MODEL PROTOCOL

For Working with Battered Women Impacted by Substance Abuse

Prepared by Lupita Patterson for the
Washington State Coalition
Against Domestic Violence

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The Washington State Coalition Against Domestic Violence is a statewide non-profit organization committed to ending domestic violence through advocacy and action for social change.

Washington State Coalition Against Domestic Violence
www.wscadv.org

1402 Third Avenue, Suite 406
Seattle, WA 98101
Phone: 206-389-2515
Fax: 206-389-2520
TTY: 206-389-2900

101 N. Capitol Way, Suite 302
Olympia, WA 98501
Phone: 360-586-1022
Fax: 360-586-1024
TTY: 360-586-1029

MODEL PROTOCOL FOR WORKING WITH BATTERED WOMEN IMPACTED BY SUBSTANCE ABUSE

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 that impact 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 that provides opportunities for substance-abusing women to safely discuss their daily struggle with sobriety and their compulsion to use. This effort will help chemically dependent battered women achieve both justice and freedom from abusers who often use their addiction to gain or maintain power and control.

At the Coalition, 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 suport 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 that 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 suffer from substance abuse problems (Kubbs, 2000).

As recently as fifteen years ago, Finkelstein reported that 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 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 co-occurs. And

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 both problems frequently co-occur, research shows neither 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).

The following are a few of the many reasons a domestic violence victim with 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 the victim from accurately assessing the level of danger posed by a batterer.
- Under the influence, victims may feel a sense of increased power. They 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 victim receiving methadone on a daily basis could easily be stalked.
- There may be reluctance on the part of the 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 to access services such as shelter.
- Additionally, recovering women 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 chemically dependent battered women 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:

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 relapse prevention plan and continuing to support the client after a relapse if she chooses to continue to work on her recovery.
4. Providing for a range of chemical dependency assistance options, such as detox, an inpatient treatment program, Alcoholics Anonymous 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 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 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.

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 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 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 chemically dependent battered women 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 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 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.

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 risks from a batterer outweigh 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 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. See Resources section of Appendix for contact information.

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 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 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, 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 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 the Alcohol/Drug Help Line Domestic Violence Outreach Project for additional tips to address both alternatives to substance abuse and relapse prevention (see Appendix for contact information).

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.

RECOMMENDED PROCEDURES

Initial Contact/Crisis Intervention

This is a critical opportunity to provide support and information for battered women impacted by substance abuse. Initially, the advocate will not know if the battered woman uses, misuses or is addicted. The advocate's ability to communicate through the appropriate knowledge of the issues that she is facing may save the victim's life and the lives of her children. During the initial contact/crisis intervention with a battered woman impacted by substance use, advocates should:

1. Inform the client 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 client has drug use issues by using the appropriate screening forms.
4. If the client is not ready to address recovery at the moment, be prepared to refer her to community resources such as the statewide Alcohol/Drug Help Line, local chemical dependency program, or 12-step meeting.
5. Make sure that all staff who are in contact with a chemically dependent client 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 sobriety.
6. If the client is seeking treatment or is in the detoxing process, refer her to the appropriate resources.
7. Inform the client on 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.

In the Shelter

When working with a battered woman impacted by substance use in the shelter, advocates should:

1. Inform the client 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 client has drug use issues by using the appropriate screening forms.
4. If the client uses or misuses substances, discuss safety issues with her. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

After screening, if the client has substance abuse issues, the advocate should:

5. Tell the client 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.
6. Work with the client on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.
7. If the client relapses and wants to keep working on her 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.
8. Make sure that all staff who are in contact with a chemically dependent client 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 sobriety.
9. Provide information to the client 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.
10. If the client 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.
11. Inform the client on 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.
12. Work with the client to develop an ongoing support plan to keep up with the actions she chose for her sobriety.
13. Make sure that the information provided to the client is clear and she can access it frequently.
14. Develop with the client a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies.
15. Meet separately with the client's children to asses their needs.
16. Provide the client with information as to what behaviors advocates and/or the agency are mandated to report to CPS. 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.

17. Advocates can assist the client with the process of resolving an outstanding warrant. The advocate should contact the court that issued the warrant and accompany the client through the process.

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 that these clients feel welcome in the agency and that they and their children are supported.

