GETTING SAFE AND SOBER: REAL TOOLS YOU CAN USE

AN ADVOCACY TEACHING KIT FOR WORKING WITH WOMEN COPING WITH SUBSTANCE ABUSE, INTERPERSONAL VIOLENCE AND TRAUMA 2ND EDITION—REVISED 2008

This project was supported by the Office of Women's Health Region X Grant #'s HHSP233200700230P and HHSP233200400566P and also by Grant #'s 2003-MU-BX-0029, 2004-MU-AX-0029 and 2007-MU-AX-0082 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed here are those of the presenters and authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women or the Office of Women's Health.

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ANDVSA
Alaska Network on Domestic Violence & Sexual Assault

Getting Safe and Sober: Real Tools You Can Use

Support Group Manual and Supplementary Materials for Advocates

U.S. Department of Health and Human Services, Office on Women's Health

(Portions of these materials were reprinted, excerpted or adapted from the manual entitled The Perinatal Partnership Against Domestic Violence Manual, 2001, Department of Health, Maternal-Child Health, principal author, Patricia J. Bland" and is provided here with permission from the Washington State Coalition Against Domestic Violence. Some portions of material pertaining to substance abuse were provided by the Domestic Violence Interdisciplinary Task Force of the Illinois Department of Human Services (2000). Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse, Springfield: IL. Other sources are noted on individual items).

Note: Alaska Network on Domestic Violence and Sexual Assault program staff can provide training and technical assistance pertaining to the link between Substance Abuse and Violence Against Women. The following are examples of recent training offerings:

1) *Substance Abuse 101 for Advocates: Physiology and Pharmacology*
2) *Domestic Violence 101 for Substance Abuse Counselors: Advocacy and Empowerment*
3) *Addiction is an Empowerment Issue: Ending Addict Phobia in Our Programs*
4) *Chemical Dependency and Domestic Violence: Overview for Multidisciplinary Teams*
5) *Safety and Sobriety: Real Tools You Can Use - Screening In not Out*
6) *Safety and Sobriety: Real Tools You Can Use – Support Group Models*
7) *Working with Parenting Women Impacted by Substance Abuse and Domestic Violence*
8) *She's Got All Kinds of Troubles – Working with Women with Co-Occurring DV/SA, Substance Abuse and Mental Health Issues*
9) *Advanced Substance Abuse Training for Shelter Advocates*
10) *Advanced Domestic Violence Training for Chemical Dependency Treatment Providers*
11) *Policy and Protocol Development*
12) *Alcohol and Sexual Assault*

SUPPORT GROUP MANUAL

Part I

GETTING SAFE AND SOBER:
REAL TOOLS YOU CAN USE

A TEACHING KIT FOR USE WITH WOMEN WHO ARE COPING WITH SUBSTANCE ABUSE, INTERPERSONAL VIOLENCE AND TRAUMA

2ND EDITION – REVISED 2008

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ACKNOWLEDGEMENTS

The Alaska Network on Domestic Violence and Sexual Assault offers sincere appreciation and respect to our member programs in Alaska who daily seek to alleviate and overcome the impact of domestic violence, sexual assault and chemical dependence in our communities. We thank you for your tireless efforts and ongoing commitment to safety, sobriety and wellness.

We offer grateful acknowledgements to the Office of Women's Health, Region X, and the Department of Justice, Office on Violence Against Women, for their financial support of this project and their commitment to women's health and well-being. We would also like to thank the staff and volunteers of the Alcohol Drug Help Line Domestic Violence Outreach Project in Seattle, WA, for their pioneering work at Residence XII, Catherine Booth House, EDVP, DAWN, and everywhere else they could get their feet in the door throughout Washington, Alaska, Illinois and points around the globe.

Many of the tools provided in this manual were initially developed or inspired by women struggling to get free from violence and addiction. These women shared their experience, strength and hope with each other and with us at New Beginnings for Battered Women and their Children and other support groups in Seattle/Tacoma, WA, and in the Women's Gender Issues group at Heritage Behavioral Health Center in Decatur, IL. Programs across the United States, including the SISTR Program in Dillingham, AK, and support groups in Anchorage, Homer, Palmer, and Bethel, are directly linked to each other through their connection to these early pioneers seeking safety and sobriety.

Special thanks to the women from the New Beginnings Wednesday night support group addressing chemical dependency and domestic violence in Seattle, WA, and their sisters in Springfield, IL, who started it all by sitting down with the authors and allowing us to interview them about their personal experiences. To date, your voices have been heard in 30 states. Special thanks also to the Women in Recovery Caucus (WIRC) of the Washington State Coalition Against Domestic Violence and to the Steering Committee of the Washington State Coalition on Women's Substance Abuse Issues.

We are grateful also to the women of Project Return, Springfield, IL; SafePlace, Austin, TX; The National Center on Trauma and Mental Health, Chicago, IL; The Integrative Services Project, University of Northern Iowa, Waterloo, IA and our colleagues and program associates from the Accessing Safety Initiative at the Vera Institute of Justice, New York, NY.

But most of all, thanks to every woman seeking safety and sobriety who shares her journey to freedom with others, one group at a time. You are our mother, sister, daughter, aunt, niece, cousin, co-worker, neighbor, inspiration, friend.

ANDVSA would like to thank everyone who made the Spanish Language edition of the Real Tools Manual possible. We salute their on-going effort, advocacy, and commitment to safety, sobriety, and justice.

Program Participants and Advocates:
Alaska Immigration Justice Project, Anchorage AK
Code Lua, Alaska
Consejo, Seattle, WA
Kodiak Women's Resource and Crisis Center, AK

ANDVSA would also like to acknowledge the technical expertise and significant editorial contributions made by the following advocates:

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In conclusion, ANDVSA would especially like to express respect and gratitude to:

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We could not have completed this project without their support, hard work, and collaborative spirit. Both of these women worked tirelessly to ensure this translation remained rooted in the experience of women who have experienced harm from abusers and abuse. ANDVSA greatly values their technical expertise as well as their commitment to ending oppression.
ANDVSA encourages individuals seeking Real Tools training or technical assistance provided in Spanish, to contact Cecilia Leal-Covey and/or Lupita Patterson for assistance.

Finally, yet most importantly, we thank you for taking the time to review materials addressing the needs of under-served women with multiple abuse issues. Women experiencing multiple forms of abuse are often invisible. Your advocacy on their behalf is critical. We thank you for your commitment to reducing barriers for battered women with substance abuse issues and we thank you for your willingness to provide services geared towards ending oppression.

U.S. Department of Health and Human Services,
Office on Women's Health

PREFACE

Getting Safe and Sober: Real Tools You Can Use is a practical tool kit for use with women experiencing trauma who have substance abuse or chemical dependence problems and who are, or have been, victims of domestic violence, sexual assault or sexual abuse. The kit also can be used to train service providers about the needs of women whose experience includes both substance abuse and victimization.

This manual is designed as a companion to the Alaska Network on Domestic Violence and Sexual Assault *Model Protocol for Working with Women Impacted by DVSA and Substance Abuse* (2004). The protocol document includes model policies and procedures offered as creative approaches or current best practice for responding to co-occurring domestic violence/sexual assault and substance abuse. The Alaska Network on Domestic Violence (ANDVSA) has also developed a basic curriculum to help advocates and providers screen for domestic violence/sexual assault, alcohol, nicotine and other drug use.

There are very few programs providing discrete services for women impacted by multiple abuse trauma issues including domestic violence, sexual assault and substance abuse. Women impacted by interpersonal violence, substance abuse and trauma are often invisible when in our progams or perceived as disruptive when their substance use or trauma symptoms becomes evident or unmanageable. Many times women with co-occurring issues are missing from community programs altogether. Yet battered women and survivors of sexual assault who struggle with substance abuse and chemical dependence often need our services the most.

Every domestic violence/sexual assault program has strengths and challenges impacting our ability to provide services. Unfortunately many advocacy programs are under-equipped to address co-occurring issues impacting women's safety and health. In order to better extend services and advocacy to battered women with separate issues of substance use, misuse or addiction we must expand our current practices and explore new strategies to address safety and support wellness.

The co-occurrence of domestic violence and substance abuse is associated with increased lethality rates and greater severity of injuries for women impacted by both these public health risks. Additionally, studies indicate domestic violence, alcohol, nicotine and other drug use are all factors associated with low birth weight and other negative health outcomes for both women and their children.

The primary goal of this support group manual is to help advocates and providers better meet the safety needs of battered women and survivors of sexual assault who are impacted by their own or another's substance use, misuse or addiction. Ideally, this manual will serve as a guide or "first step" for providing integrated information, education and support for those addressing co-occurring issues impacting safety, sobriety and wellness.

The manual is designed to supplement existing educational materials and group tools currently utilized by advocates, health care providers and chemical dependency professionals interested in

providing education and group support to women impacted by multi-abuse trauma issues. It contains 'user-friendly' support group materials developed primarily to offer options and address safety for women impacted by multiple abuse issues.

Our group design is informed by evidence-based practice in addiction treatment and utilizes concepts including brief intervention and motivational enhancement. The manual also draws from promising practices in the domestic violence field rooted in the experience of formerly battered women, women in recovery and survivors of sexual assault and other trauma.

BACKGROUND

While most women who have experienced intimate partner violence do not suffer from chemical dependence, it is important to acknowledge many women receiving services from domestic violence/sexual assault programs are dealing with addiction and recovery issues. One study of Illinois domestic violence shelters reveals that as many as 42% of service recipients abuse alcohol or other drugs (Bennett & Lawson, 1994). Researcher William Downs reports findings indicating one in four women in an Iowa shelter/safe home sample had a lifetime diagnosis of alcohol dependence and another one in four had alcohol or other drug problems (Downs, 2002).

The Women's Action Alliance experience with a domestic violence shelter program over a fifteen-month period of time indicated 60-75% of the women seeking shelter services had developed problems with their original coping mechanisms, alcohol and drugs (Roth, 1991). Preliminary data from a National Institute on Drug Abuse study noted 90% of women in drug treatment had experienced severe domestic violence from a partner during their lifetime (Miller, 1994). Similar findings have been noted on monthly client service reports from the Alcohol/Drug Help Line Domestic Violence Outreach Project in Washington State (Bland, 2003). Clearly, a significant number of women and children seen in domestic violence agencies and sexual assault victim service programs suffer from substance abuse problems (Kubbs, 2000).

As recently as fifteen years ago, Finkelstein reported alcoholism and drug abuse were still viewed primarily as "men's diseases" (Finkelstein, 1994). Substance abuse and addiction are women's issues. According to the Washington State Coalition on Women's Substance Issues, the physiological impact of substance abuse on women needs more attention. Women have higher blood alcohol levels than do males after consuming equal amounts of alcohol (LaGrange, 1994; Lieber, 1993). Research has documented women have a higher prevalence and greater severity of alcohol-related liver disease with shorter duration of alcohol use and lower consumption levels than men (Kubbs, 2000). Women also have higher death rates from alcohol-related damage (CSAT, 1994).

While using substances can initially serve as a survival strategy or coping mechanism anyone might use in the context of abuse, pain, illness or other trauma, studies indicate women are more likely to begin substance misuse in response to trauma. Women are likely to use prescription medication much more often than men. Seventy percent of prescriptions for tranquilizers,

sedatives and stimulants are written for women (Roth, 1991). The Minnesota Coalition for Battered Women (1992) states that psychotropic medication is over-prescribed for battered women. They also note that women who have been abused may also use alcohol or drugs for a variety of other reasons, including: coercion by an abusive partner, chemical dependence, cultural oppression, or—for women recently leaving a battering relationship—a new sense of freedom.

Unfortunately, using substances for any reason becomes problematic when misuse occurs or addiction is indicated. A significant number of battered women and survivors of sexual assault with substance abuse or addiction issues typically experience discrimination and barriers to services. Ability to maintain employment, housing, health insurance or child custody may be threatened by public disclosure of current or past substance abuse problems. Societal attitudes tend to view addiction as a moral failing rather than as a health problem. This can lead to isolation and shame, which may be compounded when domestic violence and/or sexual assault co-occur. Most alarming of all is the impact of multiple abuse issues on safety. Safety is strongly compromised when domestic violence and chemical dependence co-occur. While these problems frequently co-occur, there is little evidence that either problem causes the other. Individually, each can be chronic, progressive and lethal. Together, severity of injuries and lethality rates climb for chemically dependent battered women (Dutton, 1992). These problems are compounded when perpetrators include sexual assault and other forms of sexual abuse in their arsenal of violence.

OBJECTIVES

Objectives of this manual include helping women:

- Recognize signs of substance abuse and trauma stemming from victimization.
- Understand the relationship between the two.
- Learn about resources that can help them ensure their personal safety, heal from abuse, and recover from addiction.
- Integrate the philosophies employed by most substance abuse counselors and women's advocates, so that women coping with both substance abuse and victimization can use both types of services without confusion.

RATIONALE FOR DEVELOPING THE KIT

While there is little credible evidence supporting a direct cause-and-effect link, substance abuse and violence against women often occur together. For women in substance abuse treatment, failure to address current or past victimization can interfere with treatment effectiveness and can

lead to relapse. For victims of violence or abuse, active alcohol or drug abuse makes it harder to escape a violent situation or to heal from past abuse. Both issues pose serious public health consequences for women and their children.

The following are a few of the many reasons an individual who experiences domestic violence and/or sexual abuse and who also has a substance abuse problem, may be at increased risk for harm (Bland, 1997; Illinois Department of Human Services, 2000):

- Acute and chronic effects of alcohol and other drug use may prevent one from accurately assessing the level of danger posed by a perpetrator.

- Under the influence, one may feel a sense of increased power. Individuals may erroneously believe they can defend themselves against physical assaults and may not realize the impact of substances on their gross motor functioning and reflexes.

- Substance use and misuse can impair judgment and thought processes (including memory), making safety planning more difficult.

- Alcohol and other drug use may be encouraged or forced by an abusive partner as a mechanism of control. Abstinence and recovery efforts may be sabotaged. *For example, a domestic violence/sexual assault victim receiving methadone on a daily basis could easily be stalked.*

- There may be reluctance on the part of the crime victim to seek assistance or contact police for fear of arrest, deportation or referral to the Office of Children's Services.

- The compulsion to use and withdrawal symptoms may make it difficult for substance-abusing or addicted victims of domestic violence/sexual assault to access services such as shelter, advocacy, or other forms of help.

- Additionally, a recovering woman may find the stress of securing safety leads to relapse.

- If she is using or has used in the past, she may not be believed.

Given the effect that each issue has on a woman's ability to address the other, researchers have suggested the need for greater coordination of services among health care providers, substance abuse counselors and advocates addressing women's victimization. It is hoped that this manual can serve as a "bridge-building" tool for providers, counselors and advocates whose work brings them in contact with women addressing both substance abuse and current or past victimization.

COMPONENTS OF THE KIT

This kit contains guidelines and sample topics to assist in the creation of support groups for women who have substance abuse or chemical dependence problems and who are, or have been, victims of domestic violence, sexual assault or sexual abuse. Also included are a variety of user-friendly handouts.

The materials in this manual are designed for maximum flexibility. It is hoped that providers, counselors and advocates can use the materials either in group or individual advocacy-based counseling sessions. It is also hoped the materials can be used in a variety of settings: in domestic violence/sexual assault programs with women who also have substance abuse problems, in substance abuse treatment with women whose experience includes domestic violence or sexual assault/sexual abuse, and in health care settings as well.

The entire kit also can be used to educate service providers about the needs of women whose experience includes both substance abuse and victimization. Materials can also be presented in staff trainings as tools providers can use with clients who have co-occurring issues.

Please note, this kit is not intended to replace referrals to other agencies for women who could benefit from the other services. Rather, it is designed to provide information that will encourage women to follow up on referrals and use needed services. It is also designed to help women integrate, for themselves, the different language and the different approaches used by women's advocates and substance abuse counselors so they can get the maximum benefit from whatever services they are receiving. Hopefully, this kit will also help counselors and advocates feel they can encourage the use of "cross services" without compromising the integrity of their own philosophies.

CONCLUSION

We can support women seeking safety and sobriety by reducing program service barriers and ending isolation for chemically dependent battered women and their children. Because women impacted by substance use, misuse or addiction may be at greater risk for injury and lethality, support groups addressing substance use as a safety issue are essential for women impacted by domestic violence and sexual assault. This manual is designed to serve as an important tool for helping program participants identify and overcome barriers to safety and sobriety.

RESOURCES

Alaska Network on Domestic Violence and Sexual Assault *Model Protocol for Working with Women Impacted by DVSA and Substance Abuse* (2004).

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GUIDELINES FOR ORGANIZING AND CONDUCTING SUPPORT GROUPS

Support groups can serve as a valuable adjunct to counseling or advocacy. Special support groups for women impacted by multi-abuse trauma provide opportunities for participants to discuss their daily struggle with the multiple issues that affect safety, sobriety and empowerment.

Much of the power in these groups comes from the personal stories. People share their experience, strength and hope with each other. When one person breaks the silence about her experiences, others feel safer breaking *their* silence. Participants also hear success stories. They hear what others are doing to cope with problems similar to their own.

However, women who are survivors of multi-abuse trauma do have some special safety and access concerns. Support groups should have clear ground rules addressing confidentiality, a non-judgmental atmosphere and respect among group members. Following are some tips and general guidelines for these groups.

CONFIDENTIALITY

Most people in support groups respect anonymity and confidentiality. Be sure to explain what these concepts mean at your program. However, women leaving an abusive situation should be advised not to share information in a group setting if doing so could put their safety at risk. Here are some other tips to help ensure confidentiality:

- Use first names only.

- Limit notes. (Document topic covered and attendance only and require a signed release of information to disclose these.)

- Advise group participants about what you are mandated to report (children's services/child welfare or adult protective services issues, suicide threats, etc.).

- Some group members don't want to be greeted or acknowledged outside of the group due to safety or privacy concerns. Be sure to address this with the group. Some groups come up with a code to use if they see each other in a public place.

PROMOTING EASY ACCESS TO THE GROUP

Some initial discomfort is normal for anyone who is new to support groups. It is natural to feel nervous in a roomful of strangers. First-time participants may have spent years avoiding the issues the group is discussing. If a woman's experience includes violence or abuse, she also may have safety concerns. Here are some tips to help participants feel comfortable, stay safe – and hopefully, keep coming back:

- Have easy access to the group – don't create barriers.
- There is no right way to conduct these groups. Be open to suggestions from program participants.
- Prioritize childcare.
- Have healthy food, de-caffeinated coffee, and tea available.
- Assist with transportation.
- Don't screen out. Prepare for arrival!
- Have enough staff or volunteers available to deal with unexpected issues.
- Have women create their own resource book of referrals.

GENERAL TIPS

It is extremely important for facilitators to provide a safe, non-judgmental environment for women coping with multiple issues. It is also very important for facilitators to emphasize that no one deserves violence, bullying or other abuse, no matter what else is going on. Offenders should always be held solely accountable for the abuse they have directed toward their victims. Here are some general tips for effective support groups:

- Support group facilitators need to be trained about the unique problems faced by women who are survivors of multi-abuse trauma.

- Use co-facilitators when possible. Be sure to have at least one advocate with understanding of domestic violence, sexual assault and stalking and another with substance abuse, trauma and or mental health expertise. Peer group leaders are fine, the more the merrier. Embrace diversity.

- Be flexible. Think kitchen-table – have a topic in mind but be willing to change. Let women own the group.

- Include time for women to address practical issues such as housing, employment, legal or children's issues, and community resources.

- Allow participants to use the copy machine, telephone, fax, etc.

- Adjust group guidelines and topics depending on the setting (domestic violence shelter, sexual assault program, substance abuse treatment center, mental health facility, transitional housing program, self-help group, or elsewhere).

- Remember that you may only see a group member once, or you may have the member for three or more years. Be solution-based and friendly, but make the most of your interaction because it may be the only one you get.

- For drop-in groups, the average member comes about 12 times; make sure all participants understand that they are welcome to return at any time.

- Stage 2 groups led by members themselves are good options for long-term group members.

GENERAL GOALS

Regardless of the topic or setting, keep these overall goals for the group in mind:

- Address safety concerns and provide safe space. Participants need to feel safe in order to tell their story and benefit from being believed. Be sure to LISTEN and validate each person's experience, strength and hope.

- Build on existing strengths. Don't focus on what is wrong with a person. Focus on what has happened to her. Provide practical support. Help participants identify safer coping mechanisms than alcohol and other drugs, etc if her coping tools are not working well for her or pose risk.

- Provide an opportunity for connection. Encourage women to support each other, and develop phone lists when it is safe to do so.

SUPPORT GROUP FORMAT AND TOPICS

In this section, you will find a sample overall support group format. We have also included some sample weekly group topics, along with suggestions for using the individual handouts. Please feel free to adapt either the overall format or the topics in whatever way works for your particular setting or time constraints.

OVERALL FORMAT FOR GROUPS

Participants in support groups may be more comfortable when group sessions have a predictable structure. Here is an example of an overall format that has been used successfully with women who have been impacted by multi-abuse trauma *(e.g. domestic violence, sexual assault, substance use issues and trauma, etc.)*.

- ***Check in.*** Open the session by asking each group member to briefly state one thing she did right, or was proud of achieving during the previous week.

- ***Identification of problems, challenges or goals and resources.*** Ask participants if anyone is facing a special challenge, or has a particular goal she'd like to achieve. Identify resources currently utilized by group members and develop additional options to resolve problems, meet challenges and achieve goals.

- ***Educational component.*** Use a portion of the session to educate participants about some aspect of interpersonal violence, trauma, mental health, substance use or any of the other issues they may be facing. Topics may include power and control dynamics, safety issues, sobriety issues, wellness issues, children's issues, healthy boundaries, coping skills, etc. Below are some examples of possible topics, along with suggestions about how to use the handouts we've included in this kit.

- ***Closure.*** Close the session by asking each person to name one thing she can do in the coming week to achieve safety, sobriety or wellness as she sees these.

SAMPLE TOPICS FOR EDUCATIONAL COMPONENT

Here are some sample topics for use in the educational component of support groups, along with suggestions for handouts to use with each topic. Each of these topics could stand alone, so that women who only attend some group sessions won't need to rely on information from a previous session to understand the topic being discussed in the current one. The topics also may be used in any order. These are examples only! Nothing here is carved in stone – feel free to be creative with these topics and come up with some of your own.

Note about copyright: Group facilitators are free to photocopy as many of the handouts as they wish for educational use. However, please make sure the copyright notices appear on each of the handouts. We also request that the handouts not be altered in any way, especially the Power and Control Wheels. Please note that the Power and Control Wheels appear here courtesy of the National Center on Domestic and Sexual Violence, which credits the Domestic Abuse Intervention Project in Duluth, MN, for inspiring the wheels.

TOPIC #1

The relationship between substance abuse and violence. Discuss commonly asked questions about the relationship between substance abuse and violence against women. Does substance abuse cause a perpetrator to get violent? Will treatment stop the violence? If the victim abuses alcohol or other drugs herself, does this mean she's asking for trouble? Does current or past abuse cause a woman to develop substance abuse problems? Also discuss why it is usually necessary to address both substance abuse and victimization if both are part of a woman's experience.

Handouts

Woman Abuse, Substance Abuse: What is the Relationship?

Survivors of Chemical Dependence, Domestic Violence and Sexual Assault

TOPIC #2

Naming the problem. Discuss definitions of domestic violence, sexual assault/sexual abuse, and substance abuse, along with signs to look for. Encourage women to discuss signs or indicators they've experienced.

Handouts

Naming the Problem

Manifestations of Violence

TOPIC #3

Overlapping elements of co-occurring substance abuse and intimate partner violence. Help participants identify overlapping elements of domestic and sexual violence and substance use issues. Review patterns of violence; explore coercion and compulsion as barriers to safety and sobriety.

Handouts

Merry-Go Round of Addiction (With Instructions for Use)

Merry-Go Round of Violence (With Instructions for Use)

TOPIC #4

Overlapping elements of multiple issues. Help participants identify overlapping elements of issues such as domestic and sexual violence, substance use, trauma and mental health concerns. Review patterns of violence and barriers to safety, sobriety or wellness. Help participants develop tools to avoid self-blame for the harm and/or fallout from multiple abuse issues. Discuss other issues that impact safety, sobriety and wellness, such as poverty and oppression.

Handouts

1 + 1 = 10 Tons of Trouble (With Instructions for Use)

Other Issues: What Else Impacts Safety and Sobriety?

Power and Control Wheels

Power and Control Wheel for Women's Substance Abuse

Mental Health System Advocacy Wheel

TOPIC #5

Getting help. Discuss the services offered by domestic violence/sexual assault programs, mental health professionals and substance abuse treatment providers and support groups, with an emphasis on resources in your own community. Counselors and advocates will want to have addresses and phone numbers handy so they can make appropriate referrals, but also ask participants to share information about resources they are aware of. Group members may want to develop their own resource book as an on-going guide both for themselves and those who will follow.

Handouts

Getting Help

We Are Our Own Best Advocates

Note: You may also wish to provide brochures and meeting schedules from agencies/support groups in your community.

TOPIC #6

Sorting Out Messages. Women receiving services from victims' advocates, and substance abuse counselors may hear messages that seem to conflict or contradict each other. They may also face risks to their safety in traditional treatment programs, risks to sobriety in traditional advocacy programs. Discuss ways to overcome these risks and reconcile the philosophies commonly promoted by women's advocates and substance abuse counselors. Key to this, for both group facilitators and participants, may be understanding that substance abuse and violence are different problems requiring different approaches.

Handouts

Sorting Out Messages

Safety and Sobriety: Risk Factors in Traditional Advocacy and Treatment Programs

TOPIC #7

Sorting Out Demands and Conflicting Messages. Women with multiple issues may be receiving services from several different providers. For example, they may be seeing a women's advocate for domestic violence, sexual assault or stalking issues, a treatment counselor for substance abuse or chemical dependence issues and a therapist or psychiatrist for mental health issues. In the process, women experiencing multiple forms of abuse may begin to acquire numerous labels and hear contradictory messages. Encourage participants to role play the parts of the different "Helping Professionals," in the skit, *"She Has All Kinds of Troubles."* Ask for several group members to volunteer to play the part of the "Helping Professionals," the part of the "Program Participant" seeking services and the part of a Volunteer who will tape labels on the "Program Participant" while the "Helping Professionals" are speaking.

Following this role-play exercise, discuss how group members can better navigate conflicting systems and advice.

Handouts

Skit: She Has All Kinds of Troubles

Note: You will need to do some advance planning for this group. Review the script and write assorted labels such as "victim," "drug addict," "borderline," etc., on several sheets of 8 ½ X 11 paper to be taped on the "Program Participant" by the "Volunteer." The "Volunteer" can tape the actual words on to the "Program Participant" as the "Helping Professionals" are verbally labeling the "Program Participant." Once you make up your labels you may want to laminate them for future use.

TOPIC #8

Who Can We Trust? To heal and function in the world, we all need to be able to trust somebody. However, a woman's past experiences may have made this difficult, especially if she has been a victim of interpersonal violence, or has issues such as a substance use disorder, trauma or other mental health concerns. Discuss some of these experiences, and how they might impact a person's ability to trust others. Discuss how we determine who is trustworthy and who is not and point out that it's okay to make people earn our trust.

Handouts

Who Can We Trust?

TOPIC #9

Using support groups. Discuss the benefits of support groups, and ways for women to feel more comfortable using them. Include safety tips – women may need to do the same "safety planning" when they use support groups as they do when going to work, visiting relatives or using public transportation. Because of the difficulty many abused women have with boundary issues, they may also need some extra assurance that they have the right to protect their boundaries when in groups.

Handouts

Safety at Support Group Meetings

Etiquette in Groups

TOPIC #10

Using the 12 Steps. Can a feminist empowerment model used by women's advocates be compatible with the 12 Steps? Discuss ways to interpret popular 12 Step concepts so they can be used in a way that is appropriate for survivors of violence or abuse. The handout "Using 12 Step Groups" makes numerous references to the "Big Book" of Alcoholics Anonymous and The Twelve Steps and Twelve Traditions, with page numbers, to provide support for survivors who use 12 Step groups and wish to use the suggested interpretations in that handout. Encourage participants who use 12 Step groups to discuss their own ways of interpreting the Steps as well. Also, if there are "alternative" support groups in your community such as Women For Sobriety or 16 Step Empowerment Groups; make sure participants are aware of all their options.

Handouts

Using 12 Step Groups

Alternative Support Groups

TOPIC #11

Safety planning. For women with multiple abuse issues, safety, sobriety and wellness may all be priorities. Review the impact of safety on wellness and sobriety, and the impact of sobriety or wellness on safety. Women's advocates usually encourage program participants to develop a safety plan. Discuss how program participants can make wellness and relapse prevention part of their safety plans. Mental health counselors and substance abuse professionals may help women develop treatment or recovery plans. Address safety as part of a wellness or relapse prevention plan.

Handouts

Safety Plan

Mini-Safety/Sobriety/Wellness Plan(With Instructions for Use)

TOPIC #12

Children's issues. Children may not talk about problems they witness in the home, so it can be tempting to think they don't notice what's going on, or that it doesn't affect them that much. But research tells a different story. Help participants to recognize the impact of both substance abuse and violence on their children, and discuss how to create a more positive environment for children.

Handouts

Children Exposed to Domestic Violence and Substance Abuse

Children Coping With Family Violence Wheel

Safety Planning Interventions for Children

TOPIC #13

Power and control dynamics. Use Power and Control Wheels to illustrate all the various ways that power is used and abused in our society and in our personal relationships to dominate and control others. The wheels can be useful for exploring other problems in a woman's life besides

interpersonal violence, such as mental illness, substance abuse and various kinds of social oppression. Then discuss what equality and respect would look like, both in our personal relationships, our programs and the larger society. Also make use of the power and control wheels when discussing any of the other topics suggested in this section.

Handouts

Power and Control Wheel

Power and Control Model for Women's Substance Abuse

Mental Health System Advocacy Wheel

Lesbian/Gay Power and Control Wheel

Violence Against Native Women: Battering

Immigrant Power and Control Wheel

Children Coping With Family Violence Wheel

Three Circles Power and Control Wheel

Equality Wheel

Natural Life-Supporting Power Wheel

Community Accountability Wheel

Abusive Power and Control Within the Domestic Violence Shelter

TOPIC #14

Creating change. Many survivors of violence find that working for social change aids their own healing process. Many recovering alcoholics and addicts believe carrying their message to others helps them stay clean and sober. People may call their efforts *working for change, service to others* or *carrying the message*. Discuss contributions from both the women's movement and the recovery movement that have made it easier for people to get help with problems that were once denied or stigmatized. Then discuss simple things participants might do to make a difference in society. In a group setting, choosing an activity to do together as a group (such as making T-shirts for the Clothesline Project) may be an effective hands-on way to engage clients in the art of "making a difference."

Handouts

Personal Change, Social Change

Can One Person Make a Difference?

TOPIC #15

Ending isolation, connecting with others. Women attending support groups together can serve as safety net of caring individuals. Women facing similar struggles can reduce isolation, anxiety and fear through their connection to each other. Discuss how group members can support each other even when they are not in group.

Handouts

Ending Isolation: Reducing Anxiety through Connection

TOPIC #16

Sharing personal experience, strength and hope. The handout "Women Talk About Substance Abuse and Violence" is based on a series of interviews with 10 women. All 10 had experienced some form of abuse: battering, rape or sexual assault, incest or child sexual abuse. In addition to the violence, all of them had experience with alcohol or drug abuse, either on their own part, on the part of their partner, or both. At the time of the interviews, all of the women had left their abusive relationships, and those with chemical dependency problems were in recovery. They talked frankly about the impact of the substance abuse on their efforts to escape the violence and heal from abuse. They also discussed how their experiences with violence affected their efforts to recover from alcoholism or other drug addiction. Ask participants to take turns reading the parts aloud. Pause between questions on the handout for comments from participants. This particular exercise usually elicits a strong response from participants because they identify with other women who have "been there."

Handout

Women Talk About Substance Abuse and Violence

HANDOUTS

Group facilitators are free to photocopy as many of these handouts as they wish for educational use. However, please make sure the copyright notices appear on each of the handouts. We also request that the handouts not be altered in any way.

Woman Abuse, Substance Abuse: What is the Relationship?

When substance abuse and violence against women happen together, many people get confused about cause and effect. Does alcohol or drug use cause a perpetrator to get violent? Does being a victim of violence cause a woman to develop substance abuse problems? If a woman abuses alcohol or drugs, does this mean she asks for trouble? Here, based on research, are answers to some commonly asked questions.

Does alcohol or drug use cause violent behavior?

Studies show that people who get violent when intoxicated already have attitudes that support violence.[1] They believe they have the right to control another person. They believe violence and other abuse are acceptable ways to gain control. A perpetrator may use intoxication to excuse violent or abusive behavior. But substance abuse is no excuse for crimes such as domestic violence or sexual assault.

Will treatment help a perpetrator stop being violent?

If a woman leaves an abusive relationship, her partner may promise to get treatment or attend A.A. meetings. These promises may be a way to manipulate her into returning. Unfortunately, there is no guarantee that substance abuse treatment will stop violence.[2] If physical violence stops, other abusive and controlling behavior often replaces it.[2] A perpetrator must confront attitudes that support violence.

Does being a victim of violence cause substance abuse?

Not every abused woman uses alcohol or drugs. So there is not a direct cause-and-effect relationship. But trauma can increase a woman's risk for substance abuse.[1] Some women may use alcohol or drugs as an anesthetic, to relieve the pain caused by violence.[1] If the pain continues, and the "self-medicating" continues, conditions are perfect for addiction to develop.

If a woman abuses alcohol or drugs, does this mean she asks for trouble?

No woman deserves to be abused in any way, *no matter what else is going on.* If she is in a relationship, does this mean her partner must overlook substance abuse? No. Her partner has a right to ask that she get counseling or other help. Her partner has a right to end the relationship. But drinking or drug use never justifies violence.

Why is substance abuse risky in a violent situation?

While substance abuse does not cause violence, it can make a violent situation more dangerous. If the perpetrator is intoxicated, there is a greater risk the victim will be injured or killed.[3] If the victim is intoxicated, she may find it harder to get safe.[2]

Women coping with violence and their own substance abuse may find themselves caught up on a merry-go-round. Substance abuse makes it harder to escape a violent situation, or to heal from past abuse.[2] Continuing violence or unresolved feelings about abuse make it harder to stay away from alcohol or drugs.[2]

How does substance abuse interfere with safety?

Substance abuse impairs judgment. This makes safety planning more difficult. [2] The victim may avoid calling police for fear of getting arrested or being reported to a child welfare agency. [2] She may be denied access to shelters or other services if she is intoxicated. [2]

How does substance abuse interfere with healing from violence?

If a woman is abusing alcohol or drugs, it is hard to heal the pain caused by violence. Counseling or therapy sessions can bring out strong emotions. [1] Alcohol and drugs cut off these emotions, and the feelings get pushed back down inside. [1] So the work cannot go forward. The healing doesn't happen. The pain continues.

How does violence interfere with recovery from addiction?

A woman may use alcohol or drugs to "stuff" her feelings about the abuse. [1] When she stops drinking alcohol or using drugs, buried emotions may come to the surface. [1] These feelings of pain, fear or shame can lead to relapse if not addressed.[4]

In an abusive relationship, a woman's recovery may threaten her partner's sense of control. To regain control, her partner may try to undermine her recovery. [1] Her partner may pressure her to use alcohol or drugs. [1] Her partner may discourage her from seeing her counselor, completing treatment, or attending meetings. [1] Her partner may escalate the violence. [1]

How can a woman get off this merry-go-round?

Many women have found they will need to address both the substance abuse and the violence. [2] A domestic violence agency can help a woman who is in an abusive relationship. A rape crisis center can help if she has been sexually assaulted or sexually abused. Substance abuse treatment can help if she has problems with alcohol or other drugs. No matter where she goes for help first, her counselor or advocate can make referrals. This way, she can get all the services she needs.

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[1] Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. *Substance Abuse Treatment and Domestic Violence, Treatment Improvement Protocol Series 25*. Rockville, MD: U.S. Department of Health and Human Services, 1997

[2] Domestic Violence/Substance Abuse Interdisciplinary Task Force. *Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse.* Springfield, IL: Illinois Department of Human Services, 2000

[3] Bland, Patricia J. Strategies for improving women's safety and sobriety. *The Source, Reprint 50,* 1997

[4] Simmons, Katherine P., Terry Sack and Geri Miller. Sexual Abuse and Chemical Dependency: Implications for Women in Recovery. *Women and Therapy 19* (2), 22

A Note to Survivors:
DOMESTIC VIOLENCE, SEXUAL ASSAULT and SUBSTANCE USE

While not all people who drink or use drugs are alcoholics or addicts; substance use is often a safety issue for those experiencing domestic violence or sexual abuse. While there is little credible evidence indicating substance abuse alone causes domestic violence or sexual abuse; alcohol and drug use **is** associated with greater severity of injuries and increased lethality rates. These safety issues increase when addiction is present. Addiction, like domestic violence and sexual assault, causes great pain, shame, fear and isolation**.** Addiction *(also like DV and sexual assault)* is not your fault**.**

- People often believe their use of a substance means the violence directed against them is warranted. Always affirm no one has the right to hurt you. Sexual abuse, sexual assault and/or domestic violence directed against you are **never your fault** under any circumstance.

- Anyone might take a drink or use a drug to cope but there are usually safer ways to survive sexual assault, rape trauma, abuse, domestic violence and other forms of pain and oppression *(e.g. sexism, homophobia, racism, ageism, ableism, and classism).*

- Recognize euphoric recall and blackout make safety planning harder. Denial of use is not about lying; it's about surviving and it's about fear. Sometimes recall is hazy and people are confused or afraid. Facing the truth may be scary, painful or both. It may take a while but when it feels safe for you to seek help, please reach out. You are not alone.

- Both substance abusing and non-substance abusing victims of violence are victimized by perpetrators who may or may not be using themselves. You may have been introduced to drugs by a partner or an acquaintance who uses substances to gain and maintain power and control over others.

- A violent person may use alcohol or date rape drugs like rohypnol to more easily harm others. This is a form of physical, emotional, social, sexual and spiritual abuse. Recognizing this may help you understand how a perpetrator intentionally causes harm. This harm is never your fault; the perpetrator is solely responsible for any assault or resulting harm to others.

- Review options but recognize substance use impairs judgment, causing decision-making to be more challenging. It's ok to try 12-step or other programs if your circumstances make it reasonably safe to attend without fear of reprisal by the abuser. Each option has strengths and limitations. Be aware of alternatives, especially for gender-specific or culturally appropriate 12 step or other support groups and/or chemical dependency treatment.

- Being identified as either an alcoholic or an addict (even if you are in recovery) can impact your ability to get safe housing and gain or maintain child custody. This may affect careers, community standing, and/or support (or lack thereof). Increased insurance rates and legal difficulties may also be experienced. Service barriers also exist when you are actively using. Shelter space may be denied, detox may not be available immediately, and treatment may seem less urgent than getting SAFE. Getting help early can reduce some of this risk.

- If you are using to cope *(or for other reasons),* stopping drinking and drug use alone **cannot** ensure your safety. Substance mis-use and chemical dependence undermine both health and judgment. For those experiencing addiction, withdrawal symptoms can be painful and life threatening. Seek medical attention prior to detoxing.

- Treatment for substance abuse can pose many risks if either domestic violence or sexual assault is an issue. **Conjoint or couples counseling is not appropriate**. If you are enrolled in a methadone program you may be particularly vulnerable because you must appear daily at a set time for a dose and can be easily tracked or monitored by an abuser.

- Recovery may be accompanied by more danger. As sobriety increases a perpetrator may find the ability to control you is threatened. You may find your recovery efforts sabotaged as the abuser looks for new ways to regain control. Consider support groups addressing both the substance abuse as well as the domestic violence/sexual assault issues.

- Despite these barriers, people dealing with addiction, physical, emotional and sexual abuse/sexual assault or battering are not powerless. You are dealing with both a life threatening disease **and** violent crime. Empowerment involves **both** SAFETY and SOBRIETY. Help is available.

- If you are addressing chemical dependency and interpersonal violence issues you may find your local domestic violence/sexual assault program **and** your local substance abuse program helpful. The Alcohol Drug Help Line Domestic Violence Outreach Project at 206-722-3700 or 1-800-562-1240 *(WA and AK only)* is also a good resource.

Naming the Problem

Violence against women and girls takes many forms. These include domestic violence, sexual assault and sexual abuse. Substance abuse also takes many forms. The substance could be an illegal drug such as crack or heroin. The substance could also be alcohol or prescription drugs such as tranquilizers, painkillers or sedatives.

Put a check mark next to any of these signs you have experienced. Do any of your answers surprise you? Whether the issue is substance abuse or violence, it can be hard to face the situation. But the first step in addressing a situation is to recognize the situation for what it is.

What is domestic violence?

Domestic violence goes beyond normal disagreements to abuse. One person uses a pattern of abusive behavior to gain power and control over another. The abuse may be physical, sexual, psychological or economic. Examples of abuse range from putdowns and name-calling, to pushing and shoving, to severe beatings or murder. Could you be involved in an abusive relationship? Here are some warning signs. Does your partner:

__ Slap, hit, push, punch or physically hurt you in other ways?
__ Threaten to harm you or your children?
__ Say things to you that are hurtful or demeaning?
__ Discourage you from seeing or speaking to your family or friends?
__ Prevent you from leaving the house, getting a job or returning to school?
__ Force you to have sex, or pressure you to perform sexual acts you don't like?
__ Express anger physically (throw things, hit walls, destroy your belongings)?
__ Use alcohol or drugs as an excuse for saying hurtful things or abusing you?
__ Make you feel as if you need to "walk on eggshells?" In other words, are you often afraid of your partner, or afraid to express your true feelings?

What is sexual assault or sexual abuse?

Sexual assault and sexual abuse refer to any sexual contact without your consent. Examples include rape, attempted rape, unwanted touching and child sexual abuse. The abuser could be a stranger, date, friend, lover or even a spouse or relative. Sexual abuse is often involved in domestic violence, and may be one way batterers abuse their partners. Here are some examples of sexual assault and sexual abuse.
Has anyone:

__ Forced you to have sex when you didn't want to?
__ Forced you to perform sexual acts you didn't like?
__ Touched you in ways you didn't like after you said no?
__ Threatened to hurt you if you didn't cooperate?
__ Behaved in ways that caused you to feel intimidated or afraid?
__ Forced you to have sex with others, or engage in prostitution?
__ Had sex with you while you were heavily intoxicated or passed out?

Any sexual behavior between a child and someone who has power over the child is sexual abuse. This is true even if the child agreed to participate. The difference in age and power between a child and an older person makes informed consent impossible. When you were a child, were you ever:

__ Touched or fondled in a sexual way by an older person?
__ Asked to touch an older person in a sexual way?
__ Asked by an older person to look at pornographic movies or magazines?
__ Asked by an older person to undress or pose in a sexual manner for a photo?
__ Asked to keep any sexual activity a secret or warned not to tell anybody?

What is substance abuse?

Substance abuse is the continued use of drugs, including alcohol, even when such use causes problems. If a person experiences unusual tolerance or withdrawal, the substance abuse has probably progressed to addiction. Addiction is a chronic disease which is often progressive and fatal. Could you be in trouble with alcohol or other drugs? Here are some warning signs:

__ Do you often use alcohol or drugs to relieve stress or escape problems?
__ Do you use prescription drugs more often than directed, or for non-medical purposes?
__ Do you need more and more of the substance to get the same effect?
__ Do you often get drunk or high after promising yourself you wouldn't?
__ Do you have blackouts (times when you don't remember what happened while you were intoxicated)?
__ Do you have tremors, shakes or other uncomfortable symptoms when you can't get alcohol or another drug?
__ Do you often fail to meet responsibilities because of drinking or drug use?
__ Has your alcohol or drug use caused you to give up activities you enjoy?
__ Have you had legal problems related to alcohol or drug use?
__ Does the thought of running out of alcohol or drugs make you nervous?
__ Does the thought of stopping feel overwhelming or even impossible?

If you answered yes to any of these questions, you are not alone. Tell someone what is going on. Don't keep it a secret. Seek counseling. Try a support group. Please don't be afraid or embarrassed to seek this help and support. Your life is at stake. The sooner you ask for help, the sooner you can get safe, begin to recover, and heal.

Definition and warning signs of domestic violence adapted from "The Problem," National Coalition Against Domestic Violence [On-line]. Available: www.ncadv.org/problem

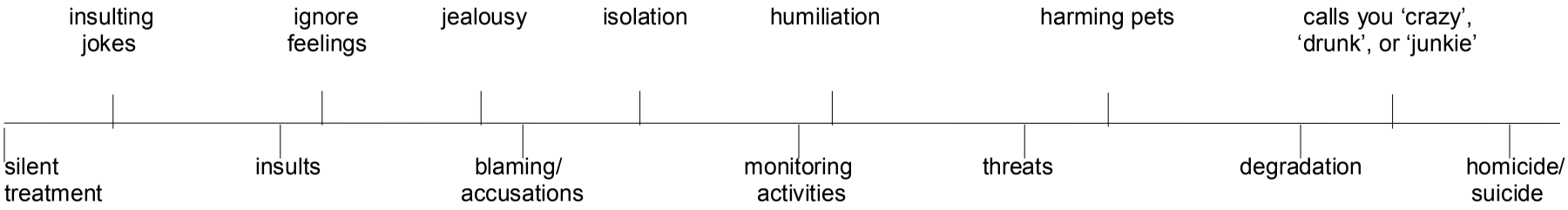
Definitions of sexual assault/sexual abuse and child sexual abuse, and some indicators, adapted from *By the numbers: Sexual violence statistics*, Illinois Coalition Against Sexual Assault, Springfield, IL, 2001. Indicators of sexual assault also adapted from *Types and signs of abuse,* Wisconsin Coalition Against Sexual Assault [On-line]. Available: http://danenet.wicip.org/dcccrsa/saissues/types.html.

Definition and warning signs of substance abuse or addiction adapted from *Diagnostic criteria from DSM-IV,* American Psychiatric Association, Washington, DC., 1994; and from the "The Definition of Alcoholism," American Society for Addiction Medicine [On-line]. Available: www.asam.org

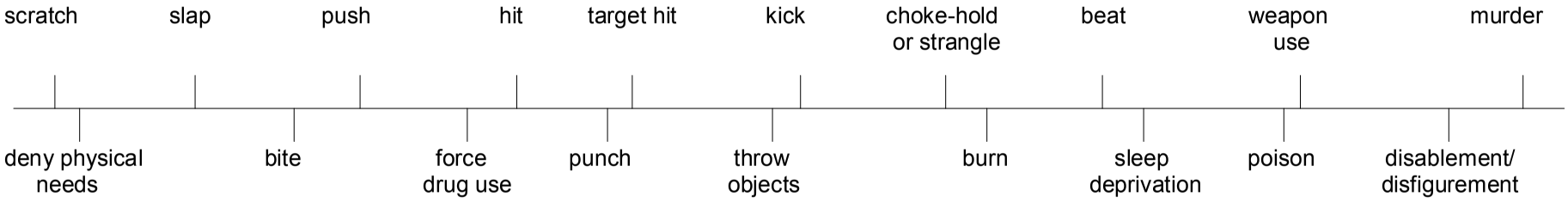
Manifestations of Violence

Abuse can occur in different forms. It can be physical, emotional, sexual, spiritual, social and/or economic. The lists below describe some of the tactics of abuse batterers use as they attempt to gain or maintain power and control over their intimate partners. Abuse does not always progress in regular steps as shown here. Sometimes the abuse may advance from pushing or hitting directly to more severe physical violence such as use of weapons. Although each relationship is unique, any type of abuse must be considered a serious cause for concern. Despite different circumstances, it is important to remember abuse can escalate (especially if intervention fails to occur). A coordinated community response holding batterers accountable for these abusive behaviors is essential as is a response acknowledging and respecting the rights of DV victims. **EXERCISE:** It is helpful for people to be aware of the tactics of domestic violence. Circle the type(s) of abuse you are now experiencing, (or have experienced in the past). Notice if the violence is increasing in intensity, severity or frequency. Talk to an advocate to develop or review your current safety plan or explore your options. Remember, domestic violence or sexual abuse directed at you is never your fault (*even if you were drinking or using drugs*).

Emotional Abuse

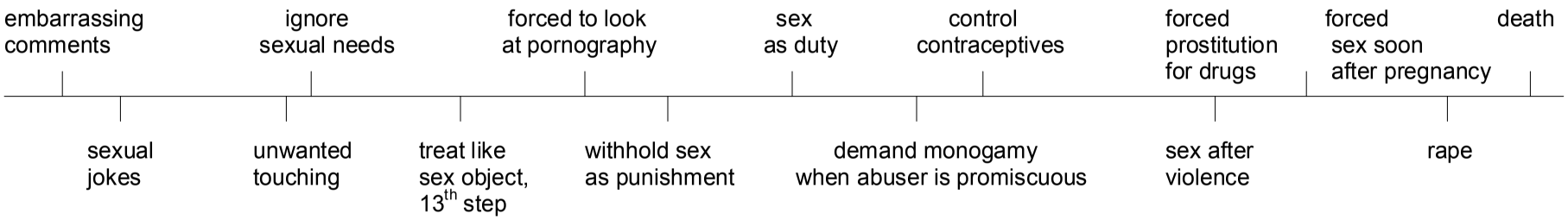


Physical Abuse

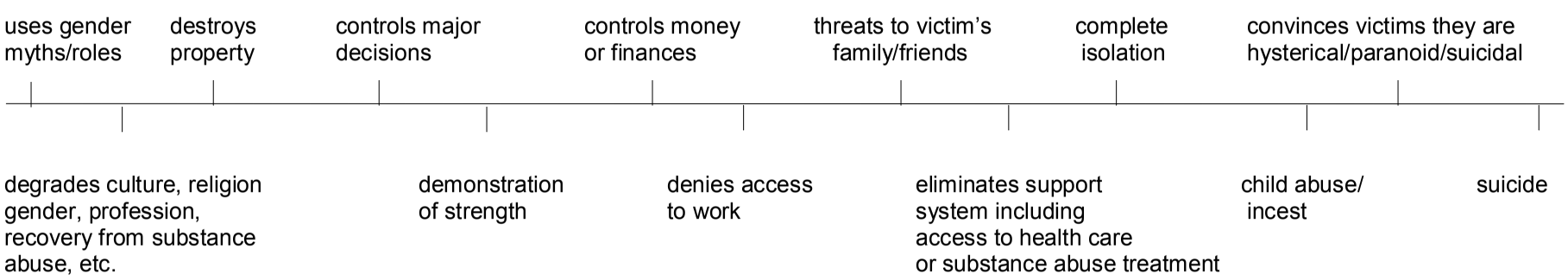


(Manifestations of Violence, continued)

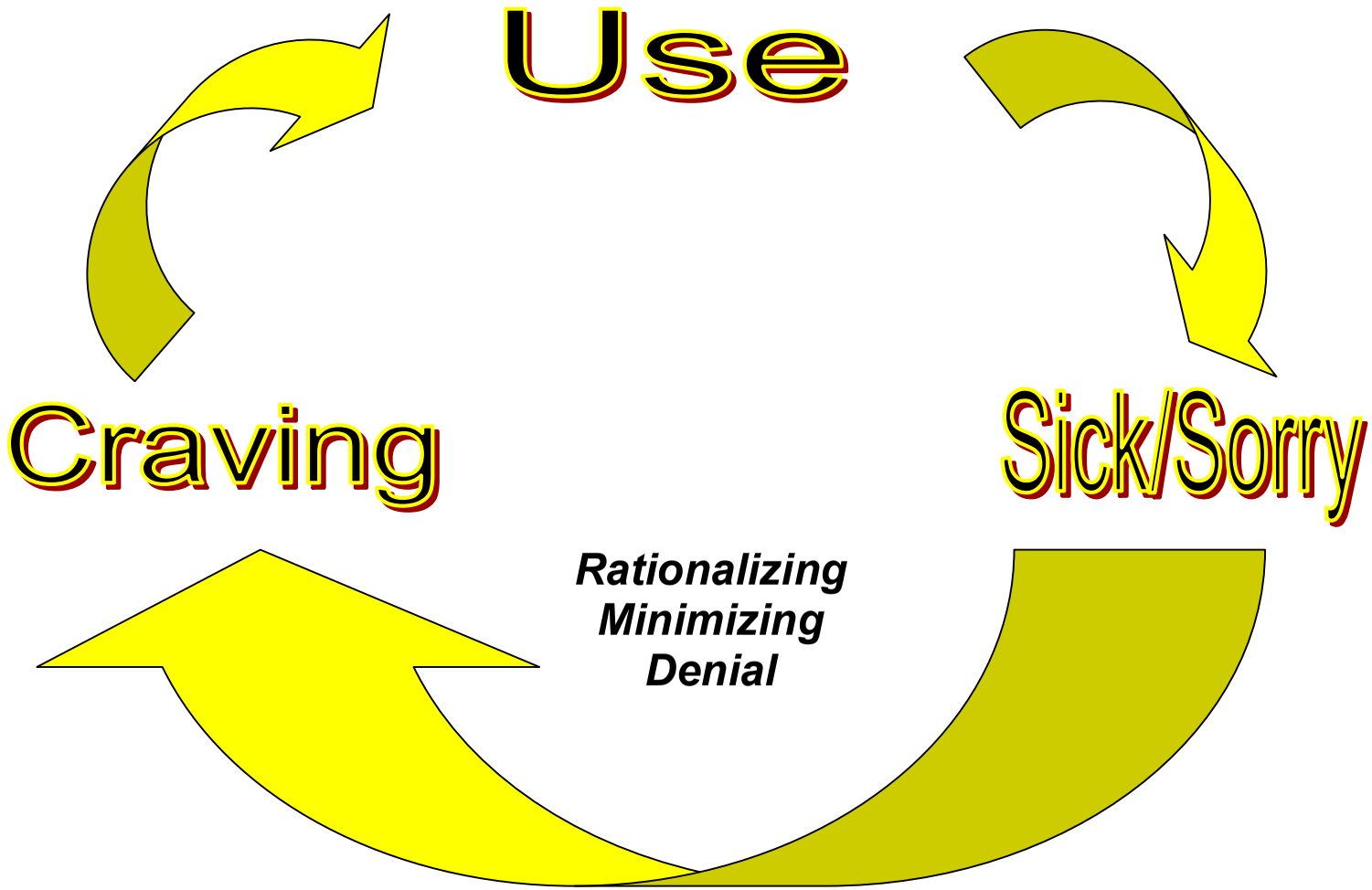
Sexual Abuse



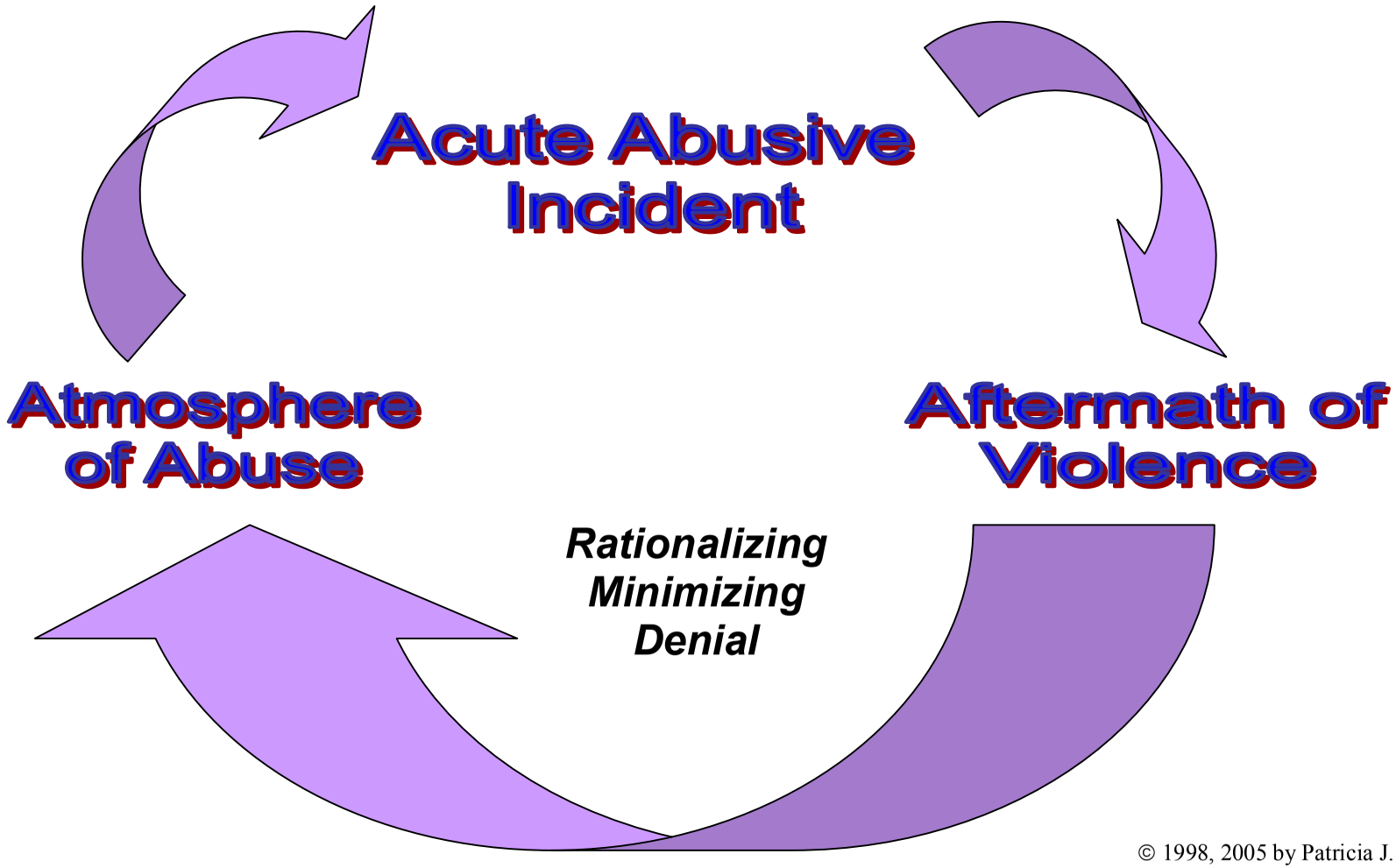
Social / Environmental Abuse



Merry-Go-Round of Addiction



Merry-Go-Round of Violence



Getting Safe and Sober: Real Tools You Can Use
Alaska Network on Domestic Violence And Sexual Assault

INSTRUCTIONS FOR MERRY-GO-ROUND EXERCISE

Group participants discuss both Merry-Go-Rounds and compare/contrast similarities and differences. Women in treatment use addiction diagram first; women in domestic violence programs use abuse diagram first.

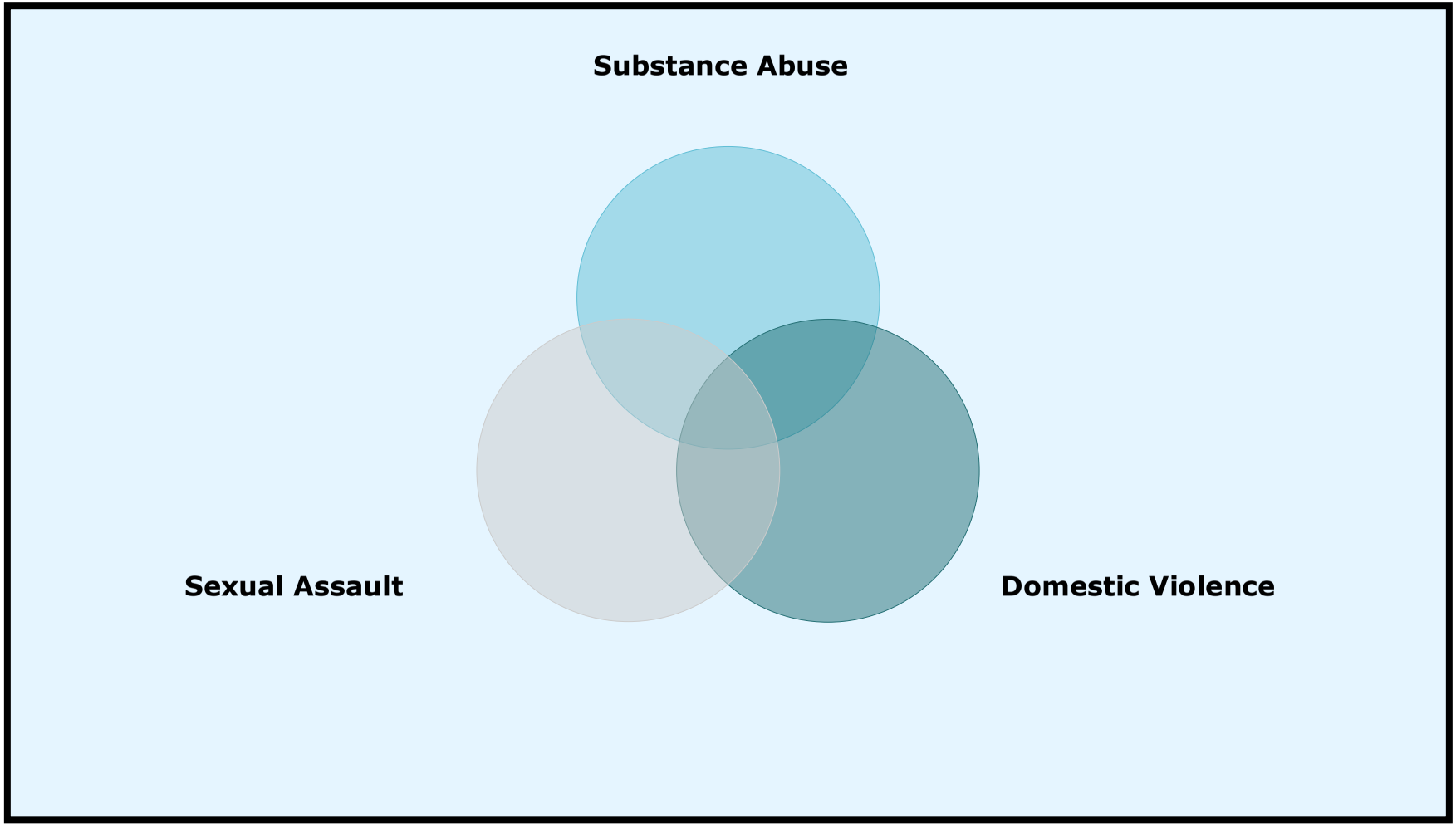
Merry-Go-Round of Addiction: *Provide Merry-Go-Round diagram to group participants and draw copy on white board or flip chart. Discuss Craving, Use and Sick and Sorry with group participants. Brainstorm group responses to the questions below and write answers down on the board. Discuss role rationalizing, minimizing and denial plays to keep the merry-go-round in motion. (When discussing "Use," it's okay to be brief, look for initial feeling and move on to 'Sick and Sorry' to avoid euphoric recall.)*

When I am craving:	**When I am using:**	**When I am sick and sorry:**
How do I feel emotionally?	How do I feel emotionally?	How do I feel emotionally?
What are my thoughts?		What are my thoughts?
What do I say?		What do I say?
How do I act?		How do I act?
What do I do?		What do I do?
Where am I spiritually?		Where am I spiritually?
Where am I economically?		Where am I economically?
Where am I socially?		Where am I socially?
Where am I sexually?		Where am I sexually?

Merry-Go-Round of Abuse: *Provide diagram to group participants and draw copy on board. Discuss Atmosphere of Abuse, Acute Episode and Aftermath with group. Brainstorm group responses to the questions below and record answers on the board. Discuss role rationalizing, minimizing and denial plays to keep the merry-go-round in motion. (When discussing "acute episode," it's okay to be brief. Graphic details may re-traumatize.)*

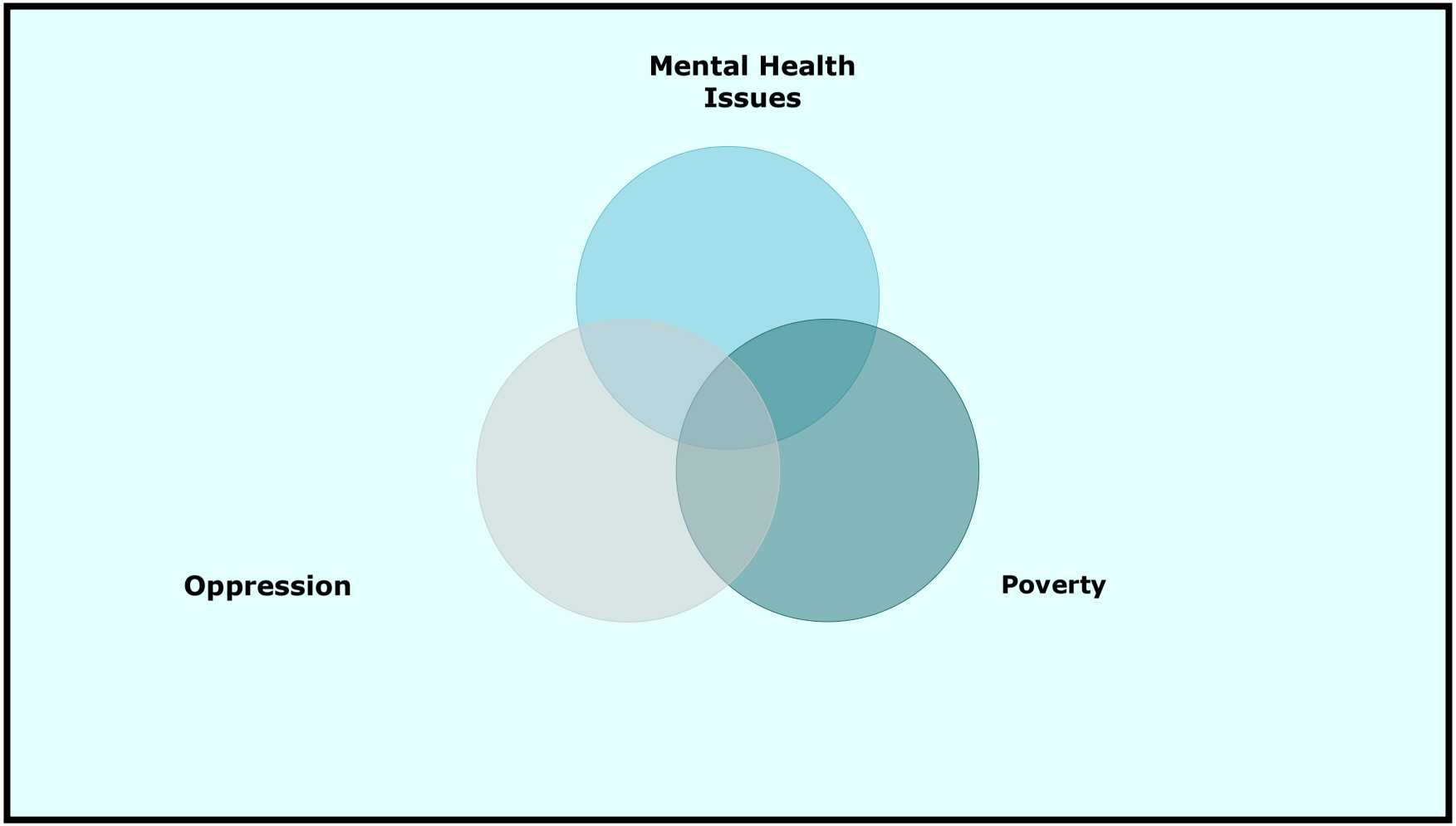
When I live in an atmosphere of abuse:	**When I experience an acute episode of abuse:** Note: Abuse is pervasive. Acute abusive incident may be physical, emotional, verbal, sexual, economic or any other form of harm, coercion or threat to gain or maintain power and control.	**When I live in the aftermath of violence:**
How do I feel emotionally?	How do I feel emotionally?	How do I feel emotionally?
What are my thoughts?		What are my thoughts?
What do I say?		What do I say?
How do I act?		How do I act?
What do I do?		What do I do?
Where am I spiritually?		Where am I spiritually?
Where am I economically?		Where am I economically?
Where am I socially?		Where am I socially?
Where am I sexually?		Where am I sexually?

1 + 1 = 10 Tons of Trouble



Getting Safe and Sober: Real Tools You Can Use
Alaska Network on Domestic Violence And Sexual Assault

Other Issues:
What Else Impacts Safety and Sobriety?



Getting Safe and Sober: Real Tools You Can Use
Alaska Network on Domestic Violence and Sexual Assault

10 Tons of Trouble Exercise

Provide each group member with copies of the handouts "1 + 1 = 10 Tons of Trouble" and "Other Issues: What Else Impacts Safety and Sobriety."

Using see-through plastic, draw and cut out a series of dinner plate sized plastic circles. Label each one with barriers and challenges individuals may face. Examples include substance abuse, sexual assault, domestic violence, poverty, homelessness, unemployment, mental health issues, oppression, etc. Leave a few circles blank for women to add their own challenges to.

Explain that these issues and challenges can seem like layers on an onion. As we look at one problem, many more are often revealed. Demonstrate how each problem compounds the other.

Have women identify which challenges they choose to 'peel back' or address first. Like peeling an onion, dealing with these challenges can cause tears.

Provide group members with additional circles. Ask the women to design circles of strength. Members can list the group itself, and add personal strengths, connections and supports that help them to survive and thrive.

Remind each woman that she possesses layers of strength, hope and connections to help her survive and thrive.

Getting Help

You can get support as you leave an abusive relationship, heal from sexual assault/sexual abuse, or recover from addiction. Here are some valuable resources in your community.

Domestic violence/sexual assault programs
Most domestic violence/sexual assault programs have a 24-hour hotline and provide emergency shelter. Services include counseling, safety planning and help getting an order of protection or appropriate medical attention. If you prosecute the offender, an advocate can go with you to court. If your experience happened in the past, you can still get counseling to help you heal from the abuse. Most programs also connect women with community services that help with housing, employment, therapy and other medical needs.

Name of agency _____ Phone: _____

Address: _____

Behavioral Health: Substance abuse and/or mental health providers
Most behavioral health providers offer counseling and education about addiction and mental health.You can learn skills for healthy recovery, and relapse prevention, and are connected with support groups in the community. Some programs offer gender-specific treatment, which is especially helpful for survivors of violence or abuse.

Name of agency _____ Phone: _____

Address: _____

Support groups
People recovering from alcohol or other drug addiction concerns can attend support groups such as Alcoholics Anonymous, Narcotics Anonymous and Women for Sobriety. Many communities have women-only groups, often a safer option for abuse survivors. Support groups for people with mental health concerns, eating disorders or other trauma-related issues are also available.

Name of group _____ Phone: _____

Address: _____

Name of group _____ Phone: _____

Address: _____

Other resources: _____

_____

_____

We Are Our Own Best Advocates:
Developing Our Own Resources

Advocates and other helping professionals are aware of many community resources which may prove helpful. Many, themselves, have had to rely on such support in the past. One evening the women at New Beginnings Wednesday Night Support Group realized they were experts on the systems they were using. Looking through a resource list provided by an advocate, a group member said, "That's out of date. You need to go here now. Another looking at the list said, "Oh, I would not go there, I would try this first."

The women began exchanging tips and making a list of, 'personal referrals.' The group decided to develop their own resource book and began by making a list of legal resources. One of the group asked for paper and pen. Another asked for a binder. Over time the binder grew and more meaningful resources were listed under different headings: Health Care, Recovery, Children's Services, Public Transportation, Affordable Mechanics, Counselors, Job Opportunities, Housing, Groceries, Law Enforcement, you name it.

The women not only listed the resources. They wrote what kind of response you could expect, who could help you if things got snagged, where to turn if a helper turned into a hindrance, tips to try if you met a roadblock, options, alternatives, who could be trusted, who and what could cause problems. They wrote it all in their own words. The book got bigger and bigger as more and more group member shared options. They said, "We are our own advocates now. And who better than us? We are out there every day and this is life or death for us."

One day the women decided they wanted to give their book a name. They narrowed their choices down to three names they liked and split the book into three sections, each reflecting an area of concern. The women decorated the cover of the book with artistic drawings, sparkles and seals and continued to add, edit and change referrals as needed. Many a New Beginnings Wednesday Night support group meeting began and ended with 'the Book.'

Today you and the women in this group are navigating helping systems now. You are experts on your own lives and your own experience. Who knows more about what you are facing than each of you? You can share your experience, strength and hope with each other and with those to come, by creating your own book, one resource at a time. Begin today by sharing one resource that has worked well for you or by asking for a referral from someone in this group who may know what it's really like to access the help you need. Tell each other what you are doing right and who can help when more options are needed. Remember, you are your own best advocates.

Getting Safe and Sober: Real Tools You Can Use, 2nd Edition – Revised 2008
Alaska Network on Domestic Violence and Sexual Assault

Sorting Out Messages

If you are recovering from an addiction, you may be seeing a substance abuse counselor. If you are dealing with violence or abuse, you may be seeing a women's advocate. If you are seeing a women's advocate *and* a substance abuse counselor, you may be getting confused! These are some of the messages you may be hearing:

Substance abuse counselor: You have a disease. You need treatment.
Women's advocate: You are a victim of a crime. You need justice.

Substance abuse counselor: Your priority must be sobriety.
Women's advocate: Our priority is your safety.

Substance abuse counselor: You must accept your powerlessness.
Women's advocate: You need to be empowered.

Substance abuse counselor: You need to look for your part in your problems.
Women's advocate: You are not responsible for what happened. The perpetrator must be held accountable.

Substance abuse counselor: You need to change yourself and be of service to others.
Women's advocate: We need to change society.

Can these statements all be true? One way to reconcile the messages is to understand that substance abuse and violence are different problems. When people talk about different problems, they may need different words and different approaches. Here are some examples.

Disease or criminal behavior?
Addiction is a disease. It is not a crime. People do not choose how their bodies will respond to alcohol or drugs. People with addictions deserve treatment and recovery. Violence is a crime. It is not a disease. Perpetrators choose to commit domestic violence, sexual assault and sexual abuse. Their victims deserve justice.

Safety first or sobriety first?
For "recovering survivors," both safety and sobriety must be priorities. Women's advocates have clients develop a safety plan. Substance abuse counselors have clients develop a recovery plan. You can make recovery part of your safety plan, and safety part of your recovery plan.

Powerlessness or empowerment?
You are powerless over the impact of chemicals on your body. You are powerless over another person's behavior. But you can choose to seek help getting safe and sober. When you make personal choices, you become empowered.

Who is responsible?
You are responsible for recovery from addiction. The perpetrator is responsible for violence. You are responsible for your own choices and your own behavior. You are not responsible for another person's choices or behavior.

Social change or service to others?
Service to others is one way to achieve social change. Working for social change can be a way to serve others. When people in 12-Step groups take a meeting to a jail or hospital, they serve others. They also create social change by making recovery available to more people. When abuse survivors make a T-shirt for the Clothesline Project, they help change public attitudes about violence. This serves other victims of violence.

Of course, sometimes the same approach *can* work for different problems. People with addictions often take a "one day at a time" approach to recovery. This approach can also work well for women leaving a violent relationship or healing from abuse. Both recovering women and abused women can benefit by getting support from others.

When sorting out messages from helping professionals, be creative. Give yourself permission to reconcile the messages in a way that works for you. The most important thing is that you be able to benefit from both kinds of services.

Some examples of the differing words and approaches used by women's advocates and substance abuse counselors are adapted from *Domestic Violence and Chemical Dependency: Different Languages,* developed by Theresa Zubretsky, New York State Office for the Prevention of Domestic Violence. Available: www.thesafetyzone.org/alcohol/language.html

SAFETY AND SOBRIETY: RISK FACTORS IN TRADITIONAL TREATMENT AND ADVOCACY PROGRAMS

There are many risks facing individuals who seek both safety and sobriety from traditional helping sources. The following is a list of five risks to safety in traditional treatment and five risks to sobriety in traditional advocacy programs.

Review these lists and brainstorm how to address these risks to safety and sobriety. Then share your experience, strength and hope by identifying other risk factors you have encountered. How have you dealt with these risks? Who are your allies?

RISKS TO SAFETY IN TRADITIONAL TREATMENT

1. Safety may not be linked to sobriety.

2. The batterer may be included as part of conjoint, couples or family counseling.

3. The batterer may sabotage treatment efforts (e.g. prevent partner from attending group, get partner to leave against medical advice, mislead counseling team, etc.).

4. Poor understanding of domestic violence by others may lead to re-victimization. An individual may be mislabeled as 'not having hit bottom yet,' 'codependent,' 'professional victim,' 'resistant to treatment' or abusive. It may be difficult for others to understand immediate danger from a partner may be more life threatening than alcohol and other drugs at times.

5. Recovery and improved health and cognitive functioning can make it harder for an abuser to control a partner. The abuser may increase physical or other forms of violence to re-establish control. (For example, an individual receiving a daily dose at a methadone program could be stalked and threatened by their abuser).

RISKS TO SOBRIETY IN TRADITIONAL ADVOCACY PROGRAMS

1. Sobriety may not be linked with safety.

2. The batterer's use of alcohol and other drugs to control a partner may not be acknowledged as a risk factor in a safety plan.

3. Poor understanding of physiology and pharmacology and focus on options and choices may lead to re-victimization. It may be difficult for others to understand the impact of blackouts, brownouts, withdrawal, craving, etc., on program participants *and* their capacity to remember and utilize safety plans. Risks stemming from substances may be more life threatening than an abusive partner at times.

4. Others may not perceive the recovering person's need for structure as empowering. Easy access to night-time medications, alcohol-containing mouthwashes or cold preparations with pseudoephedrine may be a relapse issue.

5. Strict policies against use may make program participants feel unsafe to disclose recovery status for fear of being over-scrutinized. This can make it hard to ask for help for oneself or to disclose when another program participant is using substances.

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Skit: She Has All Kinds of Troubles

Cast: Program Participant, 4 Helping Professionals (Advocate, Substance Abuse Counselor, Social Worker and Mental Health Professional) and 1-4 Volunteers to tape labels on the Program Participant as they are mentioned by the Helping Professionals. The group facilitator or a group member can moderate a discussion following the skit.

Props: 4 chairs up front for Helping Professionals. Sun glasses for Program Participant to wear. Masking tape Labels for Volunteer to tape to Program Participant. Make Labels on 8x10 sheets of paper. Laminate them if you want to re-use them. Labels Needed: Battered Woman, IV Drug User, Homeless, Borderline, Denial, Needs DV Education, Needs Housing, Defensive, In Withdrawal, Head Lice and Scabies, Not Clean-Needs Shower, Wants Meds, Paranoid, Owes Money, Has warrants, Stalking Victim, Crisis Junky, Co-dependent, Victim, Relationship Addict, Chemically Dependent, Crime Victim, Mentally Ill, Chronically Homeless, Powerless, Must Hold Batterer Accountable, To Blame for Her Part, Needs to Change, Hasn't Hit Bottom Yet, Get Sober, Get Safe, Get Well, You'll never change, You'll be back….

A/V Needs: If the group is large or the women's voices are soft, you may want to use a cordless or hand held microphone for the Program Participant and also for the Helping Professionals.

Scene: A "Program Participant" puts on a pair of sunglasses and a large, long-sleeved shirt and stands in front of a row of 4 "Helping Professionals, seated in chairs." While the "Helping Professionals" are speaking, "Volunteer" tapes labels on the "Participant to match the labeling language. Advise the Volunteer not to worry if she gets out of sequence.

Skit Script:

Women's Advocate: Why is this woman wearing sunglasses?

Substance Abuse Counselor: Why is she wearing long sleeves in the middle of summer?

All Helping Professionals (in unison): Hmmmmmmmmm.

Women's Advocate: Maybe she has a black eye …and bruises on her arms. I wonder if she's being battered.

Substance Abuse Counselor: Maybe she's wearing sunglasses to hide her pupils. And long sleeves to hide needle tracks on her arms. I'll bet she's an IV drug user.

Social Worker: Maybe she's wearing everything she owns so she doesn't have to carry it around with her. She could be homeless.

Mental Health Professional: She could be trying to attract attention to herself by dressing in an unusual manner. Attention seeking behavior is a classic symptom of borderline personality disorder.

Participant: To tell you the truth, I'm not really sure why I'm here.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: Sounds like denial to me. Drug addicts are chock full of denial, you know.

Women's Advocate: Sounds like she lacks awareness of abuse issues. I think she needs some domestic violence education.

Social Worker: Sounds like she lacks awareness of the community resources that are available to her. We need to talk with her about housing options.

Mental Health Professional: She sounds defensive. You know how touchy borderlines can be.

Participant: [Scratches herself.]

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: I think she's got coke bugs. She's in withdrawal.

Women's Advocate: Oh no! I hope it's not head lice or scabies again. We had that at the shelter last week.

Social Worker: She could just need to take a shower and wash her hair. A homeless person might not have access to facilities where she can do this.

Mental Health Professional: She's going to be asking for some kind of medication. These borderlines are in our office every five minutes wanting something.

Participant: I'm afraid to go anywhere. I know I'm being watched. I've been seeing the same car everywhere.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: Could be drug-induced paranoia. She must owe money to her dealer. Or maybe she has a warrant out for her arrest.

Social Worker: Maybe she's afraid of getting arrested for vagrancy.

Women's Advocate: I think she's being stalked. We need to help her get an order of protection.

Mental Health Professional: But you know, borderlines love a good crisis. It helps them feel more alive.

Participant: My partner won't let me go to group sessions.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: She's co-dependent, for sure.

Women's Advocate: This is classic batterer behavior. We mustn't blame the victim.

Mental Health Professional: Borderlines always have to be in a relationship, even if it's abusive.

Social Worker: She might not like filling out the forms. They always ask for an address.

Participant: Okay, I know I need some kind of help. My life is one crisis after another.

All Helping Professionals (in unison): Hmmmmmmmm.

Substance Abuse Counselor: You have the disease of chemical dependency. You need treatment, and some 12 Step meetings.

Women's Advocate: You are the victim of a crime. You need justice. And some education about the dynamics of abuse.

Social Worker: You lack adequate housing. You need some referrals.

Mental Health Professional: You have a mental illness known as borderline personality disorder. You need therapy. And perhaps some medication.

Participant: Since I seem to have all these problems, where on earth do I start?

All Helping Professionals (in unison): Hmmmmmmmm.

Substance abuse counselor: Your priority must be sobriety.

Women's advocate: Our priority is your safety.

Substance abuse counselor: You must accept your powerlessness.

Women's advocate: You need to be empowered.

Substance abuse counselor: You need to look for your part in your problems.

Women's advocate: You are not responsible for what happened. The perpetrator must be held accountable.

Substance abuse counselor: You need to change yourself.

Women's advocate: We need to change society.

Participant: You people are driving me crazy. I'm out of here!

All Helping Professionals (in unison): Hmmmmmmmm.

Substance Abuse Counselor: She hasn't hit bottom yet. Relapse is part of the recovery process for people with chemical dependency issues.

Women's Advocate: It takes a battered woman an average of 7 tries before she gets out of an abusive relationship.

Social Worker: She'll be back when the weather starts getting cold.

Mental Health Professional: She'll be back when she has another crisis. Got a stop watch?

Substance Abuse Counselor: She'll be back.

Women's Advocate: Yes, she'll be back.

Social Worker: Uh huh. She'll be back.

All Helping Professionals (in unison): She'll be ba-a-a-ck …

Post Skit Discussion Questions
The following are sample discussion questions for the facilitator to ask the group to consider:

Can anyone relate to what you just saw?
What stood out for you the most?
What other labels might someone be burdened with?
What feelings did this bring up?
How can providers make sure Program Participants are not revictimized when they seek help?
What does respectful advocacy or treatment look like?
How should the Program Participant have been treated?
What steps can be taken to ensure needs are met?

Skit adapted from model developed by King County Coalition Against Domestic Violence Interdisciplinary Training Planning Committee, 2000.

Trust Isn't Always Easy

A woman who has been traumatized may have trouble trusting others, even people who appear to have good intentions. She also may not trust social service providers or other authority figures for a variety of reasons:

- *Negative past experiences.* She may have experienced important people in her life who treated her in ways that felt confusing or disrespectful.

- *Fear of authority figures.* She may have encountered authority figures who abused their power, discounted her or blamed her for her problems instead of helping her.

- *Fear of legal sanctions.* She may fear prosecution if she discloses illegal behavior such as drug use, theft or prostitution. If she has been incarcerated, she may fear going back to jail or prison.

- *Fear of being judged*. She may have heard repeatedly that her problems are caused by her own behavior, lack of personal responsibility, inappropriate decisions or bad character traits.

- *Fear of being discounted.* She may have a history of not being believed when she is telling the truth, especially if she is a survivor of violence, or coping with mental illness, substance abuse or addiction.

- *Fear of encountering stereotypes.* She may have encountered people who avoided or excluded her because of her race, culture, socioeconomic background, mental health status, etc.

- *Fear of losing her children.* She may fear that disclosure of parental substance abuse, domestic violence or illegal activities will trigger an investigation by a child welfare agency. If she has a mental health issue, she may fear being judged incompetent to provide adequate parenting.

- *Fear of being denied services.* She may fear being barred from a residential facility, denied public assistance or disqualified from other benefits if she discloses issues such as substance abuse, mental illness, prostitution or past incarceration. A participant who receives public aid may fear losing benefits if she discloses that she is living with a partner.

- *Fear of losing autonomous decision-making power.* People who think they know a women's needs better than she does may try to impose their own solutions and values on her.

- *Fear of reprisals.* She may fear retaliation from the perpetrator if she reports sexual assault to the police, seeks an order of protection against a violent partner, or reports any kind of abusive behavior directed toward her in an institutional setting.
- *Fear of being scapegoated.* She may fear being accused of things she didn't do. For example, if she discloses a history of substance abuse or incarceration, she may be the prime suspect if something turns up missing.

Safety at Support Group Meetings

Support groups can serve as a valuable supplement to counseling or advocacy. Much of the power in these groups comes from the personal stories. People share their experience, strength and hope with each other. When one person breaks the silence about her experiences, others feel safer breaking *their* silence. You also hear success stories. You hear what others are doing to cope with problems similar to yours.

Some initial discomfort is normal if you're new to support groups. It is natural to feel nervous in a roomful of strangers. You may have spent years avoiding the issues the group is discussing. If your experience includes violence or abuse, you also may have safety concerns. Here are some tips to help you feel comfortable — and stay safe:

• ***Protect your safety.*** Most people in support groups respect confidentiality (anonymity). However, if you are leaving an abuser, don't share information that could put your safety at risk. Do carry your cell phone with you to 12 Step meetings if you have one. Tell your sponsor or someone else at the meeting what is going on.

• ***Find a home group.*** This is a group you attend regularly. You get to know other "regulars" and feel more comfortable talking at meetings. Some 12 Step veterans have two or three home groups. If you need to avoid being predictable to an abuser, have a back-up home group. Alternate between one meeting and the other one.

• ***Shop around.*** You will probably notice that each support group has a distinct personality, depending on who attends. Larger communities may have dozens of groups holding meetings in a given week. Sample several. Some abused women may feel more comfortable in small, intimate groups.

• ***Recognize the group's limitations.*** Support group meetings are not meant to be a substitute for professional help. Use sessions with a counselor or advocate for issues that are beyond the group's scope.

• ***Respect your own boundaries.*** Some people may try to sexually exploit others in the group. 12-Steppers call this practice "13th Stepping," and most consider such behavior unethical. You don't have to tolerate it! Also, don't feel compelled to talk about painful abuse issues in groups if this makes you uncomfortable.

• ***Try women-only groups.*** Survivors of domestic violence or sexual abuse may have difficulty setting healthy boundaries, especially with men. Many report that women's meetings feel safer than meetings where both men and women are present.

As a "recovering survivor," what if you feel the need to talk about the "other issue?" You can honor your own needs while respecting the group's primary purpose. Explain how sobriety, safety and healing are linked for you. Discuss how violence or past abuse issues make it harder for you to stay clean and sober. Discuss how relapse would make it harder for you to stay safe or heal from violence. Share how you've made safety part of your recovery plan, and recovery part of your safety plan.

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Etiquette in Groups

No doubt about it, early recovery can be a stressful time. The same goes for the early days when we're freeing ourselves from an abusive relationship or healing from past trauma. Our relationships with others — whether in support groups, a rehab program, a shelter, or any close living quarters — can either be a source of support or a source of additional stress. We can make things easier on both ourselves and others if we observe a few basic courtesies:

- Focus on our own issues. We avoid taking the "inventory" of others in the group or telling them what to do.

- Remember why we're here. In-house group sessions and community support group meetings are not a place to vent about a personal conflict with another individual in the group. We need to focus on our own recovery and safety — "principles before personalities."

- Respect other people's experiences. When someone is sharing, we focus on what we can identify with or agree with, rather than focusing on our differences. "Identify, don't compare."

- Respect other people's ideas and beliefs. We have a right to our own religious beliefs, political views and philosophies. We do not have a right to force these beliefs and ideas on others, nor do others have a right to force their views on us.

- Avoid letting another person's behavior affect our progress. If someone else wants to have a Bad Attitude Day, we can resolve to let their attitudes be "their stuff" and understand that they may be experiencing a great deal of stress.

- Welcome newcomers. We can remember how we felt when we attended our first meeting or group session, or first came into a new program.

- Help other people feel like they "belong," rather than finding reasons to exclude them. We may remember how we felt about those snotty junior high school cliques that seemed to exclude us. We avoid inflicting this kind of pain on others.

- No 13th Stepping! (For people in 12 Step groups, 13th Stepping is the practice of using meetings to initiate romantic relationships with someone else in the group.) Meetings and group sessions are not a dating service, and "hitting on" people is not fair to those who are attending groups to work on their issues. This applies whether we are a woman or a man, gay or straight. (Note: If you are the target of a 13th Stepper, keep in mind that healthy 12 Step groups consider this behavior unethical. Feel free to speak up about it. You do not have to put up with it.)

- Avoid gossip. Avoid gossip. Avoid gossip.

- Be considerate of the needs and feelings of others in the group. The Golden Rule applies here. If we treat others the way we want to be treated, we can go a long way toward avoiding needless conflict.

Using 12 Step Groups

People recovering from alcoholism or other addictions often participate in 12 Step groups such as Alcoholics Anonymous or Narcotics Anonymous. Many find these groups a helpful source of support. A.A.'s 12 Steps, which appear on pages 59-60 of *Alcoholics Anonymous (4th Edition),* have been adapted for use in a variety of 12-Step groups. If you have experienced violence or abuse, here are some ideas to consider while "working the Steps." As they say in 12 Step groups, take what you need and leave the rest.

Step One: We admitted that we were powerless over alcohol [or other addiction] — that our lives had become unmanageable.

When 12 Step groups discuss powerlessness, it may be helpful to explore how power is defined. Some people view power as the ability to control other people, places and things. "The program" asks you to let go of attempts to have this kind of power.

However, power can also be defined as the ability to make choices and act on them. For example, you cannot control the impact of chemicals on your body. But you can choose to seek treatment for an addiction. If you are in an abusive relationship, you cannot control your partner's behavior. But you can choose to seek help getting safe.

This step encourages you to break through denial and acknowledge that you are out of control with alcohol or another addiction. Before you can do something about a problem, you must acknowledge that the problem exists.

Step Two: Came to believe that a power greater than ourselves could restore us to sanity.

Some women feel more comfortable with feminine or gender-neutral images of God or "higher power." This may be especially true for women who have been abused by a male parent or partner. Remember that 12 Step groups encourage you to interpret "higher power" in whatever way feels right for you. A.A. literature says, "When we speak of God, we mean your own conception of God."[1] In fact, "You can, if you wish, make A.A. itself your 'higher power.' Here's a very large group of people who have solved their alcohol problem."[2]

This step encourages you to feel hope. There is a way out of your problems. Help is available. Recovery and healing are possible.

Step Three: Made a decision to turn our will and our lives over to the care of God as we understood Him.

For some women, turning over our will to someone else may sound like a demand from an abuser. It may be helpful to remember that there is a difference between turning one's will over to a deity (if that is what your religious or spiritual tradition teaches), and being asked to turn your will over to another human being.

It may also be helpful to think of "turning it over" as "letting go," and willingness as being open to new ideas. Giving up an addiction (or a relationship) can feel pretty scary. You are letting go of something familiar without knowing what will replace it. The good news is you don't have to do this alone.

This step encourages you to break your isolation by seeking help and accepting the support that is offered.

Step Four: Made a searching and fearless moral inventory of ourselves.

Keep in mind that Step Four is not an "immoral inventory." A.A. literature points out that "assets can be noted with liabilities."[3] Listing your strengths can be especially helpful if your self-esteem has been battered by abuse.

A.A. literature suggests that you "consider carefully all personal relationships which bring continuous or recurring trouble. Appraising each situation fairly, can I see where I have been at fault? … And if the actions of others are part of the cause, what can I do about that?"[4] When looking at relationships, remember that you are not responsible for violence or abuse committed against you. However, exploring the impact abuse has had on your life can strengthen your resolve to break free of the abuse and heal from it.

This step encourages you to take a realistic look at your life. This allows you to discover your strengths and limitations, and identify your needs.

Step Five: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

When you choose someone to hear your Fifth Step, A.A. literature cautions you to "take much care."[5] This care is especially important if you are a survivor of domestic violence, sexual assault or sexual abuse. Survivors may want to share this part of their experience with a qualified therapist or advocate. This person should understand that responsibility for violence belongs with the perpetrator.

This step encourages you to share your past with someone you trust. This can help you let go of the shame that comes with thinking you must keep parts of your life secret.

Step Six: Were entirely ready to have God remove these defects of character.

Nobody is perfect, so self-improvement is a worthy goal for everyone. But A.A. literature cautions you to "avoid extreme judgments" and "not exaggerate" your defects.[6] This precaution is especially important for abused women. An abuser may have whittled away at your self-esteem by encouraging you to feel defective. A person who wants to control you is not the best judge of your character!

A.A. literature also reminds you to distinguish between societal expectations and your own values. For example, when the subject is sex, "we find human opinions running to extremes — absurd extremes, perhaps."[7] This can certainly be said about the messages our society directs toward women. Women also get mixed messages about everything from their roles to how they should look or act. Step Six can be a good place to examine what your own values are.

This step encourages you to prepare for change in your usual patterns of behavior. What behaviors do you want to let go of? What patterns do you want to stop repeating?

Step Seven: Humbly asked Him to remove our shortcomings.

A.A. literature says humility is "a word often misunderstood. … It amounts to a clear recognition of what and who we really are, followed by a sincere attempt to become what we could be."[8] We should "be sensible, tactful, considerate and humble without being servile or scraping."[9] And, "we stand on our feet; we don't crawl before anyone."[9] Humility does *not* mean seeing yourself as less important than others.

This step encourages you to begin letting go of the unhealthy patterns you identified in Step Six. If some of these patterns stem from your experience of violence or abuse, you may want to seek professional help from a person trained to work with abuse survivors.

Step Eight: Made a list of all persons we had harmed and became willing to make amends to them all.

People in recovery need to acknowledge how their drinking or drug use affected others. But recovery groups remind you to make amends to yourself as well. One such amend might be to stop blaming yourself for domestic violence, sexual assault or other abuse. You are only responsible for your own behavior, not someone else's.

This step encourages you to identify what needs changing in your relationships with others. "Making amends" does *not* mean you must reconcile with an abuser. "Amend" simply means "to change or modify for the better."[10] With an abusive relationship, this may well mean ending it. According to the A.A. literature, "If there be divorce or separation, there should be no undue haste for the couple to get together. … Sometimes it is to the best interests of all concerned that a couple remain apart."[11]

Step Nine: Made direct amends to such people wherever possible, except when to do so would injure them or others.

If you have left an abusive relationship, it may be best to avoid your partner. This is true even if you believe you did something "wrong." A.A. literature does not say you must contact everyone on your amends list. In some cases, "by the very nature of the situation, we shall never be able to make direct personal contact at all." [12] If "making amends" to an abuser would put you or your children in danger, stay away!

Children often blame themselves for their parents' problems. So this can be a good time to talk with your children about incidents they have witnessed. Explain that they are not responsible for your alcohol or drug use. Nor are they responsible for an abuser's behavior toward you or them.

This step encourages you to settle with the past. "When this is done, we are really able to leave it behind us." [13]

Step Ten: Continued to take personal inventory and when we were wrong promptly admitted it.

When doing an inventory, remember to focus on strengths as well as weaknesses. A.A. literature points out that "inventory-taking is not always done in red ink. It's a poor day indeed when we haven't done something right." [14] This step encourages you to maintain the progress you have made in previous steps. Give yourself credit for things well done!

Step Eleven: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

This step encourages you to develop emotional balance. For you, this could mean prayer and meditation. It could mean keeping a journal or taking daily walks. It could mean calling a friend to help you sort out your feelings. Do whatever helps you feel centered and at peace with yourself.

Step Twelve: Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics [or other addicts], and to practice these principles in all our affairs.

A.A. literature says "helping others is the foundation stone of your recovery."[15] You can do this by sharing your experience, strength and hope with other people like you. When you take back your life from addiction (or abuse), you carry a powerful message!

Many recovering alcoholics and addicts believe carrying their message to others helps them stay clean and sober. Many survivors of violence find that working for social change aids their own healing process. People may call their efforts *working for change, service to others* or *carrying the message*. This step encourages you to discover what you have to offer others, and to pass it on!

