes of both DV and SUD providers: *The feeling that the two are not co-occurring disorders and that they can not be worked on concurrently but rather are two distinct*

issues. *SUD is not an excuse for DV and DV is not an excuse for SUD - however they often times are correlated in occurrences and just as mental health issues, a holistic plan to look at all barriers to a safe and healthy life should be addressed.* Other differences between views regarding SUD and DV were in the area of attitudes. DV providers thought of SUD providers as believing *DV is a "woman's issue. . . and the majority of substance abuse agencies in the county provide services to more men than women.* Conversely, one SUD pointed out that . . . *DV agencies have not been educated that substance abuse is a disease, believe that it is an excuse for behavior.* The two groups often use the same language, with different meaning and understanding.

Some differences shed light upon how SUD providers perceived the readiness of DV agency to work with them, *DV agencies are overly protective of their clients, even with other agencies, and even with releases of information from the client. DV agencies seem less invested in working with SUD agencies; they prefer just the referral system, rather than a working together system.* One SUD provider expressed how s/he finds the approach of DV agencies to violence gender biased, *I strongly believe the problem lies within the belief system of those within the DV community, who base their "treatment" of domestic violence on the notion that men are primarily the perpetrators of abuse and females the innocent victim w/ no responsibility. I personally strongly oppose this belief system, as I believe it does more harm than good.*

The other area of differences in views pertained to treatment philosophies or services, as pointed out by a DV provider, *Most substance abuse providers think of violence as an "anger" problem. Then they send them to anger management (often in house) instead of referring to an Indiana Coalition Against Domestic Violence Batterer Intervention Program.* One respondent pointed out how the differences in treatment styles may clash due to the issues involved, *SUD work benefits from appropriate support from significant others. With serious DV it is best not to have contact until immediate risk factors are eliminated. Treatment styles may clash.* One respondent expressed discomfort with traditional styles of therapy by saying, *problem for clients with co-occurring issues is that many traditional confrontational therapy styles are likely to be overwhelming to those clients and the stress often causes an increase in mental health symptoms.* Whereas another respondent expressed disappointment with DV providers that they are oriented to provide more shelter than offer treatment.

Turf wars, lack of communication. Respondents seemed to agree on the fact that both SUD and DV agencies have problems in collaborating with each other due to lack of time needed for coordination, lack of communication and sometimes inability of one agency to fully understand the other agency. Respondents also pointed to *turf wars* between SUD and DV agencies as a reason for these agencies not working together. In the words of the respondents both the agencies have *turf issues, reluctance to understand and honor the other's beliefs.* Another respondent used the term *silos mindset* to describe the problems related to collaboration. Other problems in collaboration and communication related to *fear of losing client to another agency.* Whereas one respondent pointed out that the obstacle is *communication across the board and not relying on one agency to handle everything and being too busy to stay connected and work together.*

Legal obstacles. Legal obstacles such as getting releases of information or abiding by rules of HIPPA were cited as obstacles in clients to seek treatment at both treatment facilities. Most often respondents noted that clients refused to sign release of information as they were reluctant to go

to the other agency. Such difficulties made referral time consuming and the SUD providers reported that they had to spend time to encourage clients to open up to two different counselors.

Process of collaboration. Some participants shared how they/their agency collaborate with DV providers: *The Council is fortunate to have a contractual relationship with a local domestic violence agency to place staff on site, so that the issue of availability is solved.* Other respondents shared that constant education of each other goals, issues and training helped in collaboration. One respondent said that there need to be systemic changes in agencies for collaborations to work, *Understanding the functions of each other's agencies. Setting up a protocol (much the same as emergency preparedness is set up) to identify how we work together.*

Conclusions

Overall, the responses indicate that SUD agencies do screenings for DV victimization on a fairly routine basis and assessing the safety of the victims seems to be a focus of such an assessment. The actual process of screening DV and whether tools/screening instruments are used for such assessment remains unclear. A few participants also mentioned screening for DV perpetration, but such screening was far less thought through than screening for victims. With both victims and perpetrators, counselors rely on referring affected individuals to DV agencies, shelters or DV groups, usually without case management. The respondents report a paucity of services for DV perpetrators compared to victims. Overall the responses suggest that SUD counselors and agencies provide far more services to DV victims than perpetrators and counselors appear more confident in dealing with DV victims. However, almost none of the respondents reported any agency-initiated policy or routine for dealing with either victims or perpetrators.

DV victimization seemed to get reported in cases where the DV victim seemed in immediate danger. SUD counselors report being obliged by 'duty to warn' about DV perpetration, an issue which has the potential of increasing the risk to victims. Counselors report their risk assessments to Probation officers and child protective services with the intention of seeking safety and preventing violence, but apparently without thinking about the adverse effects that such reports may have on victims.

Many SUD counselors report difficulties in working collaboratively with DV agencies. The main obstacles cited were lack of communication, HIPAA, funding, and turf wars between SUD and DV agencies. In addition to these problems, a number of participants mention philosophical differences between DV and SUD as a source of difficulties in working with DV professionals.

APPENDIX 3: SURVEY
(PDF File, Not Attached)