1. Inform the client 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 client has drug use issues by using the appropriate screening forms.
4. If the client is not ready to address recovery at the moment, be prepared to refer her to community resources such as the statewide Alcohol/Drug Help Line, local chemical dependency program, or 12-step meeting.
5. If the client uses or misuses substances, discuss safety issues with her. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

After screening, if the client has substance abuse issues, the advocate should:

6. Tell the client 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 client on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.
8. If the client relapses and wants to keep working on her 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 client 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 sobriety.
10. Provide information to the client 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 the client 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 the client on 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 sobriety.
14. Make sure that the information provided to the client is clear and she can access it frequently.
15. Develop with the client a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies.
16. Meet separately with the client's children to assess their needs.
17. Provide the client with information as to what behaviors advocates and/or the agency are mandated to report to CPS. 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. Advocates can assist the client with the process of resolving an outstanding warrant. The advocate should contact the court that issued the warrant and accompany the client through the process.

Transitional Housing Program

Because a client 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 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 client 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 client has drug use issues by using the appropriate screening forms.
4. If the client is not ready to address recovery at the moment, be prepared to refer her to community resources such as the statewide Alcohol/Drug Help Line, local chemical dependency program, or 12-step meeting.

5. If the client uses or misuses substances, discuss safety issues with her. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

After screening, if the client has substance abuse issues, the advocate should:

6. Tell the client 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 client on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.
8. If the client relapses and wants to keep working on her 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 client 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 sobriety.
10. Provide information to the client 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 the client 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 the client on 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 sobriety.
14. Make sure that the information provided to the client is clear and she can access it frequently.
15. Develop with the client a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies.
16. Meet separately with the client's children to assess their needs.
17. Provide the client with information as to what behaviors advocates and/or the agency are mandated to report to CPS. 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. Advocates can assist the client with the process of resolving an outstanding warrant. The advocate should contact the court that issued the warrant and accompany the client through the process.

Legal Advocacy

When doing legal advocacy with battered women impacted by substance abuse, advocates need to be aware that the client may feel threatened by the legal system. Chemical dependency is a disease that has been criminalized. The client may have faced legal consequences in the past as a result of her substance use and/or domestic violence. The legal advocate must be very clear in explaining to the client how the legal system works and that she is going to support her in addressing her legal issues if needed.

1. Inform the client 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 client has drug use issues by using the appropriate screening forms.
4. If the client is not ready to address recovery at the moment, be prepared to refer her to community resources such as the statewide Alcohol/Drug Help Line, local chemical dependency program, or 12-step meeting.
5. If the client uses or misuses substances, discuss safety issues with her. Tell her that alcohol and drugs affect the brain and the body whether addiction is present or not.

After screening, if the client has substance abuse issues, the advocate should:

6. Tell the client 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 client on a safety plan which includes relapse prevention, support group attendance and medical attention, if needed.
8. If the client relapses and wants to keep working on her 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 client 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 sobriety.
10. Provide information to the client 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 the client 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 the client on 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 sobriety.
14. Make sure that the information provided to the client is clear and she can access it frequently.
15. Develop with the client a support plan for making important calls and a reminder plan for appointments with doctors, treatment providers and other agencies.
16. Meet separately with the client's children to assess their needs.
17. Provide the client with information as to what behaviors advocates and/or the agency are mandated to report to CPS. 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. Advocates can assist the client with the process of resolving an outstanding warrant. The advocate should contact the court that issued the warrant and accompany the client through the process.

Support Groups

For battered women impacted by substance abuse, support groups play an essential role in their recovery and safety. It is extremely important that the facilitator provide a safe, non-judgmental environment to talk about both safety and sobriety. It is also very important that the facilitator acknowledge that chemical dependency is not the cause of domestic violence. Support groups should have clear ground rules that address confidentiality, a non-judgmental atmosphere and respect among group members.

Support group facilitators need to be trained in both domestic violence issues and chemical dependency issues. Collaboration with local chemical dependency programs can facilitate cross-training between domestic violence advocates and chemical dependency counselors.

The following can be useful group topics for women affected by their own or their partner's substance abuse:

- What is chemical dependency
- Tactics abusers use to control their partners
- 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

Community Collaboration

Battered women impacted by substance abuse often contact other services, such as health providers or chemical dependency agencies, before they contact a domestic violence agency. Therefore, it is essential that domestic violence agencies collaborate 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. When collaborating with other agencies, staff at the domestic violence 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 domestic violence program).

Staff and Volunteer Training

For the chemically dependant victim of domestic violence, domestic violence is not the only issue that she is facing. She is also dealing with a disease that can be lethal as well. Training in chemical dependency issues can help staff members and volunteers to better serve chemically dependant clients, improving the safety of all clients and staff at the agency. 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 clients. Volunteers play an essential role in delivering services to victims of domestic violence; 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, collaboration with other agencies plays an essential role in working with battered women impacted by substance abuse in a non-urban setting. Collaboration may include advocating with another agency on behalf of (with direction and permission from) the substance-abusing or chemically dependent battered woman, 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, client confidentiality can be compromised through information-sharing unless there are consistent efforts to adhere to the domestic violence agency's confidentiality practices. Coordination between agencies is also needed to ensure that battered women impacted by substance abuse have reliable transportation to access necessary services.

APPENDIX

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

The Alcohol/Drug Help Line Domestic Violence Outreach Project can be reached at 206-722-3700 or 1-800-562-1240 (in Washington 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.

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.

Eastside Domestic Violence Program in Bellevue provides a transitional housing program for chemically dependent battered women and their children that includes on-site outpatient treatment services through Therapeutic Health Services. Call 425-746-1940 for information.

The Mom's and Women's Recovery Center in Pierce County provides screening, assessment, intervention, treatment and support for women addressing both substance abuse and domestic violence issues. Call Sue Winskill at 253-798-6655.

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.

"Practical Tools for Domestic Violence Advocates Addressing Substance Abuse Issues" developed or written by Patti J. Bland, M.A. CCDC. This packet of materials is available

from the Washington State Coalition Against Domestic Violence. Please contact the Coalition at 206-389-2515 x100 to request the packet by mail (for a fee that includes copying and postage). The packet includes the following items:

1. Support Agreement
2. Non-Use Agreement
3. Sample Screening Questions for Shelter Intake Form
4. Sample Safety Plan
5. Manifestations of Violence and Substance Abuse Power and Control Wheel (group tools)
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
8. Handout: "Overview: Chemically Dependent Victims of Domestic Violence"
9. "Women Talk about Substance Abuse and Violence," ten women interviewed by Debi Edmund and Patti Bland; edited by Debi Edmund, June 2000
10. Screening Tools for Substance Abuse

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. *Conjoints 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.

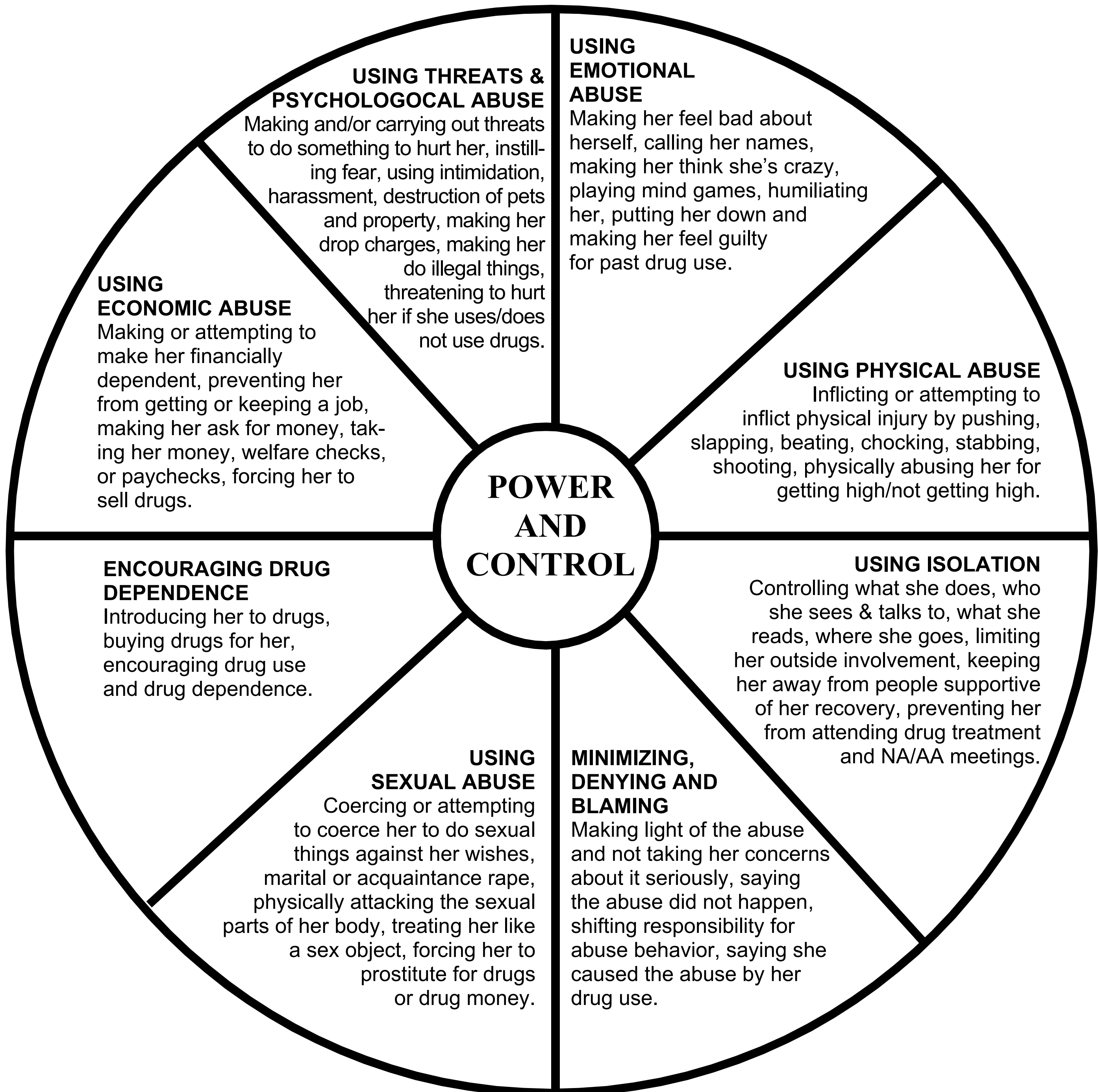
- Chemical dependency undermines both health and judgment. Withdrawal symptoms can be painful and life threatening. Encourage people to seek medical attention prior to detoxing.

- 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 at 1-800-562-1240.

A Power and Control Wheel for Women's Substance Abuse



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Adapted from: Domestic Abuse Intervention Project, Duluth, MN

REFERENCES

Bennett, L. and M. Lawson. 1994. Barriers to Cooperation between Domestic Violence and Substance Abuse Programs. *Families in Society* 75:277-286.

Bland, P. J. 1997. Strategies for Improving Women's Safety and Sobriety. *The Source* Vol. 7, No. 1, Winter. National Abandoned Infants Resource Center.

Bland, P.J. 2001. Screening Chemically Dependent Battered Women In NOT Out of Our Programs. *The A-Files* Vol. 3., No. 3, Pages 127-138. Seattle, WA: Washington State Coalition Against Domestic Violence.

Bland, P.J. 2/25/2003. Personal Communication on the Alcohol/Drug Help Line Domestic Violence Outreach Project monthly reports completed by P. Bland, K. Foley et al. Seattle, WA.

Center for Substance Abuse Treatment (CSAT). 1994. *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and other Drug Abuse.* Rockville, MD: Department of Health and Human Services, Public Health Services.

Center for Substance Abuse Treatment (CSAT). 1994. *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.* Rockville, MD: Department of Health and Human Services, Public Health Services.

Downs, W., Department of Social Work, University of Northern Iowa. Personal Communication with Patricia Bland, April 2002.

Dutton, D. G. 1992. Theoretical and empirical perspectives on the etiology and prevention of wife assault. In *Aggression and violence throughout the lifespan,* ed. R. D. Peters, R. J. McMahon and V. L. Quinsey, 192-221. Newbury Park, CA: Sage Publications.

Finkelstein, N. 1994. Treatment Issues for Alcohol- and Drug-Dependent Pregnant and Parenting Women. *Health and Social Work* 19(1): 7-15.

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

Kubbs, M., ed. 2000. *Women and Addiction in Washington State, A Report to the State Division of Alcoholism and Substance Abuse.* Seattle, WA: Washington State Coalition on Women's Substance Abuse Issues.

LaGrange, L. 1994. Gender Differences in Biological Markers of Alcohol Use. In *Addictive Behaviors in Women,* ed. R. Watson. Totawa, NJ: Humana Press.

Lieber, C. 1993. Women and Alcohol, Gender Differences in Metabolism and Susceptibility. In: *Women and Substance Abuse,* ed. E. Lisansky-Gomberg and T. Nirenber. Norwood, NJ: Ablex Publishing.

Miller, B. 1994. Partner Violence Experiences and Women's Drug Use: Exploring Connections. In: *Drug Addiction Research and the Health of Women,* ed. C. Washington, and A. Roman. Rockville, MD: U.S. Department of Health and Social Services, National Institute on Drug Abuse.

Minnesota Coalition for Battered Women. 1992. *Safety first: Battered women surviving violence when alcohol and drugs are involved*. St. Paul, MN.

Roth, P., ed. 1991. *Alcohol and Drugs Are Women's Issues, Volume One, A Review of the Issues.* New Jersey: Women's Action Alliance and Scarecrow Press.

Roth, P., ed. 1991. *Alcohol and Drugs Are Women's Issues, Volume Two, The Model Program Guide.* New Jersey: Women's Action Alliance and Scarecrow Press.