Please note: *The opinions expressed in this article are the author's only. The author makes no claim to speak for Alcoholics Anonymous or any other 12-Step group.*

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[1] *Alcoholics Anonymous,* 4th Edition, Alcoholics Anonymous World Services, New York, 2001, p. 47
[2] *Twelve Steps and Twelve Traditions,* Alcoholics Anonymous World Services, New York, 1981, p. 27
[3] *Twelve Steps and Twelve Traditions,* p. 52
[4] *Twelve Steps and Twelve Traditions,* p. 6
[5] *Twelve Steps and Twelve Traditions,* p. 61
[6] *Twelve Steps and Twelve Traditions,* p. 82
[7] *Alcoholics Anonymous,* p. 68
[8] *Twelve Steps and Twelve Traditions,* p. 58
[9] *Alcoholics Anonymous,* p. 83
[10] *Webster's Ninth New Collegiate Dictionary,* Merriam-Webster Inc., Springfield, MA, 1989
[11] *Alcoholics Anonymous,* p. 99
[12] *Twelve Steps and Twelve Traditions,* p. 83
[13] *Twelve Steps and Twelve Traditions,* p. 89
[14] *Twelve Steps and Twelve Traditions,* p. 93
[15] *Alcoholics Anonymous,* p. 97

Alternative support groups

The following support groups provide options for recovering people who do not feel comfortable with 12 Step groups. Their main limitation is that "face-to-face" meetings tend to be available only in large metropolitan areas. However, all have Web sites and on-line meetings.

16 Steps of Discovery and Empowerment. Developed by Charlotte Kasl, Ph.D., alternative wording and alternative ways of interpreting the 12 Steps are featured in her book *Many Roads, One Journey: Moving Beyond the 12 Steps.* Her 16-step empowerment model brings a flexible, socially conscious approach to recovery and seeks to build self-esteem and empower people to find their own voice. Her version of the Steps encourages addicts and people with dependency issues to examine beliefs, addictions and dependent behavior in the context of living in a hierarchical, patriarchal culture. Dr. Kasl also suggests the "Internalized Oppression" concept vs. the term codependency. Web site: www.charlottekasl.com. E-mail: ckasl@charlottekasl.com or use the e-mail link at her Web site for information about on-line support groups. Address: Many Roads One Journey, Inc., P. O. Box 1302, Lolo, Montana 59847. Fax: 406-273-0111.

Women For Sobriety. WFS was founded with the belief that women alcoholics require a different kind of program in recovery than male alcoholics. The WFS "New Life" program is based on a Thirteen Statement Program designed to assist a woman in addressing her alcoholism and lifestyle by encouraging her emotional and spiritual growth. On-line chat groups can be accessed from their Web site: www.womenforsobriety.org. Address: Women For Sobriety, Inc., P.O. Box 618, Quakertown, PA 18951-0618. Phone: 215-536-8026. E-mail: NewLife@nni.com.

White Bison, Inc. Go to this nonprofit American Indian organization's Web Site for information about the Wellbriety Movement. Wellbriety is sobriety and wellness combined. The Movement encourages American Indian and Alaska Native communities to find sobriety and recovery from alcohol and drugs, then go on to live lives of wellness and wholeness rooted both in their own tribal cultures and in the mainstream world. Some blend Alcoholics Anonymous principles with their own cultural traditions. On-line Talking Circles are available at the White Bison Web site: www.whitebison.org. Contact: White Bison, Inc., 6145 Lehman Drive, Suite 200, Colorado Springs, CO 80918. Email: info@whitebison.org. Phone: 719/548-1000. Fax: 719/548-9407.

Secular Organizations for Sobriety (Save Our Selves). SOS takes a secular approach to recovery and maintains that sobriety is a separate issue from all else. This abstinence-based organization encourages the use of the scientific method to understand alcoholism and other addictions. An on-line group, SOS Women, discusses "issues that affect a woman's goal of sobriety and healthy living." Web site: www.sossobriety.org. Address: SOS Clearinghouse, 4773 Hollywood Blvd., Hollywood CA, 90027. Phone: 323-666-4295. E-mail: SOS@CFIWest.org. SOS Women Web site: http://health.groups.yahoo.com/group/SOSWomen.

SMART Recovery. SMART Recovery (Self Management And Recovery Training) has a secular focus and helps individuals gain independence from addictive behaviors through a four-point program that includes enhancing and maintaining motivation to abstain, coping with urges, problem solving (managing thoughts, feelings and behaviors), and lifestyle balance (balancing momentary and enduring satisfactions). On-line meetings can be accessed from their Web site: www.smartrecovery.org. Address: SMART Recovery, 7537 Mentor Ave., Suite 306, Mentor, OH 44060. Phone: 440-951-5357. Toll free phone: 866-951-5357. E-mail: Srmail1@aol.com.

Safety Plan

A safety plan is unique for each individual and may need to be revised as your situation changes. A safety plan is a tool. Below are suggestions others have found helpful. You are the best expert on your own situation. Some suggestions here may be useful for you while others may not meet your needs. Feel free to add your own ideas. Take what you like and leave the rest!

The following steps will help you to prepare in advance for the possibility of future violence and will help keep you safer. Although you are not responsible for, nor do you have control over an abuser's violence, you do have a choice about how to respond to the abuser, and how best to get yourself (and your children) to safety.

Staff will support you in the decisions that you make for your life. Your physical safety will always be a priority for us. Hopefully, one or more of the following steps will help you in safety planning.

STEP 1: Safety During a Violent Incident

- If I feel the abuser is about to be violent, I will try to move to the _____. (*Try to avoid the bathroom, garage, kitchen, places near weapons or rooms without access to the front door.)*
- If it's not safe to stay, I will _____

  (Practice how to get out safely. What doors, windows, elevators or stairwells will you use?)
- I will keep my bag ready and keep it _____ in order to leave quickly.
- I will tell _____ about the violence and ask them to call the police if they hear suspicious noises coming from my home.
- I will use _____ as my code word/phrase with my children or my friends so they can call for help.
- If I leave my home, I will go to_____ *(Keep a list of emergency numbers in your purse or wallet.)*
- I will remember that if I call 911 and leave the phone off the hook, the domestic violence incident will be tape-recorded and an officer should respond to the scene.
- Remember, you know your abusive partner best. You know how to protect yourself and your children better than anyone else.

STEP 2: Safety When Preparing to Leave

- I will leave money and an extra set of keys with _____ so I can leave quickly.

- If I own a car I will try to make sure that I keep a set of car keys with _____ and adequate gas in the car.
- I will open my own bank account by _____(date) to increase my independence.
- I can also begin to _____ as a way of increasing my safety and independence.
- I will memorize the 24-hour crisis line of the agency closest to me. That number is _____. I will keep the number in my wallet along with a quarter (if possible).
- I will check with _____ and _____ to see if I could stay with them in an emergency *(It is best if the abuser does not know them or where they live.)*
- I will review and update my safety plan.

STEP 3: Safety in My Own Home

- I will find a safe place to keep this plan.
- If my abuser has recently left, I will change the locks on my doors and secure locks on my windows as soon as possible.
- I will tell school and/or child care who has permission to pick up my children.
- I will tell my neighbors if my abusive partner no longer lives with me and ask them to call 911 if he/she is seen near my home.

If there are weapons (guns, knives, etc.) in my house, I will try to remember:

- to make sure that the gun remains unloaded at all times (I will only unload the gun myself if I know how to do so safely!!!)

- to encourage my partner to get rid of the gun if it is safe for me to do so.

- to stay out of rooms where weapons are kept, especially during an explosive situation.

- to move the knives out of their usual location so that my partner will have trouble finding a knife quickly.

- that almost anything can be used as a weapon.

- that cleaning a gun or knife in front of me is a threat and may imply that my partner is capable of taking my life or hurting my children.

STEP 4: Safety With a Protective Order (or other court order)

- I will keep an emergency copy _____.

- My children's teachers and baby-sitters will have copies of the order.
- If my partner violates the order I will call the police.
- If the police are not responsive I will _____.
- I will tell _____ that I have a valid Protective Order.
- Remember that in the State of Alaska, if your partner assaults you when you have a valid Protective Order, your partner can be charged with a crime.

STEP 5: Safety on the Job and in Public

- I will inform _____ at work of my situation, if I feel safe with this person. I will ask _____ to help screen my calls at work.
- When leaving work, I will _____ to help keep myself safe.
- If problems occur while I am driving home, I will _____.
- If I ride the bus and see my abuser, I will _____.

STEP 6: Safety and My Emotional Health

- When I have to talk to my (ex) partner, I will _____ to keep myself safe and take care of myself.
- I will read _____ .
- I will call _____ for support.
- I will call my local crisis line or other support system if I need immediate help. That number is _____.
- I know that community support groups are available to help me take care of myself.

STEP 7: Safety and Sobriety

- I will remember it is easier to keep safe when I am sober.
- I know that alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services.
- I will call my local DV/SA advocate or the National Domestic Violence Hotline 1-800-799-7233 or the Rape Abuse Incest National Network (RAINN) 1-800-656-4673 when I need information, referrals or support.
- I will call a sober friend, sponsor, alcohol/drug counselor or the Alcohol Drug 24 Hour Help Line for support when I feel like drinking or drugging to cope. The number is 1-800-562-1240 *(in WA and AK only)* or 1-206-722-3700 *(in Washington).*

This safety plan is adapted from New Beginnings and Providence Health System safety plans.

PERSONAL SAFETY NOTES:

_____
_____
_____
_____
_____
_____
_____

Mini-Safety/Sobriety Plan

You are not alone.

Remember that safety, sobriety and wellness plans will change as your situation does. Each day can bring new challenges as well as rewards. Know your resources and develop safety and survival strategies.

Components of Mini-Safety/Sobriety/Wellness Plan:

Strategize: Secure and hide money, an extra house or car key, important documents, prescription medication information, ID, receipts, pay stubs, passports, children's school and immunization records, immigration papers, social security cards, etc.

Develop: A code with family/friends to signal the need for help.

Identify: Safe neighbor to call, network of resources who can help.

Plan: Escape routes, places to hide and store clothing, jewelry, photos.

Discuss: Referral resources, local advocates, shelter, legal options, 911.

Avoid: Rooms where weapons or dangerous implements are present (e.g., kitchens and knives).

Tools: Recognize vulnerability cues such as **HALT** (be aware when you are **h**ungry, **a**ngry, **l**onely or **t**ired); deal with safety, sobriety and wellness issues "one day at a time" to avoid being overwhelmed; use meditation or other activities that help you stay centered.

12 Strategies for Safety, Sobriety and Wellness

Women attempting to stay safe, sober and well may develop a plan that may include but is not limited to:

1.) Identifying who to call for help (e.g. advocate, sponsor, counselor, peer), forming support systems, knowing about safe support groups and meetings.

2.) Knowing information and getting education about domestic violence, sexual assault, addiction and mental health issues.

3.) Removing substances and paraphernalia from the home. Removing weapons from their usual spot in the home.

4.) Recognizing unsafe persons, places and things.

5.) Understanding how to deal with legal and other problems stemming from domestic violence/sexual assault/addiction/mental health issues (e.g. health, children's services involvement, poor nutrition).

6.) Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing or other options.

7.) Knowing how domestic violence/sexual assault can be a relapse issue or interfere with the ability to cope with mental health issues.

8.) Knowing how substance use or untreated mental illness can be a safety issue.

9.) Understanding physical, emotional, cognitive, environmental and other cues indicative of risk, and having a plan to deal with it. Recognizing the role of stress and craving, and having a plan to deal with it.

10.) Learning how to parent, engaging in relationships, developing sober friendships.

11.) Knowing when and where to run in a life-threatening situation that puts your safety, sobriety or wellness at risk.

12.) Having a code word children will recognize to let them know it's time to call 911.

Mini Safety/Sobriety/Wellness Plan

★ Strategize	Steps to reduce risk/use/harm
★ Develop	Options to keep safe/sober/well
★ Identify	Trusted allies/safe sponsors/supports
★ Plan	Means to escape abuser/drugs/harm
★ Discuss	Referral resources
★ Avoid	Danger/persons, places, things/isolation
★ Tools	HALT/One day at a time/medication

Children Exposed to Domestic Violence and Substance Abuse

1. Violence occurs against both women and children in the same family.

    a. Severe and fatal cases of child abuse may occur in homes where domestic violence and/or substance abuse overlap.

    b. Witnessing domestic violence and being exposed to substance abuse can put children at risk.

2. Many men who physically or sexually abuse or neglect children also abuse the children's mother.

3. Some children who witness domestic violence are affected the same way as children who are physically or sexually abused.

4. In spite of what perpetrators and non-offending parents say, children have often either directly witnessed the physical and psychological assaults or have indirectly witnessed them by overhearing the episodes or seeing the aftermath of injuries and property damage. They are often all too aware of the impact of substance abuse in their family as well.

5. Children exposed to interpersonal violence and/or substance abuse do not experience a carefree childhood and may act adult while they are children. They may be busy surviving, placating, picking up pieces, adjusting and adapting just to stay alive.

Tactics of Abuse

Domestic violence perpetrators pose the following risks to ***children***. They may:

1. Harm children by coercing them into abusing their mothers or other adult caretakers.

2. Endanger children emotionally and physically by creating environments in which children witness assaults against their mothers.

3. Physically abuse children.

4. Sexually abuse children.

5. Endanger children through neglect.

6. Focus so much attention on controlling and abusing their adult partners they ignore and neglect children.

7. Prevent adult victims from caring for children resulting in neglect.

8. Endanger children by undermining the ability of providers to intervene and protect children.

9. Endanger children by exposing them to alcohol and other drugs.

Abusers also traumatize children in the process of battering their adult intimate partner.

They do so by:

1. Intentionally injuring the children as a way of threatening and controlling the abused parent. (*For example, the child is thrown at the victim).*

2. Unintentionally injuring the children during an attack on the abused parent when the child gets caught in the fray**.** *(For example, the infant is injured when the mother is struck while holding the infant).*

3. Using children to coercively control the abused parent while living with or separated from the victim. The intent is to continue the abuser's control over the victim with little or no regard for the damage done to the children. *(For example, the child is asked to report who mommy talked to.)*

4. Creating an environment where children are forced to witness domestic violence and/or substance abuse and their effects.

Examples of a perpetrator's behavior that traumatizes children include:

1. Asserting that children's *"bad"* behavior is reason for drinking, drugging or violence directed at the adult victim by the perpetrator.

2. Threatening pets, loved objects, toys, etc.

3. Isolating children, banning friendships.

4. Interrogating children about the victim's activity.

5. Forcing the victim to always be accompanied by the children.

6. Holding the children hostage.

7. Using lengthy custody battles as a means to continue abusing the victim; demanding unlimited visitation or 24-hour access by phone; threatening to report the victim to the Office of Children's Services (OCS) for past alcohol or other drug use.

Adapted by P. Bland from Ganley, A., Schector, S. *Domestic Violence: A National Curriculum for Child Protective Services*. Family Violence Prevention Fund, 1996.

Safety Planning Interventions For Children

It's important to safety plan.

Children:

- Are at risk and need to be safe.
- Often blame themselves for both the violence and the substance abuse.
- Feel terrified and helpless; angry and sad.
- Wonder, "What can I do?" and "What should I do?"
- Need something to ease the negative impact of domestic violence and substance abuse on their lives.
- Need the power that comes from knowledge of how to keep safe.

Safety planning with children:

- Gives them skills to protect themselves.
- Helps them feel confident.
- Empowers them.
- Gives them a reality check.
- Breaks isolation.
- Helps keep them safe.

You can help develop a safety plan to protect your children.

A safety plan should include:

- How your child can escape from the house if an assault is in progress or drinking/other drug use is scaring them.
- Where to go in an emergency.
- How to call police (explain 911 – how to call and what happens when you call).
- How to call supportive family members, friends and community agencies for help.

You can help your children.

- Listen.

- Provide structure, consistency.

- Tell your children it is important for them to be safe. If you are being assaulted, they should not intervene or put themselves in harm's way.

- Reassure children that domestic violence and/or substance abuse is not their fault and that blaming themselves is a common reaction.

- If your child is called on to testify, develop a plan to support the child over issues of fear, anxiety, divided loyalties, painful memories.

- Call your local domestic violence/sexual assault victim service program and substance abuse treatment program to get information about services for children.

- Practice the safety plan with your children.

- Ensure at least one adult provides unconditional positive regard.

- Let your children know it is OK to talk about family violence and/or substance abuse.

- Provide positive messages as well as safety planning. (*For example: "Violence is not your fault. Neither is drinking or drug use."*) Let children know anger doesn't need to lead to violence or substance abuse.

- If your children are drinking, drugging, suicidal, homicidal or violent towards other family members, develop a plan for their safety and the safety of others. Set clear limits with children who are violent and abusive or using substances themselves. Refer them to appropriate services.

- Help kids be kids. Provide after school options, encourage them to participate in children's programs. If your community does not have one, explore forming an Alatot or Alateen program. Find out what children's resources are available at your local domestic violence/sexual assault program.

(Adapted by P. Bland from material originally provided by Candy Miller, Consultant, Alaska Family Violence Prevention Project, 1998.)

Personal Change, Social Change

People with alcohol or drug problems have often been stigmatized by our society. Victims of domestic violence, sexual assault or sexual abuse have also faced stigma.
This social stigma can have unfortunate results. People who fear it are more likely to deny problems and less likely to get help.

Fortunately public attitudes about both addiction, and violence against women, have begun to change. This change is due in large part to the influence of two major social movements. The recovery movement and the women's movement have removed many barriers that keep people from getting help.

The recovery movement

The recovery movement has changed the way our society understands and treats alcoholism and other drug addictions. Before Alcoholics Anonymous began in 1935, the concept of alcoholism as a treatable illness was not widely accepted. Alcoholics were mostly condemned, ostracized and locked up in jails or mental institutions.[1]

Then alcoholics began meeting together in groups to help each other stay sober. As word of their success spread, more alcoholics joined them. Some also began carrying their message of recovery to doctors, clergy, lawmakers, businesspeople and others. [1]

Alcoholics Anonymous

A.A.'s message is simple. Alcoholism is a disease, and people can recover from it.[2] Alcoholics Anonymous was founded by "Bill W." and "Dr. Bob," a stockbroker and a doctor. The two men realized they needed mutual support to stay sober for any length of time. [1] The organization grew in just this way: one alcoholic sharing personal experience, strength and hope with another. [2]

Today there are nearly 2 million A.A. members worldwide. [2] Groups such as Narcotics Anonymous and Women For Sobriety also provide support for people recovering from addictions. They meet in a variety of places, from hospitals and treatment centers to church basements and college campuses.

But members of support groups often do more than keep themselves in recovery. They carry their message of hope to others like themselves. [2] Their activism has taken many forms. Some "sponsor" newly recovering people.[3] Others staff hotlines or make personal visits to people who call for help. [3] Still others take meetings to hospitals, treatment centers or jails. [3]

Marty Mann and the NCADD

Marty Mann was the first woman to achieve long-term sobriety in A.A. [1] She understood that support for recovering people started with community understanding that alcoholism is a disease.[4] Before Marty came to A.A., she was drinking around the clock. She was destitute and convinced she was insane. [1]

Once she got into recovery, she had an ambition: to change public attitudes about alcoholism. [1] She founded what is now the National Council on Alcoholism and Drug Dependence. [1] NCADD fights social stigma by educating the public and encouraging scientific research on alcoholism and other addictions. [4] The organization also encourages legislation to make treatment more widely available. [4]

Until she was 70 years old, Marty gave as many as 200 lectures a year. [1] She carried her message to nurses, doctors, and social service providers. She carried it to educators, judges, law enforcement personnel, the clergy and employers. She carried it to women's groups all over the country. She was also a skilled lobbyist who testified frequently before Congress and state legislatures. [1]

Change happens

The pioneering efforts of people in the recovery movement have paid off. The American Medical Association now considers alcoholism and other drug addictions to be treatable illnesses. [4] Corporations often refer alcoholics or drug addicts to employee assistance programs rather than simply firing them. [4] Federal, state and local governments provide funds for treatment and scientific research. [4]

Today, help for alcoholism and drug addiction is available from treatment centers all over the country. Substance abuse treatment is often covered by medical insurance or public assistance. Support groups exist in nearly every community, and there are no dues or fees for membership. Many communities have groups exclusively for women. These are especially helpful for survivors of violence or abuse.

The women's movement

The women's movement has changed the way our society understands and treats violence against women and girls. Until recently, domestic violence was often considered "a private family matter" by the criminal justice system.[5] Many people insisted that sexual assault didn't happen to "nice girls" or "good women." [5] The existence of child sexual abuse was mostly denied.

During the 1960s, women began meeting in consciousness-raising groups. They told each other about their personal experiences with violence and abuse.[6] They urged police officers and judges to arrest and prosecute offenders. [6] They lobbied legislators for better laws. [6] They educated the public about the reality of violence against women. [6] Activities such as Take Back the Night, the Clothesline Project and Silent Witness helped them carry their message.

Take Back the Night

At Take Back the Night marches and rallies, people gather to protest violence against women and girls.[7] Most events include a "speak-out," where people tell how violence has affected them or someone they know.

Other activities may include candlelight ceremonies, voter registration, self-defense demonstrations or poetry readings. Resource tables provide information about agencies that

serve victims and survivors. People are encouraged to educate themselves about violence and take direct action against it.

Since it began in the 1970s, Take Back the Night has been international. There are marches and rallies all over the U.S., Canada, and several European countries. Supporters have included churches, social service agencies and businesses, as well as women's groups.

The Clothesline Project

The Clothesline Project lets victims and survivors of violence speak out by telling their stories on T-shirts.[8] Women who experience violence often keep their stories personal and private. Some survivors find that making a shirt helps them break the silence about their abuse. This allows them to begin or complete the healing process.

The project began in Massachusetts in 1990 with 31 shirts. It was a way to "air society's dirty laundry." Since then, the Clothesline has gathered "laundry" from women all over the world. T-shirts have come from universities, domestic violence shelters, rape crisis centers and substance abuse treatment centers.

More than a half million shirts now exist. If brought together, they would fill a clothesline at least 13 miles long. The shirts have appeared at hundreds of events that educate the public about violence against women.

Silent Witness

In 1990, a group of women decided to tell the world about domestic violence in a way that would not be forgotten. The Silent Witness memorial consists of life-sized female figures.[9] Each represents a woman who was killed by her abuser. A story on each silhouette tells the woman's name, age, where she's from and how she died.

The figures have appeared in government buildings, shopping centers, colleges, hospitals, workplaces and other public settings. Together, the silhouettes serve as a stark visual reminder that domestic violence kills women.

Change happens

The women's movement scored a major victory in 1994, with passage of the Violence Against Women Act.[10] This federal law increases funding for domestic violence shelters and rape crisis centers. It encourages police to make arrests. It provides training for helping professionals who work with victims. Most importantly, it recognizes that domestic violence and sexual assault are criminal acts.

Today, domestic violence shelters and rape crisis centers exist all over the country. Services range from personal and group counseling to court advocacy and emergency shelter. These services are offered free of charge to victims and survivors.

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[1] Brown, Sally. Marty Mann and the Evolution of Alcoholics Anonymous. *Paradigm,* Fall 1998.
[2] *Alcoholics Anonymous.* Alcoholics Anonymous World Services Inc., New York, 1976
[3] *Narcotics Anonymous (5th Ed.).* Narcotics Anonymous World Service Office, Inc. Van Nuys, CA, 1988

[4] *For 50 years the voice of Americans fighting alcoholism.* National Council on Alcoholism and Drug Dependence, Inc. New York, 1994
[5] Walters, Catherine. *Violence against women.* Illinois Coalition Against Domestic Violence and Illinois Coalition Against Sexual Assault, Springfield, IL 1984
[6] Poskin, Polly. The revolution continues. *Coalition Commentary,* newsletter of the Illinois Coalition Against Sexual Assault, Springfield, IL, Winter 1995-96
[7] All information about Take Back the Night taken from Northern California Association for Women Take Back the Night web site. Available: www.metdesigns.com/takeback/history.html
[8] Information about The Clothesline Project taken from "Airing Society's Dirty Laundry: The Clothesline Project" by Jennie Ruby, in *Off Our Backs,* v. 23, n. 11, 1998
[9] Information about Silent Witness taken from Illinois Silent Witness exhibit fact sheet available from National Council of Jewish Women, North Shore Section, Wilmette, IL
[10] Information about the Violence Against Women Act taken from Violence Against Women Act fact sheet, U.S. Department of Justice. Available: http://www.usdoj.gov/vawo/vawafct.htm

Getting Safe and Sober: Real Tools You Can Use
Alaska Network on Domestic Violence and Sexual Assault

Can one person make a difference?

Many survivors of violence find that working for social change aids their own healing process. Many recovering alcoholics and addicts believe carrying their message to others helps them stay clean and sober. People may call their efforts *working for change, service to others* or *carrying the message*. Whichever words people choose, the key idea is that people often help themselves by helping others.

What can you do to make a difference? Here are 10 ideas to get you started:

1. Take care of yourself. Working on your own issues is the first step toward working for change. As the saying goes, we must heal ourselves before we can heal the world.

2. Break the silence. Going to a support group and sharing your story can be a radical act! Our society encourages people to stay quiet about certain issues. When you say "I'm an alcoholic" or "I've been abused," others find it easier to break *their* silence.

3. Contribute to your support group. Help set up tables, chairs and literature before the meeting. Help clean up afterward. Help a new person feel welcome.

4. Get involved in your community. Join an organization that works for change. Attend a Take Back the Night rally. Make a T-shirt for the Clothesline Project.

5. Be assertive in your conversations. Refuse to laugh at sexist or racist jokes. Express your opinions about issues you care about.

6. Contact people who make decisions. Complain to TV stations about violent programs. Call radio stations that play music glorifying drug use. Write to advertisers who promote stereotypes or sponsor objectionable programs.

7. Exercise your right to vote. Also write or call elected officials to tell them where you stand on issues that affect you.

8. Talk to your children. Discuss the violence they see in TV shows, movies and video games. Help them understand what happens when people do these things in real life. Educate them about alcohol and drug abuse, dating violence and other dangers.

9. Be a role model. Host a potluck or social gathering where no alcohol is served. Refuse to buy violent toys or video games for your children. And don't hit your kids. Slapping or spanking shows them it's okay to solve problems by hitting others.

10. Resolve not to "look the other way." Call police if you suspect someone is being abused. Report criminal activities that you observe in your neighborhood.

A final note: Start small. Recovery groups do not expect a newly sober person to chair a meeting. A woman staying in a domestic violence shelter need not organize a Take Back the Night rally. Begin by seeking help for yourself. Go to a support group. Share your story. Talk to your children. The longest journey begins with the first step.

Ending Isolation:
Reducing Anxiety through Connection

Women seeking safety, sobriety and justice face many barriers. Simple tasks can be frightening or overwhelming at times. Going to court, interacting with Children's Services or just setting foot outside can bring on fear and anxiety. This uneasiness is compounded when a person feels all alone. Women attending support groups together can serve as safety net of caring individuals. Women facing similar struggles can reduce isolation, anxiety and fear through their connection to each other.

The women at New Beginnings Wednesday night Support Group came up with the following plan themselves. A member of the group was terrified to go to court alone. She was afraid she would have a panic attack, take a drink or crumple when she saw her abuser. None of these options felt good and she said in anguish, "If I just could take all of you with me, I wouldn't feel so all alone." Another group member said, "Maybe we could help you. We can't physically go but we could all write down a message for you and you could carry it into court with you. Then we would be with you. You would not be alone." Another group member said, "We can write down our numbers and you can call us before you go in, or if you get scared or after you leave." We can make a safety plan together," said yet another. "You can call us if you are thinking of taking a drink, feel like fainting or if your partner says or does something hurtful or scary."

That evening the women passed around a piece of paper. Everyone in the group wrote a note of support. Phone numbers were provided and a simple plan was formed. The next day our group member went to court but she was not alone. She had the power of the group on the paper in her pocket. She took the paper out and read, "We believe you. You can do it. We care." She made use of the phone numbers. She got through the day and she knew people believed her and cared for her. She said, "When I came in here I felt lower than the rug and so alone. Now I know I'm part of something bigger than myself. There's a whole movement out there made up of people just like me, and we are there for each other."

Today when any group member feels afraid, doesn't think she can handle a court date or other event alone, group members remind her, "You are not alone." They ask for paper and pen. Sometimes they write down their words of support; other times they designate a group member to write down words or wisdom and support. It is very healing and empowering to feel safe enough to tell your story, to be believed and to feel connected.

This simple tool is most useful and empowering because it is rooted in the experience, strength and hope of women like you. Do you need help from the group today? It is okay to ask for support if you need it now. Today you are not alone.

Note: Some member may choose NOT to provide a phone number if doing so is uncomfortable or poses a safety risk.

Getting Safe and Sober: Real Tools You Can Use, 2nd Edition – Revised 2008
Alaska Network on Domestic Violence and Sexual Assault

Women Talk About Substance Abuse and Violence

Ten women were interviewed about their experiences with substance abuse and violence. All 10 were survivors of some form of abuse: battering, rape or sexual assault, incest or child sexual abuse. In addition to the violence, all of them had experience with alcohol or drug abuse, either on their own part, on the part of their partner, or both.

At the time of the interviews, all of the women had left their abusive relationships, and those with chemical dependency problems were in recovery. They talked frankly about the impact of the substance abuse on their efforts to escape the violence and heal from abuse. They also discussed the ways in which their experiences with violence affected their efforts to recover from alcohol or other drug addiction.

Q: What was your experience with physical or sexual abuse?

A: I was in my abusive relationship for 16 years. I couldn't eat or sleep or go to the bathroom without permission. I was beaten. I was repeatedly raped. I had guns in my ears, guns down my throat, guns at my neck, guns at my stomach. I couldn't tell anyone the truth because he said he'd kill me. I knew he would.

A: Our third date he moved in with me. And about a week later he punched me upside the head and knocked me out of a chair. One night he dragged me out of bed cause I wouldn't give him any money and beat me up. I said no one time and that was it. He just started beating me. Just cause I said no.

A: After six weeks of dating, this man tried to strangle me.

A: I was a 17-year-old unwed mother and 2 days after I found out I was pregnant, he made me pull the car over and when I got out of the car, he hit me with his fist in the stomach.

A: He raped me. And when the kids came home from school, he bought them a pizza. We all had pizza. He could come home and rape me, order a pizza like nothing happened.

A: I was sexually abused when I was 5 years old. He fondled me and I fondled him. I knew that something was wrong. He said not to tell anybody.

A: I had incest in my life. I remember being in my mother and father's bedroom. And I remember feeling real physical harm inside. I had severe vaginal pain. I don't know how long that went on, but I do know it all happened before I was 8 years old.

Q: What were your personal experiences with alcohol or drug use?

A: When I was a little kid, we all got shots of whiskey. And I loved it. You got that warm feeling and everything was going to be okay.

A: For as far as I can remember, I've had some sort of substance in me. I started using drugs when I was 10 years old.

A: I had my own little chair in a closet and I'd go sit in there, just me and my bong.

A: We used marijuana every day. I did a lot of cocaine. When I used cocaine, all I wanted to do was that next line. I didn't care about putting the kids on the bus or getting the kids to school. I lost my children.

A: I was a blackout drinker from the age of 15. My alcoholism was sitting home sipping wine all day. I could sip the whole gallon. I thought I was crazy. Not really thinking, well, it's the alcohol.

A: One day I didn't want to drink and I had to. It was the scariest feeling. I got the shakes. I was real nervous, and I knew a drink would fix that.

Q: Did you see your substance abuse and woman abuse as being connected in any way? For example, did you drink or use drugs to help you cope with your feelings about the woman abuse?

A: Whenever he'd get really angry and the fights would start, it was easier for me to just go in the back bedroom and get stoned and try to put it all away.

A: For me, the substance abuse when I first started using was over abuse, was over a rape, and so that's how I learned to cope with any type of abuse was to get high, and it made everything okay.

A: I was darned lonely. I had no friends. I had nobody to talk to. So I started smoking more, getting high more often, with every aspect of the abuse, between the isolation, the physical abuse, the sexual abuse. This way, I didn't feel any pain. I didn't feel any guilt. I didn't feel anything. I didn't want to feel.

A: I just didn't want to be conscious of my actions or his actions.

A: All I know is, when I was being abused, all I wanted was more and more. The marijuana wasn't enough. Then I started getting into the crack. It was easier just to stay stoned and numb and not have to deal with it. The drugs were what made me forget about all the abuse and set aside the fear and the terror I had from the abuse and that was my only escape. It was a way to get away from my husband and not feel trapped.

A: I've known for 10 years that I had a serious problem with drug use but I was not willing to give it up because that was my way of coping. The drug didn't hurt as bad as reality hurt.

Q: Did your partner abuse alcohol or other drugs? If so, did you see a connection between his substance abuse and the violence?

A: The basement was off-limits to me. I was never allowed in the basement. He was a drug addict and that was where he kept most of his drugs.

A: He drank, and he used marijuana heavily. He also used other drugs. The abuse kept going. Not even just when he drank. I mean stressful times. He really hurt me, and I remember just laying, pregnant, in a ball, sobbing, as he just drank himself into oblivion.

A: The abuse escalated, especially when he was coming down from coke, or if he had a hangover

from coke.

A: He was violent when he wasn't drinking, but he was more violent when he was drinking. Any little thing would set him off. He'd wake up and want more alcohol. And then the cycle would start all over. I kept thinking in my heart that if he'd only quit drinking, then life would be a lot better. I've come to the understanding that a person is going to drink or not drink. It's their choice.

A: If you sober up a perpetrator and he doesn't have treatment for his issues, then what do you have? You have a sober perpetrator. And now he's more aware.

Q: Did you find that substance abuse got in the way of your efforts to cope with the battering or heal from other forms of abuse?

A: It got in the way a lot. I left the shelter because he bought a bag of cocaine. And so, here I was back in the same abusive relationship all over again. I wanted to be strong, and even though I wanted to be out of an abusive relationship, my addictions took me back.

A: I didn't have time to heal. Because every time you drink, then there's no emotional growth. Or you just start to look at an issue like alcoholism or domestic violence. You just start to look at the sexual assault and it's too painful. You drink to numb the pain. So it never really goes away. It's never dealt with. It just gets under the rug, and it resurfaces again and again.

A: It made it certainly harder for me to cope.

A: I first went looking for help to get away from the abuse. While I was in shelter, one of the things they very strongly enforced was no alcohol or drugs. And I was having a real hard time with the no drugs. So my pipe and all my goods and stuff stayed in my car. I'd get in my car and go down a couple of blocks, sit in a Safeway parking lot and get stoned.

A: The drugs are an element of control. If they can keep you on the drugs, using or addicted to the drugs, they're in control. And it's like strings on a puppet. They just keep you under control because you want that other hit. You want that other drink.

A: And drinking kept me in the relationship longer. When you're drinking and you're in that vicious circle, the other vicious circle doesn't matter. All I cared about was getting another drink.

A: Because of my drug use, I would not accept or see the violence. My head's not clear enough, or wasn't clear enough, to see the reality of the situation.

A: For me, once I pick up the alcohol or the other substances, it's like that safety plan goes out the window.

A: It kept me isolated, so I stayed at home in my room with the curtains drawn. On top of him keeping me isolated and not allowing me to go anywhere. But I think the biggest thing it did was kept me from getting out and getting that help I needed. Now, being clean and sober, I know it's so much easier for me to tap those resources.

Q: Did you find battering or other abuse got in the way of your efforts to recover from

substance abuse? Was this ever a relapse issue?

A: Every time I thought about getting into a new relationship, I just wanted to drink.
A: I think the underlying shame that I felt, and not dealing with the sexual assaults. I didn't see that at first when I got sober. The connection didn't become clear to me until I'd been in recovery for some time.

A: Not being able to go to meetings. Not being able to get out around people who were sober.

A: Going to a meeting wouldn't be anything he would tolerate because there would be other men there. Something could happen. So his controlling made it real difficult for me to do what I needed to do for myself.

A: I made it for 30 days. The minute I got out of the safe environment I was right back with the man and by midnight, using.

A: I believe I needed more than just a 12-step program.

A: You can talk about all these wonderful spiritual things, but if you don't have any food and you don't know where you're going to sleep, and you're running for your life, you don't have time for any of that stuff. You're just stuck on survival.

A: This man tried to strangle me. After that happened, then I relapsed. And I was in relapse mode off and on for a whole year after that.

A: I think when you stop denying things that have happened in your life in the beginning, all that from the incest, then you can stop the denying of things that happened a couple of years ago. Sick relationships and the drug abuse, and the self-destruction. I think from that point on, I could start to recover.

Q: Did you get any messages from others that you were to blame for battering or other abuse?

A: Yes, I got that message from family, friends and my abuser. It was always my fault.

A: He said I was ugly. He said I was a bad wife. He said I was an unfit mother.

A: Well I told you to shut up and you wouldn't shut up. Or all you had to do was make me bacon. Or I didn't hit you that hard.

A: I chose to marry a man from the other side of the tracks. Deal with it.

A: My parents and my family, they liked him. They said it was my fault he started drinking, because I was nagging him. I wasn't treating him right. That was the reason he broke my face, broke my nose, broke my jaws. I was doing something to cause him to hit me. It was my fault.

Q: Did you believe this yourself?

A: He told me it was my fault that he hurt me. And I believed him. After all, he didn't rage at anyone

else, and he didn't hit anyone else but me.

A: It just whittled away. I was told regularly if you hadn't done this, then I wouldn't have done that. Over a long period of time to the point where I thought I was crazy. And I really started to believe, if I act just right, I can keep this from happening to me.

A: Part of his abuse was brainwashing, and he was very good at it.

Q: Did you get any messages from others that you were to blame for battering, sexual assault or other abuse because of your drinking or drug use?

A: He was always saying the reason he would abuse me was because of my drug use, even though he had his drug use that was not a problem, or he would bring the drugs to me.

A: He would not admit that he was abusing me. But he was like, you did the drugs. You deserve to get your ass kicked. My mom always took his side. She was aware of my marijuana use and my cocaine use, and she'd be like, what man is going to put up with the things you do? And I got that from a lot of people. All the time it was, I deserved it because I wasn't being a good mom, I was using drugs, running around to taverns and staying up all night, and sleeping all day. Oh, yeah. Big messages.

A: I had been raped, gang raped, when I was 17 and I had been using. I didn't even realize it was rape until a woman pointed that out to me. She said any time you have sex without your consent it's a form of rape. I think that the attitude about women, if you hadn't put yourself in that situation then that wouldn't have happened to you. What did you expect?

Q: Did you believe these messages yourself?

A: Yeah, I believed it for a long time. He kept telling me I was the one who was insane, and that I was always going to be that way as long as I used the drugs. So it was my fault that I made him angry. When I'd really get into the crack I would get to the point where I'd get suicidal. And then it was him not being able to cope with my mood changes and stuff like that.

Q: When you tried to seek help for the violence, did you run into any problems? How did people respond?

A: The cops would come and they'd say, you've been together how many years? Get over it. Kiss and make up.

A: We come from a very small town, and when I got my divorce, the judge told me, we do not mention the words domestic violence in this courtroom.

A: The first time he tried to kill me, we went and saw a psychiatrist, family counseling, and I actually did kick him out of the house. The psychiatrist wanted him back in the house, told us we should be able to work it out.

A: I went to the church and told them that I was in fear for my life, and if somebody would just go

with me from the church, I could get my cat and I could get my belongings. People in the congregation patted me on the head and told me, "Oh, it's okay." Denying that there was any abuse going on. It made me turn my back on my faith.

A: People tend to look the other way. It's just not something they want to see. It's denial.

Q: Were there any personal barriers that stood in the way of your getting help for the battering or sexual abuse?

A: I never thought I'd have the strength to leave. I never knew I could. I didn't have the resources that we have now. I did not know domestic violence was against the law. I had absolutely no idea.

A: I was afraid of what life would be like alone, big time. Of the mom thing. Three children. And so finances kept me there too. I thought the only thing to do was to stay and keep on doing what I was doing. You know, domestic violence is barely out in society now. Until the police told me about the battered women's shelter, I didn't know there was help, and I think I was pretty unaware of sustance abuse help too. I just didn't know.

Q: What kept you from getting help for the substance abuse?

A: The feeling of isolation both being a female alcoholic, that internalized shame, and then the internalized shame I had from the domestic violence.

A: Pretty much what people would think was the biggest thing. The shame pretty much kept me from getting any kind of help that I needed. I just stayed addicted.

A: I thought alcoholics were people in the gutters, the winos pushing their shopping carts with all their belongings in it. And I figured since I had a job, a car, the whole nine yards, that I was doing pretty good.

A: I didn't think marijuana was addictive.

A: How do you get up in the morning and not smoke a joint?

A: And denial is an awesome thing. It truly is. If you don't want to see it, or you can't handle it, then it simply is not happening.

Q: When you were trying to recover, did your partner ever try to put roadblocks in your way?

A: Oh yeah. Because it was really tough for me when I first quit. It was difficult the first 30, 60 days. When I talked to him on the phone, he'd always tell me, all you've got to do is tell me babe, and I'll go get you some more. He kept telling me that that's all I needed was a couple of bong hits or a couple of rocks and I'd be just fine.

A: I got clean and sober and started working, and putting money away to get out of the relationship. And I think he saw that. He became more demanding. Attempts to be controlling escalated. His abuse of the kids escalated as I was sober. His attempts seemed more desperate.

Q: What finally led you to get help for the woman abuse?

A: This man was just physically beating me up. My middle daughter was between us a lot of times, and while she was standing between us, he would reach around her and pull my hair. I walked into her bedroom to check on her, and she was hiding underneath the bed. I realized he was affecting the kids.
A: The nice periods were shorter and shorter, and the abuse got longer and longer. Just couldn't take it anymore.

A: When I was using, I didn't have the ability to reach out for help, nor did I feel I needed it. Not using made me feel again, and when I felt again, I knew I needed help, because the pain was there. And that's when I reached out. If I would continue using, I would never have reached out.

Q: What led you to get help for the substance abuse?

A: The choice of either stop using or live on the street. At this time, I was smoking crack cocaine. Because I was so devastated by the use of it, I just wanted to be really free from it.

A: Once I walked away from that abuse [violence], I knew the next thing I had to do was do something about the substance abuse. And then, when I made up my mind that I wanted to quit the drugs also, the advocates at the shelter were right there for me, and got me into a treatment program.

Q: Do you think it's important to address both violence and substance abuse together?

A: I don't think I could deal with one issue alone. It was critical that I deal with the domestic violence, to get away from it, because it was just getting worse and worse. But I couldn't deal with the domestic violence if I was still getting all drugged up.

A: You've got to be sober, at least a little bit, to be able to even look at the domestic violence. But if you get sober, and you don't look at those issues, you're not going to stay sober, not in the long run.

A: I couldn't recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa.

A: Without being clean, I can't deal with the abuse issues, and without dealing with the abuse issues, I'll just go back to using.

A: Getting off the chemicals has made it much easier for me now to deal with the other situations I need to in order to get back on my feet.

Q: What has been most helpful to you in addressing both the substance abuse and the woman abuse?

A: I'm going to a domestic violence group that also addresses chemical dependency issues. The domestic violence and drug abuse have very similar qualities.

A: You have the minimizing. The denial. All that stuff that goes on with the chemical dependency, you have with domestic violence too.

A: I get a lot of support on both issues this time around.

A: Accepting suggestions and help from other people. Being clean and sober and seeing the potentials that I have.
A: Staying clean and being able to talk about what's going on really helps.

A: It helps to see that you aren't the only one. And that someone else did make it. And someone else has made a life for themselves.

A: They try to make you feel that you're not worthless or useless.

A: Somebody wanted to show me support, listen to me, not yell at me, not scream at me, just look at some options instead of that. Through them showing love to me, I began to love myself. I didn't deserve the punishment I was giving myself for all that had happened in my life. The continuous bad relationships, continuous abusing the drugs, and shame and the guilt I felt from all that. I deserved better. It was also OK to heal from all that.

A: The longer you're clean, the more you talk about it, the easier it gets. And it feels in the beginning like it's the end of the world, but it's actually the beginning of a new life.

Q: What has been your experience with support groups? Have you been encouraged to talk about both issues? How do you handle this?

A: I have a sponsor in a 12-Step program. And she is both a survivor of domestic violence, and in recovery for 14 years.

A: I'm very determined to live a violence-drug free life, so regardless of what kind of meeting I go to, I talk about what I feel I need to talk about. Anytime I talk about my domestic violence, I'm also speaking on my chemical dependency. I go to groups and I say what I feel I need to say. The meetings I go to deal with both.

A: For domestic violence survivors, women's meetings are probably safer.

A: Where it was safe to talk about both the chemical dependency and the domestic violence.

A: Especially with other women who have both issues, those who know the abuse, all aspects of the abuse.

A: The more you tell your story, the more you talk about what you did to get clean and sober, the stronger it makes you the more you hear it. And the longer we're away from the abuser, and the more education that we get, and the more we talk to other people about it, the stronger we become and the more aware.

Q: Many women have mentioned problems they encountered when they first tried to seek help. Have you done anything personally to try and change attitudes about chemical dependency or

violence against women?

A: Being a sponsor in the A.A. program. Just talking with some of the new people that are coming in.

A: Just sharing it with other people in the meetings, my experience of how I am now, compared to where I was when I first realized I needed to start doing something about the problems.

A: When I'm helping other people, it's keeping me conscious of where I'm at in my program and what I'm doing to take the steps to keep myself clean and sober.

A: Because of all the stuff that I've been through, with personal journeys, the law, and the police and the court system, I want to get involved in effecting change.

A: Working with other addicts and abused women and homeless women, that's my healing every day.

A: And put DV information everywhere. I have put it everywhere I can think of. I've got it in the schools, in the libraries, in the grocery stores, in the movie theaters, in the dentist office, in the car dealerships, in the tourist information centers. You name it, I put it there.

Q: What would you say is the best thing about being both safe and sober today?

A: I've gained more confidence in myself and learned so much more about myself. It's still lonely. It's still quiet. But it's better than being drugged up and arguing and fighting all the time. I don't have to run and hide in a closet anymore.

A: I have my youngest daughter back. She lives with me. My oldest daughter is getting married, and my middle daughter is a college student. I was blessed with talking to 3,000 teenagers this fall at the convention center. No line of cocaine, no reefer, no drugs, no man, ever brought me to the feeling of being able to talk to those children.

A: I'm able to have clear thoughts. I have a sense of reality. I'm not easily swayed. It's easier for me to pick out unsafe situations and unsafe people. By being sober, I'm more aware of what's going on around me. I don't have to be in another abusive relationship and I don't have to let people treat me like that.

A: I'm a pretty intelligent person, and I never realized that. I never realized how really intelligent I was.

A: I am my own advocate, I realized.

A: I have a lot of women friends and I've never had women friends. Never.

A: I wouldn't trade where I'm at right now. I remember that feeling. I remember the withdrawals. I remember the cocaine dreams too vividly. Nightmares. Don't want to go back. Ever.

A: I am, for the first time in my 41 years dealing with life on life's terms without somebody telling me how to do it. I can actually talk to people now without being drunk. I can actually laugh without

being high. And I can actually walk out a door without being paranoid. That feels good. That feels so good. Because I want to live.

Q: What would you tell other women who are experiencing substance abuse and violence?

A: That you can get out of an abusive relationship. That you can recover. That you're not alone.

A: No relationship is better than an abusive relationship.

A: And I don't think women should feel they need to make a man happy. That's a two-way street.

A: Just taking even baby steps toward asking for help. That was the biggest and most difficult thing for me to do.

A: It's hard picking up the phone, but both problems have hotline numbers. And once you do it, it just gets easier after that. And if you don't get help, it just gets worse. A lot worse. Both issues.

A: Please reach out. Talk to a peer. Talk to somebody you can talk to.

A: I can't go back. I can't truly ever return to that state of denial. I know too much now.

A: Knowledge is power. ... Knowledge is power.

Based on interviews conducted by
Debi Sue Edmund and Patricia J. Bland
in Springfield, IL, and Seattle, WA.

POWER AND CONTROL WHEELS

The Power and Control Wheels appear here courtesy of the National Center on Domestic and Sexual Violence, which credits the Domestic Abuse Intervention Project in Duluth, MN, for inspiring the wheels. Group facilitators are free to photocopy as many of the handouts as they wish for educational use. However, please make sure the copyright notices appear on each of the handouts. We also request that the handouts not be altered in any way. For more Power and Control Wheels and articles that educate about various aspects of abuse, visit the National Center on Domestic Violence Web site at www.ncdsv.org.

Power and Control Wheel

Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill threat of future violent attacks and allow the abuser to take control of the woman's life and circumstances.

The Power & Control diagram is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.

Developed by:
Domestic Abuse Intervention Project
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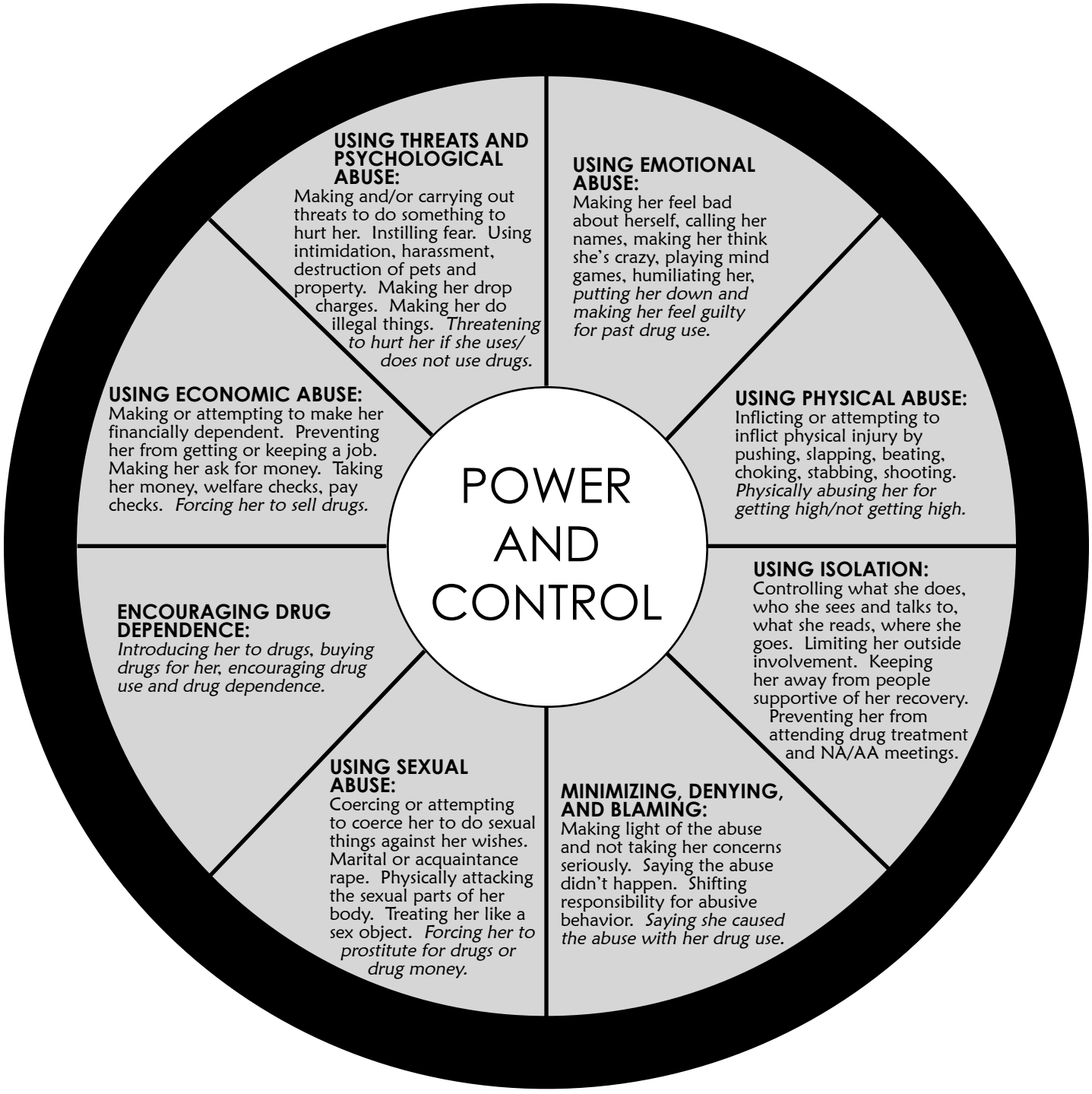
Power and Control Model for Women's Substance Abuse



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Excerpted from:
"Safety and sobriety: best practices in domestic violence and substance abuse," p. 66,
Domestic Violence/Substance Abuse Interdisciplinary Task Force, Illinois Department of Human Services.

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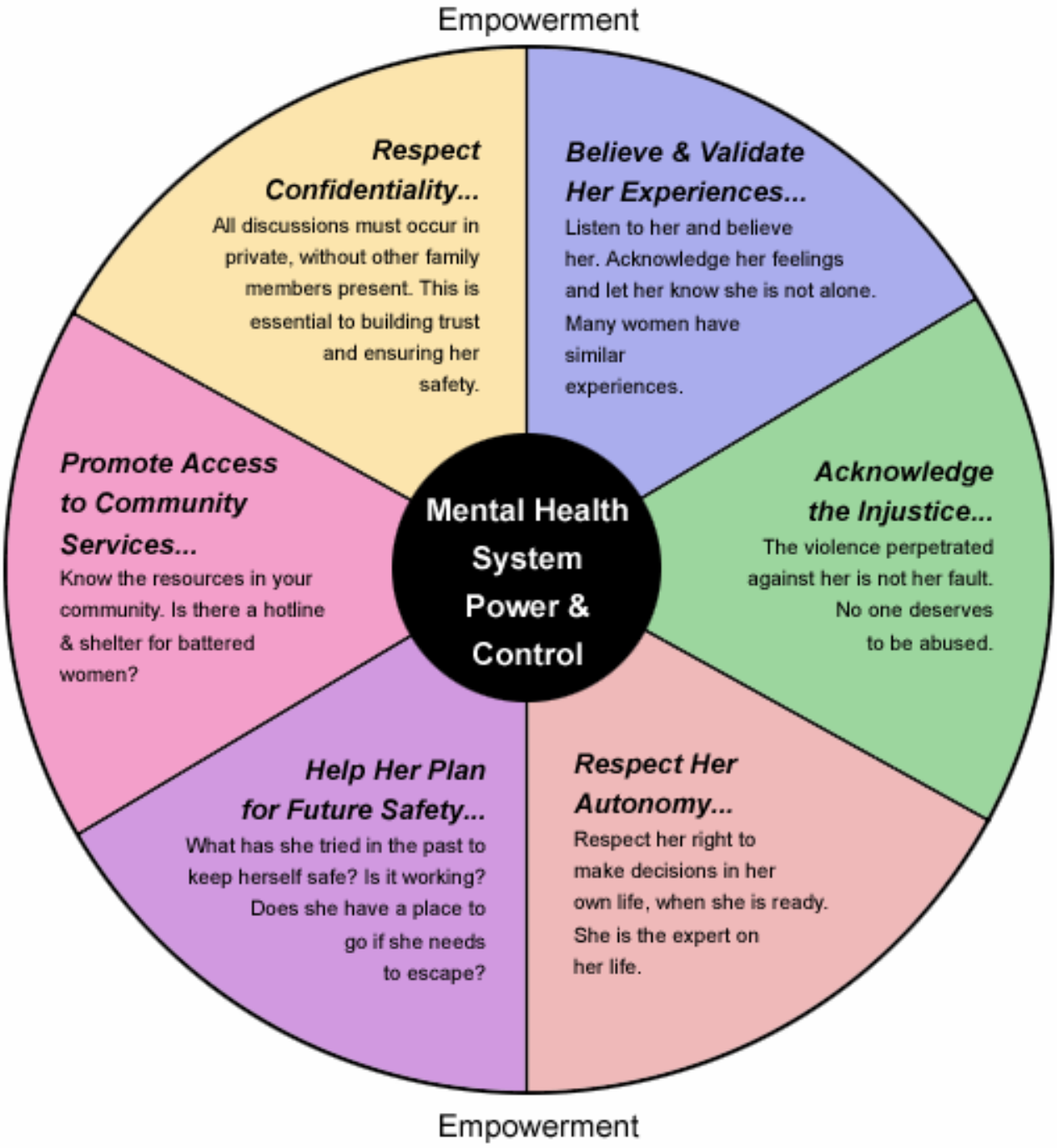
THE ADVOCACY WHEEL



DVP, Inc. Kenosha, WI, 1992

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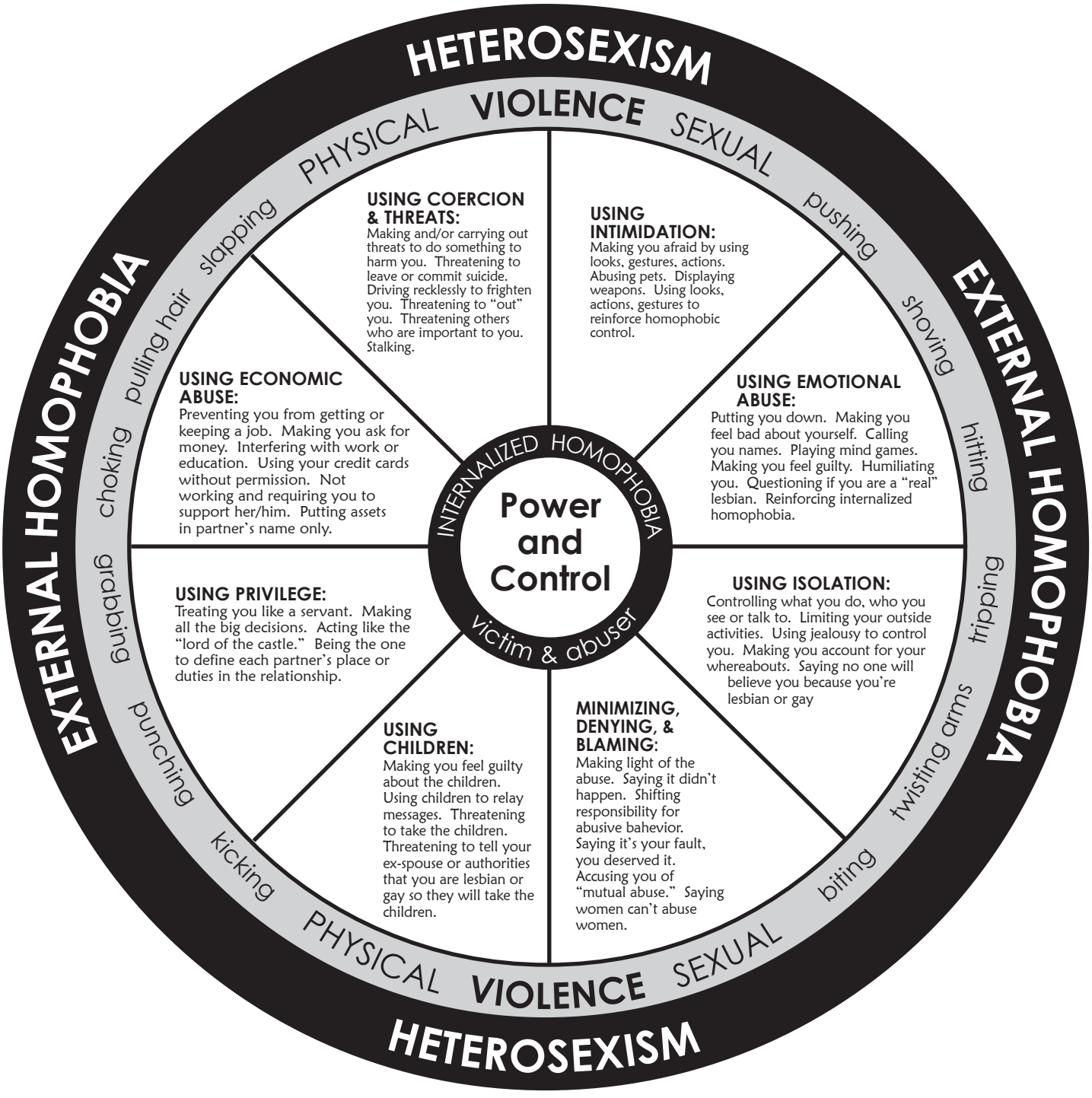
Lesbian/Gay Power and Control Wheel



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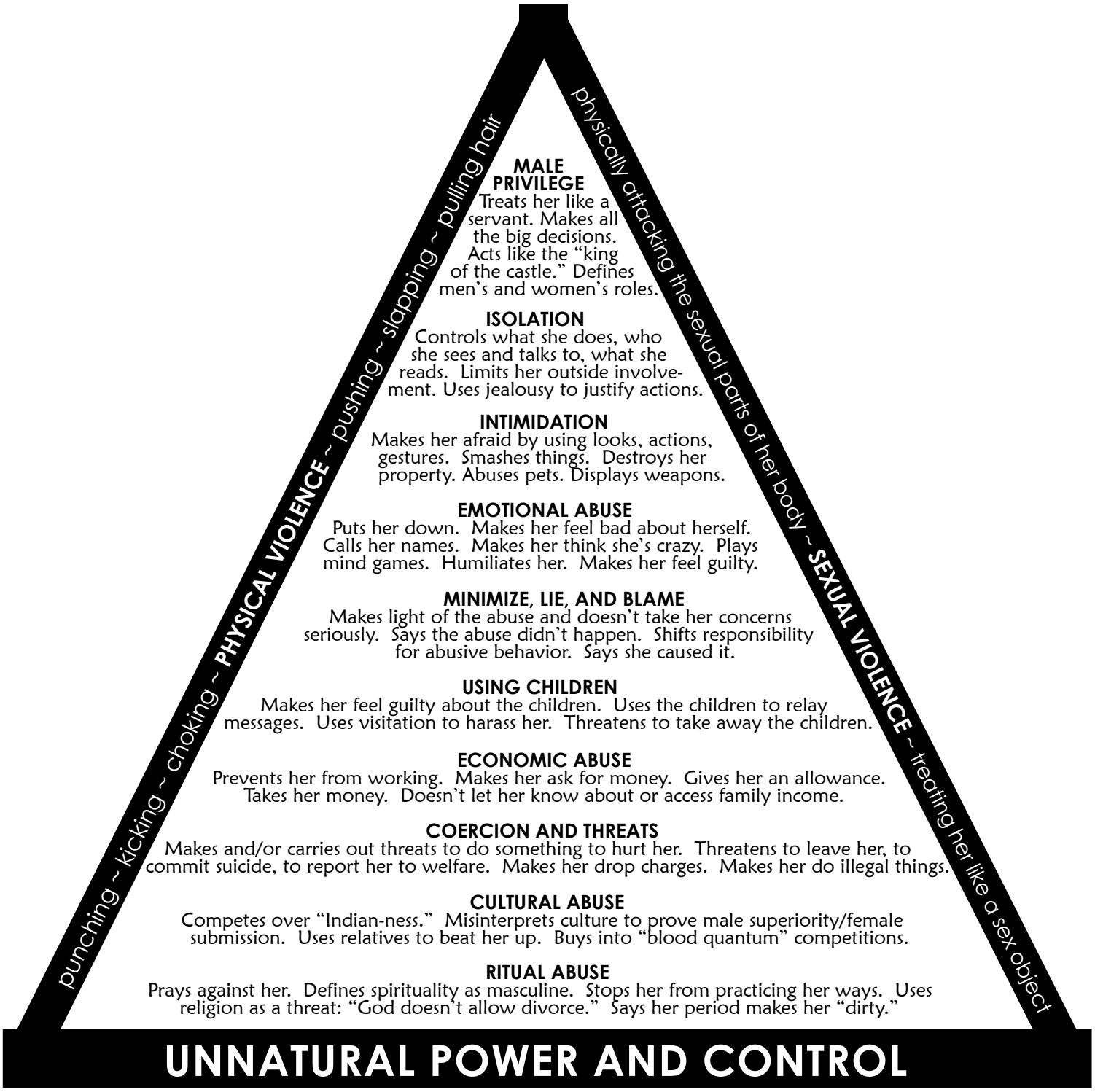
Violence Against Native Women: Battering



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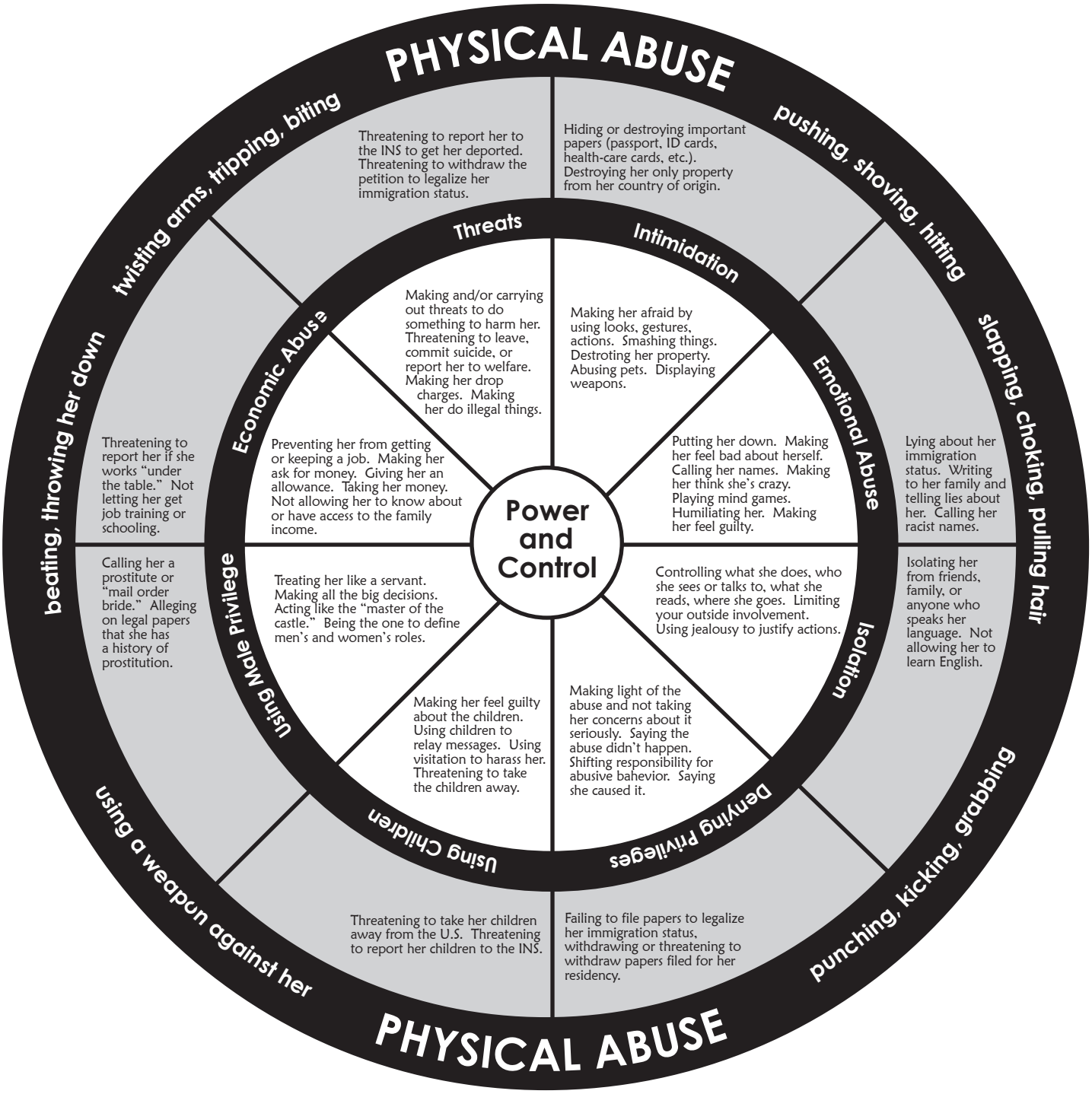
Immigrant Power and Control Wheel



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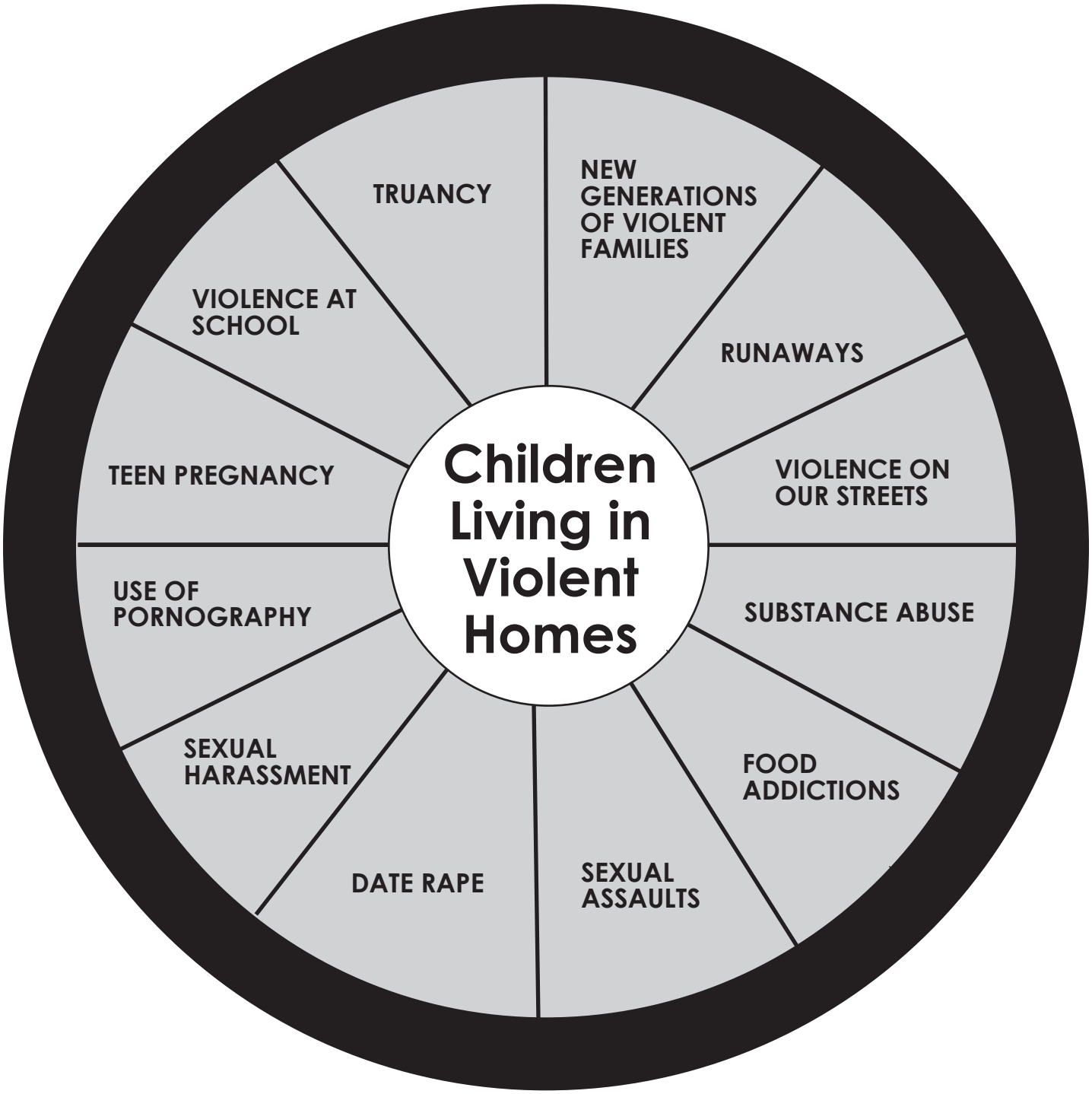
Children Coping with Family Violence



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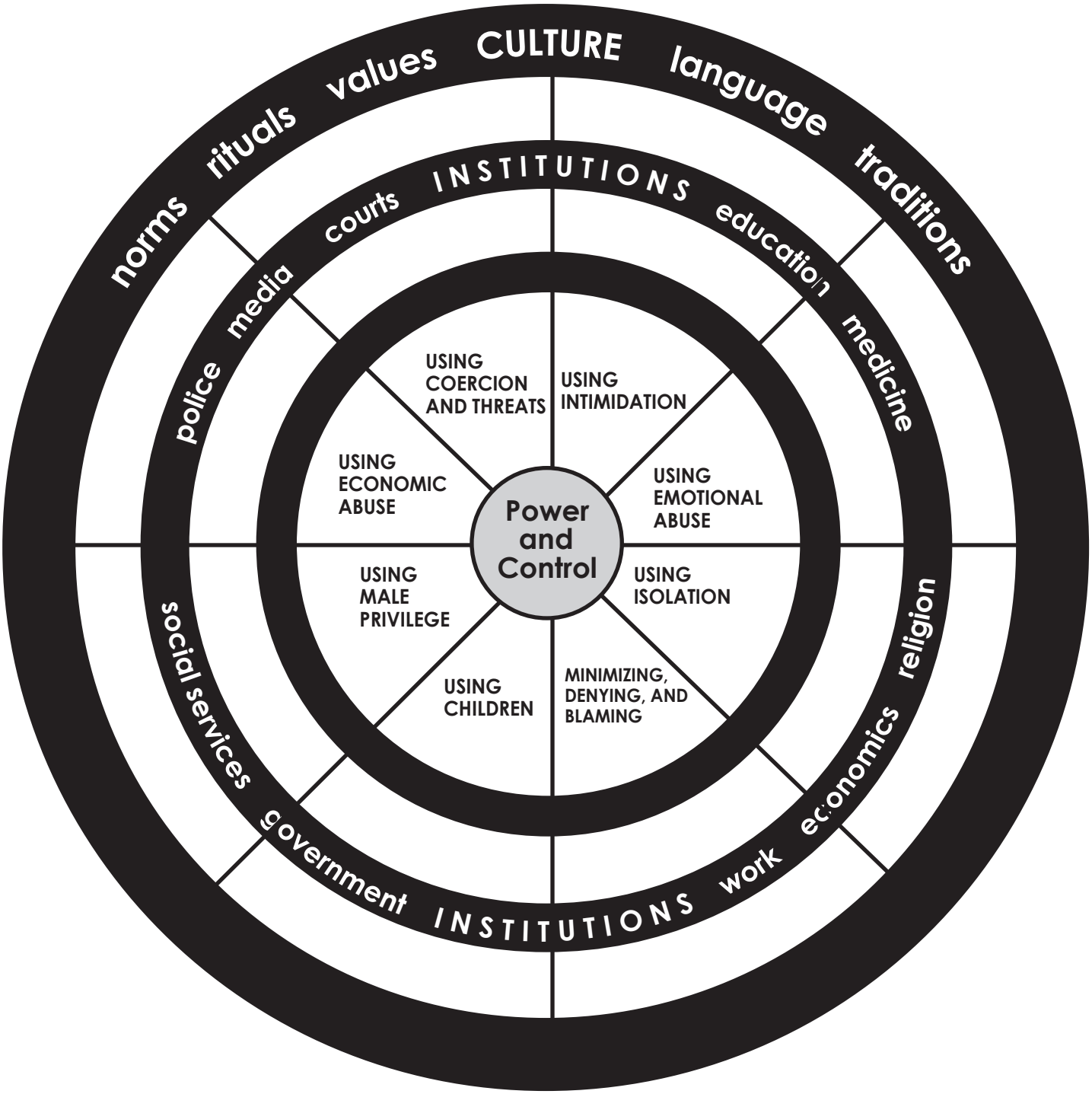
Power and Control Wheel



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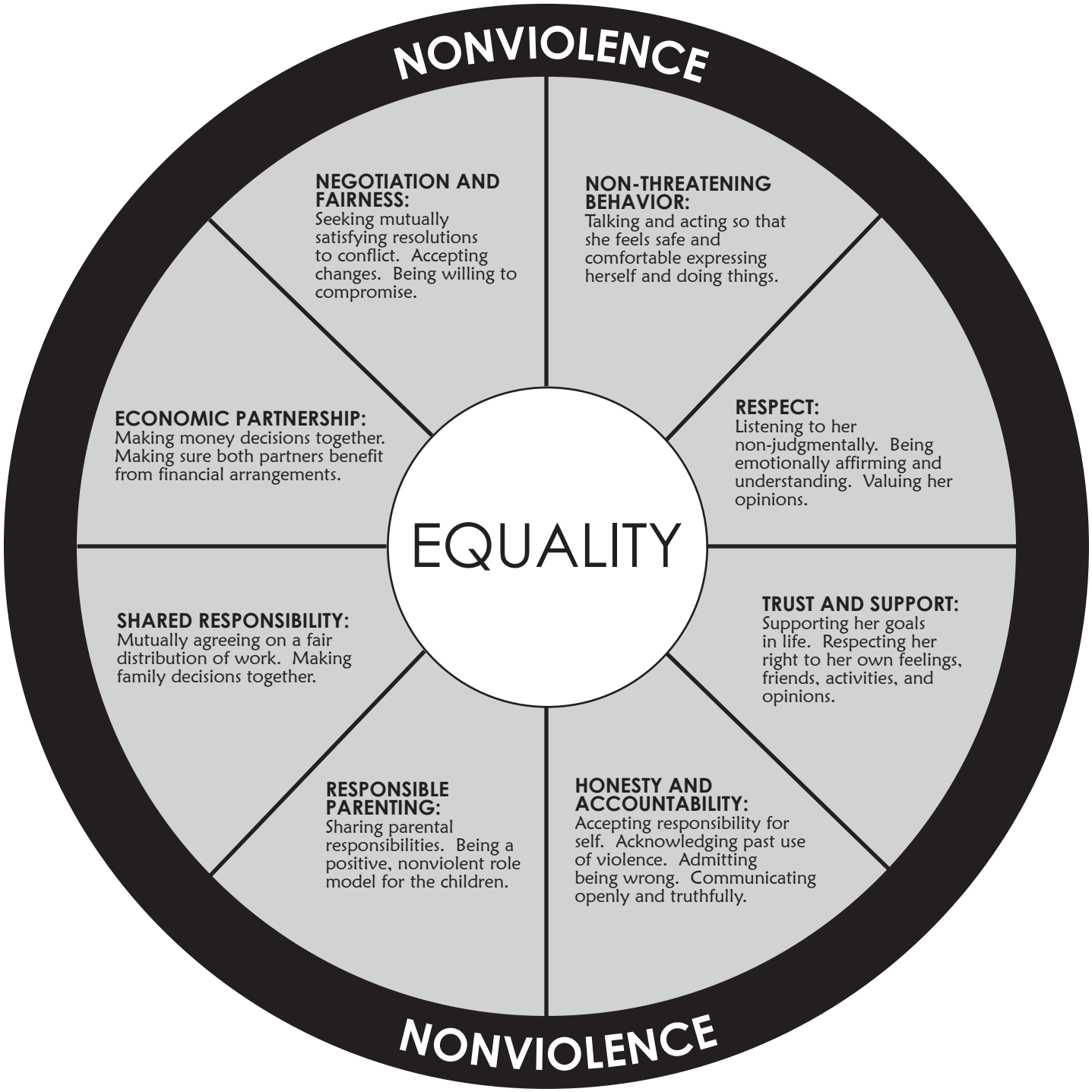
EQUALITY WHEEL



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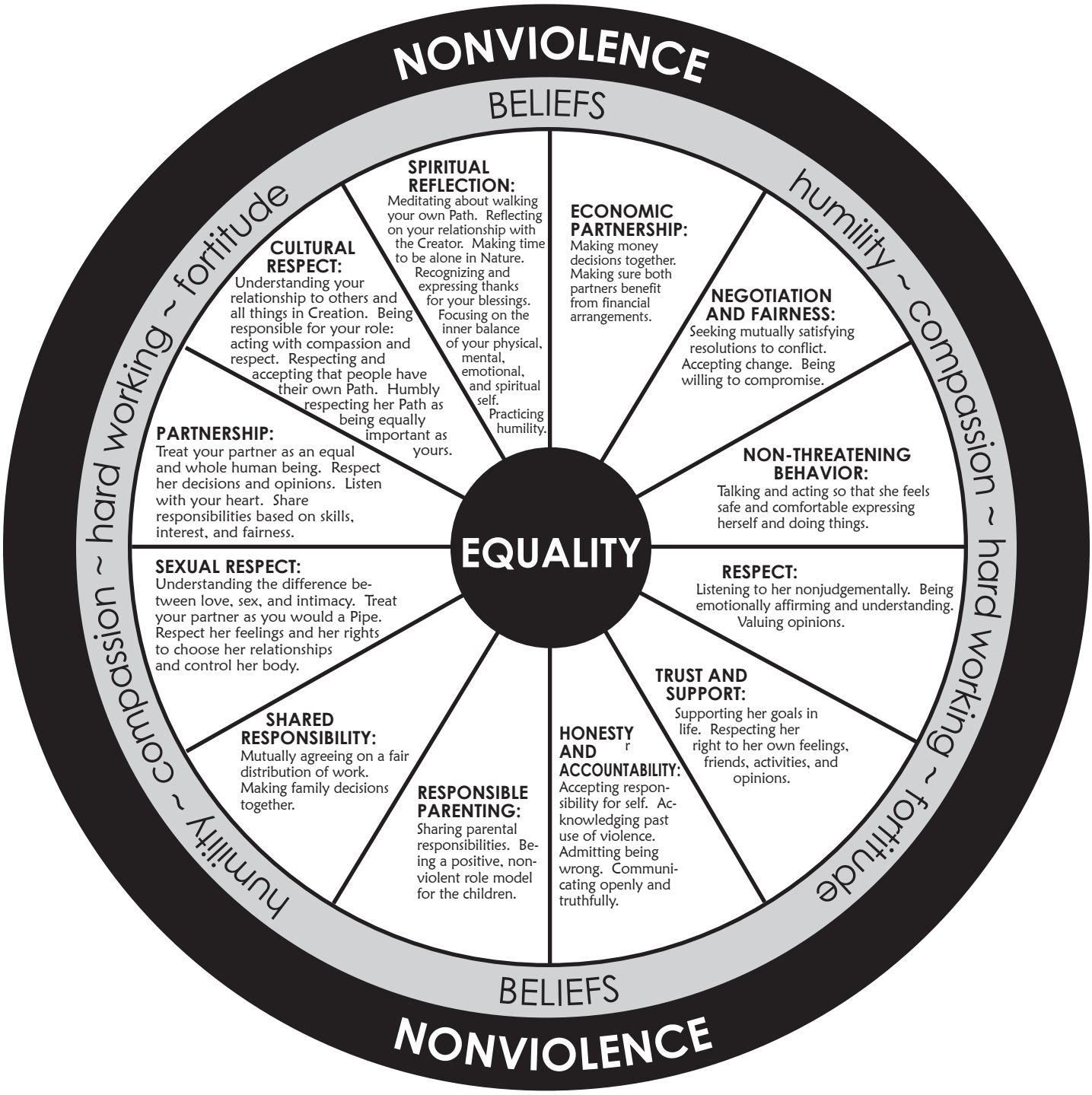
Natural Life-Supporting Power

Equality is a natural life-supporting power that is grounded in spirituality.



Produced by Sacred Circle -
National Resource Center to End Violence
Against Native Women, a project of Cangleska, Inc.
Based on DAIP's model.

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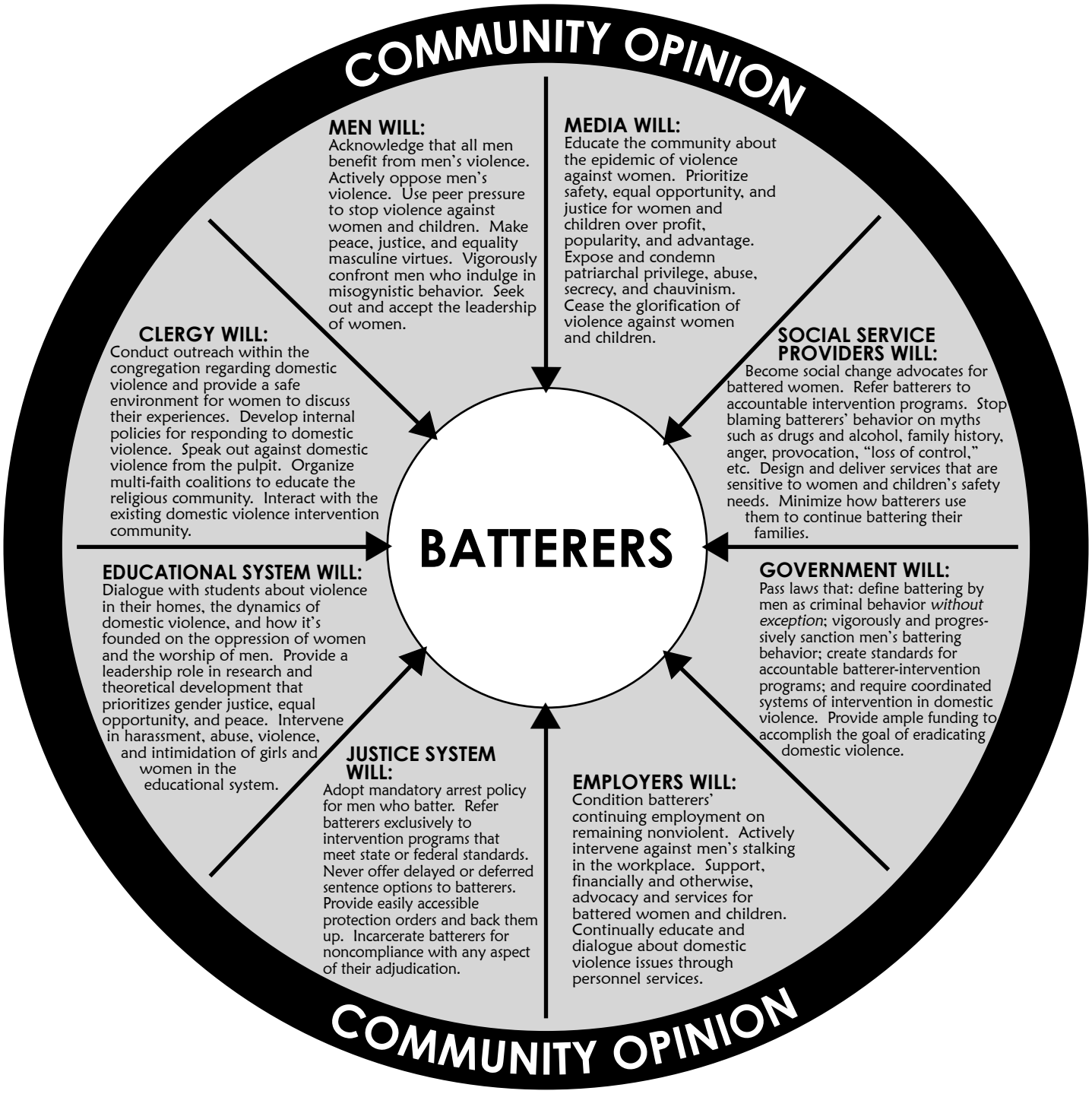
Community Accountability Wheel

This wheel *begins* to demonstrate the ideal community response to the issue of domestic violence. Community opinion, which strongly states that battering is unacceptable, leads all of our social institutions to expect full accountability from the batterer by applying appropriate consequences. This wheel was developed by Mike Jackson and David Garvin of the Domestic Violence Institute of Michigan (P.O. Box 130107, Ann Arbor, MI 48113, tel: 313.769.6334).



Inspired and adapted from the "Power & Control Equality Wheels" developed by:
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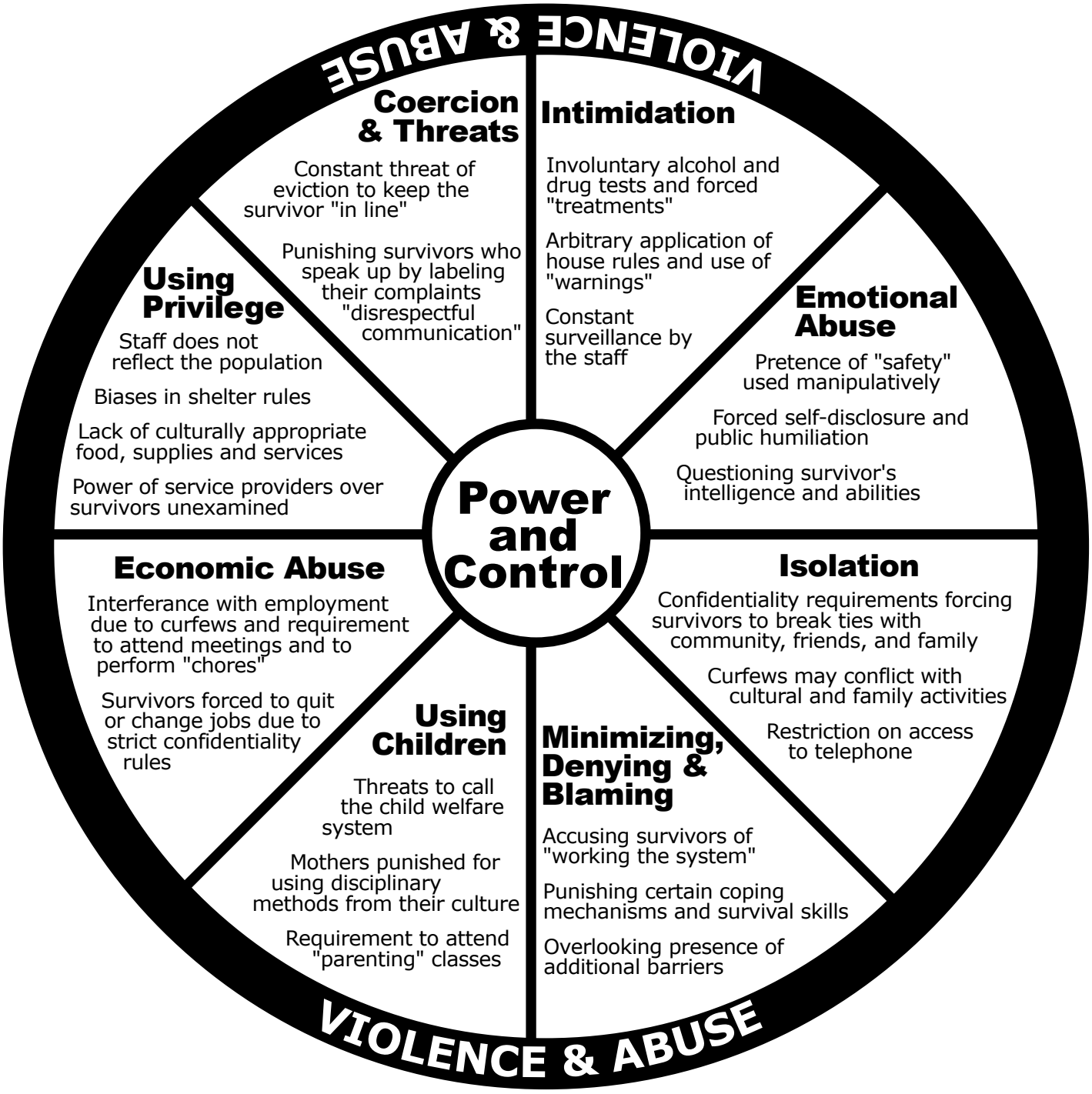
Abusive Power and Control within the Domestic Violence Shelter



This "power and control wheel" was created by **Emi Koyama** and **Lauren Martin** to illustrate how domestic violence shelters may inadvertently abuse power and control over survivors who seek services from them. In no way is this meant to discount the fact that advocates have been doing, and continue to do, extremely important and life-saving work. Rather, it is meant to incite discussion as to what we still need to work on in our empowerment-based and social change advocacy. Please contact **Survivor Project** at (503) 288-3191 or info@survivorproject.org if you are interested in distributing this wheel.

ABOUT THE AUTHORS

Debi Sue Edmund, M.A., C.A.D.C., is executive director at Project Return, a program in Springfield, IL, that assists incarcerated women seeking to reintegrate into the community. Debi is a certified alcohol and drug counselor and a trained domestic violence advocate. She has several years of experience working with clients presenting with multiple issues – among them, interpersonal violence, substance abuse, mental health issues and homelessness. She has worked in two drug and alcohol treatment programs, a domestic violence shelter and a transitional living program for survivors of sex work.

She was a member of the Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services from 1999-2004, where she served as editor of *Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse.*

Patti Bland, M.A., CCDC CDP, is director of the Train the Trainer Project for the Alaska Network on Domestic Violence and Sexual Assault in Juneau. Patti served both as an advocate and lead chemical dependency counselor at the New Beginnings for Battered Women and their Children shelter and community-based program in Seattle for eleven years. She developed the Domestic Violence/ Chemical Dependency Outreach Project for King County at the Alcohol Drug Help Line in 1994.

Patti served as the Domestic Violence Trainer for Providence Health System Family Violence Program for five years, as an Adjunct Professor at Antioch University (teaching graduate course work in psychology) as well as undergraduate course work at Seattle Central Community College. Patti also was an instructor for Child Protective Services at CPS Academy in Seattle, WA. She has published several articles on chemical dependency and domestic violence and completed development of domestic violence curricula for the Washington State Medical Association and the Perinatal Partnership Against Domestic Violence. Patti is the author of the Alaska Network on Domestic Violence and Sexual Assault Curriculum for Advocates.

OVERVIEW

Part II

MULTI-ABUSE TRAUMA: WORKING AT THE INTERSECTION OF SUBSTANCE USE DISORDERS, PSYCHIATRIC DISABILITIES AND VIOLENCE AGAINST WOMEN

By Patricia J. Bland, M.A., CCDC
and Debi Edmund, M.A., CADC

INTRODUCTION

The primary goal of the Alaska Network on Domestic Violence Real Tools Project is to help advocates, counselors and other professionals better address the safety and recovery needs of women impacted by multiple abuse issues, including domestic violence, sexual assault, trauma from past abuse, substance abuse or dependence and mental illness. The Real Tools Project also provides participants with tools to better address service needs and options.

Interpersonal violence, substance abuse or chemical dependence and mental health issues share several points in common (Bland, 2007). All:

- Involve power and control dynamics.
- Impact entire families, often harming 3 or more generations.
- Thrive in silence and isolation.
- Carry great societal stigma and shame.
- Limit freedom for members of our community, resulting in oppression.

Multi-abuse trauma: A definition

Multi-abuse trauma is a term used when an individual is impacted by more than one issue that negatively affects her safety, health or well-being (Slater, 1994). Examples include sexual assault, domestic violence, childhood sexual abuse, physical child abuse or neglect, substance use disorders, psychiatric disabilities such as depression or post-traumatic stress disorder, societal oppression, poverty, homelessness or incarceration.

Multi-abuse trauma often involves both *active* forms of abuse and *coping* forms of abuse. Active forms of abuse include the kinds of harm that one human being does to another, such as sexual assault, domestic violence, child abuse or neglect, emotional abuse, racism, sexism or homophobia. Coping forms of abuse are the methods that victims of active abuse may use to cope with their situation, such as substance abuse, compulsive eating, binging or purging, etc. The combination of active forms of abuse and coping forms of abuse may lead to further trauma, such

as prosecution or incarceration, and may also include the development of a myriad of long term health consequences for women and their children, (Felitti et al., 1998).

On the following pages advocates and other providers will find information about multi-abuse trauma and how to respond when a woman presents with multiple issues.

MULTIPLE LAYERS OF TRAUMA

Many women who come to domestic violence and/or sexual assault programs have multiple issues besides interpersonal violence. Among these issues are PTSD from past interpersonal violence or trauma, substance abuse or dependence, psychiatric disabilities, poverty and homelessness. While most women who have experienced interpersonal violence or abuse do not experience chemical dependence or mental illness, it is important to acknowledge many women receiving services from domestic violence/sexual assault programs are dealing with chemical dependence and recovery issues as well as mental health concerns stemming from trauma.

- Depression, post-traumatic stress disorder, anxiety and panic disorder are common among women in domestic violence shelters (Warshaw et. al., 2003).
- As many as 90 percent of people who have severe mental illness are survivors of at least one incident of trauma during their lifetimes (Akers et. al., 2007).
- One study of Illinois domestic violence shelters reveals as many as 42% of service recipients abuse alcohol or other drugs (Bennett & Lawson, 1994).
- Researcher William Downs reports findings indicating one in four women in an Iowa shelter/safe home sample had a lifetime diagnosis of alcohol dependence and another one in four had alcohol or other drug problems (Downs, 2002).
- The Women's Action Alliance's experience with a domestic violence shelter program over a fifteen-month period of time indicated 60-75% of the women seeking shelter services had developed problems with their original coping mechanisms, alcohol and drugs (Roth, 1991).
- Preliminary data from a National Institute on Drug Abuse study noted 90% of women in drug treatment had experienced severe domestic violence from a partner during their lifetime (Miller, 1994).
- The Minnesota Coalition for Battered Women (1992) notes abused women may also use alcohol or drugs for a variety of other reasons, e.g., coercion by an abusive partner, chemical dependency, cultural oppression, over-prescription of psychotropic medication or, for women recently leaving a battering relationship, a new sense of freedom.
- 74% of women in substance abuse treatment have experienced sexual abuse (Kubbs, 2000).

- 70% of prescriptions for tranquilizers, sedatives and stimulants are written for women (Roth, 1991).

- Psychotropic medication is over-prescribed for battered women (Minnesota Coalition for Battered Women, 1992).

While substance abuse does not directly cause domestic violence, research shows the presence of both increases both severity of injuries and lethality rates (Dutton, 1992). Fatality Review panels in Washington state identified substance use as an issue in 73% (n=8) of the reviewed domestic violence homicide cases over the past two years. In those cases, 100% of the abusers (n=8) and 62% of the victims (n=5) struggled with chemical dependency (WSCADV, 2006).

Social service providers and program participants alike are often confused about cause and effect when a woman has multiple issues. The ACE Study provides data linking adverse childhood experiences such as domestic violence and sexual abuse as factors contributing to mental illness, substance abuse and other health problems (Felitti, et al, 1998). However, the extent to which these and other issues make a person more vulnerable to interpersonal violence requires more study by feminist researchers.

It is important to emphasize battered women neither "ask for" nor deserve violence or abuse. The most important message you can give a woman whose experience includes multiple abuse issues is, "This is NOT your fault." This message is especially important if a woman has been under the influence, passed out or experiencing mental health symptoms at the time an abuser took advantage and hurt her. Along with this non-judgmental, non-blaming message, it is also important to offer a message of hope. While we can acknowledge co-occurring issues may make it harder for her to get safe, sober *or* whole, a woman experiencing multiple abuse issues must be reminded she is in control of her own decisions. She has options and advocates to support her safety, autonomy and justice. We can offer safe space, listen to her, believe her, validate her choices, and help her feel connected (Herman,1997). Support groups for women experiencing multiple abuse issues can also help foster connection and help women address emerging safety issues.

Safety issues

The co-occurrence of domestic violence and substance use (or misuse) is well documented and associated with increased lethality rates and greater severity of injuries for women impacted by these public health risks. Mental illness can also have an impact on safety. Co-occurring issues make it harder for a woman to get safe in a variety of ways (Bland, 1997; IDHS, 2000):

- Severity of injuries and lethality rates climb for women who experience both chemical dependence and battering (Dutton, 1992).
- A significant number of battered women and survivors of sexual assault with substance misuse or chemical dependence issues, typically experience discrimination and barriers to services (IDHS, 2000). Similarly, battered women with mental health concerns also face barriers and stigma (Warshaw et. al., 2003).

- Acute and chronic effects of alcohol and other drug use may prevent one from accurately assessing the level of danger posed by a perpetrator. Accurate assessment of danger may be impacted by thought disorder symptoms as well (Bland, 2007).
- Under the influence of alcohol or other drugs, or during a manic episode, one may feel a sense of increased power. Individuals may erroneously believe they can defend themselves against physical assaults and may not realize the impact of substances on their gross motor functioning and reflexes (Bland, 2007).
- Traumatic brain injury, mental health symptoms and substance use can impair judgment and thought processes (including memory), making safety planning more difficult (Bland, 2007).
- Alcohol and other drug use may be encouraged or forced by an abusive partner as a mechanism of control. Abstinence and recovery efforts may be sabotaged (IDHS, 2000). *For example, a domestic violence/sexual assault victim receiving methadone on a daily basis could easily be stalked.*
- There may be reluctance on the part of the individuals with mental health or chemical dependence symptoms to seek assistance stemming from fear of being labeled, institutionalized or medicated (Bland, 2007).
- There may be reluctance on the part of the crime victim to seek assistance or contact police for fear of arrest, deportation or referral to child welfare services (IDHS, 2000).
- The compulsion to use and withdrawal symptoms may make it difficult for victims of domestic violence/sexual assault who are actively substance-abusing and chemically dependent to access services such as shelter, advocacy, or other forms of help (IDHS, 2000).
- If she is using or has used in the past, or if she has ever disclosed mental health concerns, she may not be believed (Akers, et. al., 2007).

Additionally, inability to get safe or heal from interpersonal violence also makes it harder for a woman to address her co-occurring issues. For women in substance abuse treatment, failure to address current or past victimization can interfere with treatment effectiveness and can lead to relapse (SAMHSA, 1997). |A woman in recovery for a period of time also may find the stress of securing safety leads to relapse. Behaviors stemming from trauma, self-harming actions such as cutting or suicidal threats may make group living challenging. Alcohol or other drug overdose or suicide threats/attempts, etc. are indicators immediate intervention is required.

When any of a woman's issues are unaddressed, other problems may develop.

- Ability to maintain employment, housing, health insurance or child custody may be threatened by public disclosure of current or past substance abuse or mental health problems (Akers et. al., 2007). Societal attitudes tend to view chemical dependence and mental illness as moral failings rather than as health problems. This can lead to isolation and shame, which may be compounded when domestic violence and/or sexual assault co-occur.
- She may develop coping mechanisms to deal with continuing trauma, such as substance abuse or eating disorders to self-medicate PTSD stemming from interpersonal violence or abuse (Bland, 2007).

- Her attempts to escape victimization may be pathologized or even criminalized (Gilfus, 2002). An example of this would be an adolescent girl who runs away from home to escape incest and is forced into prostitution or is incarcerated in juvenile detention facility.

Additional layers of trauma may further complicate her situation. In addition to discrimination stemming from the stigma surrounding issues such as addiction or mental illness, she may face societal oppression due to race or ethnicity, social class, disabilities, sexual orientation or immigration status. Discrimination and social oppression may in turn lead to internalized oppression (Duran, 2006).

Barriers to service

Very few programs provide services for women impacted by multiple abuse issues including domestic violence, sexual assault, trauma, substance use problems and mental illness. Women impacted by multiple abuse issues are often invisible when in our programs or perceived as disruptive when their substance use or mental health issues become evident or unmanageable. Many times women with co-occurring or multiple abuse issues are missing from community programs altogether. Battered women and survivors of sexual assault who struggle with mental illness, substance abuse, chemical dependence or trauma issues often need our services the most. Yet, mmultiple issues make it harder for a woman to access appropriate services:

- Her behavior may bar her from services (IDHS, 2000). For example, a substance abuse or dependence problem may lead to repeated curfew violations or lead her to leave shelter prematurely. Psychiatric disabilities may make it harder for her to understand or follow certain rules (Akers et. al., 2007).
- If she lives in an urban area with many kinds of services, the system may be fragmented and she cannot receive everything she needs from one provider (Akers et. al., 2007). She may need to go to one provider to access services for domestic violence services, another provider to obtain treatment for a substance use disorder, and still another provider for mental health services. Each provider may have different rules, some of which conflict.
- If she lives in rural or remote area, services may be extremely hard to access, or may not be available at all (Bland, 2007).
- She may be unable to afford services (Warshaw et. al., 2003). And even if services are free, she may be unable to afford the transportation and babysitting costs needed to keep appointments.
- There may be a lack of gender-specific, family-focused services (Bland, 2007).
- She may have caregiver responsibilities or fear losing her children (Warshaw et. al., 2003).
- She may fear social stigma and guilt (Warshaw et. al., 2003). Women with either a substance use disorder or mental illness face tremendous stigma and are often considered bad mothers, bad people, bad victims and resistant to treatment.

- Co-occurring issues may create challenges for shelter staff and other service providers who lack cross-training on issues other than the one for which the agency provides services (Akers et. al., 2007).
- Battered women attending support groups for women with multiple abuse issues in Seattle, WA have disclosed batterers may try to lure them from shelter by offering drugs, sabotage recovery efforts by demanding they leave treatment against medical advice, prevent them from attending self-help or other support groups, make false or exaggerated allegations to the Office of Children's Services, terrorize them with threats of institutionalization and/or blame the abuse on them for their substance use disorder or mental health status (Bland, 2007).

Barriers to cooperation between providers

Every program has strengths and challenges impacting our ability to provide services. Unfortunately many advocacy programs are under-equipped to address co-occurring substance use or mental health issues impacting women's safety and health. Similarly, chemical dependency treatment services and mental health providers often struggle when addressing domestic violence, sexual assault and stalking.

In order to better extend services and advocacy to battered women with separate issues of trauma, mental illness, substance misuse or chemical dependence, providers must expand current practices and explore new strategies to address safety and support wellness. Cooperation between providers is needed in order to address the multiple issues involved in multi-abuse trauma. However, many barriers to such cooperation exist:

- Because social service systems in many communities are fragmented, providers themselves may have trouble keeping up with what's available.
- Providers from different disciplines such as women's advocates, chemical dependence counselors and mental health providers often have differing philosophies and theoretical orientations and may not trust each other because of this (Warshaw et. al., 2003). Additional trust issues may develop stemming from cultural differences between providers – for example, "wounded healers" vs. "professionalized" staff, "expert" role vs. "peer" role, and services within indigenous communities vs. those provided by the dominant culture (Duran, 2006).
- Providers have valid ethical concerns about working beyond their own competence level (SAMHSA, 1997).
- Agencies lack funding or funding streams don't favor integrated or co-located services (IDHS, 2000).
- Naive, inexperienced or inadequately trained staff may fail to adequately understand tactics batterers use or underestimate their willingness to go to whatever lengths are necessary to maintain control of those they perceive as belonging to them. This serious mistake can leave providers vulnerable to manipulation by batterers and subject to collusion. Failure to identify risk undermines treatment efficacy and victim safety. It may also lead to increased liability.

Consequences when co-occurring issues are not adequately addressed

When a woman's multiple problems are not adequately addressed, serious consequences may follow.

- She may believe she has no other choice but to return to her abuser again and again, because she has nowhere else to go where she feels welcome or safe.
- She may bounce in and out of the system, moving from one social service agency to another, resulting in a revolving door syndrome in which her problems are never adequately addressed (Akers et. al., 2007).
- Inability to access appropriate services makes it more likely that trauma of all kinds – continued abuse, poverty, etc. – will continue, resulting in even more trauma.
- Batterers are not held accountable for their actions and benefit from lack of services for battered women with multiple abuse issues. Batterers also benefit from the stigma and discrimination battered women with multiple abuse issues face. This stigma and discrimination is often fostered by batterers who use substances to induce debility and better control their partners (Hampton, 2005). Abusers may encourage, trick or force a targeted individual to use substances to facilitate rape, to undermine their victim's credibility, their access to their children and their access to support of any kind.

Still more trauma

Inability to access appropriate services creates its own trauma. The system itself often traumatizes women with multiple issues, and adds to their problems.

- When social service fragmentation leads to a woman getting passed around to numerous providers, she may be left with the feeling no one cares about her or wants to deal with her issues.
- Each provider may have their own theory about what causes her problems. If she is pressured to adopt these conflicting theories, she may become confused and angry.
- As a woman with multiple issues revolves around the system, she may acquire multiple labels. She then becomes defined by her labels rather than viewed as a human being, and is thus dehumanized by providers in the system as well as by the abuser she is in a relationship with.
- The experience of being labeled, dehumanized, and passed around the system re-traumatizes a woman with multiple issues, making it even more difficult for her to address her issues.
- Intimate partner violence, substance abuse or dependence and mental illness all may result in a woman becoming homeless (NCH, 2006). Mental illness and homelessness have become criminalized, and jails and prisons have become a dumping ground for warehousing mentally ill and homeless people (Treatment Advocacy Center, 2007).

- The tools a woman or girl uses to cope with trauma – such as substance abuse, prostitution or running away from home (if under 18 years old) – are often criminalized (Gilfus, 2002).

- If a woman with multiple issues ends up homeless or incarcerated, she may then suffer PTSD from the homeless or incarceration experience (Wong, 2007).

In four of the five cases in which Fatality Review panels identified substance use as an issue for the domestic violence homicide victim, the victims had been arrested at least once for a drug related crime and had to complete a chemical dependency evaluation as a part of their sentence or deferral program (WSCADV, 2006).

The fifth victim also had a criminal history, but the charges filed against her were for assaults and crimes related to being homeless, such as criminal trespass for sleeping under an overpass (WSCADV, 2006).

HOW SHOULD ADVOCATES RESPOND TO MULTI-ABUSE TRAUMA?

A woman who has been traumatized by multiple issues may have trouble trusting others, even people who appear to have good intentions. She may not trust advocates or other social service providers for a variety of reasons (Edmund, 2007):

- *Negative past experiences with advocates, social service agencies or providers.* She may have been passed from one agency to another for years without getting her needs met. Or she may have encountered advocates or providers who treated her in ways that felt confusing or disrespectful.

- *Fear of authority figures.* She may have encountered advocates or providers who acted as authority figures, abused their power, discounted her, blamed her for her problems or used what she told them against her later.

- *Fear of legal sanctions.* She may fear prosecution if she discloses illicit drug use or other illegal behavior such as theft or prostitution. If she has been incarcerated, she may fear going back to jail or prison.

- *Fear of being judged*. She may have heard repeatedly that her problems are caused by her own behavior, lack of personal responsibility, inappropriate decisions or bad character traits.

- *Fear of being discounted.* She may have a history of not being believed when she is telling the truth, especially if she is a survivor of violence or abuse or has a substance use disorder, mental illness or developmental disabilities.

- *Fear of encountering stereotypes on the part of the provider.* She may have encountered people who avoided or excluded her because of her race, culture, socioeconomic

background, experience of violence, substance use history, mental health status, etc. Other providers may have trouble trusting the participant because of stereotypes or unconscious bias, and may create rules and restrictions based on this lack of trust.

- *Fear of losing her children.* She may fear disclosure of parental substance abuse, mental health concerns, domestic violence or illegal activities will trigger an investigation by a child welfare agency. If she has a substance use disorder, mental health issue, or physical or developmental disabilities, she may fear being judged incompetent to provide adequate parenting.

- *Fear of being denied services.* She may fear being barred from a shelter or residential facility, denied public assistance or disqualified from other benefits if she discloses issues such as domestic violence, substance abuse, mental illness, prostitution or past incarceration. A participant who receives public aid may fear losing benefits if she discloses that she is living with a partner.

- *Fear of losing autonomous decision-making power.* Advocates and other providers who think they know the program participant's needs better than she does may try to impose their own solutions and values on her. A program participant who must abide by curfews or request a pass (get permission) to see friends or relatives may feel as if she is being treated like a child.

- *Fear of reprisals.* She may fear retaliation from the perpetrator if she reports sexual assault to the police, seeks an order of protection against a violent partner, or reports any kind of abusive behavior directed toward her in an institutional setting.

- *Fear of being scapegoated.* She may fear being accused of things she didn't do. For example, if she discloses a history of substance abuse or incarceration, she may be the prime suspect if something turns up missing from a shelter or residential facility.

Ultimately, mistrust stemming from negative stereotypes may serve as an excuse for advocates and providers to create oppressive, disempowering rules and restrictions rooted in ignorance, bias and fear. This misuse of power is counter to the mission of the battered women's movement and has the potential for confirming seeds of doubt planted by an abuser who may very well have said, "After a week in the shelter, you'll be back."

Gaining trust

Despite her valid reasons for not trusting others, a woman with multiple issues needs someone who she trusts enough to honestly tell as much of her story as she chooses to share when she is ready, if safety and recovery and healing are to occur. Here are some ways to demonstrate your trustworthiness and begin the process of gaining trust:

- Be willing to earn her trust. Try not to be hurt or offended if a traumatized woman who has been battered or sexually assaulted is angry or doesn't trust you right away. Allow her to take as much time as she needs to begin to trust you. Understand this lack of trust has more to do with her life experience and your role than it does about you personally.

- Recognize all people need to earn trust and advocates and counselors are no exception. Trust isn't automatic just because someone wants to help or is in a position of authority.

- Encourage her to participate in developing safety, service and treatment plans. This can help give her a sense of control.

- Explain what you are doing and why, up front. No surprises. If she suspects information is being withheld from her or she is being manipulated in any way, trust evaporates.

- Explain the limits of your confidentiality at the beginning of the intake process, before anyone begins talking. This may impact which issues she feels safe sharing with you.

- If lack of appropriate training or credentials prevents you from answering a question or providing a certain kind of assistance, explain this to her. Make an appropriate referral and emphasize she is not wrong for coming to you with this particular problem. Make it clear you will help her figure out who can provide the needed help and are happy to explore options with her.

- Acknowledge controversial issues. When advocates and providers are in conflict with each other over theoretical issues or philosophies, a woman with multiple issues can get caught in the middle. When program staff refuse to acknowledge the controversy – or worse, accuse the program participant of manipulating by pitting one advocate or provider against another – this creates frustration and confusion.

- Model healthy relationships and behavior. How staff and supervisors interact with each other models use of power in relationships. An abusive workplace sends an entirely wrong message.

- Walk the talk. If we have a different set of standards for ourselves than we have for program participants we convey the message we feel superior to the people we serve.

- Believe her! Do this, even if she seems confused or out of touch with reality, or says something that may be inaccurate. Try asking yourself, "What might be happening to make this seem true for her?" Consider how some of her behaviors and beliefs make sense or could be a reasonable response to multi-abuse trauma. Don't ask, "Why is she acting this way? Ask, "What happened to her to trigger this response? How can I help her find a safer way of coping that causes her less grief?"

- Consider these words of Mario Paredes from Consejo in Seattle who was once asked if a woman he was providing services to had a problem with her mental health. His reply: "No, she has a problem with her husband." When asked if the husband had an anger problem, Paredes responded, "No. He has a behavior problem. Her mental health issues are a reasonable response to the intentional fear he is causing by his intimidating behavior."

Discussing multiple issues

Interpersonal violence, substance abuse or addiction and mental health issues impacting safety, sobriety and wellness may be easily missed if we don't ask about these concerns in a non-threatening manner. Women may find it easier to talk about stress in their relationships or their

partner's substance use or mental health *before* talking about domestic violence, sexual assault or their own substance use or mental health. When discussing any of these issues:

- Conversations must be respectful, private and confidential. Make her as comfortable as possible and assure confidentiality of records when applicable. Confidentiality is extremely important. People experiencing domestic violence or suffering from substance use issues or chemical dependence may have been told they will be harmed if they reveal what is happening.
- Children should not be present.
- Validate her resourcefulness: "I'm so glad you found a way to survive." "You deserve a lot of credit for finding the strength to talk about this." "You are here today and you are doing quite a bit right." Credit each individual for finding a way to cope and offer options to make coping and surviving safer.
- At the same time, discuss risks in a respectful manner: "Drinking/drugging/cutting, etc. can kill pain for a while but there are safer ways of coping that can cause you less grief." "Addressing these concerns can help you and improve your children's safety and well-being, too." Express concern about the risks of multiple issues for both the individual and any children. Provide objective information about legal and health consequences stemming from multiple abuse concerns.
- Ask open-ended questions: "What have you done to keep safe/sober/well up until now?" "What have you been able to do to care for yourself and the welfare of your children?" "What has worked well for you and the children and what has given you problems?" "Many people tell me they have tried_____. How often has this worked for you?"
- Validate concerns and use supportive statements: "I'm sorry this happened. It's not your fault."
- "Right now you may be feeling stress but there may be some safer coping tools you might like to consider." "Give yourself credit. You've been doing your best in these circumstances."
- Avoid revictimizing: People do *not* choose to develop multiple abuse issues. Believe that domestic and sexual violence, substance use problems and mental health issues are traumatic and painful. Believe people do their best to survive. Assume the attitude she is doing the best she can and wants what is best for herself and her children.

Working with diversity

A successful culturally competent intervention incorporates awareness of one's own biases, prejudices and knowledge about the people we serve and their culture, along with recognition of professional power (power differential between staff and program participants) in order to avoid imposing one's own values on others. When working with women from different backgrounds:

- Recognize privilege.
- Be careful not to pathologize cultural differences or other kinds of diversity.

- Recognize that "recovery culture," mental health ("brain styles"), social class, etc. are diversity issues, as much so as race, gender, etc., and need to be accommodated and respected.

- Communication should be age and developmentally appropriate as well as culturally relevant.

- Each culture has its own set of "unwritten rules" governing appropriate behavior. People from diverse cultures may or may not "know" the unwritten rules prevailing at a shelter or other agency. Our rules may not reflect the values of program participants and can induce fear, confusion, isolation and/or anger. Be conscious of the impact your world view has on others.

- Being culturally competent is a life long process and requires advocates and other providers to do their homework on a daily basis. Ask for feedback. Develop flexibility and an open mind. Addressing violence involves addressing racism, sexism, classism, ableism, homophobia, addict phobia and any form of oppression that contributes to violence against women.

- Recognize same sex batterers use forms of abuse similar to heterosexual batterers but they have an additional weapon in the threat of 'outing' their partner to family, friends, employers or community (Lundy, 1993).

- Use an interpreter when necessary. Avoid using children, relatives of the batterer or people who do not understand confidentiality and domestic violence, sexual abuse and stalking issues.

- Confidentiality may be an even more important issue for an undocumented woman. Undocumented women fear being reported to Immigration and Naturalization Services *(now known as Immigration and Customs Enforcement or ICE)* by law enforcement or social services personnel from whom they may seek assistance (Jang, 1994). Reassure an undocumented woman you are not required to tell ICE about her.

- All providers should get to know the cultures existing in their community, and seek to have diversity on their staff (Duran, 2006).

Empowering women with multiple issues

Understanding multiple abuse and its impact on safety, autonomy and justice is critical. Advocates and their community partners should have training and skills to recognize signs of multiple abuse such as intimate partner violence, sexual abuse, substance use problems, trauma, and other mental health concerns *(e.g. anxiety, depression, suicidal ideation, thought disorders, etc.)*. Here are some additional ways to ensure service capacity and empower women with multiple issues:

- Develop policies and procedures to ensure program accessibility and non-judgmental, non-punitive service provision for women impacted by multiple abuse issues.

- Make it clear to her (and to other providers) that no woman deserves violence or abuse, no matter what else is going on. Acknowledge harm has been done and say, "This is not your fault. Your children's safety is important and so is your safety."

- Validate her frustration when she finds it difficult to access the services she needs.

- "Normalize" her responses to her situation, rather than pathologizing her. Normalize questions and find a way to discuss multiple issues that is comfortable for both of you.

- Be flexible – allow each program participant to tell us what she needs and when, rather than taking a cookie-cutter approach. The relationship between program participant and provider should be more like a dance – with the provider following the program participant's lead.

- Have patience. Change often happens slowly, and it may it may take a woman several tries before she succeeds in leaving an abusive partner or achieving sustained recovery from chemical dependence (IDHS, 2000) should either, or both, be her choice.

- Change your attitude if you think leaving is the only answer. A battered woman may have religious, economic, family or other reasons why she remains in her relationship and it is not our role to tell her what to do. Likewise harm reduction methods or choosing not to use medications may be controversial but also are options women with substance abuse or mental health issues may choose to explore.

- Affirm her autonomy and her right to control decision-making. Affirm her choices and explain benefits of safety planning, stopping or reducing use and seeking wellness. Advocates and other providers are asked to remember to offer respect, not rescue; options, not orders, and safe advocacy or treatment rather than re-victimization.

- Provide intensive service coordination should a woman request it. Ensure women impacted by substance use problems or chemical dependence, trauma, and other mental health issues know about available resources. Explore options such as shelter, counseling, gender specific treatment, support groups addressing multiple problems, safety planning and linkage to other providers. Also, discuss financial options, insurance, and services for children.

- Integrate the philosophies employed by many substance abuse counselors, mental health providers and women's advocates, to ensure women coping with substance use problems, trauma and interpersonal violence (e.g. domestic violence, sexual assault, stalking) can use services safely and without confusion.

- Make use of support groups. Because women impacted by trauma such as domestic and/or sexual violence and co-occurring substance use, misuse or dependence may be at greater risk for injury and lethality, support groups addressing mental health and substance use as safety issues are essential. Moderated support groups may be better at first. In the Real Tools manual, we have included a sample support group format and handouts.

- Provide clear communication. If there is any kind of sanction or consequence imposed by staff on program participants for doing or not doing something a certain way, then we

are talking about a *rule*, a *requirement* or a *policy* and should not be using any kind of language that implies "optional." Referring to a *rule* as a *suggestion* or a *recommendation* can be confusing, especially to people on the autism or FASD spectrums, who may tend to interpret language literally (Attwood, 2007).

A survivor of multiple abuse shared, "I think most people – including people seeking services from a social service agency or a shelter – are willing to abide by a few reasonable rules, with the emphasis on 'a few' and 'reasonable.' Authoritarian, to me, is when we have dozens of these rules, there are no exceptions, even when one is clearly called for, and we're told we don't need to know the reasons for them"(Name withheld, 2008).

- Developing program guidelines is generally more empowering than enforcing a litany of rules. However, the term *"guidelines"* implies flexibility. Such terminology should not be misused to mask authoritarian practice, nor to disguise or hide a rule. Doublespeak is a tactic of abuse. Use the term *"guidelines"* only when your policy truly provides a range of options.

  "There are few things more infuriating than being punished or sanctioned for not doing something that was supposedly 'optional!' I think it's good to have staff who want to avoid being authoritarian. However, instead of using 'hedge' language, staff worried about sounding authoritarian may wish to actually keep their rules or requirements to a minimum and ask themselves how many of these are really necessary. If a policy does seem necessary, then be willing to explain why and be willing to make an exception where one is called for" (Name withheld, 2008).

Working with other providers

When working with women impacted by multiple issues, cooperation with other community providers is essential. Develop community partnerships or work groups to address these issues together. Brown bag lunches and Peer Review while maintaining confidentiality can be helpful. When working with other providers:

- Do not imply other social service providers are bad people, or negligent in some way. They may be unable to provide certain services for very valid reasons, such as ethical concerns about providing services beyond their level of expertise.

- Acknowledge controversies rather than pretending they don't exist (denial!) – "wounded healers" vs. "professionals", "peers" vs. "experts", theoretical differences, etc.

- While it's important not to dilute one's own message, try to get past "language" differences and listen for the content of what the other person is saying.

- It may help to find areas of agreement first, then work on addressing differences.

- Advocates and other providers need training to recognize co-occurring issues and make appropriate referrals. Advocates and other providers also need to provide education and cross-training in partnership with each other.

- Training should address dealing with conflict stemming from philosophical differences among multiple helping systems and emphasize the importance of working together for the benefit of mutual program participants.

- There is a need for system-wide advocacy – legislation, and policy change at the agency and community level (Warshaw et. al., 2003). Advocates and other service providers need to advocate for more funding for services of all kinds; better access to services, especially for diverse groups and for women living in rural/remote areas. We also need to advocate for system change and funds to provide anti-oppression education designed to erase stigma/discrimination.

- Encourage women to advocate for themselves. Advocacy on their own behalf can empower women, and can aid in the healing process as well (Edmund & Bland, 2000). Examples may include participating in a Take Back the Night rally or a Recovery Walk if it is safe to do so, or writing a letter to an elected official urging policy change. Survivors of multi-abuse trauma often welcome the opportunity to advocate on their own behalf and may resent the idea that someone else needs to speak or act for them.

Hold batterers accountable for their behavior. Don't blame victims of domestic violence, sexual assault, stalking or other forms of abuse for the harm that has been done to them or the tools they have used to cope. Remember, in many cases batterers have fostered substance use and created stress and trauma for the women they have hurt and abused.

CONCLUSION

We can support women seeking safety, sobriety, autonomy, justice and wholeness by reducing program service barriers and ending isolation for women impacted by multiple abuse issues and for their children. Training for advocates and community partners such as substance abuse professionals and mental health providers is essential. Policies and procedures to ensure culturally competent, appropriate, non-punitive and non-judgmental accessible services are key. Holding batterers accountable for their behavior is critical. Also providing education and training designed to undermine the underpinnings of violence such as racism, classism, sexism, homophobia and ableism (including addict phobia) is also a critical element of our work to end violence against women and end oppression on all fronts. Tools to help advocates and other providers accommodate program participants, definitions and resources are provided in the Appendix to this chapter.

APPENDIX

REAL TOOLS TO ENSURE BETTER PROGRAM ACCOMMODATION

TO BETTER ACCOMMODATE ASK: SAMPLE QUESTIONS AND FRAMING STATEMENTS

Sample Screening Questions

Women often report feeling stress in their relationship. How does your partner show disapproval?

Please describe any threats made by your partner. (How often? When was the last time? Were you afraid? Were you hurt? Can you tell me what happened?)

Sample Framing Statements

Domestic Violence and sexual assault are major problems for women. Because abuse is such a common experience for women, I ask everyone I see whether they feel safe.

Women in treatment often tell me their partners complain about their using. How does your partner show disapproval?

Sample Indirect Questions

You mentioned your partner loses his temper with the kids. Can you tell me more about that? Have you ever felt afraid for yourself or your children? Can you tell me more about that?

All couples argue sometimes. Does your partner's physical or sexual behavior ever frighten you?

Sample Screening Questions if Partner is User or Abuser

Many women tell me their partners don't want to *drink/drug/smoke* alone. How often do you find yourself using when you don't really want to?

When a partner spends family money on drug use, it is a form of economic abuse. Has your partner ever used food or rent money to drink or score drugs?

Sample Framing Questions for Substance Abuse

Women I see often tell me they feel stress. There are several ways to deal with stress. What works best for you?

Many women tell me they try to sleep more, eat better or shop for baby things. Have you tried any of those ways of coping?

Many women also tell me the best way to cope is to smoke a cigarette, have a drink or take something else. How often has that worked for you? Do you find it is still working?

Being involved in a *court case/custody dispute* can be stressful. Your partner may attempt to undermine *you/ your parenting skills*. Can you identify any reasons why drinking or using drugs right now could be harmful to your case? Can you share with me what your partner might say about your drinking or drug use?

Remember to ask direct questions tactfully and respectfully!

*These questions may help advocates and other providers identify accommodation needs for program participants using services. Answers to these questions are **NOT** used to screen people out. They are provided to help program participants address safety or health risks stemming from multiple abuse issues.*

CAGE-AID QUESTIONS

1. Have you ever felt you ought to cut down or stop using alcohol or other drugs? (**C**ut down.)

2. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? (**A**nnoyed.)

3. Have you felt guilty or bad about how much you drink or use? (**G**uilty.)

4. Have you been waking up wanting to have an alcoholic drink or use drugs? (**E**ye-Opener)

Adapted from J.A. Ewing (1984). "Detecting Alcoholism: The CAGE Questionnaire," *Journal of the American Medical Association* 252: 1905-1907.

CAGE-DV

1. Have you ever felt **C**ontrolled or threatened by your partner?

2. Has anyone **A**nnoyed you or gotten on your nerves by expressing concern about your partner's behavior towards you?

3. Have you felt **G**uilty or bad about how your partner treats you?

4. How often do you wake up anxious, afraid or wanting to **E**scape your partner?

Adapted by P. Bland from J.A. Ewing (1984). "Detecting Alcoholism: The CAGE Questionnaire," *Journal of the American Medical Association* 252: 1905-1907.

Remember to ask direct questions tactfully and respectfully!

*These questions may help advocates and other providers identify accommodation needs for program participants using services. Answers to these questions are **NOT** used to screen people out. They are provided to help advocates assist program participants addressing safety or health risks stemming from multiple abuse issues.*

4 P'S FOR SUBSTANCE ABUSE

1. Have you ever used drugs or alcohol during **P**regnancy?
2. Have you had a problem with drugs or alcohol in the **P**ast?
3. Does your **P**artner have a problem with drugs or alcohol?
4. Do you consider one of your **P**arents to be an addict or alcoholic?

Ewing H. Medical Director, Born Free Project. Contra Casta County, 111 Allen Street, Martinez, CA 94553. Phone: (510) 646-1165.

4 P'S FOR DOMESTIC VIOLENCE

1. Have you ever been hit or hurt by your partner during **P**regnancy?
2. Has your *(current or former)* partner been violent or abusive in the **P**ast?
3. Does your *(current or former)* **P**artner have a problem with violence or abuse now?
4. Do you consider one of your **P**arents to be violent or abusive?

Adapted by P. Bland from the 4 P's alcohol and other drug screening tool developed by H. Ewing, Medical Director, Born Free Project.

Remember to ask direct questions tactfully and respectfully!

*These questions may help advocates identify accommodation needs for program participants using services. Answers to these questions are **NOT** used to screen people out. They are provided to help advocates assist program participants addressing safety or health risks stemming from multiple abuse issu**es.***

EMOTIONAL WELL-BEING: SAMPLE QUESTIONS TO ENSURE BETTER ACCOMMODATION

To better accommodate a program participant's needs the following questions can be asked following intake to provide information about how staff can best respond when a survivor is having an emotional crisis.

- What are situations that are particularly difficult for you or make you feel unsafe or upset (*i.e., noise, not being listened to, loneliness, being teased, contact with family, being alone, laughter, yelling, crying, being touched, time of year, time of day, particular dates/holidays, certain words, crowds, malls, bus stops, doors open/closed, smells, sounds, contact with certain people, etc*.)?

- What signs do you notice when you are beginning to feel stressed and out of control (*sweating, breathing hard, sleeping a lot, restlessness, crying, avoiding people, feeling hyperactive, eating more, eating less, etc*.)?

- If you are anxious or angry and those feelings are getting so intense they may be impacting your safety or another person's safety, how would you prefer that staff members assist you?

- What has been particularly helpful to you in the past when you had a difficult time with your thought and/or feelings (*such as more time in a quiet area, physical exercise, talking to a friend or family member, taking a bath or shower, meditation, reading, leaving the room, listening to music, journaling, reading, medication, etc*.)?

- What has not been particularly helpful to you in the past when you had a difficult time (*such as being asked to stay in a room, not being taken seriously, noisy environment, etc*.)?

- Is there a person who has been helpful to you when you were overwhelmed or distressed? Would you like to call that person if you get distressed here? Do you have that telephone number? Would you give us written consent to call this person if you are in great distress and we cannot seem to help?

- Have you noticed any triggers that you associate with being anxious or angry? If so, what are these triggers?

- Do you have coping strategies to deal with difficult memories? Group living can trigger difficult memories especially if you were ever hospitalized for mental illness or been in treatment for substance addiction. Are there any situations that might trigger difficult memories for you here? Let us know if there are ways we can offer emotional support to you during your stay?*

- *If room checks are part of the routine at the shelter:* Is there anything we can do to make the room checks comfortable for you?

- If you are taking medications and have concerns about them during your stay please let us know. Sometimes an abusive partner controls medication, tampers with meds, steals meds or withholds meds. If you take any medications, need them and were not able to bring them with you to shelter, let us know. We can provide you with information and referrals or advocacy to better accommodate you during your stay.*

- Please also advise us if you think your medication(s) is not working effectively for you or if there are any side effects from the medication(s) that we should know about to better support you during your stay. If you need or have reminders to keep your medication schedule let us know how we can help you.*

- If there is one thing I could do for you today to make life easier, what would it be?*

Reprinted by permission from *Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues* by Dianne King Akers, M.Ed., Michelle Schwartz, M.A., and Wendie H. Abramson, LMSW. Adapted from Carmen, E., et. al. (1996, January 25). *Task force on the restraint and seclusion of persons who have been physically or sexually abused: Report and recommendations.* Massachusetts Department of Mental Health.

(Note: Sections noted with an asterisk * were adapted by P. Bland, 2008).

DEFINITIONS

12 Step Program – a self help group that is often used as an adjunct to treatment but which is NOT treatment. 12 step programs can support lifetime recovery and can be extremely useful however battered women will also benefit from referrals to gender specific groups and battered women's advocacy programs for safety planning as a recovery issue (Bland, 6/2001).

Active forms of abuse - include the kinds of harm that one human being does to another, such as sexual assault, domestic violence, child abuse or neglect, emotional abuse, racism, sexism or homophobia. (Bland, 1997)

Addiction/Chemical or Substance Dependence/ Substance Use Disorder (SUD's) - are characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with use, use despite adverse consequences and distortions in thinking, (e.g. denial). The neurochemical dysfunction in addiction/dependence/SUD's is best described as a chemical deficiency in pathways of the brain. (Above definitions developed by APA & ASAM adapted by DV/SA Task Force of IL DHS, 7/2000)

Addict-phobia – includes fear of people with substance use problems, disorders or dependence) and addiction (chemical dependence or substance use disorders), holding negative stereotypes pertaining to people suffering from substance use problems; refraining from offering services, support or respect. Addict-phobia creates barriers for those who are afraid of getting labeled and fearful about seeking help. Additionally, addict-phobia negatively impacts people struggling to recover daily. Examples of addict-phobia include mistaken belief systems about addiction/dependence, failure to understand triggers, unrealistic expectations, lack of knowledge about brain chemistry, liver function, relapse processes, resources and recovery options as well as failure to understand appropriate role of accountability, consistency and structure. Addict-phobia makes it possible for individuals and systems to establish (overly rigid or overly permeable) criteria which can limit or prohibit access to services or successful outcomes to an entire class of people. Addict-phobia is a form of oppression in our society. (Bland, 6/2001).

Alcoholism – a treatable illness brought on by harmful dependence upon alcohol which is physically and psychologically addictive. As a disease, alcoholism is primary, chronic progressive and fatal. (CSAT/ACF Seminar Series Substance Abuse Lexicon, 5/2001).

****Binge*** – using large amounts of alcohol or other drugs in a short period of time. Binge drinking for women may be defined as four or more drinks in one drinking session at least once every two weeks but being abstinent in between those times.

Blackout - an amnesia like period often associated with heavy drinking
While blackouts impact memory, there is no evidence to support contention that blackouts alter judgment or behavior at the time of occurrence (Kinney & Leaton, 1991).

****Cocaine psychosis*** – a drug-induced mental illness; symptoms include extreme paranoia and hallucinations. Similar psychosis is associated with amphetamine use.

****Coke bugs*** – imaginary insects a long-term cocaine abuser thinks are crawling under the skin. They often cause substance abusers to scratch themselves bloody. Similar activity is associated with amphetamine use.

Cognitive Impairments – disruptions in thinking skills such as inattention, memory problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases). (This and the following definitions are from CSAT/ACF Seminar Series Substance Abuse Lexicon, 5/2001).

Coping forms of abuse - are the methods victims of an active form of abuse may use to cope with their situation, such as substance abuse, compulsive eating, binging or purging, etc.(Bland, 1997)

****Craving*** – the powerful desire to use a psychoactive drug or engage in compulsive behavior. It is manifested in physiological changes such as change in heart rate, sweating, anxiety, drop in body temperature, pupil dilation and stomach muscle movements. Endogenous craving is caused by neurochemical changes in the brain, such as depletion of dopamine resulting from cocaine use. Other cravings are caused by environmental triggers (cue cravings).

****Cross-dependence*** – occurs when an individual becomes addicted to or tissue dependent on one drug, resulting in biochemical and cellular changes that support addiction to other drugs.

****Cross-tolerance*** – the development of tolerance to other drugs by the continued exposure to a drug that affects body mechanisms to tolerate other drugs (e.g., tolerance to heroin translates to morphine, alcohol and barbiturates).

Delirium Tremens (DT's) – When the level of alcohol in the blood drops suddenly and the person becomes delirious as well as tremulous and suffers from hallucinations that are primarily visual but also may be tactile.

Detoxification – The process of providing medical care during the removal of dependence producing substances from the body so that withdrawal symptoms are minimized and physiological function is safely restored. Treatment includes medication, rest, diet, fluids and nursing care.

Dual Diagnosis /Co-Occurring Disorder – Clinical terms referring specifically to patients who meet the diagnostic criteria for a substance use disorder as well as meeting the diagnostic criteria for:

1.) An organic mental or developmental disorder
2.) A major psychiatric disorder with or without current symptomology
3.) A personality disorder or
4.) A compulsive disorder such as an eating or pathological gambling disorder.

Euphoric Recall - memories formed under the influence that may be used as inappropriate excuse to minimize, rationalize or deny behavior (Johnson, 1980).

****Harm Reduction*** – a tertiary prevention and treatment technique that tries to minimize the medical and social problems associated with drug use rather than making abstinence the primary goal (e.g., needle exchange and methadone maintenance

Mentally Ill Chemical Abusers (MICA) – A term used to designate people who have an AOD (alcohol or other drug) disorder and a markedly severe and persistent mental disorder such as schizophrenia or bipolar disorder.

Methadone – A synthetic narcotic. It may be used as a substitute for heroin, producing less socially disabling addiction or aiding in withdrawal from heroin.

Multiple Abuse Trauma - Multi-abuse trauma is a term used when an individual is impacted by more than one issue that negatively affects her safety, health or well-being (Slater, 1994). Examples include sexual assault, domestic violence, childhood sexual abuse, physical child abuse or neglect, substance use disorders, psychiatric disabilities such as depression or post-traumatic stress disorder, societal oppression, poverty, homelessness or incarceration.

Post Traumatic Stress Disorder (PTSD) – a type of anxiety disorder that can occur after a person has undergone a severely traumatic event in which a person perceives a threat to life or physical health, such as domestic violence or sexual assault (NIMH, 2006).

Relapse – Is common in recovery from addiction and not considered treatment failure. As with other chronic illnesses, significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

Substance abuse/substance misuse - a destructive pattern of drug use including alcohol (alcohol = ETOH) which leads to clinically significant impairment or distress. Often the substance abuse/substance misuse continues despite significant life problems. When a person exhibits tolerance and withdrawal the person has progressed from abuse to *Addiction* (a disease consisting of a number of brain chemistry disorders).

Tolerance - the need for significantly larger amounts of substance to achieve intoxication. Drug effects decrease if the usual amount is taken.

Withdrawal - adverse reaction after a reduction of substance.

Definitions compiled by Patti Bland, and Hoog, Cathy. 2001. *Enough and Yet Not Enough: An Educational Resource Manual On Domestic Violence Advocacy For Persons With Disabilities In Washington State.* Seattle, WA: Washington State Coalition Against Domestic Violence.

For information about this and other useful publications from WSCADV see wscadv.org or contact:

Washington State Coalition Against Domestic Violence
WSCADV - Seattle Office
1402 - 3rd Ave, Suite 406
(206) 389-2515
(206) 389-2520 FAX
(206) 389-2900 TTY

Definitions noted with asterisk are from Inaba, D.S. and W.E. Cohen. 2000. *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs,* 4th Edition, Ashland, OR: CNS. Other definitions compiled by Patti Bland, and Hoog, Cathy. 2001. *Enough and Yet Not Enough: An Educational Resource Manual On Domestic Violence Advocacy For Persons With Disabilities In Washington State.* Seattle, WA: Washington State Coalition Against Domestic Violence. For information about this and other useful publications from WSCADV see wscadv.org or contact:

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PTSD definition from SafePlace. For additional information about mental illness diagnoses, symptoms and treatments written primarily for advocates see also: Akers, D., Schwartz, M. and Abramson, W. *Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues*. Austin, TX: Safe Place. For information about the Safe Place Manual contact:

SafePlace
P.O. Box 1954, Austin, TX 78760
512-267-7233
512-482-0691 (business TTY)
www.austin-safeplace.org

For additional information on trauma and mental health issues contact: **The National Center on Domestic Violence, Trauma and Mental Health.** The Training and TA Center is located in Chicago, IL.

(312)726-7020, ext. 10
(312)726-7022 FAX
info@nationalcenterdvtraumamh.org

For additional information about providing advocacy services for people with disabilities contact:

Accessing Safety Initiative c/o **Vera Institute of Justice**
233 Broadway, 12th Floor, New York, NY 10279
212-334-1300
212-941-9407 FAX
www.accessingsafety.org

For additional copies of the Real Tools Manual as well as Spanish language versions of Real Tools contact:

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130 Seward St. #209
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pbland@andvsa.org or www.andvsa.org

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ADVOCATES ASK ADDICTION QUESTIONS

(revised)

Recently Advocates at the AWAIC Shelter in Anchorage and Transition Programs in BC asked me these questions to help them provide advocacy for women impacted by concurrent issues. I think these questions are often asked by advocates across the US and Canada as well as by program participants themselves. The answers below reflect an initial attempt to respond to complex issues requiring a great deal of thought. I hope you will take what you like and leave the rest. ANDVSA recommends program staff discuss concerns such as these prior to attempting to provide integrated support groups. Also we recommend Advocates explore women's substance use, abuse and addiction as anti-oppression issues and seek assistance to ensure services, safety, autonomy and empowerment for all. More thought is needed as well as a whole lot of action, one day at a tine! ----Patti Bland, M.A. CCDC CDP

1.) Why are DV and substance abuse so interconnected?

Domestic violence and substance abuse often co-occur and are highly correlated but most credible evidence does not indicate they directly cause each other.

They are inter-connected though and both severity of injuries and lethality rates increase when co-occurrence happens.

A significant correlation exists between domestic violence and chemical dependency and, depending on whose research you cite, you will note rates of co-occurrence anywhere from 50-96%. However, little has been done to help battered women with chemical dependency issues to address their need for both safety and sobriety.

Intervention strategies addressing both the domestic violence and substance abuse problems are relatively new; many have only been developed in the past 10 years. Model programs exist in WA State, Illinois, Nebraska and Iowa as well as in a handful of other states. Here in Alaska, SAFE in Dillingham has a partnership with the local chemical dependency treatment center and has developed the SISTR program for women addressing both DV and substance abuse issues. AFS in Palmer has provided integrated support groups for several years and is enhancing services for chemically battered women as well as for adolescents this year.

Many victims of domestic violence, sexual assault and other forms of abuse begin or increase their use of alcohol and other drugs in response to abuse or as a way to medicate the physical and emotional effects of domestic violence or other forms of victimization. It is important to note that while this is true for about 2/3 of victims with multiple abuse issues, a recent federal study indicated about a third may have begun using alcohol or other drugs prior to experiencing abuse. Whether abuse is experienced before or after alcohol or drugs are involved, steps must be made to reassure all victims that any violence directed toward them by a partner is not their fault. In order to ensure safety and sobriety we must hold batterers accountable for their behavior and not blame victims whether they were drunk, sober, abstinent, on medication or tricked into using a substance.

Many victims first begin using substances prescribed by their physicians. Others are forced to use by their partners who are seeking to gain or maintain power and control. Recovery efforts are often sabotaged by their partners who find it harder to control a person who is not using.

According to the New York State *OPDV Model County Policy*:

> "Alcohol and other drug use and addiction do not cause men to perpetrate abuse in their intimate relationships,[1] and substance abuse treatment alone is unlikely to stop the violence. Victims with drug-dependent partners consistently report that during their partner's recovery the abuse not only continues, but often escalates, creating greater levels of danger than existed prior to their partners' abstinence. In the cases, in which victims report that the level of physical abuse decreases, they often report a corresponding increase in other forms of coercive control and abuse—the threats, manipulation, and isolation intensify."[2]

The New York State Model Protocol also states:

> "Abusers who are also alcohol or other drug-involved need to address the alcohol/other drug problem separate from, and in addition to, being subject to appropriate criminal or civil justice sanctions for their abusive behavior. Not only is this a critical strategy to enhance victim safety, but abusers' continued use of coercive and violent acts against their partners is often a precipitant to relapse. Addictions self-help groups and substance abuse treatment programs were not designed to address battering and are not equipped to enforce abuser accountability, a role more appropriate to the criminal and civil justice systems."

2.) What kinds of drugs cause violent outbursts?

We know guns are associated with increased risk for lethality yet we hear the NRA say 'guns don't kill people, people do.' Drugs don't cause violent outbursts, people do. While alcohol and other drugs are associated with episodes of violence many people use substances without engaging in violent behavior regardless of their alcohol or other drug use.

When violence and alcohol or other drug use co-occur the following risk factors may exist:

1.) *Alcohol can lead to euphoric recall or blackout which can have a negative impact on memory.* Blackout is a form of amnesia for a specific period of time whereas euphoric recall is a distortion of perception. While both conditions impact memory neither is considered sufficient to cause a person to engage in violent behavior. Those experiencing blackout and euphoric recall can choose to engage in violence or NOT. The only thing they can't choose is accurate recall of what choice they made. Alcohol is also associated with distortions in perception that may lead one to believe people are hostile towards one. Alcohol use is also associated with depersonalization and can inhibit empathy. A batterer may use these distortions as an inappropriate excuse to justify violent behavior.

2.) *Methamphetamine/Cocaine can lead to feelings of power.* Additionally, use of these drugs is associated with paranoia. Paranoid people who feel powerful may try "BS"

[1] American Medical Association, Report of the Council on Scientific Affairs: Alcohol, Drugs and Family Violence, A-93, 1993.

[2] Minnesota Coalition for Battered Women, Safety First: Battered Women Surviving Violence When Alcohol and Drugs Are Involved, 1992.

or they may choose to engage in violent behavior. Uppers such as speed and coke are associated with poor impulse control, jumpiness and hypervigilance. Paranoia and suspicion may contribute to a person's choice to leave shelter without saying a word or can contribute to a person's choice to lash out if feeling threatened. Usually signs of agitation, pacing, nervousness, rapid and pressured speech etc. precede threats and other forms of violence.

3.) *PCP is a drug that can lead to hallucinations and paranoia.* Since it is used as an animal tranquilizer for surgery people on it are often paranoid and tend not to feel pain which makes them particularly dangerous if they decide to engage in violent behavior. People hallucinating on PCP (unlike people on LSD) cannot generally be talked down. Call the police if you are concerned about your safety or the safety of others.

4.) *Victims of domestic violence who are asked about drugs they associate with violence in their relationships often tell us marijuana is a factor in violent episodes BUT not when their partners are using it.* Individuals report more concern when their abusive partners can't find any marijuana. When the chronic marijuana user has no access to more marijuana the user may become irritable and have sleep difficulties as well as experience loss of appetite. These are minor problems unless the person rebounding from marijuana use is abusive. Batterers may use irritability associated with withdrawal as a trumped up phony excuse to engage in emotional or physical abuse.

5.) *Nicotine is an anti-hostility agent.* Chronic smokers unable to use tobacco may become hostile and irritable. This does not mean individuals unable to smoke will become violent but batterers denied access to cigarettes may use this as another phony excuse to justify their choice to engage in abusive behavior. The greatest dangers from nicotine use are long-term health consequences (e.g. lung disease, heart disease and various forms of cancer, etc.) which kill more people than alcohol and all the other illegal drugs combined. Also nicotine is associated with low-birth weight babies (as is domestic violence) and other health consequences for children. Some advocates report seeing smokers who are building up a head of steam and ready to 'blow' occasionally being diverted from choosing to engage in aggressive behavior by choosing to smoke. Shelter workers should ensure program participants have access to pamphlets and information pertaining to health risks for women and children associated with nicotine use as well as options for a safer coping tool than smoking.

6 a.) *Heroin/Opiates (e.g. "Ox," prescription painkillers, morphine) are associated with the need to continue feeding a costly habit to kill pain.* While overdose can be lethal, withdrawal symptoms are generally not usually life threatening. Withdrawal can be seriously uncomfortable and does pose risk for individuals with fragile health or who may be dehydrated. Addiction to opiates is not so much associated with physically violent behavior as it is associated with irritability, flu like symptoms, diarrhea, runny nose and of course theft. Theft is also part and parcel of any addiction since when the money runs out to feed it, an addicted individual may decide to steal to maintain the addiction whether that addiction is to cigarettes, crank, alcohol or heroin.

6 b.) *Methadone.* Other concerns here include safety risks for program participants who may be on methadone maintenance. People on methadone can do very well in Methadone programs. Risk stems not from their dose but from the requirement for

them to get their dose at a set time and place daily which makes them a sitting duck for a batterer or stalker. Safety planning and advocacy are essential for these individuals who are often denied access to services and also face unwarranted societal stigma.

7.) *Prescription Medications* – A major concern here is the onset of withdrawal symptoms. Withdrawal from prescription medication such as sedative/hypnotics e.g. Valium, Xanex, Librium, etc. can be dangerous much as alcohol withdrawal is very serious. Program participants fleeing abusive partners may be unable to bring their medications with them. This can increase risk (e.g. no access to insulin, an asthma inhaler or other critical medication can rapidly lead to a medical emergency). Lethality or other health risk occurs if alcohol and medications are mixed or combined. Barbiturates are particularly lethal when combined with alcohol and the overdose potential can be high. Also possible is misuse associated with multiple prescriptions for similar pain medications, misuse of old medications, or misuse of someone else's medications when prevented from seeking medical help. Batterers may deny partners access to medication and/or divert their partners' medication for their own use. Coercion, theft, faked prescriptions and doctor s/hopping may increase problems and lead to legal troubles or arrest.

3.) Is the Harm Reduction approach a good policy for domestic violence programs? How would that policy be implemented?

Harm Reduction can be defined by substance abuse professionals as "a tertiary prevention and treatment technique that tries to minimize the medical and social problems associated with drug use rather than making abstinence the primary goal (e.g., needle exchange and methadone maintenance," (NNEDV,2007).

In its truest sense, Harm Reduction provides an opportunity to meet people where they are so they can be offered options that may help them survive. This approach allows programs to offer people education while they determine what they want/need. In this context, harm reduction is a very valuable approach.

As advocates working on behalf of individuals impacted by domestic violence we already employ harm reduction because we do not expect people to necessarily leave their abusers, do what *we* think they should, nor do what *we* think is best. In domestic violence services, empowerment and autonomy are as critical as safety.

For many survivors with substance use disorders, abstinence is a critical part of recovery and for others the struggle for sobriety is too overwhelming. Options to support recovery are essential but the process for many begins with harm reduction or receiving support from a domestic violence program. These services help people to stay alive long enough to then possibly move on to pre-treatment services, self-help groups, treatment, and various forms of recovery.

A critical element of our work is our ability to honor diversity among survivors and their needs. We do not expect every survivor to leave her abuser, get a protection order, come to shelter or go to therapy. We know each survivor needs different types of support. We know each survivor is the person best able to determine which services to engage particularly when options are provided in a non-judgmental and caring manner. This truth applies for those seeking to heal from

substance use disorders. Each person is different and has a different timeline and process for recovery. Generally speaking, programs should not have a rigid, blanket policy around substance abuse, for example, one strike and you're out. Instead, guidelines should be in place empowering women to be honest about their behavior without shaming them. Usually, systems of accountability can be enacted offering alternatives to applying harsh consequences. While structure and accountability can be empowering, rigidity and harshness are counter to the mission of the battered women's movement which includes autonomy, empowerment and justice as well as safety.

Programs must focus on their primary mission, and view substance use as an issue that impacts safety**,** autonomy, empowerment and justice. Programs can work with survivors to determine where they are at on their path through life and the appropriate steps to support and advocate for them fairly.

4.) How can we help women get free from domestic violence when they are abusing drugs?

Our challenge as advocates is to provide as safe an environment as possible for all who use our services or work at our programs. A first step toward meeting this challenge is identifying options for both battered women impacted by substance use as well as for their advocates. In order to better extend services and advocacy to battered women with separate issues of substance use, misuse or addiction we must examine our current practices and explore new strategies. Agency policies supporting a substance-free environment will need to be balanced with a multi-step approach that provides opportunities for substance-abusing women to safely discuss their daily struggle with sobriety and their compulsion to use. This effort will help women experiencing chemical dependence achieve both justice and freedom from abusers who often use their substance dependence to gain or maintain power and control.

Some suggested policy considerations to reduce barriers and improve program access include:

1. Being aware that domestic violence, drug overdose and withdrawal from substances can all be lethal, and that assessing the immediate risk of each is essential.
2. Partnering with a local chemical dependency program and/or consulting with the statewide alcohol and drug help line to develop tools for identifying and assessing the needs of battered women impacted by substance abuse and their children.
3. Developing a safety plan that includes a relapse prevention plan and continuing to support the client after a relapse if she chooses to continue to work on her recovery.
4. Providing referrals to a range of chemical dependency assistance options, such as detox, out patient or inpatient treatment, Alcoholics Anonymous and/or other self-help meetings.
5. Addressing the impact of substance abuse on safety planning.
6. Providing written materials relevant to chemical dependency and substance abuse.
7. Developing a budget plan to implement comprehensive support services to battered women impacted by substance abuse.

8. Periodic training of staff.

9. Monitoring of the program.

OVERVIEW: A MULTI-STEP APPROACH

The overview below identifies basic elements necessary to provide appropriate services for women impacted by substance use, abuse and addiction issues. Recommended procedures for addressing service delivery in a variety of settings are discussed following this overview. The following steps are recommended:

1. Screening and identification
2. Initial intervention and follow-up
3. Information and referral
4. Alternatives to substance use/Relapse prevention
5. Emotional support

Screening and Identification

We recommend programs focus on program accessibility and examine their criteria for services with a goal to providing services rather than screening out. Avoid blanket service restrictions for women seeking shelter or other services based solely on their alcohol or drug use history. In many cases, the batterer is more of an immediate threat than the risks associated with substance use. It is important to stress that overdose and withdrawal can pose serious health risks that can become life threatening. These problems can occur even when routine screening reveals no obviously existing substance abuse issues. For this reason, it is important for programs to develop linkages with emergency department personnel, detoxification center staff and other chemical dependency professionals.

A substance screen is an opportunity to help a victim of domestic violence identify whether or not her safety is impacted by her own or another person's use, misuse or addiction to a substance. This discussion is a preliminary step to determine the likelihood that an alcohol or other drug problem exists that could impact her safety. Screening for substance use involves honest talk with individuals about their partner's alcohol and drug use as well as their own, observing their behavior and recognizing signs of use. The purpose of this talk is to provide better advocacy and appropriate services rather than to screen out.

Advocates are asked to routinely screen for substance use because some of our intervention and follow-up, including information and referrals we provide, will be based on whether or not substances pose a safety risk for the domestic violence victim and/or others. Routine screening is simple and does not require advocates to provide a full assessment.

Screening differs considerably from an assessment. An assessment uses diagnostic instruments and processes to determine if the person is abusing, or is dependent on alcohol or other drugs. We may describe assessment as an option for women who are concerned about their use and

provide information and referral should any woman we are screening express interest in an assessment for themselves or others.

Respectful screening involves conveying the message that addiction and violence can happen to anyone. Advise women "Any woman is vulnerable; you are not alone." A successful intervention requires internally moving beyond the notion, "Why doesn't she just quit?" or "Why doesn't she just leave?" Questions such as these convey lack of knowledge and failure to understand the complexity of safely ending a relationship with either a substance or an abusive partner.

Honestly discussing substance abuse as a safety risk is extremely important. A woman's decision to keep using or to decline treatment, advocacy or shelter should not be viewed as failure. Recovery is both an option and a process that can take time. Screening and referral can help build a bridge from substance abuse or addiction to health and safety for chemically dependent battered women and their children.

Women facing the dual stigma of both chemical dependence and domestic violence may be reluctant to openly seek help. Generally speaking, women do not self-identify as either addicted or battered unless their safety is assured. Safety includes knowing you are not being labeled or judged.

When screening for substance use be sure to:

- Ensure privacy. Children should not be present.

- Communicate respect and trust. When screening over the phone, let callers know you are asking these questions to better determine their safety needs rather than weed them out. Assure those you screen, both on the phone and in person, except for safety concerns (e.g., Office of Children's Services (OCS) or Adult Protective Services (APS) mandated requirements), anything discussed will be held in strictest confidence and will not jeopardize their ability to receive appropriate services.

- Listen carefully and observe behavior. Notice signs of possible alcohol and other drug use. Signs of use include slurred or rapid speech, smell of alcohol, track marks, scabbing, unusual or extreme behavior such as nodding off or being overly alert, staggering, tremors, glassy eyes, dilated or constricted pupils, difficulty sitting still, and tactile hallucinations that lead to scratching or skin picking. Notice if the person you are talking to is disoriented or confused for no apparent reason, argumentative, defensive or angry about questions relating to substance use. Please note that any one thing here does not mean a person is to be automatically labeled as an addict. For example, slurred speech could mean a hearing deficit, stroke or broken jaw. Scratching could mean scabies, eczema or allergies. Confusion could be stemming from a head injury. The purpose of screening is to notice areas of possible concern, to recognize patterns and to help women determine what might be their best options.

Keep in mind that battered women with chemical dependence have little reason to trust. Both their bodies and their partners have let them down. Consequently, substance-abusing battered women are often reluctant to disclose use. Disclosure may not be perceived as a viable option. Understand denial. Denial is the most frequent response to questions about substance use whether alcohol or other drug use is an issue or not. For this reason, it is important to provide

every woman with brief information about safety and sobriety regardless of the outcome of a screen.

Respectful screening creates an environment where it may seem safer for a woman to dislose use. Ask questions in a non-judgmental manner.

Initial Intervention and Follow-up

Described below are different categories that reflect an individual's use of substances. An advocate's response and follow-up should be determined by each individual woman's experience with substance use.

No Significant Problem with Substance Abuse

Once an initial screening occurs, an advocate may determine a woman has no significant problem with substance use. Should this be the case, information about safety should be provided. Alcohol and drugs affect the brain and the body whether addiction is present or not. This information should be included along with basic information about how substance use can compromise safety. Sometimes a woman herself may not be using or misusing substances but her safety may be compromised by another's use. Discussions about safety should explore risks associated with partner use as well.

Follow-up is advised to determine whether a woman's needs change over time. Additional options, referrals and support must be offered if, over time, an advocate becomes aware of potential difficulties stemming from the client's, or another person's, use, misuse or addiction. Follow-up may address concerns stemming from changes in observed behavior, noticeable signs of substance use or concerns about drug-seeking behavior (e.g., over-use of over-the-counter or prescription medications).

It is also helpful to be alert. Notice if the person you are working with has:

- The odor of alcohol on her breath
- Red eyes, pin-point or dilated pupils
- Track marks on arms, hands or feet
- Inflamed or eroded nasal septum

Cues which, if not directly indicative of addiction, at least indicate substance misuse may be occurring, include:

- Rapid speech
- Difficulty tracking conversation
- Scratching and picking at arms or face during a visit
- Lethargy
- Nodding
- Cigarette burns (which may also be indicative of domestic violence)

- Prescription drug-seeking behavior

Significant Problem with Substance Abuse

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. Following an initial screening, an advocate may identify a woman has an increased safety risk stemming from her, or another's, significant problem with substance misuse or abuse. Sometimes a significant problem with substance abuse is not identified at an initial contact but is revealed later. Whenever substance abuse is identified, information about safety should be provided and concern should be expressed. Options should include reviewing safer alternatives to substance use, providing linkage to counseling and on-site support systems, as well as community-based referrals. Discussions about safety should explore risks associated with partner substance abuse as well.

Battered women who are misusing substances should be asked to consider refraining from substance use while they are using services. Follow-up should include checking to see if abstinence is causing any unexpected challenges or difficulties. Should a woman feel out of control, preoccupied by use, edgy or compelled to use, substance dependence may be indicated and withdrawal symptoms may appear.

Chemical Dependence

Substance use and misuse are behaviors. Research supports several theories related to causal etiologies of substance abuse and addiction, including behavioral, medical and other models. According to the disease model, chemical dependence, unlike domestic violence, is not a behavior. It is considered a primary chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal.

When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of substance), it is likely that the person has progressed from abuse to dependence and addiction. While diversity of thought exists pertaining to substance dependence, it is critical to learn to recognize and identify women with this condition and provide appropriate intervention options.

Battered Women in Recovery from Chemical Dependence

Following an initial screening, an advocate may learn a woman is in recovery from dependence, to alcohol or other substances. Whenever past substance abuse is identified, information about safety should be provided and concern should be expressed about risks to sobriety associated with domestic violence, sexual abuse, trauma and stress. These concerns may be greater for women with less time in recovery, but warranted for any woman addressing both issues regardless of amount of time in recovery.

Basic safety and sobriety tips should be provided, as well as information about risks associated with partner substance use. Options should include reviewing current support systems, providing linkage to counseling and on-site support systems, as well as community-based referrals. Follow-up is indicated periodically to determine whether increased support is wanted. Chemical dependence is a disease marked by periodic relapse. Should obvious signs of renewed

preoccupation with substances or substance use occur, address them immediately. Discuss safety options including support groups and treatment with an open, supportive and non-judgmental attitude.

Battered Women Currently Active in their Addiction

Expressing care and concern rather than being critical is most useful when helping chemically dependent battered women address addiction and its impact on their safety. Be gentle. Always include messages linking safety and sobriety and address the benefits of stopping use any time.

Substance dependence 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). Therefore, this problem impacts sufferers whether they are actively using or not.

Substance dependence is marked by physiological and central nervous system changes that lead to the development of tolerance, loss of control, continued use in spite of adverse consequences and withdrawal symptoms. Women are often unable to discontinue use without assistance.

Should this be the case, advocates will need to help women assess whether the immediate risks from a batterer outweigh those stemming from their current substance abuse or chemical dependence. Ultimately this is not a question of whether safety or sobriety should take place first. Safety and sobriety are both important, since one is less likely without the other. Rather, the question is: What does the woman you are advocating for want to address today?

Discuss strategies to support behavior change such as 12-step programs, chemical dependency/domestic violence support groups and treatment options. If possible, suggest a referral for a more in-depth chemical dependency assessment and make the appointment together if the person is interested. Get a release of information and maintain communication with the chemical dependency treatment provider to support her progress. Be sure to follow up and provide emotional support.

Information and Referral

Providing advocacy-based counseling for battered women impacted by substance abuse is enhanced when advocates are:

- Informed about treatment options and community resources.
- Participating in cross-training with substance abuse programs to increase awareness of safety and sobriety issues.
- Willing to provide service options for victims who are substance dependent whether they are in treatment or not.

Advocates must be able to provide accurate information about substance use, abuse and addiction and know what their local resources are. The Alcohol/Drug Help Line is available twenty-four hours a day to provide information about substances, including use, abuse and addiction. They can answer specific questions for battered women addressing substance abuse issues as well as

help advocates develop options at 1-800-562-1240 (WA and AK only) or 206-722-3700 / TTY 206-722-3724.

Ideally, advocates will become familiar with their local resources. Developing a relationship with your local chemical dependency prevention service providers can enhance safety and improve advocacy. Additionally, this relationship can lead to developing collaborative partnerships that could include exchanging staff for support groups, as well as information and educational opportunities addressing both domestic violence and substance abuse issues.

Alternatives to Substance Abuse/Relapse Prevention

One-to-one advocacy and support group sessions should provide information that offers an alternative to substance use as part of a safety plan. Tools to integrate substance abuse as a safety issue are available (see Power and Control Wheel for Women's Substance Abuse, et al.).

Since addiction is marked by relapse, and relapse is often triggered by stress, women in recovery experiencing domestic violence may need additional support. According to Bland (2001), advocates may help recovering battered women develop a safety plan that includes but is not limited to:

- Identifying who to call for help (e.g., sponsor, counselor, Alcohol/Drug Help Line); forming support systems, knowing about safe meetings
- Knowing information and education about addiction
- Removing substances and paraphernalia from the home
- Recognizing unsafe persons, places, things
- Understanding how to deal with legal and other problems stemming from addiction (e.g., health, OCS involvement, poor nutrition)
- Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing or other options
- Knowing how domestic violence can be a relapse issue
- Understanding physical, emotional, cognitive, environmental and other cues indicative of risk and having a plan to deal with it; recognizing role of stress and craving, having a plan to deal with it
- Learning how to parent, engaging in relationships, developing sober friendships
- Knowing when and where to run in a life-threatening situation that puts her sobriety and safety at risk

Consult with your local chemical dependency treatment provider, the Alaska Network on Domestic Violence and Sexual Assault or the Alcohol/Drug Help Line Domestic Violence Outreach Project for additional tips to address both alternatives to substance abuse and relapse prevention.

Emotional Support

Last but not least, it is important to remind ourselves that addressing domestic violence and substance abuse issues is always difficult and challenging. Domestic violence programs can, according to Illinois Dept. of Human Services (2000), support victims struggling with issues of substance abuse in the following ways:

- Assist staff in dealing with their own feelings and prejudices about substance abuse. Provide on-going 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 and advise the victim and treatment providers of the risks of conjoint couples counseling sessions.

- While providing advocacy-based counseling, help women recognize the role substance abuse plays. It can keep them tied to an abusive relationship, increase their risk for harm and impair their safety planning ability.

- Assist victims by helping them find an alternative means of empowerment as replacement for the sense of power induced by substances.

- Include plans for continued sobriety as part of a safety plan. Help the victim understand the batterer may attempt to undermine her sobriety before the victim exits the shelter or completes advocacy services.

- Encourage and facilitate linkage with substance abuse treatment resources and abstinence-based support groups.

- Remain aware of which local substance abuse programs and support groups offer the highest degree of physical and psychological safety for victims of domestic violence.

5.) What are the signs of drug abuse?

(Note: Domestic violence and addiction definitions are adapted from definitions developed by the American Psychiatric Association and the American Society for Addiction Medicine and included in the Domestic Violence/Substance Abuse Task Force of the IL DHS 7/2000, Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse, see p.vi. For information about this publication contact: www.state.il.us/agency/dhs).**

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.

Substance use and misuse are behaviors. Research supports several theories related to causal etiologies of substance abuse and addiction including behavioral, medical and other models. According to the disease model, addiction, unlike domestic violence, is not a behavior. It is a

disease. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of substance) it is likely that the person has progressed from abuse to dependence and addiction. While diversity of thought exists pertaining to addiction it is critical to learn to recognize and identify women with this condition and provide appropriate intervention options.

Substance dependence (addiction), according to the disease model, is considered a primary chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Substance dependence 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. Substance dependence is treatable and long-term recovery is possible. Although a person may choose to use alcohol or drugs a person does not choose how one's body will respond to that choice. Alcohol and drugs affect the brain and the body whether addiction is present or not. Substance dependence, however, is marked by the development of tolerance, loss of control, continued use in spite of adverse consequences and withdrawal symptoms.

Cues indicative of substance misuse may include but are not limited to:

1.) The odor of alcohol on her breath
2.) Red eyes, pin-point or dilated pupils
3.) Track marks on arms, hands or feet
4.) Inflamed, eroded nasal septum.
5.) Rapid speech
6.) Difficulty tracking
7.) Scratching and picking at arms or face during a visit
8.) Lethargy
9.) Nodding
10.) Cigarette burns (which may also be indicative of domestic violence).
11.) Prescription drug seeking behavior
12.) Distorted Perceptions

Note: Alcohol and other drugs distort perceptions. Women experiencing substance dependence may have a hard time recognizing options or gauging their safety due to a variety of distortions in thinking. Blackouts may mean the absence of memories for some events. Experiencing a blackout does not mean a person has passed out or lost consciousness. Nor does it mean psychological blocking out of events or repression. A blackout is an amnesia-like period often associated with heavy drinking. People in a blackout state may appear to be functioning normally but later have no memory of what occurred (Kinney and Leaton, 1991).

Inability to remember events poses specific safety problems for battered women experiencing blackouts. Problems can include not being able to recall a safety plan, not being able to know how an injury was sustained, making a report to police at the time of an assault and being unable to recollect the event mere minutes or hours later, let alone in court.

The only initial memory substance users have of what happens when they use is the one that is formed when they are under the influence of alcohol or in a drugged state. Thus if a person under the influence inaccurately assesses her level of danger or perceives herself as "able to handle it," sobering up the next day may be insufficient to correct the distortion. This toxic thinking or distortion of perception is termed euphoric recall (Johnson, 1980) and theoretically has the potential to increase risk for substance abusing battered women.

Please contact the Alcohol Drug Help Line at 1-800-562-1240 (WA or AK only) or check their website **www.adhl** for more specific information about signs and symptoms of alcohol and other drug use, abuse and dependence as well as for information about indicators of overdose and withdrawal. If you are concerned a program participant may have overdosed or may be experiencing acute withdrawal either could pose serious health consequences. Medical attention should be sought immediately. If a person is not breathing or you are concerned symptoms may be life threatening call 911 or the applicable number for emergency medical services in your area.

6.) How should we approach a woman who we suspect is using?

'Suspect' is a word with negative connotations. Let's reframe the question to read, " How should we approach a woman who may be sensitive about discussing her personal substance use as a safety concern?" Keep and mind that some adults legally use alcohol and other drugs by choice. Individuals with substance use disorders often have elements of choice compromised due to a complex array of biological, psychological and other individual and social factors. Alcoholics and addicts do not cause addiction and they do not 'like' it. They have a major illness. The number one symptom of this illness is to believe one is well. This belief plus social acceptance of drinking or taking medication to kill pain makes it hard for alcoholic /addicts to seek help they need. Many times they don't seek help.

Generally speaking, it is useful to note observations of use and directly mention them to the person you are concerned about. A sample way to deal with the obvious problem head on is as follows:

"You and I both know you have been under a lot of pressure lately during your stay. And you and I both know anyone will look for a way to feel better when they are feeling stressed. I'm concerned about you because you and I both know you have been drinking this morning. Lots of women I see do the same thing. How can I help you find a safer way to cope?"

It engages the person to bring her into the discussion. Positively recognize, she knows what is going on as well as you do. Expressing care and concern rather than being critical is most useful when helping chemically dependent battered women, confront their own addiction. Confrontation by the woman of her own addiction can be a goal but should not be the style of your interaction. Be gentle. Chemically dependent battered women are often on the receiving end of unkind comments and criticism. Always include messages about the benefits of stopping use any time.

Sample topics to discuss (whether in support group or 1-1) include the following:

1.) Can you tell me why it may not be safe to use when someone is trying to stalk you/kill you?

2.) How can your partner use your drinking or drug use to hurt you?

3.) How has your partner used alcohol or other drugs to control/threaten/shame you?

4.) When you have not been able to drink or use in the past, what helped you to cope? Can you do that now?

5.) If there is one thing I (or the group) can do to help you stay safe and sober today, what would that be?

6.) What how could drinking or drug use impact parenting/housing/police response/Office of Children's Services (OCS)/Adult Protective Services (APS), or other issues?

A woman may find it easier to talk about her partner's use before she feels safe enough to talk about her own. If a woman discloses her partner abuses substances, an advocate might state:

"Many women tell me their partners don't want to drink or drug alone. How often have you found yourself stuck using when you didn't want to?" This is a non-judgmental way to elicit information and provides an opportunity to explore drug related domestic violence. I/V drug users may be particularly vulnerable when targeted by batterers.

Women disclose their partners put them on the street to trade sex for drugs against their will. Many women I/V drug users begin their drug use in the context of a relationship. They may never shoot up alone. Their partner shoots-up for them. Introducing a partner to illicit drug use is a form of domestic violence. Another form of abuse occurs when a batterer deliberately uses dirty needles or cottons or misses a vein on purpose. This also poses a risk for transmission of disease including hepatitis and HIV. Maintaining power and control by serving as a connection or determining a partner's drug supply can also be a form of domestic violence.

Women experiencing battering and chemical dependence may believe their safety will be assured if they just get sober. Getting sober, though, can pose new risk for battered women with substance use issues. An abusive partner may increase violence as the battered woman in recovery from a substance use disorder becomes harder to control. Before screening for substance abuse, validate a woman's survival and praise her sincerely for finding her own way to cope. This should lead to a discussion where you can include the following:

- "You deserve credit for finding a way to cope. Tell me what made you able to survive?"
- "Many women I see tell me when they experience pain they find a way to deal with it. Some women tell me they become compulsive cleaners; others get into shopping, eating or not eating, sleeping a lot or working too much. Have you tried any of these ways of coping? A lot of women tell me the best way to cope is to numb out by drinking or drugging. How often has this worked for you? Can you think of any reasons why drinking or drugging could be unsafe for someone with an abusive partner?" What kinds of luck have you had with other coping skills?"

7.) I want to know how to deal with the manipulations used to avoid substance abuse issues.

'Manipulation' is another word with negative connotations. Let's reframe this statement to read "I want to know how to advocate for women who do not feel safe enough to be open about their substance use." Every day advocates deal with women other systems label as impossible. In our field we understand women make decisions about their safety daily and we recognize dealing with domestic violence is a process. You, as a battered women's advocate, have all the skills you need to deal with the manipulations of

addiction (substance dependence) if you recognize the woman you are working with is in a relationship with a substance that has her in chains no less binding than the oppressive chains a batterer uses to bind a victim. Also, you are not alone. Substance abuse counselors can address the substance use disorder and help you focus on your role which is to provide advocacy. Women facing the dual stigma of both substance dependence and domestic violence may be reluctant to openly seek help. Generally speaking, women don't routinely self-identify as either addicted or battered unless their safety is assured. Safety includes knowing you are not being labeled or judged. Battered women experiencing substance dependence tell us they benefit most from advocates who:

"Try to make you feel like you aren't the only one. And that somebody else did make it. And someone else has made a life for themselves. They try to make you feel that you're not worthless or useless."

Battered women with substance dependence issues have little reason to trust. Both their bodies and their partners have let them down. Advocacy based counseling looks different for chemically dependent battered women who may have withdrawal issues, memory distortions and cognitive deficits. Advocacy-based counseling for those impacted by substance abuse and/or addiction may include: Repeating information, providing structure, simplifying goals, advocating for their inclusion in shelters and other victim service programs and understanding the impact of substances on safety planning and role identity.

Respectful screening for substance use issues that may impact safety involves conveying the message that substance use disorders and violence can happen to anyone. Advise women: "Any woman is vulnerable; you are not alone should these problems be facing you." A successful intervention requires internally moving beyond the notion, "Why doesn't she just quit?" or "Why doesn't she just leave?" Questions such as these convey lack of knowledge and failure to understand the complexity of safely ending a relationship with either a substance or an abusive partner.

Honestly discussing sobriety as a safety risk is extremely important. A woman's decision not to stop using immediately or to decline treatment, advocacy or shelter should not be viewed as failure. Recovery is both an option and a process that can take time. Know your resources. Build alliances with substance abuse prevention professionals and treatment providers. You don't need to be a chemical dependency counselor. A chemical dependency counselor can provide treatment when it is safe. Often individuals experiencing substance dependence will engage in manipulative behavior because they are terrified they cannot live without their substance. They are in pain and they are scared. If we can accept that manipulation is a reasonable way to address the tyranny of addiction we can acknowledge that manipulation is not about fooling us but about survival. If you feel manipulated, so what! Recognize manipulation is a survival strategy. Be respectful but offer program participants honesty as well as options to honestly get what they want or need when they are ready.

Example: "Mary, if I were afraid I would lose my housing I would say I was not drinking too. You don't have to cover up here. I know you were drinking cause for what ever reason, you felt you had to. People do that. But I'm worried about you. Sample follow-up statements might include:

1.) Are you more afraid of stopping drinking then of your batterer? Either one can be scary. Both together may be worse.

2.) What problem scares you the most? What do you want to work on first? What can I do to help you?

3.) If there was one thing I could do to support you, what would it be? What do you want to do?

The Intervention is in the Asking

"I could not recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa."

It is not necessary for advocates to become chemical dependency counselors but it is important for them to ask about substance use. Countless intervention opportunities are missed when advocates are afraid to ask lest they offend or view intervention as futile. The intervention is in the asking. When women are respectfully asked about both their use and their safety, they hear, even if they are not yet ready to listen or enact change immediately. Often women will later share comments such as, "You know, when you said...it really made sense to me." Supporting women through their process of change requires an understanding that motivation comes from within. It also takes knowledge of local resources. Safety and sobriety are indeed possible. Acknowledging the woman before you has managed to survive; sincerely appreciating her individual strengths and recognizing her innate dignity can support her own process and help build a healthy empowering alliance to benefit both her and her children.

We Share a Similar Story

Safety and sobriety can be addressed respectfully if we acknowledge both substance use (e.g. a glass of wine with dinner), and being in an intimate relationship (e.g. dating or having a partner) is a common experience both for the women we serve and for us. This means misuse of substances or abuse within a romantic relationship could happen to anyone. Any woman may use substances or find herself with a partner. This being the case, any woman could find herself having a problem with either or both through no fault of her own.

Women suffering from substance dependence don't know when they have the first drink or take the first drug what the future will hold. They expect to 'feel better' or 'kill pain' and find themselves believing they can 'control' it. Unfortunately, substance dependence is about loss of control and powerlessness. This loss of control and powerlessness does not mean one is weak or helpless. Instead, those who experience substance dependence cannot reasonably predict what will happen when they use. One is powerless only in terms of how one's body, one's liver, one's brain responds once alcohol or other drugs are introduced inside it. Many women experiencing substance dependence don't want to stop using alcohol or drugs. They want the craving, the problems and the pain of withdrawal to stop. They want to be like everybody else who can have a social drink or take medication without serious physical ramifications. Unfortunately, once an allergy is discovered, the addict must forever avoid substances or experience life-threatening consequences much as those who are allergic to bees must avoid getting stung. Fortunately we can support women's empowerment through our knowledge of options and available resources.

When possible, encourage women experiencing a substance use disorder to consider attending a support group addressing issues pertaining to both domestic violence and substance dependence. Integrated support groups offer women a format to heal utilizing techniques that are applicable for reaching both goals of safety and sobriety. The major goal of successful groups addressing these issues is to be a safe place where women can tell their story, be believed and begin the healing and connection process. Gender specific support groups and treatment are generally recommended for battered women.

"And it feels in the beginning that it's the end of the world, but it's actually the beginning of a new life."

Women from all walks of life are at risk for domestic violence and substance dependence but screening, identification and intervention can provide empowering options. Women from all walks of life get safe and sober and raise safe, healthy children. Be a bridge to safety and sobriety. Screen for substance abuse as part of a safety plan.

"I have my youngest daughter back. She lives with me. My oldest daughter is getting married and my middle daughter is a college student."

8.) Based on your experiences, what are some fair consequences for using in shelter? Do you feel that different levels of response are appropriate?

Based on my experience, I can tell you that there are variations in how programs respond to substance abuse issues. It helps to have a basic policy supported by procedures that advocates have been trained to utilize. Your policy should not routinely deny access to services solely based on substance use by a participant but should address a variety of options. I recommend you review the Alaska Model policy as well as that of Washington State and Illinois. I also recommend you receive training on addiction issues and how they impact safety, provide training for staff, establish linkages with treatment and support group resources and seek guidance from formerly battered women who are in recovery. The Alaska Network on Domestic Violence and Sexual Assault can provide you with sample forms, technical assistance, policy options, safety planning and other tools. Different levels of response are indeed appropriate and will take thought to apply within the framework of your agency. There are indeed fair consequences for using in shelter although I would probably reframe that to state, "Choosing to use while in shelter is a choice that impacts the safety of others and may result in: _____ as a direct result of that choice. If you are not sure you can safely choose to refrain from using during your stay we will help you explore your options which may include: _____.

Note: As advocates our primary goal is not to serve as substance abuse counselors or police officers. Exercise caution. Don't use an individual's substance use as an excuse to 'kick someone out' or 'make them go to treatment.' Deal with each person as an individual and decide how to proceed on a case by case basis. Remember batterers can be lethal. Help program participants develop a safety plan and explore workable options. What can we do to support someone where they are? How can we leave paths open, build bridges, develop alternate housing options and partner with other providers to support empowerment, autonomy, safety and sobriety for those whose addiction creates barriers and increased risk for harm? Every time a battered woman is

denied access to help due to substance abuse issues a batterer benefits. Don't forget that. Don't allow it to happen at your program.

9.) How do you maintain a drug and alcohol free shelter with issues that are so deeply embedded in each other?

Develop Strategies for Safety and Sobriety

1.) Have releases of information and identify who to call for help (e.g. sponsor, counselor, Alcohol Drug Help Line); help program participant form support systems, know about safe meetings; consider having an on-site support group.

2.) Get educated. Know information about addiction. Talk to women in recovery. Purchase resources, videos, recovery workbooks, posters, etc. to make your program 'user' friendly.

3.) Remove substances and paraphernalia from the program (e.g. cough syrup and mouth washes with alcohol, pseudoephedrine, old medications, etc.)

4.) Recognize unsafe persons, places, things putting a woman's sobriety at risk can also threaten her safety.

5.) Understand how to deal with legal and other problems stemming from addiction (e.g. health, OCS/CPS involvement, poor nutrition) contributing to safety problems

6.) Help program participants assemble paperwork to determine eligibility for substance abuse treatment, public assistance, employment, school, housing or other options.

7.) Know how domestic violence can be a relapse issue and know how batterers use both addiction status and substances to harm program participants

8.) Understand physical, emotional, cognitive, environmental and other cues indicative of risk for use and have a plan to help program participants deal with these issues; recognize the role of stress and craving, have a plan to help program participants deal with these issues as well.

9.) Help program participants learn parenting options, figure out options to engage in relationships, develop sober friendships

10.) Be consistent but flexible

11.) Address substance abuse issues promptly. Note concerns verbally or in the log (not client file) and shred the log regularly. Address alcohol/drug issues promptly. Do not fail to address alcohol/drug issues more than one shift. Delays increase risk and make advocacy and safety more challenging.

12.) Seek consultation regularly; hypotheticals with non-identifying info do not breach confidentiality.

13.) Prioritize hiring recovering advocates and/or advocates with substance abuse prevention or counseling backgrounds. Recruit recovering women as volunteers and staff.

14.) Consider addressing addiction both as a safety issue and as anti-oppression work. You are preventing able-bodyism and keeping batterers from benefiting from negative stereotypes about women with addiction. This is a life long process.

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New York State OPDV Model County Policy Substance Abuse Treatment System

NNEDV, Personal Communication with Anna Melbin, 2007.

MODEL PROTOCOL FOR WORKING WITH WOMEN IMPACTED BY DOMESTIC VIOLENCE AND SUBSTANCE ABUSE

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This project was supported by the Office of Women's Health Region X Grant # HHSP233200400566P and by Grant #'s 2003-MU-BX-0029 and 2004-MU-AX-0029 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed here are those of the presenters and authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women or the Office of Women's Health.

Introduction

The primary goal of this model protocol is to help advocates better meet the safety needs of all battered women by providing them with the tools to address service needs and options for battered women and children impacted by their own or another's substance use, misuse or addiction. Our challenge as advocates is to provide as safe an environment as possible for all who use our services or work at our programs. Ideally, this protocol and model policy will serve as a first step toward identifying options for both battered women impacted by substance use and their advocates.

Every individual we serve is unique and every advocacy program has strengths and challenges impacting our ability to provide services for battered women and their children. In order to better extend services and advocacy to battered women with separate issues of substance use, misuse or addiction we must examine our current practices and explore new strategies.

Battered women impacted by substance abuse are often invisible when in our progams or perceived as disruptive when their substance use becomes evident or unmanageable. Many times they are missing from our programs altogether. They often need our services the most and yet are among those who are least likely to seek or receive services. Hopefully, the material provided here will help reduce service access barriers as well as improve safety outcomes for women and their children.

Included in this document are model policies and procedures offered as creative approaches or current best practice for responding to substance-abusing and chemically dependent battered women. As you review the material and recommended guidelines, you may find some of the suggested best practices are initially difficult to implement.

Agency policies supporting a substance-free environment will need to be balanced with a multi-step approach providing opportunities for substance-abusing women to discuss their daily struggle with sobriety and their compulsion to use as issues that affect both safety and empowerment. This effort will help battered women achieve both justice and freedom from abusers who often use their partners' substance use, misuse or addiction to gain or maintain power and control.

At the Network, we recognize the work of advocates is both incredibly hard and vitally necessary. By critically assessing the impact of our policies and practices on battered women with substance abuse issues, we seek to reduce the barriers to safety all victims face. By listening to the experiences of battered women recovering from substance abuse and addiction, we expand our ability to respond to all women who are living with violence. We recognize and support your ongoing commitment to extend services to all battered women. We hope this protocol will help you identify small but important action steps you can implement to enhance safety for all.

BACKGROUND

While most women who have experienced intimate partner violence do not suffer from chemical dependency, it is important to acknowledge many women who work, live or receive services at our programs are dealing with addiction and recovery issues. A recent study of Illinois domestic violence shelters reveals that as many as 42% of service recipients abuse alcohol or other drugs (Bennett & Lawson, 1994). Researcher William Downs reports findings indicating one in four women in an Iowa shelter/safe home sample had a lifetime diagnosis of alcohol dependence and another one in four had alcohol or other drug problems (Downs, 2002).

The Women's Action Alliance experience with a domestic violence shelter program over a fifteen-month period of time indicated 60-75% of the women seeking shelter services had developed problems with their original coping mechanisms, alcohol and drugs (Roth, 1991). Preliminary data from a National Institute on Drug Abuse study noted 90% of women in drug treatment had experienced severe domestic violence from a partner during their lifetime (Miller, 1994). Similar findings have been noted on monthly client service reports from the Alcohol/Drug Help Line Domestic Violence Outreach Project in Washington State (Bland, 2003). Clearly, a significant number of women and children seen in domestic violence agencies and sexual assault victim service programs suffer from substance abuse problems (Kubbs, 2000).

As recently as fifteen years ago, Finkelstein reported alcoholism and drug abuse were still viewed primarily as "men's diseases" (Finkelstein, 1994). Substance abuse and addiction are women's issues. According to the Washington State Coalition on Women's Substance Issues, the physiological impact of substance abuse in women needs more attention. Women have higher blood alcohol levels than do males after consuming equal amounts of alcohol (LaGrange, 1994; Lieber, 1993). Research has documented women have a higher prevalence and greater severity of alcohol-related liver disease with shorter duration of alcohol use and lower consumption levels than men (Kubbs, 2000). Women also have higher death rates from alcohol-related damage (CSAT, 1994).

While using substances can initially serve as a survival strategy or coping mechanism anyone might use in the context of abuse, pain, illness or other trauma, studies indicate women are more likely to begin substance misuse in response to trauma. Women are likely to use prescription medication much more often than men. Seventy percent of prescriptions for tranquilizers, sedatives and stimulants are written for women (Roth, 1991). The Minnesota Coalition for Battered Women (1992) states that psychotropic medication is over-prescribed for battered women. They also note that women who have been abused may also use alcohol or drugs for a variety of other reasons, including: coercion by an abusive partner, chemical dependency, cultural oppression, or—for women recently leaving a battering relationship—a new sense of freedom.

Unfortunately, using substances for any reason becomes problematic when misuse occurs or addiction is indicated. A significant number of battered women and survivors of sexual assault with substance abuse or addiction issues typically experience barriers to services and discrimination. Ability to maintain employment, housing, health insurance or child custody may be threatened by public disclosure of current or past substance abuse problems. Societal attitudes tend to view addiction as a moral failing rather than as a health problem. This can lead to isolation and shame, which may be compounded when domestic violence and/or sexual assault co-occur. Most alarming of all, is the impact of multiple abuse issues on safety. Safety is strongly compromised when domestic violence and chemical dependence co-occur. While these problems frequently co-occur, there is little evidence that either problem causes the other.

Individually, each can be chronic, progressive and lethal. Together, severity of injuries and lethality rates climb for chemically dependent battered women (Dutton, 1992). These problems are compounded when perpetrators include sexual assault and other forms of sexual abuse in their arsenal of violence.

The following are a few of the many reasons an individual who experiences domestic violence and/or sexual abuse and who also has a substance abuse problem, may be at increased risk for harm (Bland, 1997; Illinois Dept. of Human Services, 2000):

- Acute and chronic effects of alcohol and other drug use may prevent one from accurately assessing the level of danger posed by a perpetrator.

- Under the influence, one may feel a sense of increased power. Individuals may erroneously believe they can defend themselves against physical assaults and may not realize the impact of substances on their gross motor functioning and reflexes.

- Substance use and misuse can impair judgment and thought processes (including memory) making safety planning more difficult. (See: "euphoric recall" and "blackout" in Definitions section of Appendix).

- Alcohol and other drug use may be encouraged or forced by an abusive partner as a mechanism of control. Abstinence and recovery efforts may be sabotaged. *For example, a domestic violence/sexual assault victim receiving methadone on a daily basis could easily be stalked.*

- There may be reluctance on the part of the crime victim to seek assistance or contact police for fear of arrest, deportation or referral to Child Protective Services.

- The compulsion to use and withdrawal symptoms may make it difficult for substance-abusing or addicted victims of domestic violence/sexual assault to access services such as shelter, advocacy, or other forms of help.

- Additionally, a recovering woman may find the stress of securing safety leads to relapse.

- If she is using or has used in the past, she may not be believed.

Because women impacted by substance use, misuse or addiction may be at greater risk for injury and lethality, screening for substance abuse is an important tool for identifying barriers to safety and offering options. We can support women seeking safety and sobriety by reducing program service barriers and ending isolation for chemically dependent battered women and their children.

RECOMMENDED POLICY

[Name of agency] shall work to ensure access and services for all recipients by providing universal screening which separately addresses issues of substance use, misuse and addiction, and the delivery of appropriate services and referrals. Universal screening, service delivery and referrals should consider the following issues:

10. Assessing immediate risk to program participants from domestic violence and sexual assault as well as from alcohol and other drug overdose and withdrawal is essential because both domestic violence and substance misuse can be lethal.

11. Addressing the impact of substance abuse on safety planning.

12. Partnering with a local chemical dependency program and/or consulting with local substance abuse professionals to develop tools for identifying and addressing the needs of women and children impacted by domestic violence/sexual assault and substance abuse is essential because substance use can impact safety planning.

13. For women with addiction issues, safety planning includes developing a relapse prevention plan and continuing support after relapse for women choosing to continue to work on their safety and recovery.

14. Providing linkages to a range of chemical dependency assistance options, such as medical detox, inpatient or outpatient treatment programs, counseling, Alcoholics Anonymous meetings, and other support groups.

15. Providing written materials relevant to domestic violence, sexual assault, chemical dependency and substance abuse.

16. Developing a budget plan to implement comprehensive support services to battered women impacted by substance abuse.

17. Developing on-site integrated support groups to address safety issues for program participants and their children who are impacted by their own or another's substance use, misuse or addiction.

18. Periodic training of staff.

19. Monitoring of the program.

OVERVIEW: A MULTI-STEP APPROACH

The overview below identifies basic elements necessary to provide appropriate services for women impacted by violence and substance use, abuse and addiction issues. Recommended procedures for addressing service delivery in a variety of settings are discussed following this overview.

The following steps are recommended:

6. Screening and identification
7. Initial intervention and follow-up
8. Information and referral
9. Alternatives to substance use/Relapse prevention
10. Safety planning
11. Emotional support

Screening and Identification

We recommend that programs examine their criteria for services and avoid blanket service restrictions for women seeking shelter or other services based solely on their alcohol or drug use history. In many cases, the perpetrator is more of an immediate threat than risks associated with substance use. It is important to stress overdose and withdrawal can pose serious health risks and can become life threatening. These problems can occur even when routine screening reveals no obviously existing substance abuse issues. For this reason, it is important for programs to develop linkages with emergency department personnel, health care providers, detoxification center staff and other chemical dependency professionals.

A substance screen is an opportunity to help a victim of domestic violence/sexual assault identify whether or not her safety is impacted by her own or another person's use, misuse or addiction to substances. This discussion is a preliminary step to determine whether alcohol or other drug problems exist that could impact her safety. Screening for substance use involves talking with individuals about their partner's alcohol and drug use (*as well as their own)*, observing behaviors and recognizing signs of use.

Advocates are asked to routinely screen for substance use because some of our intervention and follow-up, including information and referrals we provide, will be based on whether or not substances pose a safety risk for the domestic violence/sexual assault victim and/or others. Routine screening is simple and does not require advocates to provide a full assessment.

Screening differs considerably from an assessment. An assessment uses diagnostic instruments and processes to determine if the person is abusing, or is dependent on alcohol or other drugs. We may describe assessment as an option for women who are concerned about their use and provide information and referral should any woman we are screening express interest in an assessment for themselves or others.

Respectful screening involves conveying the message that addiction and violence can happen to anyone. Advise women "Any woman is vulnerable; you are not alone." A successful intervention requires internally moving beyond the notion, "Why doesn't she just quit?" or "Why doesn't she just leave?" Questions such as these convey lack of knowledge and failure to understand the complexity of safely ending a relationship with either a substance or an abusive partner.

Honestly discussing substance abuse as a safety risk is extremely important. A woman's decision to keep using or to decline treatment, advocacy or shelter should not be viewed as failure. Recovery is both an option and a process that can take time. Screening and referral can help build a bridge from substance abuse or addiction to health and safety for chemically dependent battered women and their children.
Women facing the dual stigma of both addiction and domestic violence may be reluctant to openly seek help. Generally speaking, women do not self-identify as either addicted or battered unless their safety is assured. Safety includes knowing you are not being labeled or judged.

When screening for substance use be sure to:

- Ensure privacy. Children should not be present.
- Communicate respect and trust. When screening over the phone, let callers know you are asking these questions to better determine their safety needs; not to weed them out. Assure those you screen, both on the phone and in person, that, except for specific mandated safety concerns *(e.g., CPS or APS-mandated requirements)*, anything discussed

will be held in strictest confidence and will not jeopardize their ability to receive appropriate services.

- Listen carefully and observe behavior. Notice signs of possible alcohol and other drug use. Signs of use include slurred or rapid speech, smell of alcohol, track marks, scabbing, unusual or extreme behavior such as nodding off or being overly alert, staggering, tremors, glassy eyes, dilated or constricted pupils, difficulty sitting still, and tactile hallucinations that lead to scratching or skin picking. Notice if the person you are talking to is disoriented or confused for no apparent reason, argumentative, defensive or angry about questions relating to substance use. Please note that any one thing here does not mean a person is to be automatically labeled as an addict. For example, slurred speech could mean a hearing deficit. Scratching could mean scabies. Confusion could be stemming from a head injury. The purpose of screening is to notice areas of possible concern, to recognize patterns and to help women determine what might be their best options.

Keep in mind that women impacted by both domestic violence/sexual assault and addiction have little reason to trust. Both their bodies and their partners have let them down. Consequently, substance-abusing women who experience domestic violence and /or sexual assault are often reluctant to disclose substance use. Disclosure may not be perceived as a viable option. Understand denial. Denial is the most frequent response to questions about substance use whether alcohol or other drug use is an issue or not. For this reason, it is important to provide every woman with brief information about safety and sobriety regardless of the outcome of a screen.

Respectful screening creates an environment where it may seem safer for a woman to dislose use. Ask questions in a non-judgmental manner.

Initial Intervention and Follow-up

Described below are different categories that reflect an individual's use of substances. An advocate's response and follow-up should be determined by each individual woman's experience with substance use.

No Significant Problem with Substance Abuse

Once an initial screening occurs, an advocate may determine a woman has no significant problem with substance use. Should this be the case, information about safety should be provided. Alcohol and drugs affect the brain and the body whether addiction is present or not. This information should be included along with basic information about how substance use can compromise safety. Sometimes a woman herself may not be using or misusing substances but her safety may be compromised by another's use. Discussions about safety should explore risks associated with partner use as well.

Follow-up is advised to determine whether a woman's needs change over time. Additional options, referrals and support must be offered if, over time, an advocate becomes aware of potential difficulties stemming from the client's, or another person's, use, misuse or addiction. Follow-up may address concerns stemming from changes in observed behavior, noticeable signs of substance use or concerns about drug-seeking behavior (e.g., over-use of over-the-counter or prescription medications).

It is also helpful to be alert. Notice if the client has:

- The odor of alcohol on her breath
- Red eyes, pin-point or dilated pupils
- Track marks on arms, hands or feet
- Inflamed or eroded nasal septum

Cues which, if not directly indicative of addiction, at least indicate substance misuse may be occurring, include:

- Rapid speech
- Difficulty tracking conversation
- Scratching and picking at arms or face during a visit
- Lethargy
- Nodding
- Cigarette burns (which may also be indicative of domestic violence)
- Prescription drug-seeking behavior

Significant Problem with Substance Abuse

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. Following an initial screening, an advocate may identify a woman has an increased safety risk stemming from her, or another's, significant problem with substance misuse or abuse. Sometimes a significant problem with substance abuse is not identified at an initial contact but is revealed later. Whenever substance abuse is identified, information about safety should be provided and concern should be expressed. Options should include reviewing safer alternatives to substance use, providing linkage to counseling and on-site support systems, as well as community-based referrals. Discussions about safety should explore risks associated with partner substance abuse as well.

Substance-abusing women should be asked to consider refraining from substance use while they are using services. Follow-up should include checking to see if abstinence is causing any unexpected challenges or difficulties. Should a woman feel out of control, preoccupied by use, edgy or compelled to use, addiction may be indicated and withdrawal symptoms may appear.

Chemical Dependence

Substance use and misuse are behaviors. Research supports several theories related to causal etiologies of substance abuse and addiction, including behavioral, medical and other models. According to the disease model, chemical dependence, unlike domestic violence, is not a behavior. It is considered a primary chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal.

When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of

substance), it is likely that the person has progressed from abuse to dependence and addiction. While diversity of thought exists pertaining to addiction, it is critical to learn to recognize and identify women with this condition and provide appropriate intervention.

Battered Women in Recovery from Chemical Dependence

Following an initial screening, an advocate may learn a woman is in recovery from addiction to alcohol or other substances. Whenever past substance abuse is identified, information about safety should be provided and concern should be expressed about risks to sobriety associated with domestic violence, sexual assault and stress. These concerns may be greater for women with less time in recovery, but warranted for any woman addressing these issues regardless of amount of time in recovery.

Basic safety and sobriety tips should be provided, as well as information about risks associated with partner substance use. Options should include reviewing current support systems, providing linkage to counseling and on-site support systems, as well as community-based referrals. Follow-up is indicated periodically to determine whether increased support is wanted. Chemical dependence is a disease marked by periodic relapse. Should obvious signs of renewed preoccupation with substances or substance use occur, address them immediately. Discuss safety options including support groups and treatment with an open, supportive and non-judgmental attitude.

Battered Women Currently Active in their Addiction

Expressing care and concern rather than being critical is most useful when helping chemically dependent battered women address addiction and its impact on their safety. Be gentle. Always include messages linking safety and sobriety and address the benefits of stopping use at any time.

Addiction 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). Therefore, this problem impacts sufferers whether they are actively using or not.

Addiction is marked by physiological and central nervous system changes that lead to the development of tolerance, loss of control, continued use in spite of adverse consequences and withdrawal symptoms. Women are often unable to discontinue use without assistance.

Should this be the case, advocates will need to help women assess whether the immediate risk from a perpetrator outweighs those stemming from their current substance abuse and addiction. Ultimately this is not a question of whether safety or sobriety should take place first. Safety and sobriety are both important, since one is less likely without the other. Rather, the question is: What does the woman you are advocating for want to address today?

Discuss strategies to support behavior change such as 12-step programs, chemical dependency/domestic violence support groups and treatment options. If possible, suggest a referral for a more in-depth chemical dependency assessment and make the appointment together if the client is interested. Get a release of information and maintain communication with the chemical dependency treatment provider to support her progress. Be sure to follow up and provide emotional support.

Information and Referral

Providing advocacy-based counseling for battered women and survivors of sexual assault impacted by substance abuse is enhanced when advocates are:

- Informed about treatment options and community resources.
- Participating in cross-training with substance abuse programs to increase awareness of safety and sobriety issues.
- Willing to provide service options for individuals who are substance dependent whether they are in treatment or not.

Advocates must be able to provide accurate information about substance use, abuse and addiction and know what their local resources are. Linkages with your local substance abuse treatment program as well as knowledge of local medical options for program participants who may have a medical crisis stemming from overdose or withdrawal is essential.

Ideally, these linkages will help advocates become familiar with their local resources. Developing a relationship with your local chemical dependency prevention service provider can enhance safety and improve advocacy. Developing this relationship can lead to collaborative partnerships and staff exchanges for support groups. Victim service programs and chemical dependency programs can provide information and educational opportunities together to address both domestic violence and substance abuse issues. Many such collaborative ventures are working well here in Alaska in Dillingham, Palmer, Anchorage and other communities.

For general information about chemical dependency, The Alcohol/Drug Help Line 206-722-3700 or 1-800-562-1240 (*WA or AK only)* is available twenty-four hours a day to provide information about substances, including use, abuse and addiction. They can answer specific questions for battered women and survivors of sexual assault who are addressing substance abuse issues as well as help advocates develop options. See Resources section of Appendix for contact information.

Alternatives to Substance Abuse:

Relapse Prevention and Safety Planning
One-to-one advocacy and support group sessions should provide information that offers an alternative to substance use as part of a safety plan. Tools to integrate substance abuse as a safety issue are included in the Appendix (see Power and Control Wheel for Women's Substance Abuse).

Since addiction is marked by relapse, and relapse is often triggered by stress, women in recovery experiencing domestic violence may need additional support. According to Bland (2001), advocates may help recovering battered women and survivors of sexual assault develop a safety plan that includes but is not limited to:

- Identifying who to call for help (e.g., advocate, rape crisis line, sponsor, counselor, Alcohol/Drug Help Line); forming support systems, knowing about safe meetings
- Knowing information and education about addiction, domestic violence and sexual assault.

- Removing substances and paraphernalia from the home
- Recognizing unsafe persons, places, things
- Understanding how to deal with legal and other problems stemming from addiction, domestic violence and sexual assault (e.g., health, CPS involvement, poor nutrition)
- Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing or other options
- Knowing how domestic violence and sexual assault can be relapse issues
- Understanding physical, emotional, cognitive, environmental and other cues indicative of risk and having a plan to deal with it; recognizing role of stress and craving, having a plan to deal with it
- Learning how to parent, engaging in relationships, developing sober friendships
- Knowing when and where to run in a life-threatening situation that puts her sobriety and safety at risk

Consult with Patti Bland at the Alaska Network on Domestic Violence and Sexual Assault Office by phone: 907-586-3650 or email: pbland@andvsa.org or consider contacting the Alcohol/Drug Help Line Domestic Violence Outreach Project in Washington State for additional tips to address both alternatives to substance abuse and relapse prevention 1-800-562-1240.

Emotional Support

Last but not least, it is important to remind ourselves that addressing domestic violence, sexual assault and substance abuse issues is always difficult and challenging. Domestic violence and sexual assault programs can, according to Illinois Dept. of Human Services (2000), support victims struggling with issues of substance abuse in the following ways:

- Assist staff in dealing with their own feelings and prejudices about substance abuse. Provide on-going 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 and advise the victim and treatment providers of the risks of conjoint couples counseling sessions.
- While providing advocacy-based counseling, help women recognize the role substance abuse plays. It can keep them tied to an abusive relationship, increase their risk for harm and impair their safety planning ability.
- Assist victims by helping them find an alternative means of empowerment as replacement for the sense of power induced by substances.

- Include plans for continued sobriety as part of a safety plan. Help the victim understand the batterer may attempt to undermine her sobriety before the victim exits the shelter or completes advocacy services.

- Encourage and facilitate linkage with substance abuse treatment resources and abstinence-based support groups.
- Remain aware of which local substance abuse programs and support groups offer the highest degree of physical and psychological safety for victims of domestic violence and sexual assault.

RECOMMENDED PROCEDURES

Initial Contact/Crisis Intervention

This is a critical opportunity to provide support and information for battered women and survivors of sexual assault impacted by substance abuse. Initially, the advocate will not know if the individual uses, misuses or is addicted to alcohol and/or other substances. The advocate's ability to communicate through the appropriate knowledge of the issues that she is facing may help save the victim's life and the lives of her children. During the initial contact, following initial crisis intervention and safety planning, advocates should:

1. Inform the program participant of agency policy regarding chemical dependency and the agency goal of providing an environment of safety and sobriety. Be clear that you are asking about the substance use in order to best plan for her safety and sobriety, not as the basis for denying services.

2. Affirm the woman's survival skills and praise her sincerely for finding ways to cope with her situation before screening for substance abuse.

3. Determine if the program participant has drug use issues that affect her safety by using the appropriate screening forms.

4. Discussion about safety may include her opinions on how drinking or drug use could affect her safety.

5. If the program participant has substance abuse or addiction issues but is not ready to address recovery at the moment, provide safety planning that includes referrals to community resources such as the local chemical dependency program, 12-step meetings or Alcohol/Drug Help Line as an option in the future.

6. Make sure all staff who are in contact with a chemically dependent program participant know about the resources available (i.e., contact information for the local chemical dependency program, emergency health care provider numbers, list of AA/NA meetings, Alcohol/Drug Help Line, etc.) and how to support her in her choice of sobriety.

7. If the program participant is seeking treatment or is in the detoxing process, refer her to the appropriate medical or counseling resources.

8. Inform the program participant what her legal rights are, as well as what to expect from a police response. Discuss alternatives and options with her. Advise her how to call the police if she feels she is in immediate danger. Let her know this program will always support her.

In the Shelter

When working with a battered woman impacted by substance use in the shelter, advocates should:

1. Inform the program participant of agency policy regarding chemical dependency and the agency goal of providing an environment of safety and sobriety. Be clear that you are asking about the substance use in order to best plan for her safety and sobriety, not as the basis for denying services.

2. Affirm the woman's survival skills and praise her sincerely for finding ways to cope with her situation before screening for substance abuse.

3. Determine if she has drug use issues by using the appropriate screening forms.

4. If the program participant uses or misuses substances, discuss safety issues with her. Discussion about safety may include her opinions on how drinking or drug use could affect her safety.

5. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not. Discuss options and alternatives to substance use as a coping mechanism.

After screening, if the program participant has substance abuse issues, the advocate should:

6. Tell the program participant about the non-alcohol or other drug use agreement and ask her to support her recovery by signing it and adhering to this agreement during her stay in the program.

7. Work with the program participant on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.

8. If the she relapses and wants to keep working on her safety and sobriety, support her choice to sign the non-alcohol and other drug use agreement again and adhere to it during her stay in the program.

9. Make sure that all staff who are in contact with chemically dependent program participants know about available resources (i.e., local chemical dependency program, list of AA/NA meetings, contact information for Alcohol/Drug Help Line) and how to support then in their choice of both safety and sobriety.

10. Provide information regarding chemical dependency support groups in the community (for women, suggest same-gender 12-step groups) and provide internal support groups with a chemical dependency focus to foster both safety and sobriety efforts.

11. If a program participant is seeking treatment or is in the detoxing process, refer her to the appropriate resources and make the necessary follow-up to support her through this process.

12. Inform program participants how to contact the police and explain their legal rights, as well as what to expect from a police response. Discuss alternative options with her if she is not comfortable calling the police.

13. Work with program participants to develop an ongoing support plan to keep up with the actions she chose for her safety and sobriety.

14. Make sure that the information provided is clear and easily accessible.

15. Develop a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies WITH the program participant.

16. Meet separately with program participants' children to assess their needs.

17. Provide the program participants with information as to what behaviors advocates and/or the agency are mandated to report to OCS. <u>This information should make clear that disclosure of the use of alcohol and other drugs in and of itself is not a mandatory reporting issue.</u>

18. If a program participant has legal issues stemming from their substance abuse history, advocates can assist them by providing advocacy and contacting the LAP for a referral for help with the process of resolving outstanding warrants, etc.

19. Let her know this program will always support her efforts.

Community Program

When working in the community program, advocates need to remember that battered women impacted by substance abuse are struggling both with safety and sobriety. Advocates need to make sure these program participants feel welcome in the agency and that they and their children are supported.

1. Inform the program participants of agency policy regarding chemical dependency and the agency goal of providing an environment of safety and sobriety. Be clear that you are asking about the substance use in order to best plan for her safety and sobriety, not as the basis for denying services.

2. Affirm the woman's survival skills and praise her sincerely for finding ways to cope with her situation before screening for substance abuse.

3. Determine if she has drug use issues by using the appropriate screening forms.

4. If she uses or misuses substances, discuss safety issues with her. Discussion about safety may include her opinions on how drinking or drug use could affect her safety. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

5. If she is not ready to address substance use or addiction at the moment, be prepared to include a referral to community resources such as the local chemical dependency program, 12-step or other support group meetings and the Alcohol/Drug Help Line as an option in the future.

After screening, if the program participant has substance abuse issues, the advocate should:

6. Tell her about the non-alcohol or other drug use agreement and ask her to support her safety and sobriety by signing it and adhering to this agreement during her stay in the program.

7. Work with her on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.

8. If she relapses and wants to keep working on her safety and sobriety, support her to choose to sign the non-alcohol and other drug use agreement again and adhere to it during her stay in the program.

9. Make sure that all staff who are in contact with a chemically dependent program participant know about the resources available (i.e., contact information for Alcohol/Drug Help Line, local chemical dependency program, list of AA/NA meetings) and how to support her in her choice of safety and sobriety.

10. Provide information to her regarding chemical dependency support groups in the community (for women, suggest same-sex 12-step groups) and provide internal support groups with a chemical dependency focus.

11. If she is seeking treatment or is in the detoxing process, refer her to the appropriate resources and make the necessary follow-up to support her through this process.

12. Inform her how to contact the police and explain to her what her legal rights are, as well as what to expect from a police response. Discuss alternative options with her if she is not comfortable calling the police.

13. Work with her to develop an ongoing support plan to keep up with the actions she chose for her sobriety.

14. Make sure that the information provided to her is clear and she can easily accessible.

15. Develop a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies WITH the program participant.

16. Meet separately with program participants' children to assess their needs.

17. Provide program participants with information as to what behaviors advocates and/or the agency are mandated to report to OCS. <u>This information should make clear that disclosure of the use of alcohol and other drugs in and of itself is not a mandatory reporting issue.</u>

18. If a program participant has legal issues stemming from their substance abuse history, advocates can assist them by providing advocacy and contacting the ANDVSA Legal

Advocacy Project (LAP) for a referral for help with the process of resolving outstanding warrants, etc.

19. Let her know this program will always support her efforts.

Transitional Housing Program

Because a program participant will remain for a longer period of time in this program, transitional housing advocates have a key opportunity to provide a continuum of support to women working towards safety and sobriety. Advocates can also link a battered woman and survivors of sexual assault impacted by substance abuse with resources in the community to help her and her children, such as: chemical dependency treatment, health care providers, legal resources, community activities, 12-step and other chemical dependency type groups. In order to do this, advocates should:

1. Inform the program participant of agency policy regarding chemical dependency and the agency goal of providing an environment of safety and sobriety. Be clear that you are asking about the substance use in order to best plan for her safety and sobriety, not as the basis for denying services.

2. Affirm the woman's survival skills and praise her sincerely for finding ways to cope with her situation before screening for substance abuse

3. Determine if she has alcohol or drug use issues by using the appropriate screening forms. If she uses or misuses substances, discuss safety issues with her. Discussion about safety may include her opinions on how drinking or drug use could affect her safety. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

4. If she uses or misuses substances, discuss safety issues with her. Discussion about safety may include her opinions on how drinking or drug use could affect her safety. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

5. If she is not ready to address substance use at the moment, be prepared to refer her to community resources such as the local chemical dependency program, 12-step or other support group meetings and the Alcohol Drug Help Line as an option in the future.

After screening, if the program participant has substance abuse issues, the advocate should:

6. Tell her about the non-alcohol or other drug use agreement and ask her to support her safety and sobriety by signing it and adhering to this agreement during her stay in the program.

7. Work with her on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.

8. If she relapses and wants to keep working on her safety and sobriety, support her choice and encourage her to sign the non-alcohol and other drug use agreement again and adhere to it during her stay in the program.

9. Make sure that all staff who are in contact with a chemically dependent program participant know about the resources available (i.e., contact information for Alcohol/Drug

Help Line, local chemical dependency program, list of AA/NA and meetings, medical referrals) and how to support her in her choice of safety and sobriety.

10. Provide information to her regarding chemical dependency support groups in the community (for women, suggest same-sex 12-step groups) and provide internal support groups with a chemical dependency focus.

11. If she is seeking treatment or is in the detoxing process, refer her to the appropriate resources and make the necessary follow-up to support her through this process.

12. Inform her how to contact the police and explain what her legal rights are, as well as what to expect from a police response. Discuss alternative options with her if she is not comfortable calling the police.

13. Work with her to develop an ongoing support plan to keep up with the actions she has chosen for her safety and sobriety.

14. Make sure that the information provided to her is clear and easily accessible.

15. Develop a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies WITH the program participant.

16. Meet separately with her children to assess their needs.

17. Provide her with information as to what behaviors advocates and/or the agency are mandated to report to OCS. <u>This information should make clear that disclosure of the use of alcohol and other drugs in and of itself is not a mandatory reporting issue.</u>

18. If a program participant has legal issues stemming from their substance abuse history, advocates can assist them by providing advocacy and contacting the LAP for a referral for help with the process of resolving outstanding warrants, etc.

19. Let her know this program will always support her efforts.

Legal Advocacy

When doing legal advocacy with battered women impacted by substance abuse, advocates need to be aware that program participants may feel threatened by the legal system. Chemical dependency is a disease that has been criminalized. A program participant may have faced legal consequences in the past as a result of her substance use and/or domestic violence. She may have been criticized for a sexual assault because of substance use. The legal advocate must be very clear in explaining to the program participant how the legal system works and that she is going to support her in addressing her legal issues if needed.

1. Inform the program participant of agency policy regarding chemical dependency and the agency goal of providing an environment of safety and sobriety. Be clear that you are asking about the substance use in order to best plan for her safety and sobriety, not as the basis for denying services.

2. Affirm the woman's survival skills and praise her sincerely for finding ways to cope with her situation before screening for substance abuse.

3. Determine if she has drug use issues by using the appropriate screening forms.

4. If she uses or misuses substances, discuss safety issues with her. If she uses or misuses substances, discuss safety issues with her. Discussion about safety may include her opinions on how drinking or drug use could affect her safety. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

5. If she is not ready to address substance use at the moment, be prepared to include a referral to community resources such as the Alcohol/Drug Help Line, local chemical dependency program, or 12-step or other support group meetings as an option for the future should she need it then, as part of her safety plan.

After screening, if she has substance abuse issues, the advocate should:

6. Tell her about the non-alcohol or other drug use agreement and ask her to support her safety and sobriety by signing it and adhering to this agreement during her stay in the program.

7. Work with her on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.

8. If she relapses and wants to keep working on her safety and sobriety, support her choice and encourage her to sign the non-alcohol and other drug use agreement again and adhere to it during her stay in the program.

9. Make sure that all staff who are in contact with a chemically dependent program participant know about the resources available (i.e., contact information for the Alcohol/Drug Help Line, local chemical dependency program, list of AA/NA and other meetings) and how to support her in her choice of safety and sobriety.

10. Provide information to her regarding chemical dependency support groups in the community (for women, suggest same-sex 12-step groups) and provide internal support groups with a chemical dependency focus.

11. If she is seeking treatment or is in the detoxing process, refer her to the appropriate resources and make the necessary follow-up to support her through this process.

12. Inform her how to contact the police and explain to her what her legal rights are, as well as what to expect from a police response. Discuss alternative options with her if she is not comfortable calling the police.

13. Work with the client to develop an ongoing support plan to keep up with the actions she chose for her safety and sobriety.

14. Make sure that the information provided to her is clear and easily accessible.

15. Develop a support plan for making important calls and a reminder plan for court dates and appointments with lawyers, doctors, treatment providers and other agencies WITH the program participant.

16. Meet separately with the program participant's children to assess their needs.

17. Provide her with information as to what behaviors advocates and/or the agency are mandated to report to OCS. This information should make clear that disclosure of the use of alcohol and other drugs in and of itself is not a mandatory reporting issue.

18. If program participants have legal issues stemming from their substance abuse history, advocates can assist them by providing advocacy and contacting the LAP for a referral for help with the process of resolving outstanding warrants, etc.

19. Legal Advocates need to develop strategies to counter "bad victim" "bad mother" issues facing program participants' with substance abuse issues. Legal advocates must also be aware that alcohol and other substance misuse can lead to impaired memory and blackouts which could result in poor recollection and inconsistencies in the testimony of a witness.

Support Groups

For women impacted by domestic violence, sexual assault and substance abuse, support groups can play an essential role in their safety, sobriety and recovery. It is extremely important for facilitators to provide a safe, non-judgmental environment to talk about safety, sobriety and justice. It is also very important for facilitators to acknowledge a woman's use, misuse or addiction to substances is not the cause of domestic violence or sexual assault. Offenders should always be held solely accountable for the violence they have directed towards their innocent victims. Support groups should have clear ground rules addressing confidentiality, a non-judgmental atmosphere and respect among group members.

Support group facilitators need to be trained in domestic violence and sexual assault issues as well as knowledgeable about substance use, misuse and addiction. Collaboration with local chemical dependency programs can facilitate cross-training between domestic violence/sexual assault advocates and chemical dependency counselors.

The following can be useful group topics for women affected by their own or their partner's substance abuse:

- Use, Misuse and Addiction: Impact on Safety
- What is chemical dependency?
- Tactics abusers use to control their partners (related to substance use)
- Date Rape Drugs
- Safety planning and relapse prevention
- Safety planning for stalking victims
- Continuum of domestic violence and of addiction manifestations
- Power and control wheel for chemical dependency issues

The Alaska Network on Domestic Violence and Sexual Assault is in the process of developing a support group manual to assist you in the provision of support groups which will be completed in the Fall of 2005.

Community Partnership

Battered women and victims of sexual assault impacted by substance abuse often contact other services, such as health providers or chemical dependency agencies, before they contact an advocate. Therefore, it is essential that victim service agencies partner closely with other social services agencies in order to expand their knowledge and options to better serve substance-abusing and chemically dependent victims of domestic violence and sexual assault. When partnering with other agencies, staff at the domestic violence/sexual assault program must remain vigilant about confidentiality restrictions and must have written releases if sharing information about a chemically dependant client with anyone outside of the agency (even another DV/SA program).

Staff and Volunteer Training

For people impacted by multi-abuse trauma, domestic violence and sexual assault are not the only life-threatening issues they face. Women impacted by violence and addiction are also dealing with a disease, chemical dependence, that can be lethal as well. Training in chemical dependency issues can help staff members and volunteers better serve chemically dependant women and their children. Better training can also improve the safety of program participants and staff present in our programs. Recruiting staff and volunteers who have chemical dependency knowledge or who are in recovery could provide an additional opportunity to meet the needs of chemically dependant program participants. Volunteers play an essential role in delivering services to victims of domestic violence and sexual assault; it is therefore very important to make sure that they receive the same level of training in providing services to chemically dependent clients as other staff. It is also essential that staff members and volunteers be asked to honor a non-alcohol or substance use policy during work hours, and the agency should offer support for them to be able to meet this requirement.

Rural Issues

Advocates working in rural communities face many barriers, including the lack of resources, transportation and confidentiality. Because resources may be limited, partnership with other agencies plays an essential role in working with women impacted by domestic violence, sexual assault and substance abuse in a rural or off the road communities. Partnership may include *(with direction, permission and a release of information)* advocating with another agency on behalf of the substance-abusing or chemically dependent woman impacted by domestic violence and sexual assault, in order to strengthen the other agency's response to that particular individual's needs. When advocates work with other agencies in a small or insular community, program participant confidentiality can be compromised through information-sharing unless there are consistent efforts to adhere to the domestic violence/sexual assault agency's confidentiality practices. Coordination between agencies is also needed to ensure that women impacted by DVSA and substance abuse have reliable transportation to access necessary services.

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DEFINITIONS

By Patti Bland, from Hoog, Cathy. 2001. *Enough and Yet Not Enough: An Educational Resource Manual On Domestic Violence Advocacy For Persons With Disabilities In Washington State.* Seattle, WA: Washington State Coalition Against Domestic Violence.

Definitions noted with asterisk are from Inaba, D.S. and W.E. Cohen. 2000. *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs,* 4th Edition, Ashland, OR: CNS Publications.

12-Step Program – a self-help group that is often used as an adjunct to treatment but which is not treatment. 12-step programs can support lifetime recovery and can be extremely useful; however, battered women will also benefit from referrals to gender-specific groups and battered women's advocacy programs for safety planning as a recovery issue.

Addiction or Chemical Dependence – is characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with use, use despite adverse consequences and distortions in thinking (e.g., denial). The neurochemical dysfunction in addiction is best described as a chemical deficiency in pathways of the brain.

Addict phobia – includes fear of addicts and addiction; holding negative stereotypes pertaining to people suffering from addiction; refraining from offering services, support or respect. Addict phobia creates barriers for those who are afraid of getting labeled and fearful about seeking help. Additionally, addict phobia negatively impacts people struggling to recover daily. Examples of addict phobia include mistaken belief systems about addiction, failure to understand triggers, unrealistic expectations, lack of knowledge about brain chemistry, liver function, relapse processes, resources and recovery options, as well as failure to understand appropriate role of accountability, consistency and structure. Addict phobia makes it possible for individuals and systems to establish overly rigid or overly permeable criteria, which can limit or prohibit access to services or successful outcomes to an entire class of people. Addict phobia is a form of oppression in our society.

Alcoholism – a treatable illness brought on by harmful dependence upon alcohol, which is physically and psychologically addictive. As a disease, alcoholism is primary, chronic progressive and fatal.

**Binge* – using large amounts of alcohol or other drugs in a short period of time. Binge drinking for women may be defined as four or more drinks in one drinking session at least once every two weeks but being abstinent in between those times.

Blackout – an amnesia-like period often associated with heavy drinking. While blackouts impact memory, there is no evidence to support contention that blackouts alter judgment or behavior at the time of occurrence.

**Cocaine psychosis* – a drug-induced mental illness; symptoms include extreme paranoia and hallucinations. Similar psychosis is associated with amphetamine use.

**Coke bugs* – imaginary insects a long-term cocaine abuser thinks are crawling under the skin. They often cause substance abusers to scratch themselves bloody. Similar activity is associated with amphetamine use.

Cognitive Impairments – disruptions in thinking skills such as inattention, memory problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases).

**Craving* – the powerful desire to use a psychoactive drug or engage in compulsive behavior. It is manifested in physiological changes such as change in heart rate, sweating, anxiety, drop in body temperature, pupil dilation and stomach muscle movements. Endogenous craving is caused by neurochemical changes in the brain, such as depletion of dopamine resulting from cocaine use. Other cravings are caused by environmental triggers (cue cravings).

**Cross-dependence* – occurs when an individual becomes addicted to or tissue dependent on one drug, resulting in biochemical and cellular changes that support addiction to other drugs.

**Cross-tolerance* – the development of tolerance to other drugs by the continued exposure to a drug that affects body mechanisms to tolerate other drugs (e.g., tolerance to heroin translates to morphine, alcohol and barbiturates).

Delirium Tremens (DTs) – When the level of alcohol in the blood drops suddenly and the person becomes delirious as well as tremulous and suffers from hallucinations that are primarily visual but also may be tactile.

Detoxification – The process of providing medical care during the removal of dependence-producing substances from the body so that withdrawal symptoms are minimized and physiological function is safely restored. Treatment includes medication, rest, diet, fluids and nursing care.

Dual Diagnosis – A clinical term referring specifically to patients who meet the diagnostic criteria for an addictive disorder as well as meeting the diagnostic criteria for:

- An organic mental or developmental disorder
- A major psychiatric disorder with or without current symptomology
- A personality disorder, or
- A compulsive disorder such as an eating or pathological gambling disorder.

Euphoric Recall – memories formed under the influence of alcohol or other drugs that may be used as inappropriate excuse to minimize, rationalize or deny behavior.

**Harm Reduction* – a tertiary prevention and treatment technique that tries to minimize the medical and social problems associated with drug use rather than making abstinence the primary goal (e.g., needle exchange and methadone maintenance).

Mentally Ill Chemical Abusers (MICA) – A term used to designate people who have an alcohol or other drug disorder and a markedly severe and persistent mental disorder such as schizophrenia or bipolar disorder.

Methadone – A synthetic narcotic. It may be used as a substitute for heroin, producing less socially disabling addiction or aiding in withdrawal from heroin.

Relapse – Is common in recovery from addiction and not considered treatment failure. As with other chronic illnesses, significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

Substance abuse – a destructive pattern of drug use, including ETOH (alcohol), which leads to clinically significant impairment or distress. Often the substance abuse continues despite significant life problems. When a person exhibits tolerance and withdrawal, the person has progressed from abuse to *Addiction* (a disease consisting of a number of brain chemistry disorders).

Tolerance – the need for significantly larger amounts of substance to achieve intoxication. Drug effects decrease if the usual amount is taken.

Withdrawal – adverse reaction after a reduction of substance use. Withdrawal is the body's attempt to balance itself after prolonged use of a psychoactive drug. The symptoms range from mild (caffeine withdrawal) to severe (heroin withdrawal) to life-threatening (alcohol and prescription drug withdrawal). The onset of symptoms is generally predictable.

RESOURCES

Organizations/Agencies

Alaska Network on Domestic Violence and Sexual Assault
Address: 130 Seward St. #209 l // Juneau, AK 99801
Phone (907)-586-3650
FAX: (907)-463-4493
Web Address: http://www.andvsa.org

Contact Patti Bland, M.A. CCDC at the Alaska Network on Domestic Violence and Sexual Assault for technical assistance, consultation and training on the intersection between Domestic Violence and Substance Abuse and other forms of Oppression. Patti can be reached at 907-586-3650 ext 34 or by email at: pjmbland@hotmail.com

Alaska Family Services (AFS)

AFS has provided support groups for women with multiple abuse problems for several years. Recently they have developed a wrap-around program to support both safety and sobriety for women with substance abuse and DV/SA issues that includes linkage to both treatment and shelter. Contact them at 907-746-4080.

South Peninsula Haven House (SPHH)

SPHH is a domestic violence/sexual assault program in Homer, AK that works closely with their local substance abuse treatment program to provide support groups and services for women impacted by multiple abuse issues including substance abuse.
Contact Peg Coleman at 907-235-7712.

Safe and Fear-Free Environment SAFE -SISTR Program

The DV program and treatment center in Dillingham, AK have partnered to provide integrated services for women seeking both safety and sobriety. Contact Ginger Baim at 907-842-2320 for information about starting a similar program.
Email: VRBaim@besafeandfree.org

State of Alaska H&SS
DIVISION OF BEHAVIORAL HEALTH
Toll free Juneau number: (800) 465-4828
Toll free Anchorage number: (800) 770-3930
http://www.hss.state.ak.us/dbh/contacts.htm

This web site has a list of substance abuse treatment programs in Alaska plus links to other useful information about addiction and behavioral health.

The Alcohol/Drug Help Line Domestic Violence Outreach Project can be reached at 206-722-3700 or 1-800-562-1240 (in Washington and Alaska only), or see their website at http://www.adhl.org. They can provide information about accessing detox services and ADATSA as well as Washington state programs such as the Washington State Coalition on Women's Substance Abuse Issues. They can also provide information about gender-specific treatment options in Washington, such as Residence XII (Kirkland), Perinatal Treatment Services (Seattle), Mom's Program (Tacoma), Isabella House (Spokane) and Riel House (Yakima), and other treatment and support group options for those impacted by both substance abuse and domestic violence in Washington State.

The Washington State Alcohol/Drug Clearinghouse provides literature, videos and information about substance abuse and addiction, much of it for free. To order, call 1-800-662-9111 (toll free in Washington). From Seattle or out of state, call 206-725-9696. Fax: 206-722-1032, email: clearinghouse@adhl.org, website: http://www.adhl.org/clearinghouse.

Recommended Reading and Materials

Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse, Domestic Violence Interdisciplinary Task Force of the Illinois Department of Human Services, 2000. For information about this publication contact: www.dhs.state.il.us.

Roth, P. (Ed). *Alcohol and Drugs Are Women's Issues, Volume One, A Review of the Issues.* New Jersey: Women's Action Alliance and Scarecrow Press, 1991.

Roth, P. (Ed). *Alcohol and Drugs Are Women's Issues, Volume Two, The Model Program Guide.* New Jersey: Women's Action Alliance and Scarecrow Press, 1991.

Chemically Dependent Victims of Domestic Violence and Sexual Assault

Adapted from Bland, P. 2001. *Perinatal Partnership Against Domestic Violence: Train the Trainer Curriculum.* Seattle, WA: Washington State Department of Health, Community & Family Health, Maternal Child Health and the Washington State Coalition Against Domestic Violence. Revised 2002 for Alaska Network on Domestic Violence and Sexual Assault *Basic Curriculum for Advocates.*

Keep in mind that not all people who drink or use drugs are alcoholics or addicts. When alcoholism or addiction is present, there is great pain, shame, fear and isolation.

- Alcohol and drug use is associated with greater severity of injuries and increased lethality rates. However, *substance abuse does not cause domestic violence or sexual assault.*

- Being identified as either an alcoholic or an addict (even if people are in recovery) can impact ability to get housing and gain or maintain child custody. This may affect careers, community standing, and/or support (or lack thereof). Increased insurance rates and legal difficulties may also be experienced.

- Chemically dependent people face many service barriers. Shelter space is often denied, detox may not be available immediately, and treatment may seem less urgent than getting safe.

- Chemically dependent battered persons and survivors of sexual assault are not powerless. They are victims of both a life-threatening disease *and* violent crime. Empowerment for these survivors involves *both* safety and sobriety.

- Many substance-abusing victims of domestic violence and sexual assault are introduced to drugs by partners who use substances to gain and maintain power and control. A violent person may use alcohol or date rape drugs like rohypnol to more easily harm another. This is a form of physical, emotional, social, sexual and spiritual abuse. Recognizing this may help establish trust and reduce stigma.

- Substance-abusing victims of violence are often victimized by substance-abusing perpetrators. Cessation of drinking and drug use alone *cannot* ensure safety. Often, recovery is accompanied by more danger for victims. As victim sobriety increases, perpetrators may find their ability to control their partners threatened. They may seek to sabotage recovery efforts or look for new ways to regain control. Refer victims to support groups addressing both the substance abuse as well as the domestic violence/sexual assault issues.

- Treatment for substance abuse can pose many risks for victims of domestic violence/sexual assault. *Conjoint and couples counseling are not appropriate and should not be encouraged by providers.* Domestic violence/sexual assault victims in methadone programs may be particularly vulnerable because they must appear daily at a set time for their dose and thus can be easily tracked by an abuser.

- Validate that anyone might use drinking or drugging to cope, but there are safer ways to survive sexual assault, rape trauma, abuse and domestic violence. Offer options, but recognize that substances impair judgment, making advocacy-based counseling more

challenging. Don't be afraid to refer to 12-step programs, but be able to explain both strengths and limitations. Be aware of alternative referrals, especially for gender-specific or culturally appropriate support groups or chemical dependency treatment providers.

- Recognize euphoric recall and blackout make safety planning harder. Denial of use is not about fooling the provider. It's a tactic to be addressed in a respectful manner. Facing the truth is scary and painful for the alcoholic or addict. Always be honest and direct, but remember tact and dignity.

- Chemical dependency undermines both health and judgment. Withdrawal symptoms can be painful and life threatening. Encourage people to seek medical attention prior to detoxing.

- Chemically affected victims of violence often believe their use of a substance means the violence directed against them is warranted. Always affirm that no one has the right to hurt them, and that violence directed against them is *never their fault* under any circumstance.

- Understand both negative stereotypes and negative internal views about domestic violence, sexual assault and addiction act as barriers preventing people from realizing they need support. Additionally, service providers must examine their own beliefs about alcohol and other drug use, abuse and addiction to ensure addict phobia is not impairing their ability to effectively advocate for recovering or actively using victims of violence.

- Refer people addressing both chemical dependency and domestic violence issues to the Alcohol/Drug Help Line Domestic Violence Outreach Project (www.adhl.org) at 206-722-3700 or 1-800-562-1240 *(WA and AK only)*.

SCREENING MATERIALS

Part III

GENERAL GUIDELINES FOR IDENTIFYING PEOPLE WHO **MAY BE AFFECTED BY ALCOHOL OR OTHER DRUG USE**

- LOOK FOR CHANGE IN BEHAVIOR, ATTITUDE, OR APPEARANCE

- IDENTIFY BEHAVIOR WHICH DOESN'T SEEM RIGHT

    - Individual cannot stay awake
    - Is unable to sit still
    - Is disoriented or confused for no apparent reason
    - Laughs or cries at inappropriate times
    - Displays rapid shifts in mood
    - Slurs speech
    - Speech is rapid and loud, and it is difficult to follow person's train of thought

- DO NOT AUTOMATICALLY ASSUME BEHAVIOR IS CAUSED BY ALCOHOL OR OTHER DRUG USE. RULE OUT OTHER CAUSES FIRST.

    - Individual is physically ill (e.g., flu)
    - Is upset about some obvious problem (e.g., has been victimized by sexual partner or other person; is concerned about son's gang involvement)
    - Person's physician has recently prescribed new medication, particularly for psychiatric reasons

- DO NOT ARGUE WITH PEOPLE YOU PROVIDE SERVICES FOR REGARDING THEIR USE OF ALCOHOL OR OTHER DRUGS

Adapted from:

Domestic Violence/Substance Abuse Interdisciplinary Task Force, IL DHS (7/2000). *Safety & Sobriety: Best Practices* in *DV & SA*.

Common Signs/Symptoms of the Five Basic Abused Substances

Stimulants including speed, cocaine, caffeine, ephedrine, etc.	**Depressants** including barbituates, minor tranquilizers, alcohol, opiates, etc.	**Hallucinogens** including LSD, acid, PCP, angel dust, wicki sticks, mushrooms, etc.	**Cannabis** also known as marijuana, pot, weed, reefer, dope, buds, etc.	**Inhalants** examples of what is commonly used: glue, gasoline, paint, etc.
Intoxication Characteristics	**Intoxication Characteristics**	**Intoxication Characteristics**	**Intoxication Characteristics**	**Intoxication Characteristics**
dilated (large) pupils	slurred speech	pupils dilate (large)	increased appetite	dizziness
restlessness/excitement	drowsiness	fast heart rate	dry mouth	blurred vision
insomnia	staggering	sweating	fast heart rate	slurred speech
flushed face	impairment in attention or memory	blurring of vision	delusions	unsteady gait
increased urination	pupil constriction (small)	tremors	decreased body temperature	slowed reflexes
muscles twitching	smell of alcohol	hallucinations	panic	
rambling speech				
irregular heartbeat				
perspiration or chills				

ANDVSA Real Tools from:

Domestic Violence/Substance Abuse Interdisciplinary Task Force, IL DHS (7/2000). *Safety & Sobriety: Best Practices* in *DV & SA.*

Screening Tools

Sample Screening Instruments from *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*, published by the national Center for Education in Maternal and Child Health, 1997.

4Ps

Have you ever used drugs or alcohol during this **P**regnancy?

Have you had a problem with drugs or alcohol in the **P**ast?

Does your **P**artner have a problem with drugs or alcohol?

Do you consider one of your **P**arents to be an addict or alcoholic?

This screening device is often used as a way to begin a discussion about drug or alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

Ewing H. Medical Director, Born Free Project. Contra Casta County, 111 Allen Street, Martinez, CA 94553. Phone: (510) 646-1165.

T-ACE

How many drinks does it take for you to feel high? (**T**olerance)

Have people **A**nnoyed you by criticizing your drinking?

Have you ever felt you ought to **C**ut down on your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

(**E**ye-opener)

Any woman who answers more than two drinks on the tolerance question is scored 2 points. Each yes to the additional three questions scores 1. A score of 2 or more is considered a positive screen, and the woman should be referred to specialist for further assessment.

Sokol RJ, Martier SS, Ager JW, 1989. The T-ACE questions: Practical prenatal detection of risk drinking. *American Journal of Obstetrics and Gynecology 160(4).*

TWEAK

How many drinks does it take for you to feel high? (**T**olerance)

Does your partner (or do your parents) ever **W**orry or complain about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

(**E**ye Opener)

Have you ever **A**wakened the morning after some drinking the night before and found that you could not remember part of the evening before?

Have you ever felt that you ought to **K**/Cut down on your drinking?

A woman receives 2 points on the tolerance questions if she reports that she can hold more than 5 drinks without falling asleep or passing out. A positive response to the worry question scores 2 points, and a positive response to each of the last 3 questions scores 1 point each. A total score of 2 or more indicates that the woman is a risk drinker and requires further assessment.

Russell M. 1994. New assessment tools for risk drinking during pregnancy. Alcohol, Health and Research World 18(1).

Ten-Question Drinking History (TQDH)

Beer:	How many times a week do you drink beer?
	How many cans do you have at one time?
	Do you ever drink more?
Wine:	How many times per week do you drink wine?
	How many glasses do you have at one time?
	Do you ever drink more?
Liquor:	How many times per week do you drink liquor?
	How many drinks do you have at one time?
	Do you ever drink more?

Has your drinking changed during the past year?

Any woman who reports drinking more than four drinks once a week or more is considered at risk and requires further evaluation.

Weiner L, Rosett HL, Edelin KC. 1982. Behavioral evaluation of fetal alcohol education for physicians. *Alcoholism: Clinical and Experimental Research6(2).*

Spouse Abuse Risk Assessment

From the Domestic Violence/Substance Abuse Interdisciplinary Task Force of the IL DHS (7/2000). Safety and Sobriety: *Best Practices in Domestic Violence and Substance Abuse.*

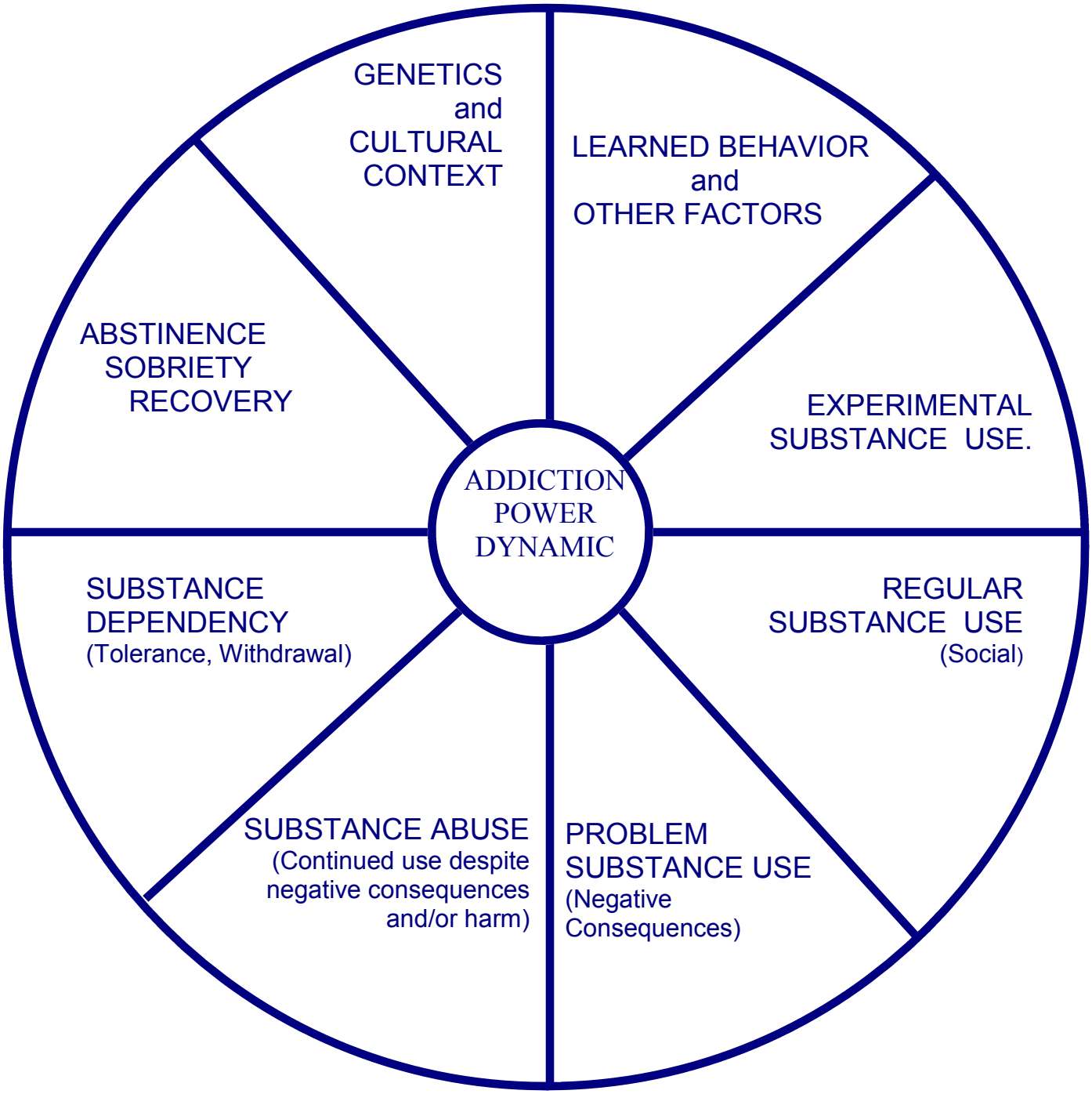
Name: _____ Date: _____

Risk Factors	LOW (L)	Moderate (M)	High (H)	Comments
History of Abuse	No prior reports or injuries	Prior minor injuries	Subsequent incident or serious injury	
Substance Abuse	None	Some use, non-contributing factor	Significant use, contributing factor	
Extent of Physical Injury	No medical treatment needed	Minor physical injuries/treatment	Major physical injury/hospitalization/injury during pregnancy	
Use of Weapons	None	Weapons available, not used	Weapons used, or threat to use	
Emotional Maltreatment	None/infrequent	Frequent/chronic	Threats of death or serious injury/stalking	
Location of Children	Known/no risk	Known/minimal risk	Unknown, or with perpetrator	
Forced Sex	No evidence or allegation	Allegation with no evidence	Evidence of forced sex	
Family Stressors	None	Minimal	Multiple	
Location of Perpetrator	Known, no access to victim	Known, access to victim	Unknown, or at large	
Assault History	None	Infrequent/occationsl episodes	Frequent/chronic episodes	
Fear of Perpetrator	None	Minimal	Significant	
Safety Plan	Appropriate	Vague	None	

Any "H" must be thoroughly evaluated; majority of "M's" require additional evaluation; advise the victim of the assessment and recommendations

Warning/Protection Plan:

Alcohol and Other Drug Use from Abstinence to Addiction



Screening Chemically Dependent Battered Women IN...NOT OUT of our Programs

Reprinted from The A Files Washington State Coalition Against Domestic Violence Newsletter, Vol. 3., No. 3, Pages 127-138, October 2001

Note: This article is written primarily for Domestic Violence Program Advocates. A companion article written by Patti Bland specifically for Substance Abuse Treatment Providers can be found at the Washington State Coalition on Women's Substance Abuse Issues web page http://www.wscwsai.org.

About the Issue

This issue of the A-Files makes visible the experience of substance abusing battered women and our challenge as advocates to develop responsive services in our programs. Safety is an essential element frequently lacking in the lives of women and children who have been impacted by domestic violence. While most women who have experienced intimate partner violence do not suffer from chemical dependency, it is important to acknowledge the many women who live, work or receive services at our programs who are dealing with addiction and recovery issues. Although we cannot always ensure safety, we are obliged to provide as safe an environment as possible for all women who use our services or work at our programs. Barriers to women's safety and sobriety are magnified when routine screening for substance abuse fails to occur.

In her article, "Building A bridge from Substance Abuse to Safety – for Battered Women", author Patti Bland lays out a strong rationale for including substance abuse screening and making room in our programs for women who misuse substances. When our advocacy is not informed by the experience of substance abusing battered women, we are limiting our ability to respond and learn from women who are living with violence. We must ask ourselves touch questions and reevaluate our work practices. Do our practices increase safety and validate the experiences of chemically dependent battered women? What message do we send to the victim, to the batterer, to our community if we do not serve substance abusing women in our programs? Additionally, this issue of the A-Files includes: support group tools, practical strategies, resources, and information about Patti Bland's supplemental resource packet in the *And Now What* section.

At the Coalition, we recognize the work of advocates is both incredibly hard and vitally necessary. Showing up everyday with compassion, an open mind and resilience is the least that is asked of advocates. By stretching our thinking about what it takes and with whom we work to end all forms of violence, we remain rooted in the experience of recovering battered women. We encourage you to read this A-Files. Let the voices of survivors direct us to apply their experience, strength and hope to our daily advocacy work.

Screening Chemically Dependent Battered Women: IN ... NOT OUT!

By Patricia J. Bland, M.A. CCDC ©2001

(Includes excerpts from Women Talk about Substance Abuse and Violence, ten women interviewed by Debi Edmund and Patti Bland; edited by © Debi Edmund, 6/2000)

Safety is an essential element frequently lacking in the lives of women and children who have been impacted by domestic violence. While most women who have experienced intimate partner violence do not suffer from chemical dependency, it is important to acknowledge the many women who live, work or receive services at our programs who are dealing with addiction and recovery issues. Although one cannot always ensure safety, we are obliged to provide as safe an environment as possible for all women who must use our services or work at our programs. Barriers to women's safety and sobriety are magnified when routine screening for substance abuse fails to occur.

Screening for substance misuse is often routinely neglected by advocates for battered women. Failure to ask key questions or to recognize cues indicating the presence of both domestic violence and addiction stems from a variety of causes. These causes include: lack of time, sense of helplessness to assess outside one's own area of expertise, fear of "opening up a can of worms," concerns about angering or hurting a woman's feelings, lack of knowledge of community resources as well as lack of trust in other system providers. These barriers are compounded if they exist within a culture that routinely denies access to services for women with substance abuse or addiction issues.

Why Screen?

Domestic violence and addiction frequently occur in tandem although research indicates neither causes the other. Individually, each can be chronic, progressive and often lethal. Together, severity of injuries and lethality rates climb (Dutton, 1992). Battered women's advocates have an ethical responsibility to routinely screen for addiction issues as well as offer options and services to women who may be at increased risk for more lethal domestic violence due to their own or a partner's substance abuse. Advocates for battered women need to ask women about both their own substance use as well as their partners' use. "Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their partners" (AMA, 1994). A recent study in Memphis, TN found in 94% of domestic violence calls, the assailant had used alcohol alone or in combination with cocaine, marijuana, or other drugs within six hours of the assault. Brookoff et al found 92% of assailants and 42% of victims in the Memphis study used alcohol or other drugs on the day of the assault.

"He drank and he used marijuana heavily. He also used other drugs. The abuse kept going. Not even just when he drank. I mean stressful times. He really hurt me, and I remember just lying, pregnant, in a ball, sobbing as he just drank himself into oblivion."

Research supports universal screening. Actually finding out whether substance abuse or addiction is impacting safety and being able to effectively advocate requires more than checking off boxes or asking questions from a list. The first requirement for respectful screening is an honest evaluation of one's own attitudes and beliefs about addiction. Before a woman can open up to an advocate she must feel safe. Components of safety include ensuring confidentiality, being culturally competent, and avoiding judgmental or overly directive interactions. Effective screening and intervention requires system-wide respect for women's choices and autonomy. Screening for safety and sobriety cannot guarantee survival but may increase a woman's options and improve her odds. Women benefit from non-judgmental advocacy that acknowledges the impact of substance use, abuse and addiction on safety for women and their children. Advocates for battered women must understand getting safe is a process possible for addicted battered women only when tools to support sobriety are provided as part of the process.

"Somebody wanted to show me support, listen to me, not yell at me, not scream at me, just look at some options, instead of that. Through them showing love to me, I began to love myself. I didn't deserve the punishment, the continuous bad relationships, continuous abusing the drugs, and the shame and the guilt I felt from all that. I deserved better. It was also okay to heal from all of that."

Screening In...Not Out

Chemically dependent battered women typically experience barriers to services and are often denied shelter, housing, employment, child custody, health insurance and other services. Impacted by both domestic violence and addiction, they are attempting to survive in a world that condemns them for both their substance abuse and their choice of partner. Failure to provide safe services for chemically dependent battered women is a form of able-bodyism. Shelter policies that deny access to services for an entire class of people are both discriminatory and oppressive and cannot be tolerated. The point of screening battered women for substance abuse is not to deny access to victim services but to improve advocacy and safety planning for any women in need of assistance or support. Model programs in Washington state welcome women seeking safety and sobriety and are committed to reducing service barriers and ending isolation for chemically dependent battered women and their children.

"It (using) kept me isolated so I stayed at home in my room with the curtains drawn. On top of him keeping me isolated and not allowing me to go anywhere. I think the biggest thing it did was keep me from getting out and getting the help I needed."

Think-Rethink

A commitment to serve women dealing with both domestic violence and substance abuse requires critical thinking about policies on the part of battered women's advocacy programs. Policies supporting a clean and sober environment must be balanced with guidelines making it safe for women who are unable to refrain from use without support to safely tell us they need help. We must keep in mind that in many cases the immediate risk from domestic violence may

be more acute than risk from chronic drug or alcohol abuse. We must also be aware risks from overdose or withdrawal can be as lethal as any batterer.

Ideally substance use and abuse should be discouraged as a safety issue for those living and working in our shelters and programs. Guidelines supporting both abstinence and harm reduction are important. This can be challenging for both battered women and advocates who may not be experiencing problems with alcohol or other drugs as well as for those who are. For those whose lives are not threatened by a chronic progressive illness marked by relapse (non-alcoholic/addicts), alcohol or other drug use is merely an option. For women who are not chemically dependent, being unable to have access to substances during a shelter stay or before group may merely be an inconvenience rather than a major barrier to safe services. Chemically dependent battered women have a right to ask us to support their sobriety. To do so is empowering. To do so makes it possible for them to get free from both batterers and substances that put them at risk.

Understanding Domestic Violence and Substance Abuse

"All I know is when I was being abused, all I wanted was more and more. The marijuana wasn't enough. Then I started getting into the crack. It was easier just to stay stoned and numb and not have to deal with it. The drugs were what made me forget about all the abuse and set aside the fear and terror I had from the abuse and that was my only escape. It was a way to get away from my husband and not feel trapped."

Understanding the impact of dual problems may very well enhance a woman's chances for achieving both safety and sobriety. A correlation between substance abuse and domestic violence occurs in 44% to 80% of reported domestic violence incidents depending on what research one chooses to cite (Mackey, 1992). Most women are neither chemically dependent nor battered. However, should women experience domestic violence, develop substance abuse, addiction or both, risks to their health and that of their children increase significantly. Substance abuse may occur as a coping method some battered women use as they attempt to survive the ongoing threat of violence directed at them by intimate partners seeking to gain or maintain power and control (Bland, 1994).

"For me the substance abuse when I first started using was over abuse, was over a rape, and so that's how I learned to cope with any type of abuse was to get high, and it made everything okay."

Some battered women may consider using substances less emotionally and physically damaging than facing daily bouts of physical, emotional and sexual abuse with little to blunt the pain.

"The drug didn't hurt as much as reality hurt."

The Minnesota Coalition for Battered Women (1992) notes abused women may also use alcohol or drugs for a variety of other reasons including: coercion by an abusive partner,

chemical dependency, cultural oppression, over-prescription of psychotropic medication or, for women recently leaving a battering relationship, a new sense of freedom.

"The drugs are an element of control. If they can keep you on the drugs, using or addicted to the drugs, they're in control. And it's like strings on a puppet. They just keep you under control because you want that other hit. You want that other drink."

Defining Substance Abuse and Addiction

It is critical for advocates to learn to recognize the differing safety and advocacy needs of women who are alcoholic/addicts versus those who use or misuse substances.

Alcohol and drugs effect the brain and the body whether addiction is present or not. Substance abuse is a destructive pattern of use of drugs including alcohol, which leads to significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use.

"We used marijuana every day. I did a lot of cocaine. When I used cocaine all I wanted to do was that next line. I didn't care about putting the kids on the bus or getting the kids to school. I lost my children."

Substance use and misuse are behaviors not character defects. According to the American Society for Addiction Medicine, addiction is not a behavior, it is a disease. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of substance) it is likely that the person has progressed from abuse to dependence and addiction.

"One day I didn't want to drink and I had to. It was the scariest feeling."

Addiction, according to the medical model, is considered a primary chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Addiction 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.

"I didn't think marijuana was addictive."

"How do you get up in the morning and not smoke a joint?

Although a person may choose to use alcohol or drugs a person does not choose how one's body will respond to that choice.

"When I was a little kid, we all got like, shots of whiskey. And I loved it. You got that warm feeling and everything was going to be okay."

Alcoholics and addicts do not cause addiction and they do not 'like' it. They have a major illness. The number one symptom of this illness is to believe one is well.

"I thought alcoholics were the people in the gutters, the winos pushing their shopping carts with all their belongings in it. And I figured since I had a job, a car, the whole nine yards, that I was doing pretty good."

This belief plus social acceptance of drinking or taking medication to kill pain makes it hard for alcoholic addicts to seek help they need. Many times they don't seek help. As advocates we must remember addiction is treatable and long-term recovery is possible.

"I am for the first time in my 41 years dealing with life on life's terms without somebody telling me how to do it. I can actually talk to people now without being drunk. I can actually laugh without being high. And I can actually walk out a door without being paranoid. That feels good. That feels so good. Because I want to live."

The Family Disease – Risks when Domestic Violence is Present

While chemical dependency is often considered the 'family disease,' looking for a 'family cure' when domestic violence is present can be dangerous. Battered chemically dependent women should not be required to participate in family counseling or conjoints that include their abuser. While a chemically dependent battered woman may choose to participate in counseling that includes her abusive partner, advocates should advise her of both the risks and limitations of such a plan. Refer women to chemical dependency treatment programs where family counseling includes safety planning for children and strong linkages exist between the treatment program and its sister domestic violence victims service program.

Women with substance abusing partners may consider participating in 12 step or other support groups such as Al -Anon or Nar-Anon but risks should be explored. Sometimes practicing detachment and avoiding enabling can lead to increased risk for harm if their partner is a batterer. Should a woman be partnered with an abuser who is enrolled in a chemical dependency treatment program, under no circumstances should she be asked to lift a protection, no contact or other type of restraining order in order to support that partner's recovery from substance abuse.

"I got clean and sober and started working, and putting money away to get out of the relationship. And I think he saw that. He became more demanding. Attempts to be controlling escalated. His abuse of the kids escalated as I was sober. His attempts seemed more desperate."

Effective Safety Planning for Substance Abusing Battered Women

Chemically dependent battered women may have a hard time recognizing options or gauging their safety. Some women may experience blackouts. Blackouts may mean the absence of memories for some events. Experiencing a blackout does not mean a person has passed out or lost consciousness. Nor does it mean psychological blocking out of events or repression. A blackout is an amnesia-like period often associated with heavy drinking. People in a blackout state may appear to be functioning normally but later have no memory of what occurred (Kinney and Leaton, 1991).

"I was a blackout drinker from the age of 15. My alcoholism was sitting home sipping wine all day. I could sip a whole gallon. I thought I was crazy. Not really thinking, it's the alcohol."

Safety planning problems can include being unable to recall a safety strategy, not knowing how an injury was sustained or failing to remember making a police report, let alone remembering a court date.

"Getting off the chemicals has made it much easier for me to deal with the other situations I need to in order to get back on my feet."

The only memory substance users have of what happens during use is the one that is formed when they are under the influence of alcohol or in a drugged state. Thus if a person under the influence inaccurately perceives herself as safe or "able to handle it," sobering up the next day may be insufficient to correct the distortion. This toxic thinking or distortion of perception is termed euphoric recall (Johnson, 1980) and theoretically has the potential to increase risk for substance abusing battered women.

"For me once I pick up the alcohol or the other substances, it's like that safety plan goes out the window."

While blackouts impact memory, there is no evidence to support the contention that a blackout alters judgment or behavior at the time of its occurrence (Kinney and Leaton, 1991). Thus, batterers cannot be excused for their behavior when they are under the influence merely because they cannot remember it. Euphoric recall, like blackout, may be misused by batterers to minimize, rationalize or deny their abusive behavior:

"*He was more abusive when he was drinking and he was abusive when he was not drinking."*

"The abuse escalated, especially when he was coming down from coke, or if he had a hangover from coke."

Advocates must consistently give the message that using substances as an excuse for violence is not acceptable. Collusion with this erroneous belief helps a batterer avoid accountability for abusive actions and can mistakenly encourage a victim to believe once substance abuse ceases the violence will definitely stop.

"If you sober up a perpetrator and he doesn't have treatment for his issues, then what do you have? You have a sober perpetrator. And now he's more aware."

Domestic Violence as a Barrier to Recovery

Recovery for women, especially battered women, is all about empowerment. Recovery is built on an individual woman's experience, strength and hope as well as her belief that change can successfully occur for herself and for her children. Women may not be able to choose how their bodies respond to substances but they have power to take action. This power may be reflected in their decision to go to whatever lengths are necessary to survive for themselves and for their children when they are ready and when it is safe to do so. Recovery is hampered when domestic violence is present.

"This man tried to strangle me. After that happened, then I relapsed. And I was in relapse mode off and on for a whole year after that."

Abusers want to exert power and will go to whatever lengths are necessary to gain and maintain control.

"Going to a meeting wouldn't be anything he would tolerate because there would be other men there. Something could happen. So his controlling made it real difficult for me to do what I needed to do for myself."

Both battered women and addicted women may blame themselves if they are unable to stay safe or sober. If the battered woman and addicted woman are one and the same, the level of guilt and shame may be compounded.

"He was always saying the reason he would abuse me was because of my drug use, even though he had his drug use, or he would bring the drugs to me."

Talking to Women about Substance Abuse Issues

Many women find it easier to discuss their partner's substance use as opposed to their own. This is particularly true of women in abusive relationships whose abusers drink or use drugs. A conversation about an abusive partner's substance abuse gives one the opportunity to explore any history of substance use, abuse and possible addiction.

If a woman discloses her partner abuses substances, an advocate might state:

- " Many women tell me their partners don't want to drink or drug alone. How often have you found yourself stuck using when you didn't want to?"

This is a non-judgmental way to elicit information and provides an opportunity to explore drug related domestic violence. I/V drug users may be particularly vulnerable when targeted by batterers.

"I made it for 30 days. The minute I got out of safe environment I was right back with the man and by midnight using."

Women disclose their partners put them on the street to trade sex for drugs against their will. Many women I/V drug users begin their drug use in the context of a relationship. They may never shoot up alone. Their partner shoots-up for them. Introducing a partner to illicit drug use is a form of domestic violence. Another form of abuse occurs when a batterer deliberately uses dirty needles or cottons or misses a vein on purpose. This also poses a risk for transmission of disease including hepatitis and HIV. Maintaining power and control by serving as a connection or determining a partner's drug supply can also be a form of domestic violence.

"When I talked to him on the phone, he'd always tell me, all you've got to do is tell me babe, and I'll go get you some more. He kept telling me that's all I needed, a couple of bong hits or a couple of rocks and I'd be just fine."

"I left the shelter because he bought a bag of cocaine. And so, here I was back in the same abusive relationship all over again. I wanted to be strong and even though I wanted to be out of an abusive relationship, my addictions took me back."

Chemically dependent battered women may believe their safety will be assured if they just get sober. For a chemically dependent battered woman, getting sober can pose new risk. An abusive partner may increase violence as the recovering battered woman becomes harder to control. Before screening for substance abuse validate a woman's survival and praise her sincerely for finding her own way to cope. This should lead to a discussion where you can include the following:

- " You deserve credit for finding a way to cope. Tell me what made you able to survive?"
- "Many women I see tell me when they experience pain they find a way to deal with it. Some women tell me they become compulsive cleaners, others get into shopping, eating or not eating, sleeping a lot or working too much. Have you tried any of these ways of coping? A lot of women tell me the best way to cope is to numb out by drinking or drugging. How often has this worked for you? Can you think of any reasons why drinking or drugging could be unsafe for someone with an abusive partner?" What kinds of luck have you had with other coping skills?"

Screening Builds a Bridge to Safety and Sobriety

"And drinking kept me in the relationship longer. When you're drinking and you're in that vicious circle, the other vicious circle doesn't matter. All I cared about was getting another drink."

Screening and referral can help build a bridge from substance abuse or addiction to health and safety for chemically dependent battered women and their children. Women facing the dual stigma of both addiction and domestic violence may be reluctant to openly seek help. Generally speaking, women don't routinely self-identify as either addicted or battered unless their safety is assured. Safety includes knowing you are not being labeled or judged. Chemically dependent battered women tell us they benefit most from advocates who:

" Try to make you feel like you aren't the only one. And that somebody else did make it. And someone else has made a life for themselves. They try to make you feel that you're not worthless or useless."

Chemically dependent battered women have little reason to trust. Both their bodies and their partners have let them down. Respectful screening involves conveying the message addiction and violence can happen to anyone. Advise women: "Any woman is vulnerable; you are not alone should these problems be facing you." A successful intervention requires internally moving beyond the notion, "Why doesn't she just quit?" or "Why doesn't she just leave?" Questions such as these convey lack of knowledge and failure to understand the complexity of safely ending a relationship with either a substance or an abusive partner.

Honestly discussing sobriety as a safety risk is extremely important. A woman's decision not to stop using immediately or to decline treatment, advocacy or shelter should not be viewed as failure. Recovery is both an option and a process that can take time.

The Intervention is in the Asking

"I could not recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa."

It is not necessary for advocates to become chemical dependency counselors but it is important for them to ask about substance use. Countless intervention opportunities are missed when advocates are afraid to ask lest they offend or view intervention as futile. The intervention is in the asking. When women are respectfully asked about both their use and their safety, they hear, even if they are not yet ready to listen or enact change immediately. Often women will later share comments such as, "You know, when you said...it really made sense to me." Supporting women through their process of change requires an understanding that motivation comes from within. It also takes knowledge of local resources. Safety and sobriety are indeed possible. Acknowledging the woman before you has managed to survive, sincerely appreciating her individual strengths and recognizing her innate dignity can support her own process and help build a healthy and powerful alliance that benefits both her and her children.

We Share a Similar Story

Safety and sobriety can be addressed respectfully if we acknowledge both substance use (e.g. a glass of wine with dinner), and being in an intimate relationship (e.g. dating or having a partner) is a common experience both for the women we serve and for us. This means misuse of substances or abuse within a romantic relationship could happen to anyone. Any woman may use substances or find herself with a partner. This being the case, any woman could find herself having a problem with either or both through no fault of her own.

Women suffering from addiction don't know when they have the first drink or take the first drug what the future will hold. They expect to 'feel better' or 'kill pain' and find themselves believing they can 'control' it. Unfortunately, addiction is about loss of control and powerlessness. This loss of control and powerlessness does not mean one is weak or helpless.

Instead, those who experience addiction cannot reasonably predict what will happen when they use. One is powerless only in terms of how one's body, one's liver, one's brain responds once alcohol or other drugs are introduced inside it. Many addicted women don't want to stop using alcohol or drugs. They want the craving, the problems and the pain of withdrawal to stop. They want to be like everybody else who can have a social drink or take medication without serious physical ramifications. Unfortunately, like anyone else discovering an allergy (e.g. an allergy to bee stings), the addict, once "stung," must forever avoid substances or experience life-threatening consequences. Fortunately we can support women's empowerment through our knowledge of options and available resources. The Alcohol Drug Help Line Domestic Violence Outreach Project can provide information about Washington State programs addressing both domestic violence and chemical dependency. They can be reached at 206-722-3700 or 1-800-562-1240 (WA State only). Other supportive options include: Support Groups Addressing Safety and Sobriety.

"The more you tell your story, the more you talk about what you did to get clean and sober, the stronger it makes you the more you hear it. And the longer we're away from the abuser, and the more education we get, and the more we talk to other people about it, the stronger we become, and the more aware."

When possible, encourage chemically dependent battered women to consider attending a support group addressing issues pertaining to both domestic violence and chemical dependency. Integrated support groups offer women a format to heal utilizing techniques that are applicable for reaching both goals of safety and sobriety. The major goal of successful groups addressing these issues is to be a safe place where women can tell their story, be believed and begin the healing and connection process.

Gender Specific Treatment Recommended

"For domestic violence survivors, women's meetings are probably safer."

Chemically dependent battered women should be encouraged to consider gender specific treatment as an option that may best enhance their chances for both safety and sobriety.

Advocacy Based Counseling

"Once I walked away from that abuse (domestic violence), I knew that the next thing I had to do was something about the substance abuse. And then when I made up my mind that I wanted to quit drugs also, the advocates at the shelter were right there for me, and got me into a treatment program."

Advocacy based counseling looks different for chemically dependent battered women who may have withdrawal issues, memory distortions and cognitive deficits. Advocacy-based counseling may include: Repeating information, providing structure, simplifying goals, advocating for their inclusion in shelters and other victim service programs and understanding the impact of chemicals on safety planning and role identity.

"And it feels in the beginning that it's the end of the world, but it's actually the beginning of a new life."

Conclusion

Women from all walks of life are at risk for domestic violence and chemical dependency but screening, identification and intervention can provide empowering options. Women from all walks of life get safe and sober and raise safe, healthy children. Be a bridge to safety and sobriety, screen for substance abuse as part of a safety plan.

"I have my youngest daughter back. She lives with me. My oldest daughter is getting married and my middle daughter is a college student."

"I've gained more confidence in myself. I don't have to run and hide in a closet anymore."

"Knowledge is power, knowledge is power.

And Now What?

Developing Strategies for Safety and Sobriety

Women attempting to get sober may develop a plan that may include but is not limited to:

15.) Identifying who to call for help (e.g. sponsor, counselor, Alcohol Drug Help Line); forming support systems, knowing about safe meetings

16.) Knowing information and education about addiction

17.) Removing substances and paraphernalia from the home

18.) Recognizing unsafe persons, places, things

19.) Understanding how to deal with legal and other problems stemming from addiction (e.g. health, CPS involvement, poor nutrition)

20.) Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing or other options

21.) Knowing how domestic violence can be a relapse issue

22.) Understanding physical, emotional, cognitive, environmental and other cues indicative of risk and having a plan to deal with it; recognizing role of stress and craving, having a plan to deal with it

23.) Learning how to parent, engaging in relationships, developing sober friendships

24.) Knowing when and where to run in a life-threatening situation that puts your sobriety and your safety, at risk.

Know Your Local Resources

"I needed more than a 12 step program."

a.) The Alcohol Drug Help Line Domestic Violence Outreach Project can be reached at 206-722-3700 or 1-800-562-1240 (WA State only). They can provide information about accessing Detox services and ADATSA as well as Washington State programs such as the Washington State Coalition on Women's Substance Abuse Issues. They can also provide information about gender specific treatment options in Washington such as Residence XII, Kirkland; Perinatal Treatment Services, Seattle; Mom's Program, Tacoma; Isabella House, Spokane and Riel House, Yakima as well as other treatment and support group options for those impacted by both substance abuse and domestic violence in Washington state.

b.) The Washington State Alcohol Drug Clearinghouse provides literature, videos, and information about substance abuse and addiction, much of it for free. To order call 1-800-662-9111 toll free from Washington State. From Seattle or out of state call 206-725-9696 or FAX 206-722-1032. E-mail: clearinghouse@adhl.org Web site: http://www.adhl.org/clearinghouse

c.) New Beginnings for Battered Women and their Children provides a weekly drop-in support group for chemically dependent battered women seeking safety and sobriety in Seattle/King County. Contact 206-783-2848 for information.

d.) Eastside Domestic Violence Program provides a transitional housing program for chemically dependent battered women and their children that includes on-site out patient treatment services through Therapeutic Health Services. Call 425-746-1940 for information.

e.) The Mom's and Women's Recovery Center in Pierce County, Washington provides screening, assessment, intervention, treatment and support for women addressing both substance abuse and domestic violence issues. Call Sue Winskill at 253-798-6655.

f.) Recommended reading: Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse, Domestic Violence/Substance Abuse Task Force of the IL DHS 7/2000. For information about this publication contact: www.state.il.us/agency/dhs).

g.) The Washington State Coalition Against Domestic Violence has the following materials developed or written by Patti Bland, M.A. CCDC available upon request. Please contact Leigh Hofheimer for copies: leigh@wscadv.org

1.) Support Agreement
2.) Non-Use Agreement
3.) Sample Screening Questions for Shelter Intake Form
4.) Sample Safety Plan
5.) Manifestations of Violence (group tool)
6.) Non-shaming meeting documentation form and progress note form
7.) Article: Chemical Dependency and Domestic Violence: Screening Pregnant and Postpartum Women for Safety and Sobriety, accompanying bibliography and PowerPoint presentation for perinatal health care providers

8.) Article: Collaborative Strategies for Addressing Women's Safety and Sobriety

9.) Sample Guideline for working with chemically dependent women

10.) Sample Policy for working with chemically dependent battered women

11.) Women Talk about Substance Abuse and Violence, ten women interviewed by Debi Edmund and Patti Bland; edited by ©Debi Edmund, 6/2000)

12.) Screening Tools for Substance Abuse

End Notes

1.) Addiction definition is adapted from definitions developed by the American Psychiatric Association and the American Society for Addiction Medicine and included in the Domestic Violence/Substance Abuse Task Force of the IL DHS 7/2000, Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse, p.vi. For information about this publication contact: www.state.il.us/agency/dhs).

2.) Special thanks to the women from New Beginnings Wednesday night support group addressing chemical dependency and domestic violence in Seattle, WA and their sisters in Springfield, IL. Grateful acknowledgements to Debi Edmund of Springfield, IL who served as their editor, Lee Berg, R.N. of St. Joseph's Hospital, Syracuse, NY who provided technical assistance and, as always, thanks to the Alcohol Drug Help Line Domestic Violence Outreach Project Staff in Seattle, WA for everything they do.

Patti Bland, MA. CCDC, received a Master's degree in Public Communications from Fordham University in 1979 and a Certificate in Addiction Studies from Seattle University in 1990. Patti began her career at Residence XII Treatment Center for Women in Burien, WA. She has served both as an advocate and lead chemical dependency counselor at New Beginnings for Battered Women and their Children's shelter and community-based program in Seattle for eleven years. Patti developed the Domestic Violence/ Chemical Dependency Outreach Project for King County at the Alcohol Drug Help Line in 1994. She also served as the Domestic Violence Trainer for Providence Health System Family Violence Program for five years. Patti is an Adjunct Professor at Antioch University and Seattle Central Community College. She is a member of the Steering Committee for the Washington State Coalition on Women's Substance Abuse Issues. Recently, Patti joined the Alaska Network on Domestic Violence and Sexual Abuse in Juneau as their Training Project Coordinator. She has published several articles on chemical dependency and domestic violence and completed development of domestic violence curricula for the Washington State Medical Association and the Perinatal Partnership Against Domestic Violence. Patti can be reached by e-mail at pjmbland@hotmail.com and by phone at the Alaska Network on Domestic Violence and Sexual Assault at 907-586-3650 effective December 1, 2001.

TRAINING and GROUP EVALUATION TOOLS

Part IV

ANDVSA Substance Abuse Needs Assessment for Advocates Real Tools You Can Use

Demographics (Please circle the number corresponding to your response.)

1. a.)Profession? 1 Advocate 2 Legal Advocate 3 Children's Advocate 4 Other_____

b.) Geographic Location _____ 2.) *(Optional)* I am in recovery. 1 Yes 2 No

Please circle the number that best fits your response to each of the questions below.	**Strongly Agree**	**Agree**	**Not Sure**	**Dis-Agree**	**Disagree Strongly**	**N/A**
3. I would like to receive technical assistance to develop protocols, policies and procedures to better address service provision and advocacy for survivors of DVSA impacted by their own or another's substance abuse	1	2	3	4	5	6
4. My agency provides me with tools to help me provide services for program participants with substance abuse issues	1	2	3	4	5	6
5. My agency does not provide services for program participants with substance abuse issues	1	2	3	4	5	6
6. My agency has a protocol to assess immediate risk to program participants from DVSA as well as from alcohol and other drug use because each can be lethal	1	2	3	4	5	6
7. My agency has a protocol for partnering with chemical dependency programs to develop tools for identifying and assessing the needs of women impacted by DVSA and substance abuse	1	2	3	4	5	6
8. My agency has a protocol to address the impact of substance abuse on safety planning	1	2	3	4	5	6
9. My agency has a safety planning protocol that includes developing a relapse prevention plan and continuing support after relapse for women choosing to work on safety and sobriety	1	2	3	4	5	6
10. My agency has a protocol for providing linkages to a range of chemical dependency assistance options including medical detox, inpatient and outpatient treatment programs, AA and other support groups	1	2	3	4	5	6
11. My agency provides me with written materials relevant to DVSA and substance abuse issues	1	2	3	4	5	6
12. My agency has developed a budget plan to implement comprehensive support services for people impacted by DVSA and substance abuse	1	2	3	4	5	6
13. My agency has a protocol to provide on-site integrated support groups to address safety issues for program participants and their children impacted by DVSA and substance abuse	1	2	3	4	5	6
14. My agency has a protocol to provide outreach and safety planning education on DVSA to chemical dependency treatment program clients	1	2	3	4	5	6
15. My agency has a protocol to provide on-going training and consultation on substance abuse issues for staff	1	2	3	4	5	6
16. My agency has a protocol to provide on-going training and consultation on DVSA issues to substance abuse professionals	1	2	3	4	5	6
17. My agency has a substance abuse protocol that includes a multi-step approach for screening/identification; initial inter-vention and follow-up; information and referral; alternatives to substance use; integrated safety planning/relapse prevention options and steps for community and emotional support	1	2	3	4	5	6
18. My agency has a protocol to monitor the implementation of program policies and procedure pertaining to DVSA and substance abuse	1	2	3	4	5	6
19. I would like more training on substance abuse issues and protocol development, implementation and funding	1	2	3	4	5	6

20 Please write any comments you would like to make about substance abuse protocol needs on the back of this sheet.

ANDVSA DV/SA Needs Assessment for CD Counselors Real Tools You Can Use

Demographics (Please circle the number corresponding to your response.)

1. a.)Profession? 1 Chemical Dependency Professional 2 Social Worker 3 Mental Health Provider 4 Other_____

b.) Geographic Location _____ c.) *(Optional)* I am a survivor of DV and/or sexual abuse. 1 Yes 2 No

Please circle the number that best fits your response to each of the questions below.	**Strongly Agree**	**Agree**	**Not Sure**	**Dis-Agree**	**Disagree Strongly**	**N/A**
3. I would like to receive technical assistance to develop protocols, policies and procedures to better address service provision, counseling and treatment outcomes for people in recovery impacted by domestic violence and sexual assault.	1	2	3	4	5	6
4. My agency provides me with written materials / tools to help me provide services for individuals with current safety issues.	1	2	3	4	5	6
5. My agency policy provides for gender specific services for individuals impacted by domestic violence and sexual assault.	1	2	3	4	5	6
6. My agency has a protocol to assess immediate risk from abusers to treatment program participants.	1	2	3	4	5	6
7. My agency has a protocol for partnering with victim service programs to develop tools for identifying and assessing the needs of recovering individuals impacted by domestic violence and sexual assault including referrals to shelter, legal and other forms of advocacy and assistance.	1	2	3	4	5	6
8. My agency has a protocol to address the impact of domestic violence and sexual assault on sobriety as part of lectures and education provided during treatment and aftercare.	1	2	3	4	5	6
9. My agency includes a safety plan as part of recovery and relapse prevention planning.	1	2	3	4	5	6
10 My agency provides on-site integrated support groups to address sobriety and safety issues during treatment and aftercare.	1	2	3	4	5	6
11. My agency provides me with training relevant to substance abuse and DV and sexual assault and their impact on recovery.	1	2	3	4	5	6
12. My agency has developed a budget plan to implement services for those dealing with multiple-abuse and safety issues	1	2	3	4	5	6
13 My agency has a policy that discourages victims of DV and sexual assault from self-blame for the crimes directed against them while they were using. In other words, we do not victim blame. We hold batterers/offenders accountable for their abusive/criminal actions.	1	2	3	4	5	6
14. My agency has a protocol to provide outreach and education on chemical dependency to victim service program staff, program participants and shelter residents who may have substance abuse issues that affect their safety.	1	2	3	4	5	6
15. My agency has a policy that precludes us from providing substance abuse treatment to both a victim and his/her abuser at the same time due to safety and liability issues.	1	2	3	4	5	6
16. My agency policy does **not** mandate couples or family counseling when DV and/or sexual assault are indicated.	1	2	3	4	5	6
17. My agency has a protocol to refer batterers and offenders to certified batterer intervention/accountability programs. *(We do **not** refer batterers and perpetrators to anger management.)*	1	2	3	4	5	6
18. My agency has a protocol to reduce liability and monitor the implementation of program policies and procedures pertaining to domestic violence and sexual assault.	1	2	3	4	5	6
19. I would like more training on DV and sexual assault issues.	1	2	3	4	5	6

20. Please write any comments you would like to make about domestic violence/sexual assault protocol needs on the back of this sheet.

Please mark True (T) or False(F) in the space provided.

1. ____ Chemical dependency is the leading cause of domestic violence.
2. ____ Substance abuse is the leading cause of domestic violence.
3. ____ Misuse of substances is associated with increased severity of injuries and higher lethality rates for victims of domestic violence.
4. ____ Cessation of substance use will always lead to cessation of domestic violence.
5. ____ Euphoric recall and the "honey-moon" phase are identical terms.
6. ____ Blackouts occur when substance mis-users pass out.
7. ____ Victims of domestic violence provoke the violence directed against them and often enjoy the battering experience.
8. ____ Domestic violence is usually an isolated event that may only happen once.
9. ____ Addicts are responsible for having the disease of chemical dependency.
10. ____ Addicts are responsible for their recovery from the disease of addiction.
11. ____ Perpetrators of domestic violence are generally mentally ill.
12. ____ Men and women are equally violent.
13. ____ Leaving is always the safest choice once domestic violence occurs.
14. ____ Anger is the leading cause of abusive behavior and domestic violence.
15. ____ One must always address domestic violence before addressing substance abuse issues.
16. ____ One must always address substance abuse before addressing domestic violence issues.
17. ____ Getting sober can pose certain safety risks for battered women.
18. ____ Quitting drinking and drugging is a matter of will power and can always be safely done without medical intervention if one tries hard enough.
19. ____ Chemically dependent battered women should never be referred to AA or other 12-step programs.
20. ____ Chemically dependent battered women should always be required to attend AA or other 12-step programs.

Answer Key

1.) False Some studies indicate social drinkers are a greater risk to their partners than late stage addicts. Domestic violence is caused by many factors. While chemical dependency and domestic violence do not have a causal relationship they can co-occur. According to the AMA nearly 75% of the wives of alcoholics have been threatened and 45% have been assaulted by their husbands. Any woman referred to Al Anon should also be referred to a victim services program.

2.) False While 44%-96% of reported cases of domestic violence to police involve the use of a substance by one or both parties most domestic violence cases are NOT reported. Domestic violence is caused by many factors. While substance abuse and domestic violence are often correlated they do not have a causal relationship. Many batterers and victims of domestic violence do not misuse substances.

3.) True While substance misuse and addiction do not cause domestic violence and sexual assault, when they occur together, severity of injuries and lethality may be increased. Some studies indicate an individual's beliefs about what happens when one drinks is more important than the presence of alcohol itself. A belief that drinking causes violence can escalate risk. Additionally other studies indicate substance use may impact hostility and empathy as well as memory. While these factors may escalate risk they do not cause violence.

4.) False Batterer's who stop using substances may change their tactics. They may become more effective at monitoring and tracking their partners as well as controlling them. Victims who stop using substances may be harder for batterer's to control. An abuser may decide to sabotage a victim's treatment efforts or escalate violence to regain control. Batterer's may force their partners to leave treatment against medical advice, prevent them from participating in self-help and other support groups or force them to use substances against their will.

5.) False Euphoric recall is a term coined by Vernon Johnson in his book I'll Quit Tomorrow to describe the distortion in memory that occurs when substances are used. Honey-moon phase is a term coined by Lenore Walker to describe an abuser's efforts to use the tactic of being nice to regain power and control following another type of abusive behavior.

6.) False Blackouts are temporary periods of amnesia associated with substance abuse. Most people in a blackout appear normal and have not passed out. While people in a blackout state may not remember what they choose to do; there is no evidence to indicate they are not capable of forming intent. Blackouts are not an acceptable excuse for domestic violence and sexual assault committed by perpetrators under the influence.

7.) False There is no credible scientific evidence indicating any behavior on the part of a victim can cause a batterer to act in a violent manner. Additionally, studies pertaining to the experience of victimization overwhelmingly indicate victims of domestic violence feel terror, fear and shame.

8.) False Domestic Violence is a pattern of coercive behaviors whereby once person in an intimate partner relationship seeks to gain and maintain power and control over another. Domestic violence tends to be chronic, it is often progressive and can be lethal.

9.) False Chemical dependence is a bio/psycho/social health problem. It effects the liver and the brain as well as other areas of human functioning. While there are genetic components, one does not know prior to use whether one will develop addiction.

10.) True While one is not responsible for having the disease of addiction one is responsible for participating in recovery efforts once it becomes obvious that a problem exists that effects others as well as oneself.

11.) False Most perpetrators of domestic violence do not suffer from mental illness. Some perpetrators experience depression, have trauma from head injury or could be labeled anti-social but the majority of batterers do not have a mental health diagnosis.

12.) False US arrest records and criminal justice data indicate the majority of violent crimes committed in the United States are committed by men. While women can indeed be violent, statistically speaking, incarcerated violent perpetrators are more likely to be male.

13.) False Leaving can pose increased risks for battered women. According to the US Department of Justice up to 75% of domestic violence assaults reported to police are made after separation. Studies in Washington State and Florida showed 40-65% of victims killed by their perpetrators were in the process of leaving. 16-17% of these victims actually had protection orders in place at the time of the homicides.

14.) False Anger is an emotion and emotions are neutral. Violence is a behavior and a choice. While some angry people may choose to engage in violent behavior; anger does not cause violence. Anger is merely an excuse some batterers try to use to justify their inappropriate behavior rather than accept responsibility for their actions.

15.) False Victims of domestic violence may choose to get safe before seeking sobriety or seek sobriety before getting safe. Victims must decide for themselves which task is most necessary initially. Ultimately, safety and sobriety are linked but one does not guarantee the other.

True Perpetrators may not benefit from batterer intervention programs if they are actively using substances however substance abuse treatment cannot be a substitute for batterer intervention. Accountability for batterers may include incarceration if their use of substances prevents them from being able to benefit from batterer intervention programs that require victim safety, cessation of violence and batterer accountability.

16.) False Victims of domestic violence may choose to get safe before seeking sobriety or seek sobriety before getting safe. Victims must decide for themselves which task is most necessary initially.

Ultimately safety and sobriety are linked but one does not guarantee the other.

Addressing substance abuse may be essential for perpetrators to benefit from batterer intervention programs but victim safety must always take precedence. Batterers in early recovery may increase risk for victims by being more aware and better able to control their partners. Studies indicate the persons least likely to benefit from batterer intervention programs are chronic inebriates. Additionally, studies indicate, reoccurrence of violence rates are highest in batterer's intervention programs well inside the first year such efforts are made.

17.) True Victims who stop using substances may be harder for batterer's to control. An abuser may decide to sabotage a victim's treatment efforts or escalate violence to regain control. Batterer's may force their partners to leave treatment against medical advice, prevent them from participating in self-help and other support groups or force them to use substances against their will. Additionally, batterers may threaten to turn their partners in to DFYS, tell others of their treatment issues or mislead counselors in family sessions. Couples counseling can pose risk for very significant harm for victims of domestic violence and is not recommended.

18.) False Will power alone cannot prevent withdrawal symptoms or abstinence syndrome. Many individuals who suffer from chemical dependence require medical detoxification to safely stop using. Failure to receive medical intervention can lead to life-threatening symptoms and or death.

19.) False Many battered women benefit from AA and other 12 step programs particularly if they are referred to gender specific groups. Battered women should be advised of the strengths and limitations of 12 step programs. Risks include being re-traumatized by drunk-a-logs involving domestic violence, having a batterer locate a first step and attempt to use it against a woman in court or being around people who encourage her to look at her part in any negative personal relationship. It is essential to advise any battered woman considering attendance at AA or other 12 step program that she has no part in the violence and that amends need not be made to dealers or batterers. Also women need to be advised of the risks for sexual abuse from "13th Steppers" (those who prey on the vulnerability of newcomers for sexual favors who could be present at a self-help meeting).

20.) False Sometimes it is not safe for battered women to be referred to AA or other 12 step meetings if her partner is actively seeking her. Additionally some battered women may have trouble with the concept of powerlessness. When it is safe for women to attend it may be useful for them to try about 6 meetings to see if they can find any value in attending. If this does not appeal other options should be explored.

Understanding Domestic Violence and Substance Abuse
Pre-test Questionnaire

Please fill out the following information as completely as possible. Do not put your name on it. Your answers will be helpful for us in evaluating the effectiveness of this training program.

Which of the following best describes your occupation? (check only one, please)

____ Administrative	____ Nurse	____ Reception/Records
____ Business/Professional	____ Advocate	____ Health Care Provider
____ Educator	____ Law Enforcement	____Attorney/Legal
____ Social Worker	____ Physician	____ Clergy/Spiritual Counselor
____ Chemical Dependency Professional	____ Government	____ Other _____

Check the box that describes your comfort level in performing the following tasks. (Note: unless otherwise indicated, these tasks are relevant to all staff.)

TASK	**1 Extremely Uncomfortable**	**2 Uncomfortable**	**3 Neutral**	**4 Comfortable**	**5 Extremely Comfortable**
Identify warning signs of DV/SA					
Ask screening questions about DV/SA (if this is appropriate to your professional role.)					
Assist a victim of DV/SA with a safety plan					

List two DV/SA referral resources within your community.

1. _____

2. _____

List two safety and sobriety planning techniques you can explore as options for people who may be impacted by DV/SA.

1. _____

2 _____

Understanding Domestic Violence and Substance Abuse in the Healthcare Setting

Pre-test Questionnaire

Please fill out the following information as completely as possible. Do not put your name on it. Your answers will be helpful for us in evaluating the effectiveness of this training program.

Which of the following best describes your occupation? (check only one, please)

____ Administrative ____ Nurse ____ Reception/Medical Records
____ Nurse Practitioner ____ Medical Assistant ____ Physician Assistant
____ Social Worker ____ Physician ____ Other _____
____ Chemical Dependency Counselor

Check the box that describes your comfort level in performing the following tasks. (Note: unless otherwise indicated, these tasks are relevant to all staff.)

TASK	**1 Extremely Uncomfortable**	**2 Uncomfortable**	**3 Neutral**	**4 Comfortable**	**5 Extremely Comfortable**
Identify warning signs of domestic violence/ substance abuse.					
Ask female patients screening questions about domestic violence/ substance abuse (if this is appropriate to your professional role.)					
Assist a victim of domestic violence/ Addiction with a safety plan/recovery plan.					

List two domestic violence and substance abuse referral resources within your community.

1. _____

2. _____

List two safety planning techniques you can use with a domestic violence victim and two recovery planning tools you can use with an substance abuser/person with addiction.

1. _____

2. _____

Understanding Domestic Violence and Substance Abuse
Post-test Questionnaire

Please fill out the following information as completely as possible. Do not put your name on it. Your answers will be helpful for us in evaluating the effectiveness of this training program.

Which of the following best describes your occupation? (check only one, please)

____ Administrative ____ Nurse ____ Reception/Records
____ Business/Professional ____ Advocate ____ Health Care Provider
____ Educator ____ Law Enforcement ____Attorney/Legal
____ Social Worker ____ Physician ____ Clergy/Spiritual Counselor
____ Chemical Dependency Professional ____ Government ____ Other _____

Check the box that describes your comfort level in performing the following tasks. (Note: unless otherwise indicated, these tasks are relevant to all staff.)

TASK	**1 Extremely Uncomfortable**	**2 Uncomfortable**	**3 Neutral**	**4 Comfortable**	**5 Extremely Comfortable**
Identify warning signs of DV/SA					
Ask screening questions about DV/SA (if this is appropriate to your professional role.)					
Assist a victim of DV/SA with a safety plan					

List two DV/SA referral resources within your community.

1. _____
2. _____

List two safety planning techniques you can explore as options for people who may be impacted by DV/SA.

1. _____
2. _____

Understanding Domestic Violence and Substance Abuse in the Healthcare Setting

Post-test Questionnaire

Please fill out the following information as completely as possible. Do not put your name on it. Your answers will be helpful for us in evaluating the effectiveness of this training program.

Which of the following best describes your occupation? (check only one, please)

____ Administrative ____ Nurse ____ Reception/Medical Records
____ Nurse Practitioner ____ Medical Assistant ____ Physician Assistant
____ Social Worker ____ Physician ____ Other _____
____ Chemical Dependency Counselor

Check the box that describes your comfort level in performing the following tasks. (Note: unless otherwise indicated, these tasks are relevant to all staff.)

TASK	**1 Extremely Uncomfortable**	**2 Uncomfortable**	**3 Neutral**	**4 Comfortable**	**5 Extremely Comfortable**
Identify warning signs of domestic violence/ substance abuse.					
Ask female patients screening questions about domestic violence/ substance abuse (if this is appropriate to your professional role.)					
Assist a victim of domestic violence/ Addiction with a safety plan/recovery plan.					

List two domestic violence and substance abuse referral resources within your community.

1. _____

2. _____

List two safety planning techniques you can use with a domestic violence victim and two recovery planning tools you can use with an substance abuser/person with addiction.

1. _____

2. _____

Date/Time:

Presenter/s:

Workshop Title:

INSTRUCTIONS: This confidential questionnaire will help us to design training that is responsive to providers' needs and concerns. It is also required for our continued funding. Thank you for your help.

1. Please indicate your position/job title: _____

Please also circle letter below best describing your current employment setting:

a.) DVSA Program Staff

b.) Health Care/Substance Abuse Provider

c.) Legal/Criminal Justice

d.) Other_____

Please circle your rating choice:

2. Presenter effective:

1	2	3	4
Outstanding	Very good	Good	Poor

3. General level of material was:

1	2	3
About right	Too basic	Too detailed

4. How much did you learn from this presentation?

1	2	3
Very much	Some	Very little

5. To what extent will you be able to apply what you learned to your job?

1	2	3
Very much	Some	Very little

6. What was the <u>most</u> useful to you?

7. What else would be useful to you in a future training?

8. Any other comments are greatly appreciated (Use back if necessary).

ANDVSA Post Training Survey Real Tools You Can Use

Demographics (Please circle the number corresponding to your response.)

1. Profession? 1 DVSA Program Staff 2 Health Care/Substance Abuse Provider 3 Legal/Criminal Justice 4 Other_____ 2a. I am in recovery from substance abuse. 1 Yes 2 No 2b.I am a survivor of DV and/or sexual assault 1 Yes 2 No

Please circle the number that best fits your response to each of the questions below.	**Strongly Agree**	**Agree**	**Not Sure**	**Dis-Agree**	**Disagree Strongly**	**N/A**
3. This training provided technical assistance to develop protocols, policies and procedures to better address service provision and advocacy for survivors of DVSA impacted by their own or another's substance abuse	**1**	**2**	**3**	**4**	**5**	**6**
4. This training provided me with tools to help me provide better services for program participants with substance abuse issues e.g. screening, education, support group etc.	**1**	**2**	**3**	**4**	**5**	**6**
5. During the past 12 months my agency has provided support group services specifically designed for program participants with substance abuse issues	**1**	**2**	**3**	**4**	**5**	**6**
6. This training can help me to assess immediate risk to program participants from DVSA as well as from alcohol and other drug use	**1**	**2**	**3**	**4**	**5**	**6**
7. This training provided tips for partnering with chemical dependency programs to develop tools for identifying and assessing the needs of women impacted by DVSA and substance abuse	**1**	**2**	**3**	**4**	**5**	**6**
8. This training provided an improved protocol to address the impact of substance abuse on safety planning	**1**	**2**	**3**	**4**	**5**	**6**
9. This training provided safety planning tools to help me develop a relapse prevention plan and offer support groups.	**1**	**2**	**3**	**4**	**5**	**6**
10. This training provided tips to help me link to a range of chemical dependency assistance options	**1**	**2**	**3**	**4**	**5**	**6**
11. This training provided me with written materials relevant to DVSA and substance abuse issues	**1**	**2**	**3**	**4**	**5**	**6**
12. During the past 12 months my agency allocated funds to provide comprehensive support services for people impacted by DVSA and substance abuse	**1**	**2**	**3**	**4**	**5**	**6**
13. This training provided me with new tools for integrated support groups to address safety issues for program participants impacted by DVSA and substance abuse that I will use	**1**	**2**	**3**	**4**	**5**	**6**
14. This training has provided me with tools to provide outreach and safety planning education on DVSA to chemical dependency treatment program clients in a group setting	**1**	**2**	**3**	**4**	**5**	**6**
15. I need more on-going training / consultation on substance abuse issues such as drug facilitated date rape, coping, etc.	**1**	**2**	**3**	**4**	**5**	**6**
16. During the past 12 months my agency has provided on-going training and consultation on DVSA issues to substance abuse professionals	**1**	**2**	**3**	**4**	**5**	**6**
17. My agency has a substance abuse protocol that includes a multi-step approach for screening/identification; initial inter-vention and follow-up; information and referral; alternatives to substance use; integrated safety planning/relapse prevention options and steps for community and emotional support	**1**	**2**	**3**	**4**	**5**	**6**
18. My agency monitors the implementation of program policies and procedures pertaining to DVSA and substance abuse	**1**	**2**	**3**	**4**	**5**	**6**
19. I would like more training on substance abuse issues and protocol development, group implementation and funding	**1**	**2**	**3**	**4**	**5**	**6**

20. Please write additional comments on the back of this sheet.

Facilitator/s: **Group Date/Time**:_____

Group Topic:

INSTRUCTIONS: This confidential questionnaire will help us to design support groups that are responsive to your needs and concerns.

1. Please circle issues you addressed in group today:

a.) Safety
b.) Sobriety
c.) Legal/Criminal Justice
d.) Other:_____

Please circle your rating choice:

2. My needs were met in group today:

1	2	3
Very much	Some	Very little

3. Facilitator effectiveness:

1	2	3	4
Outstanding	Very good	Good	Poor

4. General level of material was:

1	2	3
About right	Too basic	Too detailed

5. How much did you learn from this group?

1	2	3
Very much	Some	Very little

6. To what extent will you be able to apply what you learned to your life?

1	2	3
Very much	Some	Very little

7. I feel safe in this support group:

1	2	3
Very much	Some	Very little

8. I can tell my story and be believed in this support group:

1	2	3
Very much	Some	Very little

9. This group helps me connect with others and feel empowered:

1	2	3
Very much	Some	Very little

10. What is most useful for you in this group?

11. What is most challenging for you in group?

12. What could we do better?

13. If there is one thing we could do for you, what would it be?

14. Any other comments or suggestions for improvement?