Comments on the National Alcohol Harm Reduction Strategy: Consultation Document (2002)
City of Sunderland Social Services Department

1. Partnership and Multi – agency responses

- Needs to be a focus on partnership arrangements / agreements within the strategy which are not solely health related i.e. a social model of health.
- Consideration should be given to putting partnership arrangements on a statutory footing, unlike the current situation for DAT's where decisions are not binding and strategy can become incoherent.
- Combined partnerships do require power, resources, staffing capacity and support to function efficiently, these factors should be considered.
- Needs to be a recognition that alcohol misuse has a significant impact on Social Services.
- There is a need to develop a national partnership approach to data collection and performance monitoring on alcohol service issues.

2. Isolation, Vulnerability, and Mental Health Issues

- Specific groups considered to be vulnerable and at risk are: older people; people living alone; and children of parents who have alcohol problems, services should be geared to meet the associated needs.
- There is an identified gap in services for homeless people and transient populations.
- There is evidence that more and more older people have alcohol problems, particularly those who are socially isolated. These problems in turn can be associated with mental health problems.
- Mental Health service users who have severe and enduring mental health problems can also have an alcohol dependency problem. This is included in the overall cost of Social Services Mental Health Services.
- A large gap in services is the inability to provide specialist support for alcohol related dementia's (i.e. within the Younger People with Dementia Team).

3. Training and Inter – Agency Specialist Advice

- There is a need for a general comprehensive alcohol harm reduction training strategy for users of service and staff, possibly as a result of new guidance (and extra resources) from the central government (or through the National Treatment Agency). This would provide for a comprehensive multi - agency approach, which could be overseen by the combined leadership of the Local Strategic Partnership, the Children and Young People's Strategic Partnership, and the Drugs action Team.

- Consideration should be given to inclusion of national guidance on monitoring use and harm reduction programmes for Children Looked after. This should be part of the DAT training and IT development budget.

- There is a need for Social Services staff to be able to call on specialist advice, which could be provided through training to cover early signs of alcohol abuse, inter- agency referral protocols, joint assessments, the available variety of treatment regimes, access to child psychiatry and psychology services, and other specialist medical services.

4. Service Choices

- There need to be a choice of services both in the statutory and independent sectors for people both in the local community and outside of the area for those who wish to go away for treatment.

5. Waiting Lists

- There needs to be a fast track optimum time for individual rehabilitation and recovery; adequate provision is required in order to avoid long waiting lists.

6. Young People's Residential Detoxification

Accommodation for young people is generally thought to be a priority issue especially in relation to accessing detoxification residential accommodation

7. Domestic Violence

- There is a need for more co-ordinated multi – agency responses to the needs of children in situations of domestic violence where alcohol abuse is a factor. Examples would be links with Domestic Violence Strategies and initiatives aimed at childhood development (e.g. Sure Start and Children's Fund activity).
- Research has proven that over 60% of incidents occur when the perpetrator has NOT used / misused alcohol.
  Alcohol is often used as an ' excuse / reason ' why an incident occurs but is usually a cover.
- Some victims will use / misuse alcohol as an escape route.
- Some incidents occur because there has been misuse of alcohol or the perpetrator is an alcoholic which exacerbates the problem.
  Alcohol may fuel an already volatile situation.
- There needs to be much closer multi and interagency work in this area; with the sharing of information being at the heart of offering advice and help, to both victims and perpetrators. If alcohol misuse is seen as the major factor, rather than as a contributory factor to domestic violence, than the violence may continue even if the alcohol misuse is tackled.
- Children who grow up in a violent household are more likely to misuse alcohol and drugs than children who do not witness violence, so not only does work need to be done with perpetrators and victims, but also with their children.
- There is a wide body of research evidence that there is often a false connection between alcohol abuse and domestic violence as a causal factor. However evidence suggests a wider multi-agency partnership and whole family

approach is required which assesses the effects on and the needs of the child, as well as the victim and the perpetrator of domestic violence, where chemical dependency is a factor (see Appendix 1).

8. Workforce Issues

- With regard to local workforces, there is a need to have mechanisms in place whereby occupational health and other support mechanisms can play a full part in supporting staff. Personnel policies should be family friendly and provide carer support where required.

- Although the extent of problematic use of alcohol among staff is not know, information on access to confidential support services could be beneficial to those seeking help.

9. Research and evidence based outcomes

- There is a need for specialist guidance on alcohol harm reduction research programmes to facilitate evidence - based outcomes.

10. Crime

- Efforts need to be made to engage local licensees. There should be more involvement of the Local Authority in planning decisions e.g. covering how many public houses in an area have extended hours yet do not take responsibility for alcohol related crime on or outside of their premises.

Appendix 1

The False Connection Between Adult Domestic Violence and Alcohol

Theresa M. Zubretsky and
Karla M. Digirolamo

Introduction

Batterers: Relationship of Alcohol Use to Violence

DisplayText cannot span more than one line!

Interventions with Substance-Abusing Batterers

Impact of Co-dependency Treatment on Battered Women

DisplayText cannot span more than one line!

Lack of Information in the Domestic Violence Field

Creating an Effective Partnership

References

INTRODUCTION
Since the 1970's, significant efforts have been made to increase the public's understanding of domestic violence and to educate professionals and service providers about this problem. Through accounts from battered and formerly battered women, domestic violence is now understood to include a range of behaviors - physical, sexual, economic, emotional and psychological abuse - directed toward establishing and maintaining power and control over an intimate partner. There is also an increased awareness that the societal tendency to blame domestic violence victims and excuse perpetrators is rooted in a history of cultural and legal traditions that have supported the domination and abuse of women by men in intimate relationships. Despite greater public awareness, however, myths and misconceptions about battered women's experiences persist. Interventions based on these myths can have a devastating effect on victims and their families.

Despite the significant correlation between domestic violence and chemical dependency, hardly any research has been conducted and little has been written about the need to develop intervention strategies that address both the domestic violence and

the substance abuse problems of chemically dependent men who batter. Similarly, little has been done to assist battered women with chemical dependency problems to meet their need for both safety and sobriety. Neither system currently is equipped to provide the range of services needed by battered women and batterers who are affected by chemical dependency.

In the addictions treatment system, misinformation often leads counselors to understand and respond to domestic violence through the use of an addictions framework, an approach that has particularly harmful consequences for battered women. Such an approach identifies battering either as a symptom of alcohol abuse or addiction or as an addiction itself. The interventions that follow are based on a number of harmful, false assumptions:

Alcohol use and/or alcoholism causes men to batter.

Alcoholism treatment alone will address the abuse adequately.

Battered women are "co-dependent" and thus contribute to the continuation of abuse.

Addicted battered women must get sober before they can begin to address their victimization.

BATTERERS: RELATIONSHIP OF ALCOHOL USE TO VIOLENCE

The belief that alcoholism causes domestic violence is a notion widely held both in and outside of the substance abuse field, despite a lack of information to support it. Although research indicates that among men who drink heavily, there is a higher rate of perpetrating assaults resulting in serious physical injury than exists among other men, the majority of men are not high-level drinkers and the majority of men classified as high-level drinkers do not abuse their partners (Straus & Gelles, 1990).

Even for batterers who do drink, there is little evidence to suggest a clear pattern that relates the drinking to the abusive behavior. The majority (76 percent) of physically abusive incidents occur in the absence of alcohol use (Kantor & Straus, 1987), and there is no evidence to suggest that alcohol use or dependence is linked to the other forms of coercive behaviors that are part of the pattern of domestic violence. Economic control, sexual violence, and intimidation, for example, are often part of a batterer's ongoing pattern of abuse, with little or no identifiable connection to his use of or dependence on alcohol.

The belief that alcoholism causes domestic violence evolves both from a lack of information about the nature of this abuse and from adherence to the "disinhibition theory." This theory suggests that the physiological effects of alcohol include a state of lowered inhibitions in which an individual can no longer control his behavior. Research conducted within the alcoholism field, however, suggests that the most significant determinant of behavior after drinking is not the physiological effect of the alcohol itself, but the expectation that individuals place on the drinking experience (Marlatt & Rohsenow, 1980). When cultural norms and expectations about male behavior after drinking include boisterous or aggressive behaviors, for example, research shows that individual men are more likely to engage in such behaviors when under the influence than when sober.

Despite the research findings, the belief that alcohol lowers inhibitions persists and along with it, a historical tradition of holding people who commit crimes while under the influence of alcohol or other drugs less accountable than those who commit

crimes in a sober state (MacAndrew & Edgerton, 1969). Batterers, who have not been held accountable for their abusive behavior in general, find themselves even less accountable for battering perpetrated when they are under the influence of alcohol. The alcohol provides a ready and socially acceptable excuse for their violence.

Evolving from the belief that alcohol or substance abuse causes domestic violence is the belief that treatment for the chemical dependency will stop the violence. Battered women with drug-dependent partners, however, consistently report that during recovery the abuse not only continues, but often escalates, creating greater levels of danger than existed prior to their partners’ abstinence. In the cases in which battered women report that the level of physical abuse decreases, they often report a corresponding increase in other forms of coercive control and abuse—the threats, manipulation and isolation intensify (Minnesota Coalition for Battered Women, 1992).

POWER AND CONTROL, NOT "LOSS OF CONTROL"

The provision of appropriate services for families affected by domestic violence and substance abuse is further complicated by the belief that battering itself is addictive behavior. This belief may arise in part from an attempt to explain why violence often increases in severity over time. The progressive nature of the violence is likened to the progressive nature of the disease of addiction, inviting the use of an addictions model for responding to the problem of battering.

An addictions framework assumes that there is a point at which a batterer can no longer control his abuse, just as an addict experiences loss of control over the substance use. The experiences of battered women, however, challenge this view. Battered women report that even when their partners appear "uncontrollably drunk" during a physical assault, they routinely exhibit the ability to "sober up" remarkably quickly if there is an outside interruption, such as police intervention.

Batterers also exhibit control over the nature and extent of the physical violence they perpetrate, often directing their assaults to parts of their partners' bodies that are covered by clothing. Conversely, some batterers purposefully target their partners' faces to compel isolation or to disfigure them so that "no one else will want them." Batterers can articulate their personal limits regarding physical abuse, reporting, for example, that while they have slapped their partners with an open hand, they would never punch them with their fists. