Practical Tools for Domestic Violence Advocates Addressing Substance Abuse

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Packet Includes:

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.) 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

SUPPORT AGREEMENT

During my residency here, I choose to remain clean and sober and agree to take steps to ensure this is a workable personal goal.

I choose to strengthen my safety and sobriety by agreeing to attend_________________ support group meetings a week.

I am willing to participate in treatment or relapse prevention services should my safety and sobriety be at risk, because I understand inability to remain sober is a safety risk for me and others.

I understand inability to remain sober may result in my choosing to make other housing arrangements. Although I am <u>not</u> responsible for having an illness, I <u>am</u> responsible for my recovery and my choices.

I understand that staff here will support my efforts to maintain safety and sobriety in a caring, nonjudgmental manner and will respectfully honor my decisions and choices.

DATE RESIDENT

_________________________ _______________________________

DATE ADVOCATE

_________________________ _______________________________

c P. Bland 1/2001

ALCOHOL/DRUG NON-USE DURING STAY AGREEMENT

During my residency here, I choose to remain clean and sober , both on and off the premises, and agree to refrain from using alcohol and illegal substances (including drugs or other intoxicants) during my stay. Additionally I agree to refrain from mis-using prescription and over-the-counter medications.

I understand that although I am not responsible for wanting to drink or drug, I am responsible for choosing a safer coping measure during my stay.

I understand inability to remain sober is a safety risk for me and others and may result in my choice to make other housing arrangements should I **choose** to drink alcohol or use illegal drugs or other intoxicants (including misuse of controlled substances, prescription or over-the-counter medications) during my stay.

I understand that staff here will support my efforts to maintain safety and sobriety in a non-judgmental manner and will respectfully honor the decisions I choose to make.

DATE RESIDENT

________________________ ______________________________

DATE ADVOCATE

________________________ ______________________________

c P.Bland 1/2001

CHEMICAL DEPENDENCY ISSUES

"Our agency provides services for people whose lives have been impacted by both domestic violence and substance use. The next few questions address safety concerns should your partner (or you), drink alcohol or use other substances. Your answers will not prevent you from receiving services at our program."

Yes No 30. Does your partner/ex-partner drink or use other drugs? What kind?

Type of Substance: ______________________________

Frequency/Volume of use: ______________________________

How do you think your safety might be impacted by your partner's drinking or drugging?______________________________

IF the caller's abuser uses cocaine or amphetamines (crack or crank): please remind the caller to be doubly cautious about revealing her plans to anyone the abuser knows, since drug-induced paranoia can be dangerous, even deadly.

Yes No 31. Has your partner/ex ever asked or forced you to use drugs or alcohol?

32. When was the last time you drank alcohol and/or used any other drugs? And the time before that? Which drugs or alcohol do you use?

Yes No 33. Often, women use drugs or alcohol to cope with the abuse.
Is this something that you do or have done?
About how often?
When was the last time?
What drugs/alcohol?

Yes No 34(a). Have you experienced any problems due to drinking or drugs?
Due to your own or your partner's/ex's?

Yes No 34(b). Can you think of any safety risks drinking or drug use makes worse now?

Yes No 35. Have you ever had blackouts or seizures as a result of drinking or drugs?

Explain.

Yes No 36. Are you in treatment now or have you ever been in treatment for drugs And or alcohol?

Treatment Center: ______________________________

Addiction: ______________________________

If Methadone program, please encourage woman to be extra cautious because abuser could track her through the clinic.

Yes No 37. Do you attend twelve-step meetings or other chemical dependency Support Groups now?
Have you in the past?
(When and where? By choice or mandated by court?)

Our program is a safe place for women. Many women who live or work here are in recovery. For your safety and that of the other residents we ask that you try not to use alcohol or other substances during your stay.

Yes No 38. How comfortable are you with this? What challenges do you expect?

<u>Rough Guidelines for Referring Women to Meetings</u>

1 meeting Woman's abuser is an addict
2 meetings 1 year or more sobriety from alcohol or other drugs
3 meetings Less than 1 year sobriety from alcohol or other drugs
4 meetings Use of cocaine, heroin, crack, crystal, any methamphetamines within **2 weeks** or an episode of acute drunkenness within **1 week.**

Based on our conversation I will ask that you attend ______ support groups/week while you are here. These groups offer you a chance to talk to other women about options and coping tools as well as help address any of your safety concerns stemming from anyone's substance use.

At our program we can work with you to develop both safety and sobriety plans tailored to your needs, should that be helpful for you.

Yes No 39. Do you have any questions or concerns?

(Sample shelter screening tool based on New Beginnings model, 7/2001)

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 Protection 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 Protection Order.
- Remember that in the State of Washington, if your partner assaults you when you have a valid Protection Order, your partner can be charged with a felony.

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 the **Alcohol Drug 24 Hour Help Line** for support when I feel like drinking or drugging to cope. That number is **1-800-562-1240**. (WA Only)
- I will call the **Washington State Domestic Violence Hotline** when I need information, referrals or support. That number is **1-800-562-6025.** (WA Only)
- *(This safety plan is adapted from New Beginnings and Providence Health System safety plans)*
- **PERSONAL SAFETY NOTES:**

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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 a domestic violence advocate to develop or review your current safety plan or explore your options. Remember, domestic violence directed at you is never your fault (*even if you were drinking or using drugs*).

Emotional Abuse

Above the line: insulting jokes — ignore feelings — jealousy — isolation — humiliation — harming pets — calls you 'crazy', 'drunk', or 'junkie'

Below the line: silent treatment — insults — blaming/ accusations — monitoring activities — threats — degradation — homicide/ suicide

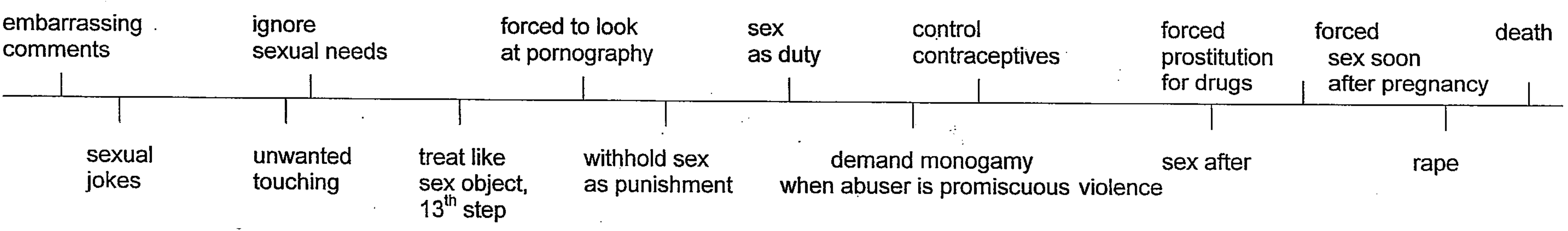
Physical Abuse

Above the line: scratch — slap — push — hit — target hit — kick — choke — beat — weapon use — murder

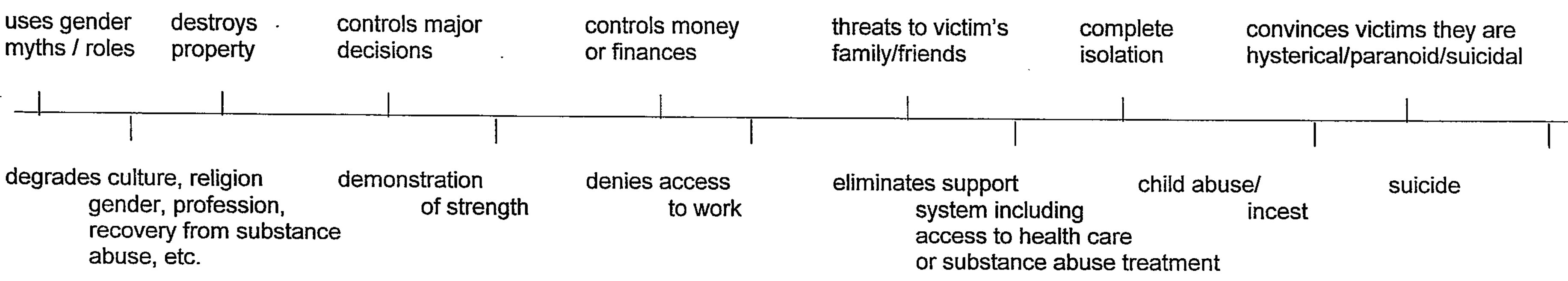
Below the line: deny physical needs — bite — force drug use — punch — throw objects — burn — sleep deprivation — poison — disablement/ disfigurement

(Manifestations of Violence, continued)

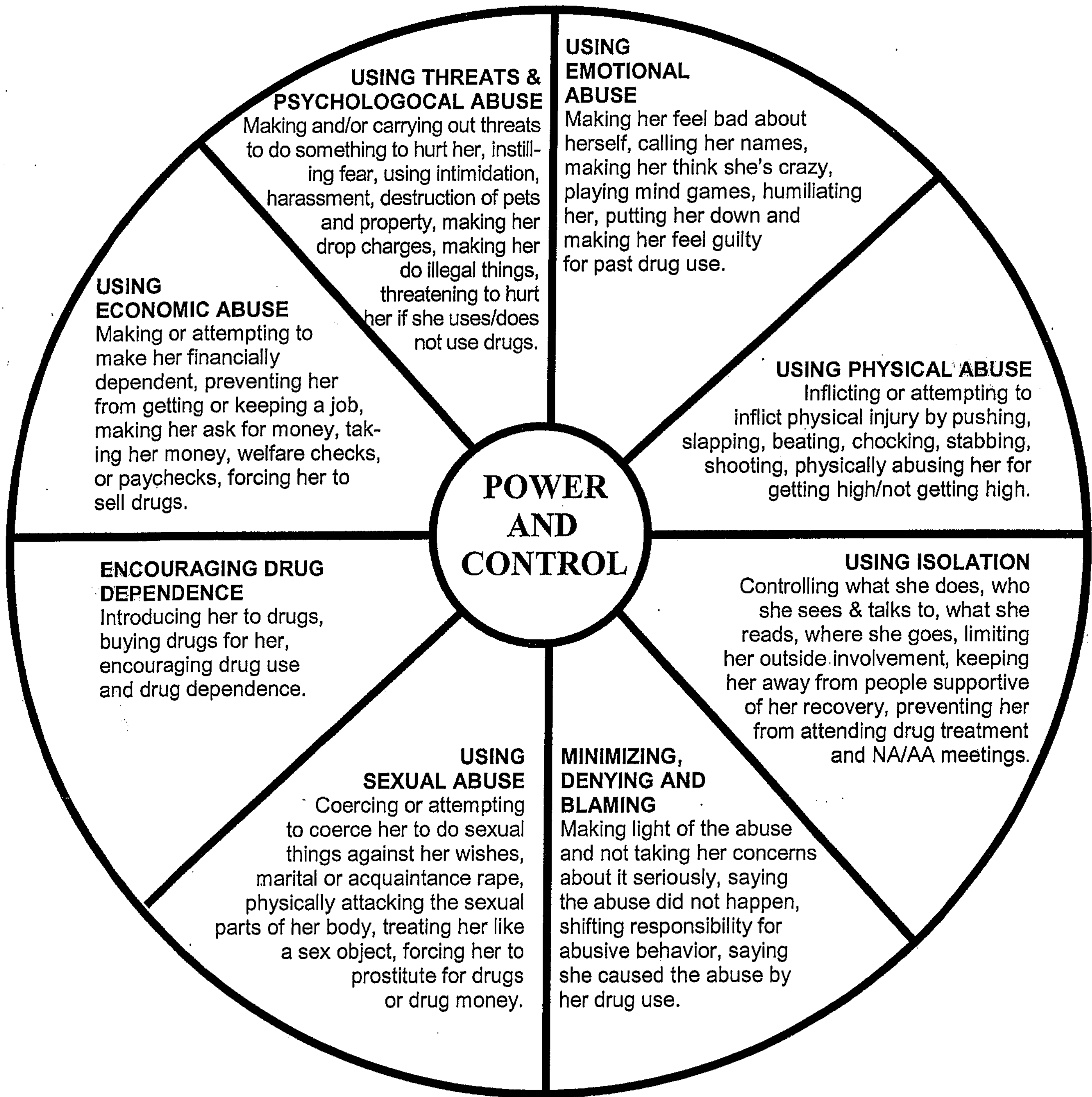
Sexual Abuse



Social / Environmental Abuse



A Power and Control Model for Women's Substance Abuse



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Adapted from: Domestic Abuse Intervention Project, Duluth, MN

I CHOOSE TO HONOR MY OWN RECOVERY BY DOCUMENTING MEETING ATTENDANCE AND OTHER ACTIVITIES SUPPORTING MY SAFETY AND SOBRIETY.

(copyright p. bland, 1992)

DATE	TIME	MEETING/ACTIVITY	INITIALS/PHONE # *(optional)*

C. P.BLAND 1/92

COPING – Domestic Violence Narrative (C-DV)

Date	*Name/ID #*	*Time Began/Ended*	*Total Hrs.*	*Advocate Initials*

NARRATIVE

Domestic Violence and Chemical Dependency: Screening Pregnant and Postpartum Women for Safety and Sobriety

By Patricia J. Bland, M.A. CCDC

(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)

"I was a 17 year old unwed mother and two days after he 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."

Women from all walks of life are at risk for domestic violence that can begin or escalate during pregnancy (Salber and Taliaferro, 1995). The occurrence of DV in pregnant women is more common than pre-eclampsia, gestational diabetes and placenta previa. Estimates of domestic violence prevalence for pregnant women range from .9 to 20.1% (Gazmararian, 1996, McFarlane, 1999). The wide range of prevalence data may be explained in part by researchers' inability to agree on a uniform definition of domestic violence. The prevalence of physical violence during pregnancy in Washington State during 1993-1995 is estimated at 5% (approximately 4,000 women per year). This estimate is based on women's responses to the Washington State Department of Health's PRAM's Survey which asks postpartum women, "Did your husband or partner physically hurt you during the 12 months prior to delivery?"

Domestic violence during pregnancy can have a negative impact on pregnancy outcomes. Low birth weight is one of several negative

outcomes associated with domestic violence (Bullock 1989; Schei, 1991; Parker, 1994; Fernandez, 1999). Birth weight is the most significant predictor of infant wellness and future development. Newborns of abused women average 133 grams less birth weight than those of non-abused women (McFarlane, 1992).

"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, 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."

Women from all walks of life are also at risk for substance misuse or addiction that can begin or escalate during pregnancy. Alcohol and tobacco are the most commonly used drugs among pregnant women according to the National Institute of Drug Abuse (NIDA1996). The CDC reports a significant increase in women's drinking during pregnancy with alcohol consumption climbing more than 60 % from 1992-1995 and frequent drinking (at least seven drinks in one week or five on one occasion) quadrupling (Drug Strategies, 1998). A national survey found that more than half of women age 15-44 drank while pregnant (US Dept. of Health and Human Services, 1998). According to the Surgeon General, estimates of women smoking during pregnancy range from 12.9 % to as high as 22% (Surgeon General's Report: Women and Smoking 2001).

Substance abuse during pregnancy has been identified as an issue critical to the health of mothers and babies from all socioeconomic groups (Taylor, 1999*). It is estimated between 8,000 and 10,000 infants are born each year in Washington State exposed to drugs and alcohol. Roughly 10%

of these infants are drug or alcohol affected. (Cawthon, L., DSHS, RDA, 1997).

*(NOTE: See also, Taylor, P. (Ed.) (1999). Guidelines for Screening for Substance Abuse During Pregnancy. Washington Department of Health. Publication No. 950-135.)

Substance abuse contributes to obstetric and pediatric complications, including fetal alcohol syndrome, miscarriage, stillbirths, prematurity, abrutio placenta, SIDS, and neonatal abstinence syndrome. For mothers, besides the risks associated with abruption, there is a risk from some substances for seizures and cardiopulmonary problems. Alcohol is the leading known preventable cause of birth defects and mental retardation. Children with Fetal Alcohol Syndrome (FAS) suffer from irreversible physical and mental defects including small brains, facial abnormalities, poor coordination, short attention span and mental retardation (Drug Strategies, 1998).

According to birth certificate data for 1999: 12% of women giving birth in Washington State smoked cigarettes. While this data indicates Washington women smoke nicotine less than the national average there is still cause for serious concern. When moms smoke during pregnancy the rate of infant deaths increases by 50%, the incidence of sudden infant death syndrome doubles; respiratory infections are common and cigarette smoking accounts for 20% of low birth weight babies. Also associated with low birth weight, as well as preterm delivery and neonatal seizures, is in utero exposure to cocaine. (Drug Strategies, 1998).

Tandem Issues

One in four women will be assaulted by an intimate partner (US Dept. of Health and Human Services) and "more than half of domestic violence cases nationwide involve drinking at the time of an attack" (Drug Strategies, 1998). 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). Of particular concern also, is the need to ask women about their partners' substance 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."

Yet, interdisciplinary screening for both domestic violence and substance misuse is often routinely neglected. Barriers to women's safety and sobriety are magnified when routine screening for both domestic violence and substance abuse fails to occur. Failure to ask key questions or to recognize cues indicating the presence of domestic violence or 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 patient'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 medical culture that simplifies or trivializes women's issues or assumes addressing a presenting problem without exploring context is safe. Health care providers have an ethical responsibility to routinely screen and offer options to pregnant and postpartum women who may be at increased risk for both domestic violence and substance abuse.

"I thought the only thing I could do was to stay and keep on doing what I was doing. You know, domestic violence is barely out in society now. Until they told me about the battered women's shelter, I didn't know there was help, and I think I was pretty unaware of substance abuse help, too. I just didn't know."

Effective screening and intervention for domestic violence and substance misuse for pregnant and postpartum women in our patient population requires system-wide respect for women's choices and autonomy. Additionally, providers must assess health risks, offer safety and sobriety options, provide health care treatment and maintain confidentiality. Perinatal health care providers are an essential part of our coordinated community response to end problems stemming from both domestic violence and addiction. Women who may be reluctant to call a domestic violence shelter or chemical dependency treatment program may very well seek medical help during pregnancy. Screening for domestic violence and substance abuse is an excellent "first step'" toward going to "whatever lengths are necessary" to address the needs of chemically dependent battered women and their children in our patient population.

"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."

Understanding Domestic Violence and Substance Abuse

Understanding the impact of dual problems may very well enhance a woman's chances for achieving both safety and sobriety during pregnancy and beyond. A correlation between substance abuse and domestic violence occurs in 44% to 80% of domestic violence incidents depending on what research one chooses to cite (Mackey, 1992). Most pregnant or postpartum women are neither chemically dependent nor battered. However, should pregnant/postpartum women experience domestic violence, develop substance abuse, addiction or both, risks to their health and that of their children increase significantly.

"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."

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). 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."

During pregnancy this coping response is especially dangerous. Since there are no defined safe limits during pregnancy, **any** use of alcohol and other drugs at this time in a woman's life should be avoided.

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.

"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."

Comparison of Domestic Violence and Addiction

Domestic violence and addiction are two separate problems. At first glance, the similarities between the two are striking. Domestic violence and chemical dependency both impact entire families, often harming three or more generations.

"As a young girl, I started to use alcohol and drugs to cope with the domestic violence inflicted on my mother by my father and then my step-father after him. I repeated the pattern in my own teen and adult life, finding myself in violent situations over and over again until I got clean and sober. Not that abuse can't happen if you're sober, but if you are sober, at least you can see it coming."

Domestic violence and chemical dependency negatively impact pregnancy outcomes. Both are marked by the development of elaborate denial systems that include minimizing, rationalizing and blaming others.

"I didn't even realize I had domestic violence until after I was sober."

Addicts cover up to protect their supply and avoid pain.

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

Victims of domestic violence are aware of their situation but may be numb or afraid to tell.

"I didn't have time to heal. You just start to look at an issue like alcoholism or domestic violence. You just to start to look at a sexual assault and it's too painful. You drink to numb the pain. It just gets under the rug."

Victims of domestic violence may deny what is happening when speaking to a provider because an abuser threatens them with grave harm or because they do not feel safe sharing their story.

"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."

Abusers blame others and engage in denial to avoid being held accountable and to continue getting their way.

"I didn't hit you that hard."

"If you hadn't of done this, then I wouldn't have had to...."

"He would not admit he was abusing me. People tend to look the other way. It's just not something they want to see. It's denial."

Both domestic violence and addiction carry great societal stigma and shame. They both thrive in silence and isolation.

"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."

*What is Domestic Violence?

(*See full cite under, "What are Substance Abuse and Addiction?" to follow.)

Despite similarities, domestic violence and addiction are vastly different. According to the AMA (1994), domestic violence is a pattern of coercive behaviors, marked by physical, emotional or sexual abuse. Domestic violence as defined by the American Psychological Association (APA, 1996) is " a pattern of abusive behaviors including a wide range of physical, sexual, and psychological maltreatment used by one person in an intimate relationship to gain power unfairly or maintain that person's misuse of power, control and authority."

Domestic violence is not a disease. "Domestic violence is an attempt to control the behavior of a partner. Abuse is a misuse of power that uses the bond of intimacy, trust and dependency to make a partner feel unequal, powerless and unsafe" (Domestic Violence/Substance Abuse Interdisciplinary Task Force of the IL DHS, 7/2000). The decision to abuse an intimate partner is a behavioral choice made by batterers who generally rationalize their behavior by blaming their victims.

"Well I told you to shut up and you wouldn't shut up."

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

Domestic violence is supported by belief systems sanctioned in our culture.

"I went to the church and told them I was in fear of my life. People in the congregation said, 'Oh, it's okay,' denying that there was any abuse going on. It made me turn my back on my faith."

Victims of intimate partner domestic violence are victims of an abusive partner and often victims of a violent crime. Sometimes the justice system's response to that crime is more abuse.

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

"We came 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 court room."

Victims of domestic violence do not cause abuse nor do they 'like' it. They are not 'sick' but are often injured and traumatized by their partners. Sometimes they are re-victimized by others who fail to understand the nature of domestic violence.

My parents, 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."

Victims of domestic violence are not 'co-dependent.' They are survivors. They survive threats, intimidation and abuse that may not be obvious.

"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."
Sometimes victims of domestic violence do not survive.

*What are Substance Abuse and Addiction?

(**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.

"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. 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.

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.

"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."

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?

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."

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."

Alcohol and drugs effect the brain and the body whether addiction is present or not. Addiction, however, is marked by the development of tolerance, loss of control, continued use in spite of adverse consequences and withdrawal symptoms.

"One day I didn't want to drink and I had to. It was the scariest feeling."

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.

Building a Bridge to Safety and Sobriety

Screening and referral can help perinatal health care providers build a bridge from substance abuse or addiction to health for chemically dependent women concerned about their health and that of their children. Perinatal health care providers can also help women build a bridge from violence to safety. 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. For many substance abusing battered women, safety needs include knowing they are not being labeled or judged.

"They 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."

Safety and sobriety can be addressed respectfully in our patient population 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 our patients and for us. This means misuse of substances or abuse within a romantic relationship could

happen to anyone. We can reduce shame and stigma by acknowledging any woman in any given culture 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 the disease of 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.

"And it feels in the beginning that it's the end of the world, but it's actually the beginning of a new life."

Challenges to Healing

Recovery for women, especially battered women, is all about empowerment. Recovery is built on an individual woman's strength, hope and belief that change can successfully occur for herself, as well as 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."

Women who find themselves in relationships with batterers don't know on the first date what the future will hold. They may expect to find 'romance' and 'love' and find themselves hoping the relationship will 'work out.' Domestic violence though, is about power and control. 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."

Many battered women do not want their relationships to end. They want the violence to stop. They want to be like everybody else who can have a happy, healthy relationship.

"And I really started to believe, if I act just right, I can keep this from happening."

Both battered women and addicted women blame themselves when they are unable to be safe or sober.

"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."

If the battered woman and addicted woman are one and the same, the level of guilt and shame is 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."

If this woman is pregnant she may be both isolated and vulnerable as well as at risk for:

1.) Low maternal weight gain, infections, anemia, first and second trimester bleeding (McFarlane et al., 1994)
2.) Third trimester entry into prenatal care (Parker et al. 1994)
3.) Maternal depression, suicide attempts, tobacco, alcohol and illicit drug use (McFarlane et al., 1996)
4.) Preterm labor, premature rupture of membranes and low birth weight (Fernandez et al., 1999 and Shumway et al., 1999)
5.) Greater severity of abuse (ACOG, 1999).

Rationale for Screening

Research supports universal screening. According to Wiist and McFarlane, (1999), use of a specific screen alone in prenatal clinics led to a 9% increase in DV detection. Detected domestic violence prevalence jumped 22% higher when providers personally asked about DV rather than relying on a questionnaire alone. Increased domestic violence assessment, referral and documentation occurred following the implementation of an abuse assessment protocol in prenatal clinics.

Screening for domestic violence and substance misuse or addiction can be very simple. Actually finding out whether these problems exist and being able to effectively intervene, however, require 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 and domestic violence. Next, it is important to understand these how these attitudes and beliefs shape practice when

addiction and domestic violence occur during pregnancy. Before a woman can open up to a provider she must feel safe. Components of safety include ensuring confidentiality, being culturally competent, and avoiding judgmental or overly directive interactions.

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. Tell patients:

- "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.

Provider Challenge

Although addicts attempt to quit using, addicts can't stop being addicts anymore than diabetics can stop being diabetic. Also, relationships aren't easy to end, especially when an abusive partner won't willingly let go. The challenge is to screen, intervene and offer support to encourage a person to begin the lifelong process of recovery. Motivational interviewing to encourage behavioral change is extremely helpful. A woman may choose not to tell the truth initially due to denial or fear or simply because her response may be all she is able to control in her life. Being asked, though, is something she will remember when her substance use is out of control

and she is looking for help or when the threat of violence is too terrifying to bear alone.

People are people and there will be ups and downs along the way. Abstinence is merely a part of the recovery process, though an extremely important one. Likewise, escaping an abusive partner poses risks and may be difficult or impossible for a woman to consider initially. Resistance to change is normal. A woman's decision not to stop using immediately or to decline treatment, advocacy or shelter should not be viewed as failure. Countless intervention opportunities are missed when providers are afraid to ask lest they offend or view intervention as futile. Again, 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. Recovery is a process that takes time.

"I've known for 10 years that I had a serious problem with drug use but I was unwilling to give it up because that was my way of coping."

Safety and sobriety are indeed possible. During pregnancy, behavioral changes can lead to improved outcomes for both women and their children whenever they begin. Acknowledging that 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 healing alliance that benefits both her and her

children. It is also important to explore domestic violence as a barrier to recovery.

"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."

"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."

Separation Violence

According to the U.S. Department of Justice, up to 75% of DV assaults are reported to the police after separation. At least 31,260 women were killed by their current or former intimate partners in the United States since 1976. Between 30% and 50% of all female homicide victims are killed by their current or former male intimate partners, compared to less than 4% of male partners killed by an intimate partner (US Dept. of Justice, 1998).

91 Washington State women were killed by their current or former male partners between January 1997 and August 2000. "An additional 35 people were killed in domestic violence related fatalities. These included the children, friends and family of abused women. Two law enforcement officers were killed by abusers as they intervened in domestic violence" (Hobart, 12/2000).

These numbers echo the 38 DV homicides Washington State local press reported in 1999. According to the press, in 40% of 1999 DV homicides in Washington State, a female victim was trying to leave or had left her

partner. The female murder victim had a protection order in 16% of these cases (WA State Fatality Review Project, WSCADV, 2000).

Defining Success

Providers are not responsible for 'curing' DV. Define success not as "getting her to leave" (she may leave but the partner may follow). Success does not involve making decisions for a battered woman. Rather, define success as breaking the isolation and giving the message:

- "You are not alone and this is not your fault."

When asked what kept her from getting help, a recovering formerly battered woman in Seattle said:

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

Again, the challenge for providers is not to get women to leave. More importantly, our challenge is to support their process, provide information, assist with referrals for safety planning and convey the notion that:

- " No one ever has the right to hurt you to get their way."

This message is especially important for the chemically dependent battered woman to hear, for she may buy into the negative societal view that alcoholic/addicted women are worthless and deserve to be punished.

"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 do you expect?"

Women Do Leave

Victims of domestic violence do attempt to get safe. Each year in King County, Washington State, more than 11,000 women and children fleeing violent homes are turned away from shelters due to lack of space (Domestic Violence Public Education Plan: Revised, WA State, 1994). The limited shelter resources available for women attempting to flee abuse make it important for providers to be knowledgeable about a variety of legal and other options as well as local referrals to domestic violence programs and 24-hour domestic violence crisis lines.

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

Leaving an abusive relationship is a process. Perinatal providers may meet women at the beginning, middle or end of their process. Often women are unaware of their options.

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

Distorted Perceptions

Alcohol and other drugs distort perceptions. Chemically dependent battered women 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).

"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."

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.

"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 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.

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

It must be noted that while blackouts impact memory there is no evidence to support the contention that a blackout alters judgement 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."

Providers must consistently give the message that using substances as an excuse for violence is not acceptable. Provider collusion with this erroneous belief can contribute to a batterer's ability to avoid accountability for abusive actions or encourage a victim's erroneous belief that 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."

Advocacy-Based Counseling

All domestic violence programs receiving funding from the Washington State Department of Social and Health Services must provide advocacy-based counseling as a condition for receiving funding. "Advocacy-based counseling means the involvement of a client with an advocate counselor in an individual, family or group session with the primary focus on safety planning and empowerment of the client through reinforcing the client's autonomy and self-determination. Advocacy-based counseling uses problem-solving methods and includes identifying the barriers to safety;

developing safety checking and planning skills; clarifying issues; solving problems; increasing self-esteem and self awareness; and improving and implementing skills in decision making, parenting, self-help and self-care" (DSHS).

Providers of advocacy-based counseling must take into account the realities of chemical dependency in order to remain rooted in the experience of chemically dependent battered women.

"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."

Accurate assessment is essential. Just as leaving an abusive relationship can be lethal, abruptly discontinuing substance use without medical assistance can pose serious health risks. Pregnant women suffering from severe alcoholism should never be advised to quit 'cold turkey,' for if they experience delirium tremens (DT's) it can be fatal for the fetus and, in some situations, also for the mother. Medical detox is advised for pregnant women seeking to discontinue alcohol and other drug use during pregnancy. Withdrawal from substances at best is uncomfortable, and can also pose extremely serious health risks.

Advocacy based counseling, while generally optimal, may look different for chemically dependent battered women who may have withdrawal issues, memory distortions and cognitive deficits.

"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 for chemically dependent battered women may include: Repeating information, providing structure, simplifying goals, advocating for their inclusion in shelters and other victim service programs, understanding the impact of chemicals on safety planning and self esteem.

"You've got to be sober, at least a little bit, to be able to even look at 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."

Providers must also be aware of the wide-spread systemic prejudice directed against substance abusing battered women that serves as a barrier for both safety and sobriety.

Screening Tips

Effective screening for domestic violence and substance abuse occurs within the framework of respect. Make sure your discussion is age, developmentally and culturally appropriate as well as respectful. Conversations about addiction and or violence need to take place in private. Children should not be present lest they repeat what they hear, putting a woman at risk. It is most useful to address the relationship first. Many women find it easier to talk about partners rather than themselves. This does not stem from co-dependency, but occurs because women in our culture are socialized to define themselves in terms of their role rather than who they are as individuals. It might be simplest to begin screening for domestic violence prior to screening for substance abuse but both issues often overlap. Discussion about either topic may lead to clinical suspicion

about the existence of the other. Be flexible and able to shift gears if your assessment warrants it.

**Screening for Domestic Violence

(**Note: Please refer also to the Perinatal Partnership Against Domestic Violence Train the Trainer Manual, principal author Patricia J. Bland MA CCDC CDP, in collaboration with the Washington State Department of Health (Olympia, WA: DOH 2000). This publication is available from the WSCADV, 1402 3rd AV, # 1127, Seattle, WA 98101, phone: 206-389-2515, fax: 206-389-2520).

Many providers are afraid to bring up the subject of domestic violence. You do not have to become a detective. More important than the woman's response is your asking the question. Asking the question is the intervention. It lets a woman know this is a safe place to talk about domestic violence when she is ready regardless of what she says today. I recommend a subtle approach. The following is offered as a basic script; however, you are encouraged to adapt language to suit your style, as you become more comfortable screening possible victims of domestic violence:

- "We recognize many women are dealing with stress in their relationships, and we are committed to your safety and health. We are asking each woman we see the following questions so we may better meet their needs. This information is kept confidential."

- "During pregnancy women often tell us they experience difficulties in their relationships with their partners. How often do you feel stress in your relationship? When was the last time you felt threatened, controlled, afraid or abused? How often are your feelings hurt by your partner?"

Or

- "How does your partner show disapproval? When was the last time you felt threatened by your partner?

All women seen need to be routinely screened and given domestic violence brochures as well as local 24 hour help line numbers during visits for health care. Perinatal providers should be sure to repeat the screening each trimester during pregnancy and again postpartum. Don't be afraid to ask again. Feel free to ask in different ways. It may take time for women to feel safe enough to talk about what is really going on. Women can be told:

- "You may not need these numbers but we are giving them to all the women we see in case they have a friend who may need them."

Also be sure to advise patients they can leave these brochures behind if it is not safe to bring them home. Although the best way to find out about domestic violence is to ask, the following may be indicative of possible battering or abuse:

1.) Injuries to face, neck, bathing suit area
2.) Bilateral injuries, injuries at multiple sites or at varying stages of healing
3.) Stories inconsistent with injury or no explanation for obvious injury given
4.) Vague somatic complaints
5.) Injuries during pregnancy especially to abdomen, breasts and genitals
6.) Substance abuse, panic attack, PTSD symptoms *(Post Traumatic Stress Disorder)*, eating disorder, depression, suicidal ideation, IBS *(Irritable Bowel Syndrome)* or ulcers.

Be wary of partners who refuse to leave a woman's side, seem controlling and always speak for her. Frequently missed appointments or cancellations of appointments by a woman's partner may also be provider cues of domestic violence.

When a woman discloses abuse, acknowledge the problem. Tell her:

- "Information shared with us is confidential.
- This is not your fault. No one deserves to be abused.
- You are not alone. Others are in this situation and help is available. We respect your ability to cope and are available to share safety options or just listen."

Make referrals to your local community-based battered women's program, crisis line or shelter. Always offer a victim of domestic violence the use of a phone at your office to call the domestic violence victim's services program because she may not be able to make a call at home. Be sure to establish a working relationship with your local battered women's advocates and victim service agency. This will make it easier for you to describe services to your clients as well as provide you with linkage to competent professionals to consult with. (See PPADV Train the Trainer Manual Appendix for a complete list of Washington State community-based domestic violence victim service agencies.)

Safety Assessment

When domestic violence is suspected or confirmed a brief safety assessment should occur (See PPADV Train the Trainer Manual Appendix). Determine if the abuser is present now and if not, where the abuser is. Find out if the woman is afraid to go home, whether weapons are involved as well as whether threats of homicide or suicide have been made. It is also useful to know whether children are witnessing and/or experiencing abuse so their safety can be assessed and appropriate referrals made. While a CPS report may be mandated following your assessment if children are at risk for harm, Washington State does not require mandatory reporting of adult intimate partner domestic violence in most cases. Women may

choose not to call police for a variety of reasons including fear of repercussions. While it is okay to ask a woman if she would like to call the police, please respect her wishes if she chooses not to. Be aware of local statutes as well as your facility's reporting protocols for child abuse.

When a woman chooses not to talk about the abuse she has disclosed, tell her:

- "If you want to talk about this in the future, we are committed to your safety and health and we will be here for you when you are ready."

At the Intersection

Screening for substance abuse is an opportunity to sow seeds that can ultimately reap recovery and better health outcomes for mothers and their children. The intervention again, is in the asking. Although recognized tools for assessing an individual's alcohol use (e.g., CAGE, MAST, DAST) have been around for years, 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 your patient's history of substance use, abuse and possible addiction. When women disclose stories of domestic violence offer supportive statements such as:

- "It must be hard for you to believe someone who started out so nice could become so hurtful."

Then validate the fact that this woman has survived and praise her sincerely for finding a 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. During their pregnancy 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?"

Another way of approaching the intersection, following her disclosure that a partner uses substances, is to say:

- " 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 useful way to get information without threatening a woman. It also gives one an opportunity to explore drug related domestic violence. Many women disclose their partners put them on the street to trade sex for drugs. Additionally many I/V drug users have never shot up alone; their partners have done it for them.

One way of maintaining power and control is through maintaining or restricting their drug supply.

"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."

A 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.

Important Messages

Both domestic violence and substance abuse pose risks for pregnant and lactating women. According to the Alaska Family Violence Project, a leading reason women wanting to breastfeed may be unable to do so, is because a male partner forbids it (Chamberlain, 1998). It is important to convey the message that both domestic violence and alcohol and other drug use are not safe during pregnancy and lactation. Women benefit from learning substance use and breastfeeding are incompatible. They also benefit from clear information about the impact of domestic violence on birth weight and their baby's ability to thrive. Brief intervention techniques (15 minutes) have been shown to have a significant impact on reduction of alcohol and drug use during pregnancy and lactation (Taylor,1999). Combining information about domestic violence and substance abuse at this intersection can be a useful option for providers.

Additional Patient Education

Additionally, it is helpful to explain that drinking or other drug use does not cause domestic violence. Women must be informed that alcohol

and other drug treatment for batterers, does not ensure safety nor end abuse. Neither does 'anger management,' as anger is usually merely a tactic batterers' use as an excuse to be violent. Anger is an emotion and violence is a behavior.

Couples counseling is contraindicated when domestic violence is present and may actually increase risk for victims of DV. *Certified batterer's intervention programs in conjunction with chemical dependency treatment may prove helpful but do not guarantee a woman's safety. Battered women may respond well to this clarification although there may be disappointment that getting clean or going to a batterer's program can't fix everything.

*(See Washington State Department of Social and Health Services brochure, What You Should Know about Your Abusive Partner, reprinted with permission from EMERGE, Cambridge, MA).

Chemically dependent battered women may also 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.

Women with substance abusing partners should always be given the number of a domestic violence victim service crisis line even if an Al -Anon or Nar-Anon meeting seems like the most appropriate referral. While physical or other forms of violence may not currently be present, women learning to practice detachment may find themselves at increased risk for harm. 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."

The Family Disease - Risks when DV is Present

While chemical dependency is often considered the 'family disease,' 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, health care providers should advise her of both the risks and limitations of such a plan.

Providers should be aware of ethical considerations such as conflict of interest, potential safety risks and liability issues. 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.

Benefits of Universal Integrated Screening

The benefits of universal integrated screening include early intervention and the opportunity to refer women to specialized treatment for addiction or to a community-based domestic violence program for safety planning. Universal screening makes it possible to explore a variety of options. Women facing domestic violence have many options for support and assistance including: the Domestic Violence Hotline, support groups, shelters and community, legal and children's advocacy. Victim services advocates can discuss options such as 911 and protection orders as well as explore in-depth safety planning options with women and their children (See: PPADV Training Manual Appendix for WA State Victim Service Program list).

Women facing substance abuse or addiction issues also have numerous options including: the Alcohol Drug Help Line, self-help support groups, ADATSA assessments, acute and sub-acute detox, opiate dependency, outpatient and intensive outpatient treatment services. Other options may include residential services such as intensive inpatient treatment, recovery houses and long-term treatment (See PPADV Training Manual Appendix for Definitions of Treatment Service Categories per WAC 440-22-010).

NOTE: The *Directory of Certified Chemical Dependency Treatment Services in Washington State* is published annually. To order, call the Washington State Alcohol/Drug Clearinghouse: 1-800-662-9111 toll free (from within Washington State) or 206-725-9696 (from Seattle or out of state) or FAX 206-722-1032. The Washington State Coalition Against Domestic Violence has compiled and produced the *Washington State Domestic Violence Victim Services Directory* which can be ordered by calling 360-407-0756, Voice; 360-407-0760, TTY or 360-407-0761 FAX.

Universal integrated screening also provides women an opportunity to learn about the risks of alcohol, illicit drugs, tobacco and other substances. Exploring O'Neil's Power and Control Model for Women's Substance Abuse or the Duluth Power and Control Wheel with a woman (see PPADV Train the Trainer Manual Appendix) can be very helpful, in addition to using standard tools such as the CAGE, MAST or DAST to determine addiction potential. Ability to support safety and sobriety efforts is enhanced when providers recognize skills to screen, intervene and refer for both addiction and domestic violence often overlap. Washington State has a number of programs able to provide specialized services to women and children impacted by both substance abuse and domestic violence. Two such efforts are the collaboration between East Side Domestic Violence Program and East Side Recovery Center and New Beginnings for Battered Women and their Children and the Alcohol Drug Help Line Domestic Violence Outreach Project in Seattle.

Screening Tools for Substance Abuse and Addiction

The CAGE is a tool, which, according to NIDA (1990) can be self-administered or given by a clinician. The CAGE asks respondents the

following yes/no questions about their drinking and can be administered in 5 to 10 minutes or less:

C attempts to Cut down on drinking?
A Annoyance with criticism about drinking?
G Guilt about drinking?
E using alcohol as an Eye-opener

Affirmative answers to two or more of these questions is generally considered a positive screen for alcohol abuse (Ewing, 1984). Following a positive screen share your health care concerns with the patient and explain the health risks for both the mother and baby. Validate your belief she wants her baby as healthy as possible and that she can improve her own health and that of her child by stopping use of alcohol and drugs. Be supportive and stress your willingness to support her efforts. Be positive. Praise any efforts she has made to cut down.

Discuss strategies to support behavior change such as 12 Step Programs, Chemical Dependency/Domestic Violence groups, and treatment options. If possible, suggest a referral for a more in-depth chemical dependency assessment and make the appointment together before she leaves. Get a release of information and maintain communication with the chemical dependency treatment provider to support her progress. Be sure to make a follow-up appointment.

The MAST (Michigan Alcoholism Screening Test) also can be self or professionally administered, and it measures the consequences of alcohol on a person's life (Selzer, Vinokur & van Rooijen, 1975). The T-ACE, TWEAK and 10 Question Drinking History (TQDH) are also brief, useful tools. (See PPADV Train the Trainer Manual Appendix). Other instruments (e.g.,

Drug Abuse Screening Test (DAST) and Drug Abuse Index (DUI) are similar tools for assessing use and consequences of drugs other than alcohol.

Additionally, asking about the 4 **P**'s can provide useful information:

Present use of drugs, alcohol, cigarettes
Past problem
Partner with a problem
Parent alcoholic or addict

The 4 P's was designed by the Born Free Project in California for use in prenatal settings. The Washington State MOM's Project Perinatal Research and Demonstration Project found women who failed to enter treatment were significantly more likely to identify their friends as substance abusers, significantly less likely to have been treated with psychotropic medications and significantly more likely to deliver a pre-term infant (Lanz, 1999). In light of their findings perhaps another 3 **P**'s perhaps should be added to the screen:

People you hang out with
Psychotropic medication not in use
Preterm labor in past.

The Born Free screen is a first-level intervention designed to separate out patients in need of further assessment, education and possibly monitoring or referral (Ewing, 1990, Hamilton 1993). Any positive answer generates a positive screen. When the screen is positive a full interview can be arranged as part of comprehensive prenatal care.

When a substance abuse screen is positive a woman needs more comprehensive assessment which may include lab testing to identify substances and patterns of use. Monitor pregnancy and fetal development

and advise her of both treatment options and any legal ramifications (Taylor, 1999).

(NOTE: See Taylor, P. (Ed.) (1999). Guidelines for Screening for Substance Abuse During Pregnancy. Washington Department of Health. Publication No. 950-135. This manual can be ordered by calling 360-236-3505 or by contacting the Washington State Alcohol Drug Clearinghouse 206-725-9696).

If your screen is negative review the benefits of abstinence from substances. Continue to screen throughout pregnancy at least once each trimester and postpartum. It is also very helpful to be alert. Notice if the patient has:

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.

Other cues which, if not directly indicative of addiction, at least indicate substance misuse may be occurring include:

1.) Rapid speech
2.) Difficulty tracking
3.) Scratching and picking at arms or face during a visit
4.) Lethargy
5.) Nodding
6.) Cigarette burns (which may also be indicative of domestic violence).
7.) Prescription drug seeking behavior.

Generally speaking, it is useful to note these observations and directly mention them to the patient. 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 this pregnancy. 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 patient to bring her into the discussion, positively recognizing 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 during pregnancy.

"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."

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.

"I needed more than a 12 step program."

Working a program where battered women put their own needs first may not go over well with their abusive partners whether that program is a 12 step program for addiction, traditional treatment or a program for the

partners of alcoholics/addicts. Women are often asked to work a 'selfish' program by participants in traditional treatment or other self-help groups. Adhering to this philosophy may yield increased attempts by their abusive partners to regain control, sabotage their recovery plans or pull them out of treatment against medical advice.

Safety Planning and Relapse Prevention

Both safety planning and relapse prevention are key issues for chemically dependent battered women. Support groups recognizing women's needs to maintain both safety and sobriety rather than prioritizing one at the expense of the other are most effective.
"I get a lot of support on both issues this time around."

Integrated strategies drawing from both fields are most useful. Part of safety planning involves helping women determine safer coping mechanisms than drug and alcohol use. Clear nonjudgmental information connecting the impact of substance use on one's ability to make safe decisions is very useful. Group leaders can explain blackout, euphoric recall and the resultant difficulty to assess danger. Discussion about barriers facing substance abusing battered women can help begin the process of contemplation and also prove practical. Many service providers respond negatively to substance abusing battered women. Some providers may deny access to help for people under the influence or ask them to leave if a relapse occurs.

Refer women to your local domestic violence victim service program where they can begin important work such as role playing a safety plan that may include but is not limited to:

1.) Identifying who to call for help
2.) Having a code word children will recognize to let them know it's time to call 911
3.) Removing weapons from their usual spot in the home
4.) Understanding how to get a protection order and a host of other safety options (all of which are easier to effectively carry out when one is sober)
5.) Knowing how to contact local domestic violence advocates
6.) Assembling important papers and records which may include but are not limited to: Social security numbers for both a woman and her children, lease, house title, health insurance, immunization records
7.) For Immigrant or Refugee women: assembling: marriage certificate, residency permit, green card, passport and children's passports (can be difficult because batterer often has papers locked away)
8.) For Native women: making sure to bring the Tribal Enrollment Card
9.) Knowing how substance use may impact safety
10.) Knowing when and where to run in a life threatening situation as the only thing you may be able to save in a hurry is your own life and that of your child.

(See PPADV Train the Trainer Manual Appendix - Safety Immigrant/Refugee Safety Plan and Immigrant/Refugee Power and Control Wheel from Team 3 Manual).

Refer women also to your local chemical dependency treatment program, self help groups and other support systems designed to help substance-abusing women reduce harm as they strive to get and stay sober. Often safety plans and relapse prevention plans can look remarkably similar. Women attempting to get sober may develop a plan that may include but is not limited to:

1.) Identifying who to call for help (e.g. sponsor, counselor, Alcohol Drug Help Line); forming support systems, knowing about safe meetings
2.) Knowing information and education about addiction
3.) Removing substances and paraphernalia from the home
4.) Recognizing unsafe persons, places, things
5.) Understanding how to deal with legal and other problems stemming from addiction (e.g. health, CPS 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 can be a relapse issue
8.) 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
9.) Learning how to parent, engaging in relationships, developing sober friendships
10.) Knowing when and where to run in a life-threatening situation that puts your sobriety and your safety, at risk.

Support Groups Addressing Safety and Sobriety

When possible, encourage chemically dependent battered women to consider attending a support group addressing issues pertaining to both domestic violence and chemical dependency.

" 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 need to say. The meetings I go to deal with both."

Integrated support groups offer women a format to heal utilizing techniques that are applicable for reaching both goals of safety and sobriety.

"Where it was safe to talk about both the chemical dependency issues and the domestic violence."

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

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.

"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."

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).

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. No matter when a woman begins to seek safety and sobriety during pregnancy, current data indicates both she and her child can benefit. Screen women for safety and sobriety each trimester and postpartum. Be a bridge to safety and sobriety.

"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."

"I have a lot of women friends and I never had women friends. Never."

"I'm a pretty intelligent person, and I never realized that. I never realized how intelligent I was."

"I wouldn't trade where I am right now."

"I am my own advocate, I realized."

"You can get out of an abusive relationship. You can recover. You're not alone.

"Knowledge is power...Knowledge is power."

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References

American Medical Association (1994). *Diagnostic and Treatment Guidelines on Domestic Violence*, American Medical Association, Chicago: IL.

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

Bennett, L. (1995). "Substance Abuse and the Domestic Assault of Women," *Social Work*, 40, 760-772.

Bland, PJ. (1994). "Domestic Violence and Addiction in Women's Lives," *Journey*, pp. 3-4.

Bland, PJ. for Washington State Coalition Against Domestic Violence (2000). *Perinatal Partnership Against Domestic Violence: Train the Trainer Curriculum.* Washington State Department of Health, Community & Family Health, Maternal Child Health and Statewide Perinatal Advisory Committee, Seattle; WA.

Bland, PJ. (1977). "Strategies for Improving Women's Safety and Sobriety," *National Abandoned Infants Resource Center, The Source*, Vol. 7, No. 1, Winter.

Brookhoff, D; O'Brien, KK; Cook, CS; Thompson, TD. (1997). "Characteristics of Participants in Domestic Violence: Assessment at the Scene of Assault," *JAMA*, 227:1369-1373.

Campbell, JC. (1992). *Addressing Battering During Pregnancy: Reducing Low Birth Weight and Ongoing Abuse*, WB Saunders Company.

Campbell, JC. "The Danger Assessment Instrument: Risk Factors of Homicide of and by Battered Women," pp. 27-38, in *Assessing Dangerousness, Potential for Further Violence of Sexual Offenders, Batterers, and Child Abusers.* Sage Publications. Newbury Park: CA.

Campbell, JC. (1986). "Nursing Assessment for Risk of Homicide with Battered Women," *Advances in Nursing Science*, pp. 36-50.

Campbell, JC., Humphreys, J. (1993). *Nursing Care of Survivors of Family Violence*, Mosby.

Campbell, JC., Parker B. (1992). "Battered Women and their Children." *Annual Review of Nursing Research*, 10: 77-94.

Campbell, JC., Pliska, MJ., Taylor, W., Sheridan, D. (1994). "Battered Women's Experience in the Emergency Department, " *Journal of Emergency Nursing.*

Campbell, JC., Torres, S., Ryan, J., King, C., et al (1999). "Physical and Nonphysical Partner Abuse and Other Risk Factors for Low Birth Weight Among Full Term and Preterm Babies: A Multiethnic Case-Control Study," *American Journal of Epidemiology.*

Cawthon, L. DSHS, RDA, (1997).

"Center for Science in the Public Interest," (1998). *The Booze News*, Volume 7 No.1, August.

Centers for Disease Control and Prevention, (2001). *Women and Smoking; A Report of the Surgeon* General, World Wide Web Document http://www.cdc.gov/tobacco/sgr/sgr_forwomen/ataglance.htm

Chez, N. (1994). "Helping the Victim of Domestic Violence," *American Journal of Nursing*, 7: 33-37.

Chez, RA.; Jones, RF. (1995). "The Battered Woman," *American Journal of Obstetrics and Gynecology.*

Cokinides, VE., Coker, AL., et al (1999). *Physical Violence During Pregnancy: Maternal Complications and Birth Outcomes.*

Covington, DL., Dalton, VK., et al (1997). "Improving Detection of Violence Among Pregnant Adolescents," *Journal of Adolescent Health.*

Curry, MA, RN, (1998). 'The Interrelationships Between Abuse, Substance Use, and Psychosocial Stress During Pregnancy," *JOGNN Clinical Issues*, May.

Division of Alcohol and Substance Abuse (DASA) State of Washington (2000). *Directory of Certified Chemical Dependency Treatment Services in Washington State,* Olympia: WA.

Division of Alcohol and Substance Abuse (DASA) State of Washington (2001). *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State 2001 Report,* Olympia, WA.

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.

Drug Strategies (1998). Keep*ing Score, Women and Drugs: Looking at the Federal Budget,* Washington: DC.

Dutton, D. G. (1992). " Theoretical and Empirical Perspectives on the Etiology and Prevention of Wife Assault,"in R. D. Peters, R. J. McMahon & V. L. Quinsey (Eds.). *Aggression and Violence throughout the Lifespan*, pp. 192-221, Sage Publications, Newbury Park: CA.

Edmund, D., (2000) *Women Talk About Substance Abuse and Violence.* Rose Hill Press, Springfield: IL.

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

Fazzone, P., Holton, J. & Reed, B, (co-chairs) (1997). *Substance Abuse Treatment and Domestic Violence, Treatment Improvement Protocol (TIP) Series 25,* U.S. Department of Health and Human Services, SAMHSA/ CSAT.

Fernandez, FM., Krueger, PM., (1999) "Domestic Violence: Effect on Pregnancy Outcome," *JAOA*.

Flitcraft, A. (1993). "Physicians and Domestic Violence: Challenges for Prevention," *Health Affairs*, 12:154-161.

Flitcraft, AH., Hadley, SM., et al (1992). "American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence," *Archives of Family Medicine*, 1:39-47.

Gazmararian, JA., Lazorick, S., et al (1996). "Prevalence of Violence Against Pregnant Women," *JAMA*.

Gazmararian, JA., Adams, MM., et al (1995). *The Relationship Between Pregnancy Intendedness and Physical Violence in Mothers of Newborns.*

Gondolf, EW. (1993). "Treating the Batterer," in M Hansen, M Harway, eds. *Battering and Family Therapy: A Feminist Perspective.* Newbury Park, CA: SAGE Publications.

Gondolf, EW. *Wife Assault Among Virginia Alcohol Rehabilitation Patients.* Hospital & Community Psychiatry, 1991, 42: 74-79.

Hamilton, A. (1993). "Screening and Assessment, " in *Pregnancy and Exposure to Alcohol and Other Drug Use,* pp. 69-87, US Department of Health and Human Services Public Health Services, SAMHSA/ CSAT, Rockville: MD.

Hobart, M. for the Washington State Coalition Against Domestic Violence (2000). *Honoring their Lives, Learning from their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review Project,* (206) 389-2515, Seattle: WA.

Horan, DL., Chapin, J., et al (1998). *Domestic Violence Screening Practices of Obstetrician-Gynecologists.*

Johnson, M., Elliott, BA. (1997)."Domestic Violence Among Family Practice Patients in Midsized and Rural Communities," *The Journal of Family Practice.*

Johnson, V. (1980). *I'll Quit Tomorrow*, revised, New York: Harper & Row, Publishers, Inc.

Koss, MP., Heslet, L. (1992). "Somatic Consequences of Violence Against Women," *Archives of Family Medicine*, 1:53-59.

Kinney, J., Leaton, G. (1991). "Loosening the Grip," *Mosby Year Book.* St. Louis: MO.

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

Lieberman, LD. (1998). "Evaluating the Success of Substance Abuse Prevention and Treatment Programs for Pregnant and Postpartum Women and Their Infants," *Women's Health Issues*, Vol. 8, No. 4 July/August.

Lieberman, LD. (1998). "Overview of Substance Abuse Prevention and Treatment Approaches in Urban, Multicultural Settings: The Center for Substance Abuse Prevention Programs for Pregnant and Postpartum Women and Their Infants," *Women's Health Issues*, Vol. 3, No 4, July/August.

Lindquist, T., ed., (1995). *She's Got All Kinds of Troubles,* Washington State Coalition on Women's Substance Abuse Issues, Funded by DSHS contracted through Tacoma Community College, Tacoma: WA.

Love Shouldn't Hurt Campaign, (1994). *Domestic Violence Public Education Plan: Revised.* Seattle: WA.

Mackey, R. (1992). "Facts on Alcohol, Drugs and Domestic Violence" *Rutgers University Resource Center and Clearinghouse Center of Alcohol Studies.*

Mayer, L., Liebschutz J. (1998). "Domestic Violence in the Pregnant Patient: Obstetric and Behavioral Interventions," *Obstetrical and Gynecological Survey*, Vol. 53, No. 10.

McFarlane, J. (1998). "Safety Behaviors of Abused Women After an Intervention During Pregnancy," *JOGNN Clinical Studies*, Lippincott-Raven Publishers.

McFarlane, J. et al (1999). "Severity of Abuse Before and During Pregnancy for African American, Hispanic, and Anglo Women," *Journal of Nurse-Midwifery, American College of Nurse-Midwives*, Vol. 44, No. 2, Mar/Apr.

McFarlane, J., Gondolf, E. (1998). "Preventing Abuse During Pregnancy: A Clinical Protocol," *MCN*, Vol. 23, Jan/Feb.

McFarlane, J., Parker, B. *Abuse During Pregnancy: A Protocol for Prevention and Intervention*. White Plains, NY: March of Dimes Foundation.

McFarlane, J., Parker, B., Soeken, K., Bullock, L. (1992). "Assessing for Abuse During Pregnancy: Severity and Frequency of Injuries and Associated Entry into Prenatal Care," [*Journal of the American Medical Association,* 267 :3176-3178.

McFarlane, J., Soeken, K. (1999). "Weight Change of Infants, Age Birth to 12 Months, Born to Abused Women," *Pediatric Nursing*, Vol. 25, No. 1, Jan/Feb.

Minnesota Coalition of Battered Women (1992). *Safety first: Battered Women Surviving Violence when Alcohol and Drugs are Involved*, St. Paul: MN.

Morse, B., Gehshan, S., Hutchins, E. (1997). "Screening for Substance Abuse During Pregnancy," *Improving Care, Improving Health,* National Center for Education in Maternal and Child Health, Arlington: VA.

Newberger, EH., Barkan, SE., Lieberman, ES; McCormick, MC; Yllo, K; et al (1992). "Abuse of Pregnant Women and Adverse Birth Outcome," *Journal of American Medical Association*, 267: 2370-2372.

NiCarthy, G., Merriam, K., Coffman, S. (1984).*Talking it Out: A Guide to Groups for Abused Women*. Seal Press, Seattle: WA.

NIDA (1996). "Screening for Alcoholism." *Alcohol Alert*, p. 1-3.

NIDA and Washington State Department of Social and Health Services Division of Alcohol and Substance Abuse (1999). *Washington State Moms Project Perinatal Research and Demonstration Project – The Mom's Project Final Report.*

Norton, LB; Peipert, JF; Zierler, S; Lima, L; Hume, L. (1995). " *Battering in Pregnancy: An Assessment of Two Screening Methods*," *Obstetrics & Gynecology*, Vol. 85, no. 3, March.

O'Neil, M. T. (1996). *A Power and Control Model for Women's Substance Abuse* . Adapted with permission from: Domestic Abuse Intervention Project, Duluth, MN.

Parker, B., McFarlane, J., Soeken, K., Torres, S., Campbell, D. (1993). "Physical and Emotional Abuse in Pregnancy: A Comparison of Adult and Teenage Women," *Nursing Research*, 42: 173-177.

Parker, B. *Abuse of Adolescents: What Can We Learn from Pregnant Teenagers?* University of Maryland, School of Nursing, Baltimore: MD.

Parker, B., McFarlane, J., Soeken, K., Silva, C., Reel, S. (1992). "Testing an Intervention to Prevent Further Abuse to Pregnant Women," Researching in Nursing & Health, 22, 59-66.

Parker, B., McFarlane, J., Soeken, K. (1994). "Abuse During Pregnancy: Effects on Maternal Complications and Birth Weight in Adult and Teenage Women," *Obstetrics & Gynecology*, Vol. 84, No. 3, September.

Renker, P.R. (1999). "Physical Abuse, Social Support, Self-Care, and Pregnancy Outcomes of Older Adolescents," *JOGNN Clinical Studies*, 28, 377-388.

Robrecht, L. (1998). "Interpersonal Violence and the Pregnant Homeless Woman," *JOGNN Clinical Issues*, 27, 684-691.

Rosensweig, M. (1993). "Reflections on the Center for Substance Abuse Prevention's Pregnant and Postpartum Women and their Infants Program," *Women's Health Issues*, Vol. 3, No. 4.

Salber, P.R., Taliaferro, E. (1995). *The Physician's Guide to Domestic Violence: How to Ask the Right Questions and Recognize Abuse . . . Another Way to Save a Life.* Volcano Press, Volcano: CA.

Saunders, DG., Hamberger, LK., Hovey, M. (1993). "Indicators of Woman Abuse Based on a Chart Review at a Family Practice Center." *Archives of Family Medicine*, 2: 537-543.

Schei B. (1991). *"Physically Abusive Spouse—A Risk Factor of Pelvic Inflammatory Disease?," Scandinavia Journal of Primary Health Care*, 9: 41-45.

Schornstein, SL. (1997). *Domestic Violence and Health Care: What Every Professional Needs to Know.* Thousand: Sage Publications, Oaks: CA.

Scott, CJ., Matricciani, RN. (1994). " Joint Commission on Accreditation of Healthcare Organizations' Standards to Improve Care for Victims of Abuse.," *Maryland Medical Journal*, 43: 891-898.

Selzer, M. L., Vinokur, A. & van Rooijen, L. (1975). "A self-administered short Michigan Alcoholism Screening Test (SMAST)," *Journal of Studies on Alcohol*, 36: 117-126.

Sheridan, D. (1996). "Forensic Documentation of Battered Pregnant Women," *Journal of Midwifery*, Vol. 41, No. 6.

Sherman, B., Sanders, L., Yearde, J. (1993). "Role-Modeling Healthy Behavior: Peer Counseling for Pregnant and Postpartum Women in Recovery," *Women's Health Issues*, Vol. 3 No. 4.

Shumway, J., O'Campo, P., Gielen, A., Witter, F., Khouzami, A., Blakemore, K. (1999). "Preterm Labor, Placental Abruption, and Premature Rupture of Membranes in Relation to Maternal Violence or Verbal Abuse," *Journal of Maternal-Fetal Medicine*, 8, 76-80.

Stark, E; Flitcraft, A. (1996). *Women at Risk*, Sage Publications, Thousand Oaks: CA.

Stark, E. (1992). "Focus: Managing Care For Victims of Violence: Discharge Planning With Battered Women," *Discharge Planning Update*, 14:1-7.

Sugg, N., Inui, T. *(1992).* "Primary Care Physician's Response to Domestic Violence: Opening Pandora's Box," *Journal of the American Medical Association*, 267:65-68.

Taylor, P., (ed.) (1999). *Guidelines for Screening for Substance Abuse During Pregnancy.* Washington State Department of Health. Publication No. 950-135.

Taylor, WK., Campbell, JC. (1981). "Treatment Protocols for Battered Women," *Response*, 14: 16-21

Thompson, M., Kingree, JB (1998). "The Frequency and Impact of Violent Trauma Among Pregnant Substance Abusers," *Addictive Behaviors*, 23, 257-262.

Toquinto, S. (2001). *Personal Communication.* Washington State Coalition Women's Substance Abuse Issues.

Warshaw, C; Ganley, A. (1995). *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers.* The Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence.

Lindquist, T. for the Washington State Coalition Against Domestic Violence (1998) *Basic Educational Resource to Help Advocates: Revised,* (206) 389-2515, Seattle: WA.

Washington State Coalition Against Domestic Violence (1999-2000) *Washington State Domestic Violence Victim Services Directory.* (206) 389-2515, Seattle: WA.

Washington State Department of Social and Health Services, (1999). *What You Should Know about Your Abusive Partner* (brochure: reprinted with permission from EMERGE, Cambridge, MA). DSHS 22-309(x) (Rev. 8/99).

Wiist, W., McFarlane, J. (1998). "Severity of Spousal and Intimate Partner Abuse to pregnant Hispanic Women," *Journal of Health Care for the Poor and Underserved,* Vol. 9, No. 3.

Wiist, William; McFarlane, J. (1999). "The Effectiveness of an Abuse Assessment Protocol in Public Health Prenatal Clinics," *American Journal of Public Health*, 1217-1221.

Wildin, SR., Williamson, WD., Wilson, GS. (1991). "Children of Battered Women: Developmental and learning Profiles," *Clinical Pediatrics,* 3: 299-304.

Williams, Campbell D. (1993). "Nursing Care of African American Battered Women: Afrocentric perspectives," *Association of Women's Health Obstetric and Neonatal Nurses Clinical Issues,* 4: 407-415.

Zorza, J. (1996). "Most Therapists Need Training in Domestic Violence," *Domestic Violence Report*, Vol. 1, No. 6.

Overview: Chemically Dependent Victims of Domestic Violence

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.
- 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 effect 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 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 are introduced to drugs by partners who use substances to gain and maintain power and control. This is a form of physical, emotional, social 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 encourage relapse by seeking to sabotage recovery efforts or looking for new ways to regain control. Refer people to support groups addressing both CD and DV issues.
- Treatment for substance abuse can pose many risks for victims of domestic violence. **Conjoints, and couples counseling are not appropriate and should not be encouraged by providers**. Domestic violence 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 a batterer.
- Validate that anyone might use drinking or drugging to cope but there are safer ways to survive. Offer options but recognize 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.

- Realize, chemically affected victims of violence often believe their use of a substance means the violence directed against them is warranted. Always affirm 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 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 addictophobia 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. (WA only) or 206-722-3703.**

DEFINITIONS

Substance abuse - a destructive pattern of drug use including ETOH 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.

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). (Above definitions developed by APA & ASAM adapted by DV/SA Task Force of IL DHS, 7/2000) The neurochemical

dysfunction in addiction is best described as a chemical deficiency in pathways of the brain.

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).

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

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

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).

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 – A clinical term referring specifically to patients who meet the diagnostic criteria for an addictive 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.

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.

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.

Addictophobia – includes fear of addicts and addiction, holding negative stereotypes pertaining to people suffering from addiction; refraining from offering services, support or respect. Addictophobia creates barriers for those who are afraid of getting labeled and fearful about seeking help. Additionally, addictophobia negatively impacts people struggling to recover daily. Examples of addictophobia 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. Addictophobia 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. Addictophobia is a form of oppression in our society. (Bland, 6/2001).

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).

DEFINITIONS OF TREATMENT SERVICE CATEGORIES

The following are definitions of certified treatment services authorized by Washington Administrative Code (WAC) 388-805:

INFORMATION AND ASSISTANCE SERVICES

ALCOHOL & DRUG INFORMATION SCHOOL

An education program about the use and abuse of alcohol and other drugs, for persons referred by the courts and others, who do not present a significant chemical dependency problem, to help those persons make informed decisions about the use of alcohol and other drugs.

INFORMATION & CRISIS SERVICES

Response to persons having chemical dependency related needs, by telephone or in person.

EMERGENCY SERVICE PATROL

Assistance provided to intoxicated persons in the streets and other public places.

TASC

TASC means Treatment Alternatives to Street Crime. TASC is a referral and case management service. TASC providers furnish a link between the criminal justice system and the treatment system. TASC identifies, assesses and refers appropriate alcohol and other drug dependent offenders to community-based substance abuse treatment and monitors the outcome for the criminal justice system.

ASSESSMENT SERVICES

ADATSA ASSESSMENTS

Alcohol and other drug assessments of clients seeking financial assistance from the department due to the incapacity of chemical dependency. Services include assessment, referral, case monitoring, and assistance with employment.

DUI ASSESSMENTS

Diagnostic services requested by the courts to determine a client's involvement with alcohol and other drugs and to recommend a course of action.

DETOXIFICATION SERVICES

(Assists patients in withdrawing from drugs, including alcohol)

ACUTE DETOX

Provides medical care and physician supervision for withdrawal from alcohol or other drugs.

SUB-ACUTE DETOX

Non-medical detoxification or patient self-administration of withdrawal medications ordered by a physician and provided in a home-like environment.

OUTPATIENT TREATMENT SERVICES

(Provides chemical dependency treatment to patients less that 24 hours a day)

INTENSIVE OUTPATIENT

A concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families.

OUTPATIENT

Individual and group treatment services of varying duration and intensity according to a prescribed plan.

OUTPATIENT CHILDCARE

A certified outpatient chemical dependency treatment provider may offer on-site child care services approved by the department, offering each child a planned program of activities, a variety of easily accessible, culturally and developmentally appropriate learning and play materials, and promoting a nurturing, respectful, supportive and responsive environment.

OPIATE DEPENDENCY

Meets both outpatient and opiate dependency treatment service requirements.

RESIDENTIAL SERVICES

INTENSIVE INPATIENT

A concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families.

RECOVERY HOUSE

A program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities.

LONG-TERM

A program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health.

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from: Division of Alcohol and Substance Abuse (DASA) State of Washington (2001). *Directory of Certified Chemical Dependency Treatment Services in Washington State.* Olympia:WA.

Alcohol and Other Drug Use Guidelines

Historical Background: New Beginnings for Battered Women and their Children began as a shelter program. Prior to 1990 support groups and 1-1 counseling services for battered women impacted by their own or another's substance abuse were not available on site at our shelter. Following shelter stays cards were made for former residents who were perceived as problem people indicating either DNA (do not admit) or Screen Carefully. Approximately 40-45% of women listed as DNA or Screen Carefully received that designation due to alcohol or other drug use. Today our shelter has access to CD services through staff trained in both Chemical Dependency and Domestic Violence Issues as well as improved access to shelter services for chemically dependent battered women and their children. Additionally we have a Community Advocacy Program which includes support groups for chemically dependent battered women and child care for their children. Many women seek our services who are addressing multi-abuse issues and though our primary role is to provide safety and empowerment we have come to recognize that battered women addicted to alcohol and/or other drugs or who are vulnerable through substance misuse, face many barriers. We seek to reduce barriers for women by offering basic guidelines to support recovering battered women's efforts to achieve both safety and sobriety as well as to provide options for women whose goals may be different. Today we have a Transitional Housing Program and an opportunity to provide long term services for women who face many serious barriers. Guidelines listed below are suggestions not permanent directions. We must always keep in mind that each individual woman (and family) has a unique set of circumstances, experiences, strengths, hopes, and dreams that will assist us in supporting her on her terms.

Suggestions for Screening Applicants

We recommend potential THP residents have two months of sobriety at the time of application. (Note: women who have a long term history of recovery marked by a relapse following a battering episode can still apply although we will recommend participation in relapse prevention activities on a case by case basis). In addition, the following guidelines are also offered as basic suggestions to help ensure both safety and sobriety:

1. We recommend women w/2-6 months of recovery attend 2-4 recovery support groups or meetings per week during their stay at the transitional program.

2. Women with six months to one year of sobriety are recommended to attend 2 recovery support groups or meetings per week during their stay at the transitional program.

3. Women with more than one year of recovery are encouraged to attend one recovery support group or meeting per week throughout their stay at the

transitional program.

NOTE: These recommendations can be changed or waived at the discretion of the advocate in consultation with the Program Manager. These serve as guidelines rather than rules and are particularly useful for women seeking consistency and support to maintain both safety and sobriety. Recovering battered women entering our Transitional Program with less than two months sobriety will benefit from increased staff support and understanding during this stressful period. Recovering battered women should be advised of The CAP office cd/dv support group and also informed of their ability to access support from the Alcohol Drug Help Lines's Outreach Program for chemically dependent battered women.

Suggestions for Supporting Residents when Concerned about Substance Misuse

The most important task before us is to be respectful and view our concerns as an opportunity to both support and inform our residents of safer ways to cope, deal with stress and meet their own personal goals for themselves and their children. Once staff is concerned about a resident's substance misuse we recommend staff address these concerns with the resident as soon as safely possible. Advocacy based counseling is about empowerment and choice. As advocates for battered women we recognize that battered women are adults and capable of making informed decisions. We therefore owe the women we work with both respect and honesty. Alcohol and other drug misuse can impair judgment and be a safety risk impacting residents, their children and our staff. Substance misuse can hamper traditional notions of advocacy based counseling however an appropriate response is always both honest, respectful and one that offers options, choices and support in a non-judgmental manner.

Generally speaking, it is useful to discuss observations about the resident's behavior, including specific concerns, i.e. strong odor of alcohol on breath, directly with the client in a non-threatening manner.

Example: Lois, you have seemed very stressed lately. I am concerned about you. You and I both know stress can be very difficult. You have been doing a fine job here and I want you to know the staff at New Beginnings are here to support you. I am really concerned because you and I both know your drinking has increased. I am worried about you because although you have found a way to deal with stress it does not seem to be helping and in fact is stressing you more. What can I do to help you find a safer way to cope? What are things that have worked for you in the past? How comfortable are you considering_______________? You are in the driver's seat here, Lois, and you have the right to make choices. Choosing to take steps now can make it easier for you to______________________(mention known goals of the resident) as well as to maintain stable housing. I want you to succeed and I care about you. It's normal to feel like drinking but for now it's not safe. You have a number of options open to you including: (1)________________,(2)_____________________, and (3)________________. (Always include current behavior as one of the options). We

are here to support you. What can I do to help you get the support you need?
Choosing______________________is a choice for both safety and sobriety.
Choosing_________________________is a more risky choice and could have the probable outcome of putting your housing in jeopardy. Still, it is up to you and I will support whichever decision you make.(Refer to any non-use agreement, contract or policy, resident has agreed to in the past. If needed and agreed on, make any changes client chooses, i.e. extra meetings, assessment, CAP group, Alcohol Drug Help Line, treatment, etc. Set the stage for the resident's success by respecting both her and the choices she makes). Always end sessions on a positive note and remind resident about her accomplishments to date and your belief in her worth as a human being.

We recognize that many of our staff feel overwhelmed when asked to address a resident's drinking and/or other drug misuse. This feeling is normal and can be caused by any number of factors including: fear, worry about labeling a resident, concern that "maybe I'm mistaken," anxiety about being confrontive, and other issues stemming from addict phobia and societal oppression. Advocates sometimes feel hurt , angry or frustrated when a resident lies to cover up her substance misuse. It is important to realize that women dealing with alcoholism and addiction have a history of perceiving their substance use as a solution rather than a problem. When this solution becomes a problem it is terrifying and frightening.

Attempts to cover up this fear to maintain the fiction that "Every thing is all right," lead to very strong denial and should be viewed with compassion. Recognize that euphoric recall and blackout impair judgment and make safety planning harder. Denial of use is not about fooling the advocate. It is only a tactic to avoid pain. We must remember that if we are overwhelmed addressing this issue, our residents are feeling even greater discomfort. Our residents may be in crisis but it is important to remember we are not in crisis.

We recommend staff consult with New Beginnings Chemical Dependency Specialist at CAP as soon as concerns about a resident's substance misuse arise. Other CD/DVcross-trained staff based at Shelter or Admin are available to discuss empowering strategies and creative options as well as to offer encouragement when needed.

Additionally the Alcohol Drug Help Line Domestic Violence Outreach Project can be reached at 1-800-562-1240 (WA only) or 206-722-3700. The ADHL-DVOP are available for consultation, education, advocacy and support as well as for information and referral. Addressing substance misuse and addiction does not need to be overwhelming. Get into the habit of regular consultation as soon as a resident's problem with substances is indicated. Also, make sure these issues are staffed at your regularly scheduled team meetings so that other staff are aware and able to support the resident in a very consistent manner. Consistent support by staff is an opportunity to model appropriate behavior and helps prevent miscommunication and triangulation. Honesty, respect, options and accountability are essential elements leading to safety, sobriety and empowerment.
Draft submitted by P. Bland for the Chemical Dependency Committee 12/97

Alcohol and Other Drugs Policy

We believe safety is an essential element frequently lacking in the lives of women and children who have been impacted by domestic violence. We believe women and children have the right to feel safe in their homes and at work. We recognize that while one cannot always ensure safety we are obliged to provide as safe an environment as possible for our residents and staff who live or work at our programs. We also recognize that alcohol and other drug misuse impairs judgment and negatively impacts safety both for those who consume substances and those around them.

We believe in reducing barriers to services for battered women and their children and we believe in providing an environment that is safe for all. We recognize many women living or working at our program do **not** suffer from chemical dependency but acknowledge the special needs recovering women living and working at our program share: **primarily a need for a clean and sober environment in order to feel safe**. For those whose lives are not threatened by a chronic progressive illness marked by relapse, alcohol or other drug use is merely an option. For women who are not chemically dependent, not having access to substances may merely be an inconvenience rather than a major barrier to safe services.

We believe chemically dependent battered women experience barriers to services and are often denied shelter, housing, employment, child custody, health insurance and other services that may put their lives at risk. We believe chemically dependent battered women attempt to survive societal oppression and stigma that is often expressed in racist, sexist and homophobic terms. We believe failure to provide safe services for chemically dependent battered women is a form of able-bodyism and oppressive. New Beginnings welcomes women seeking safety as well as sobriety and is committed to reducing service barriers for chemically dependent battered women and their children.

Because we believe sobriety is a safety issue for many of our residents and staff we ask residents to refrain from alcohol and other substance use during their stay at New Beginnings. (Note: Staff are also asked to adhere to Drug Free Work Place Policy, per personnel manual).

Residents are asked to support safety for recovering women who live and work on these program premises by choosing to sign a non-alcohol or other drug use agreement and adhering to this agreement during their stay at our program.

We welcome residents with a history of alcohol and/or other drug misuse or chemical dependency and seek to support both safety and sobriety for these residents during their stay. Residents with recovery issues are asked to support their own and other's safety by agreeing to sign a support agreement indicating steps they choose to take, to make both safety and sobriety workable, accountable, goals during their stay, (i.e. attending support groups, evaluations, counseling etc.). Support agreements are also signed by staff who agree to support residents efforts in a respectful and non-judgmental manner.

Residents finding sobriety difficult are encouraged to seek support from their advocate. Behaviors indicating difficulty maintaining sobriety, will be addressed promptly and respectfully by staff. Inability to remain sober is a safety risk for residents and staff and this choice may lead to choosing to live elsewhere. We encourage residents to advise us when stresses build up. Options may include adding 1-1 counseling, increasing support group attendance, assessment, outpatient treatment or other referrals. New Beginnings currently has a Chemical Dependency Specialist on staff available for support group etc.

We believe our policy protects the rights of women and children whose safety depends on a clean and sober environment. Chemically dependent battered women have traditionally been invisible or ignored at best; rejected or reviled at worst. We seek to provide safety for all battered women seeking our services including chemically dependent battered women seeking safety and sobriety. Your commitment to a clean and sober environment during your stay reduces barriers to safety for residents and staff at our program. We ask that you indicate you have read or have had read to you the above policy and that you understand it.

Resident______________________________________Date__________________

Advocate______________________________________Date__________________

Draft Submitted by Patti Bland and the Chemical Dependency Committee 12/97

Women talk about substance abuse and violence

Ten women were interviewed about their experiences with substance abuse and violence. All 10 are survivors of some form of abuse: battering, rape or sexual assault, incest or child sexual abuse. In addition to the violence, all of them have 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 impacts 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.

The interviews were conducted by Debi Sue Edmund and Patricia Bland. The identities of the women have been kept confidential. Ms. Edmund is a trained domestic violence shelter volunteer, and a master's degree student in the Child, Family and Community Services program at the University of Illinois-Springfield. Ms. Bland is a certified chemical dependency counselor at New Beginnings for Battered Women and Their Children in Seattle, WA.

Q: The women began by describing their experiences 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 back 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? Ws 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 assault. 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 need 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: 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 substance 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 and 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. You have the minimizing. The denial. All that stuff that goes on with the chemical dependency, you have with domestic violence.

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 AA program. Just talking with some of the new people that are coming in.

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: [Having] no relationship is better than [having] 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.

Copies of "Women Talk" are available on either audiotape or compact disk. To order, send $7.50 per tape or CD, plus $2.50 for shipping and handling, to Debi Edmund, 545 S. Feldkamp Ave., Springfield, IL, 62704. Questions? Email dedmund@fgi.net.

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).*

(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.)

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).*

(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.)