Published in final edited form as:

J Psychoactive Drugs. 2007 September ; 39(3): 251–257.

Substance Abuse Treatment Staff Perceptions of Intimate Partner Victimization Among Female Clients†

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Abstract

Providing intimate partner violence (IPV)-related services to women enrolled in substance abuse treatment programs has the potential to reach a population disproportionately affected by IPV. Integrating basic IPV services into substance abuse treatment, however, poses challenges to organizations and staff. Using focus groups, the authors examined the experiences and attitudes of substance abuse treatment staff towards clients with IPV victimization experiences in order to elucidate factors that might affect the implementation of IPV services within substance abuse treatment. Seven focus groups were conducted with staff members from substance abuse treatment programs in New York City. Although participants believed that IPV is common and negatively affects client recovery, they felt competing time demands, complex confidentiality issues, insufficient training and lack of agency leadership would impede their provision of IPV-services. The study suggests that system-level assessment and change is needed to provide IPV-related services in substance abuse treatment settings.

Keywords

domestic violence; staff; substance abuse

†This work was supported in part by a grant from the Alcoholism and Substance Abuse Professionals of New York State, and by the Center for AIDS Research at the Albert Einstein College of Medicine and Montefiore Medical Center, funded by the National Institutes of Health (NIH AI-51519). Dr. Kunins was supported in part by a General Clinical Research Center grant from the National Institutes of Health (MO1-RR12248) awarded to the Albert Einstein College of Medicine of Yeshiva University. A version of this work was presented as a poster at the International Conference on Urban Health, New York, 2003. The authors thank the New York State Office of Alcoholism and Substance Abuse Services for their support, Dale Thompson for participant recruitment, and Assel Terlikbayeva for her assistance with focus group facilitation and data analysis.

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EDITED BY: RICHARD B. SEYMOUR, M.A., TERRY CHAMBERS, B.A.

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Victimization from intimate partner violence (IPV) occurs with high frequency among women with substance abuse disorders (Wenzel et al. 2004; Fals-Stewart, Golden & Schumaker 2003; El-Bassel et al. 2000). In some investigations, more than one-half of women enrolled in substance abuse treatment have reported recent IPV, substantially higher than prevalence rates of 2% to 12% found in community-based studies. (Velez et al. 2006; Wathen & MacMillan 2003; Caetano, Melson & Cunradi 2001; Chermack, Fuller & Blow 2000; Tjaden & Thoennes 2000; Bennett & Lawson 1994; Straus & Gelles 1990).

The provision of IPV-related services—such as routine screening for IPV, trauma-informed counseling, advocacy, and referrals—in the context of substance abuse treatment has the potential to reach a population highly affected by IPV. Such dually-offered or coordinated services may enable persons affected by violence and substance abuse to realize further benefits from treatment. Interventions and services that address IPV and trauma are infrequently integrated into substance abuse treatment programs, but an emerging literature shows researchers and practitioners grappling with how best to provide comprehensive, effective services (Fals-Stewart & Kennedy 2006; Fazzzone, Holton & Reed 1997).

Demonstration projects have shown that that delivery of IPV-related services in substance abuse treatment is feasible, may increase the identification of and referrals for IPV, and may decrease substance abuse (O'Brien et al. 2002; Fazzzone et al. 1997). In a 1994 survey of program directors and staff from substance abuse treatment programs and domestic violence programs in Illinois, investigators found that substance abuse treatment programs inconsistently screened for IPV, offered no trauma-related services on-site, and infrequently made referrals. Despite these findings, respondents believed that one-half of their clients were involved in abusive relationships, and that increased cooperation would be beneficial to clients (Bennett & Lawson 1994). Subsequently, in Illinois, through a coordinated effort among substance abuse and violence prevention agencies, investigators found that provision of coordinated and integrated services was feasible in four demonstration sites (O'Brien et al. 2002). In a program to provide trauma-informed services to women with substance abuse and mental health disorders, investigators found that staff lacked sufficient knowledge to integrate trauma-informed services (Markoff et al. 2005). Furthermore, staff training alone was insufficient to change behavior; successful adoption of IPV-informed practices occurred only after institution of on-site specialized trauma supervision. This experience suggests that staff incorporation of new practices requires system-level support for staff needs and behavior change. There is a paucity of data, however, on substance abuse treatment staff knowledge about providing about IPV-related services, and perceptions of organizational readiness and capacity to integrate IPV-related services. To further understand staff attitudes towards and readiness to provide IPV-related services to women who have been victims of IPV, the present authors conducted focus groups with front-line substance abuse treatment counselors and immediate supervisors.

MATERIALS AND METHODS

Participants and Recruitment

Seven focus groups were conducted between August and December of 2002. Participants included counselors, clinical supervisors, and administrators recruited from New York State-licensed substance abuse treatment programs. A staff member from the Office of Alcoholism and Substance Abuse Service of New York State recruited participants by telephoning program administrators to ask them to send a staff member to a focus group on IPV. Participants were recruited from methadone maintenance, residential, and outpatient day treatment programs. Two groups were conducted with counselors from residential programs, two groups with counselors from outpatient programs, one group with methadone maintenance treatment (MMT) counselors, one group with administrators from residential

programs and one group with administrators from outpatient and MMT programs. Continuing education credit for the Credentialed Alcoholism and Substance Abuse Counselor was offered for participation in the focus groups. The study protocol was reviewed and approved by the Institutional Review Board at Montefiore Medical Center prior to implementation.

Data Collection

At each focus group, informed written consent was obtained by an investigator. Participants filled out short surveys to elicit demographic information, practice setting, and staff position in agency. The groups lasted 90 to 120 minutes. Another investigator took detailed notes during each focus group on content and process.

Each focus group was conducted using a discussion guide that contained a series of open-ended questions. Discussion guide questions were derived from guidelines on providing IPV-related treatment in health care settings (Family Violence Prevention Fund 2004; Zubretsky 1998; Nudelman et al. 1997). The guide included questions about providers' knowledge, beliefs and attitudes regarding victimization from IPV among clients in drug treatment; clinical experiences with IPV and its impact on substance abuse and recovery; their agency's current practices and policies regarding IPV; and attitudes and perceived barriers towards incorporating additional/new IPV-related services into their practice setting. The group facilitator defined IPV at the outset of each group as physical, verbal, or emotional abuse occurring between intimate partners. She further told each group to focus on service provision for female victims of IPV, acknowledging that different issues were important for male victims, and batterers of both sexes. The group facilitator asked questions, allowed participants to comment and react until discussion quieted, and redirected discussion when conversation strayed. The first two groups were not audiotaped, but were used to refine the focus group guide. The subsequent five groups were audiotaped and transcribed verbatim.

Coding and Data Analysis

Notes from all seven groups were used to develop a preliminary coding scheme. The analysis was conducted on the five transcribed groups. The coding scheme was revised and simplified iteratively after each investigator had coded one transcript. Each transcript was then independently coded by two other members of the research team. Differences were resolved by consensus. Following coding of the five focus groups, broad themes were identified, and comments relevant to each theme from each transcript were collated into theme-based documents.

RESULTS

Participants

Seven focus groups with 41 staff members from 40 unique substance abuse treatment programs in New York City and Long Island, New York were conducted between August and December of 2002. Five focus groups with 26 staff members participated in audiotaped focus groups. Participants were mainly women ($n = 23$, 89%). African Americans comprised the majority of participants ($n = 16$, 62%); the remainder were Hispanic ($n = 5$, 19%), White ($n = 3$, 12%) or identified as other races ($n = 2$, 8%). Slightly more than one-half the participants had completed college ($n = 14$, 54%). Participants worked in a range of programs: 35% (9) in methadone maintenance, 31% (8) in outpatient treatment, and 35% (9) in residential treatment. Nearly one-half of the participants were front-line counselors ($n = 12$, 46%); the remainder described themselves as clinical supervisors ($n = 5$, 19%), administrators ($n = 7$, 27%), or having another role in the agency ($n = 2$, 8%).

Themes

Themes that emerged from the focus groups fell into five broad categories.

Theme 1: Relationship between IPV and Substance Abuse

IPV is common among clients enrolled in substance abuse treatment: In each focus group, participants readily concurred that IPV occurred commonly among female clients. Participants had a complex understanding of the interrelationship among IPV, drug use, and engagement in substance abuse treatment. In every focus group, participants extensively conversed about the multiple ways in which IPV affected clients' patterns of drug use, patterns of relapse and/or recovery, and ability to engage in substance abuse treatment.

IPV impedes recovery from drug abuse: Participants offered multiple examples of how IPV made recovery from drug use more difficult for clients. For example, one participant noted how her client's fear of IPV acted as a trigger for prescription drug abuse: "Every time she knew her husband was going to come home, she felt like she had to take a codeine pill ..." Some participants noted that abstinence or reduction in drug use sometimes was associated with worsening violence: "if one tends to grow, the other (partner) pulls her back ... if one begins to provide negative urine profiles, that's when I see the chaos."

Batterers control access to drugs and drug treatment: In all the focus groups, participants discussed ways in which drugs are a key aspect of batterer control in the abusive relationship, with the abusive partner controlling access to drugs as well as access to treatment services. Many participants observed that abusive partners use drugs as a way to assert control in the relationship. For example, one participant noted, "if the partner continues to feed [drugs to] the client, that helps them stay in control ... after they abuse them, then they'll get them high, and say it's okay, I love you. And, in her mind, she'll be thinking ... he really loves me; he didn't mean to hit me."

Engagement in substance abuse treatment gives batterers a new arena in which to assert control over the relationship. Participants observed this control to occur in a number of ways. A methadone maintenance counselor noted that, "females come in and want their dose lowered only because their mates said to lower it." Other participants noted that clients would only speak with their counselors after getting permission from their partners, and in some cases, were only willing to consent to counseling sessions if the partner could sit in.

Theme 2: Skill Levels in Addressing IPV

Basic but not advanced training in addressing IPV: Most participants had attended at least one training session on IPV, yet there were mixed assessments of the training that had been provided: "I've been around for 15 years.... you can pick up a class here and there ... you would think there would be some in depth training, and it's not. So you go on instinct." Another participant noted, "I don't have the training in domestic violence ... I'm not sure how to deal with it. I don't want to bring up any (issues that) make the patient uncomfortable. Other times, I'd like to know more, but I don't know what to ask ...I wish I had more training, but we don't."

Heterogeneous levels of training and access to expertise: Other participants reported having positive training experiences, citing ongoing relationships with agencies that provide trauma services and offered repeated training contacts. Other positive training experiences occurred via informal mechanisms within the treatment center. For example, one participant reported that her center has "permanently trained social workers," who facilitate a women's group in which trauma issues are addressed and also provide consultation to staff members. In another case, the agency did not have dedicated staff providing trauma-related services,

but the participants reported an informal “peer supervision” between more and less experienced staff members.

Fear of opening Pandora’s Box: Participants’ perceptions of inadequate training led them to report fearing to “open Pandora’s Box.” Although nearly all participants reported that their agency screened for a history of IPV among clients, most screening occurred in the context of completing the Addiction Severity Index, a standardized instrument for collecting substance abuse history, or another standardized psychosocial intake interview. During these initial interviews, participants reported a variety of experiences that hindered in-depth exploration of trauma-related issues. First, some participants reported feeling uncomfortable asking questions: “I think it’s very uncomfortable for patients that you meet the first time to ask very deep questions about [IPV]. I just don’t know which way to go sometimes.” Several participants expressed feeling inadequate in knowing what to do once a client disclosed IPV. For example, one participant reported, “... to me, I think, maybe we’re not fully equipped to deal with it psychologically. It’ll open something up, right there as you’re doing the ASI which you might not be able to deal with without calling the supervisor.” Another participant further described, “[The client says] yes, then what? Then what? ‘Cause I mean really, there’s nobody trained to do anything to go further. So fine, you find out, yes, domestic violence occurs. Now what? Common sense would say, refer them, but we have no tools.”

Participants also expressed skepticism about the utility of screening for IPV, with many sharing experiences that even when they screened during or soon after intake, clients were reluctant to disclose it. One participant noted, “You can ask them about it even in the intake process. That doesn’t mean they are going to give it to us ... because a lot of people we deal with are [mandated by criminal justice]. They are forced to come there. They’re angry ... They don’t want to be open, they just want to say I need to go home and get some clothes.”

Counselors perceive that women do not leave partners: poor training reduces their ability to cope or offer standard of care: In all focus groups, participants brought up their experience of clients’ failure to leave or separate from abusive partners. In only one group did a participant mention that counseling the client to leave her partner was not the only, or even appropriate goal of IPV-related care. Participants expressed significant frustration over the failure of clients to leave partners. They further reported feeling that clients’ failure to leave indicated their failure to help the client in a meaningful way.

Training needs to address staff experiences of IPV: In several groups, participants commented that adequate training in IPV ought to address staff members’ own experiences of IPV in order to help them integrate trauma-informed services in their substance abuse treatment settings. One administrator related that, at a domestic violence training she had attended, many participants wanted to speak about their own experiences of IPV. She reported concerns about “staff wellness,” and the need for “folks being able to work out their own stuff,” before being able to provide appropriate counseling regarding IPV.

Theme 3: Perceptions about Organizational Mission, Leadership and Capacity

Tensions in the mission: IPV versus substance abuse services: Although participants generally recognized the complex interplay between substance abuse and IPV among their clients and agreed that addressing IPV is necessary to assist clients in substance abuse treatment, many participants expressed the tension they see in their organizational mission between “doing it all” and preserving their focus on substance abuse. A minority of participants in fact felt that a focus on issues other than substance abuse, including IPV, detracted from their principle task of helping clients reduce drug use. As one counselor

articulated, “our primary task is substance abuse. So, when we start getting into domestic violence, it takes away from our role as a substance abuse counselor.” Another participant noted, “... to be honest ... even if they tell you at the outset (about abuse), the person that do the questions, they’re not focusing on that piece of information, because, guess what, that’s not what they’re there for.” Conversely, in two of the focus groups, there was a consensus among participants that IPV needed to be addressed prior to clients being able to reduce or abstain from drug use. As one participant noted, “IPV will affect whether or not recovery can even happen.... you have to address the domestic violence piece first and foremost as part of the treatment plan with the client before you could even, I think, set any long term recovery goals.”

Regardless of whether participants believe the substance abuse had to be addressed first, concomitant with, or after the IPV, many participants embraced the multiple demands placed on substance abuse counselors. As one counselor reported, “we are titled substance abuse counselors, but the reality is, that people are more complex ... so, you should be versed in all issues, regardless of what your title might be.”

Absence of leadership: Participants perceived that absent or inadequate administrative support and direction hindered their adequately addressing IPV among clients. As one counselor described it, “my agency implies not to ask, not to go further ... [The client] says yes, then what? It’s like a silent message. Be very careful, do not get into that ...”

Theme 4: Organizational Capacity and Variations in Practice

Large caseloads: The experience of demanding caseloads contributed to skepticism among participants about whether their organizations had the capacity to effectively address IPV. Several counselors indicated that the large number of clients prevented them from handling other than the core problems. One counselor from a residential program noted, “you can be very overwhelmed in this field. I [work] four to 12 with 98 clients. I’m the only staff member.” One counselor from a methadone maintenance program reported, “if we are going to have 30 clients maximum, that would be great. Then you’ll be able to do a lot of things. But when you have all these other patients waiting to see you, it’s hard even to think about going to the bathroom.”

Short treatment episodes: Participants also noted that the time-limited nature of most substance abuse treatment programs limits the breadth and depth of the counseling. One residential treatment program counselor stated that, “we can address all that stuff in treatment, but if they don’t have no aftercare to address it, that stuff that comes out, is the stuff that makes you use [drugs] ... We open the door, but we’re not out there to close it.”

Treating batterers: In all groups, participants noted special challenges in working with victims of violence because most substance abuse treatment programs also treat abusive partners. Such dual enrollment occurred in the context of unclear agency policies. As one participant noted: “I have one client, I have the woman saying [he’s beating her up], and the male is on your caseload. You know, and how do I address that ... what do I do, send her back home with him. Or, do I go to the counselor of record and say listen, you know, how do we get together as a team ... If he’s in the clinic, she’s scared, what can I do? I can’t call the police on him. She can’t leave. He has rights as a client in the clinic.” Even after clinics take action, however, the abusive partner can continue to affect the client’s treatment. One participant explained, “If he threatens you, he would be discharged. However, she does not come to clinic unless he’s with her. He’s no longer a client in our population ... but she does not come to the clinic without him. And, the security has to constantly tell him to leave from the clinic.”

Practices varied among programs: During focus groups, most participants reported that screening for abuse occurs during or soon after intake at their agencies. Beyond screening at intake, however, practice varied considerably. Some participants reported being able to refer to specialized on-site relationship or women-only groups or to social workers. Few participants believed that counselors in their agencies conducted safety assessment and planning, an important aspect of counseling clients who are in abusive relationships. Furthermore, few participants were aware that offering directive counseling for clients to leave partners is not accepted standard practice.

On-site IPV expertise: Very few programs had staff dedicated to addressing IPV. Some had designated a staff member, such as a social worker or supervisor, but these were not universally perceived to be more experienced than the rest of the staff. Participants felt that the availability of an on-site team or coordinator would be critical to providing additional IPV-related services, and could be analogous to other specialty programs, such as vocational services. One participant noted that referring off-site meant that clients had the potential to “get lost” and not receive needed services.

Strong linkages with IPV providers: A minority of participants reported working at programs with strong linkages to off-site IPV providers. In one case, the substance abuse treatment program’s location in the same building as a victim services agency had facilitated a close relationship between agencies. Other staff, who reported regular contact with trainers from one IPV agency had developed a sense of trust in the IPV agency. For the most part, however, participants reported inconsistent linkages. At worst, as one participant noted, “they’re giving us a session now, and then you run into a situation where, oh, we don’t have our funding anymore, or the person who used to do the domestic violence is no longer here.”

Theme 5: Staff Perceptions about the Availability of a Coordinated Community Response

Absence of shelters for drug-using women: In each focus group, participants reported difficulty in locating shelters that accepted drug-using women. Methadone maintenance counselors reported that even for clients not actively using illicit drugs, shelters were reluctant to accept clients on methadone maintenance. The difficulty in accessing specialized domestic violence shelters for clients led many counselors to refer clients to general homeless shelters. But clients perceived general shelters as posing additional risk of violence and exposure to drug use. One residential counselor reported, “The females will get into these shelters, things will happen to them, and they will rather go home to their family, where the abuse continues as opposed to staying in the shelters.”

Lack of trust in orders of protection: Virtually all participants agreed that clients infrequently trusted or accepted orders of protection as an effective way to achieve safety. One participant noted that, “Some women are scared to have an order of protection because ... the men are not afraid ... and they get more angry at them.” Another explained, “Well, most of our clients say, [orders of protection] do nothing. Yeah, ... [she] ... has an order of protection, and he still blew her brains [out]. So they don’t think the order of protection is of any worth.”

Staff attributed clients’ ambivalence as contributing to the failure of orders of protection to promote safety. “I have one [client who] was supposed to update this order of protection every few months or something, and the order of protection was being violated ... When she wanted to use, or when he wanted ... to be with her, he would call her up to get her high ... Now, when he had no more money and no more drugs, she would choose not to be with him ... And if he wanted to be with her anyway, that’s when the violence ensued.”

Finally, participants believed that clients' conflicts with the legal system prevented them from employing orders of protection. One participant noted that clients are "afraid of going forward to get help with the law, because they have records, and outstanding warrants ... So, they kind of just stay in the background and just deal with it. You know, until they're ready to just walk away from the relationship. But, they don't want to open up a can of worms with the legal system."

DISCUSSION

These findings suggest that participants have had limited experience with integrating IPV-related services for victims of abuse into their treatment programs. Participants consistently identified victimization from IPV as a problem for clients enrolled in their treatment programs. Furthermore, staff was receptive to providing services that addressed violence in their clients' lives. The minority of staff from agencies who had access to an IPV specialist expressed confidence in having had sufficient training in addressing IPV with their clients (i.e. conducting screening for IPV, safety assessment, safety planning, and referral to appropriate IPV-related services), and in their agency's ability to handle IPV.

Despite provider awareness of and receptivity towards addressing IPV, our focus groups indicated a need for additional training and integration of IPV-related practices. Although staff readily identified IPV as a frequent problem for clients and were willing to "ask about" IPV, few participants reported feeling that they had sufficient training. When asked about specific strategies or protocols they might employ in this area, few staff were able to articulate how to conduct adequately detailed assessments and safety planning generally accepted to be the standard of care. In addition, participants were familiar with only rudimentary counseling skills in the area of IPV. Despite the fact that counseling victims to leave partners is not accepted as best practice in preserving safety, in most focus groups, this was the main strategy that staff identified.

In addition to identifying their own limited skills in offering IPV-related services and counseling, participants identified system-level limitations to addressing violence-related issues among clients. Participants believed that they received mixed messages from administrative staff about their roles and responsibilities with regard to IPV, and felt confused about the depth expected from them. Uniformly, staff expressed that IPV referrals and shelter referrals were difficult to obtain, particularly for women actively using drugs.

Similar to prior investigations, this study found that staff training and education alone on IPV may be insufficient to help programs modify their services; rather, system-wide approaches may be necessary for successful change. (Feder, Ramsay & Zachary 2006; Zachary et al. 2002). We believe that participants' enthusiasm for and awareness of addressing IPV victimization among clients reflects larger system- and societal-level awareness of IPV. Focus group participants had received basic training in IPV, reflecting these changes. The staff who participated in this study demonstrated readiness for change, but needed additional in-depth training, clear messages and expectations from leaders and a greater awareness of the limits and strengths of local resources. As previous demonstration projects show, successful and uniform integration of IPV-related services needs to address change at multiple levels: staff, organization and management, and system-wide capacity (Markoff et al. 2005; O'Brien et al. 2002). Successful organizational change may require on-site expertise, cross-system collaboration and perhaps expansion of resources for drug-using women. (Lehman, Greener & Simpson 2002; Simpson 2002; D'Aunno, Vaughn & McElroy 1999).

Our recruitment methodology may have biased in finding staff willing to address IPV in substance abuse treatment. We recruited staff participants by asking substance abuse treatment programs to send a staff member to a focus group on IPV. Thus, we expect that, in many cases, agency administrators sent participants who were already interested and willing to discuss IPV. This selection may explain why there was ready consensus among participants that IPV was a common problem among clients, and that substance abuse staff were generally willing to provide more services in this area. On the other hand, we believe that our conclusion that staff has basic, but not in-depth training on IPV is strengthened by this bias: if agencies sent their most well-trained or interested staff members, and they reported and demonstrated inadequate skills in this area, substance abuse treatment staff at large are likely to be at least as poorly informed. An additional limitation of this study is that we did not contrast counselor and administrator/supervisor comments, and so cannot comment on differences between these groups.

In conclusion, this focus group study of substance abuse treatment staff suggests their awareness of and receptiveness to addressing IPV among female clients. We believe our focus group participants' willingness to address IPV is consistent with the changing culture of substance abuse treatment in response to national and local awareness of the relationship between substance abuse, recovery, and IPV. Yet, staff from many of the agencies that participated in this study felt inadequately trained, confused about their roles with regard to IPV counseling and services, and frustrated with their limited skills and access to resources. Clearer messages from leaders, in-depth training, and increased coordination with community-based services might promote effective delivery of IPV-related services in substance abuse treatment programs. Future studies are needed to extend these findings and to determine the content, effectiveness, and implementation of such change in a highly heterogeneous substance abuse treatment system.

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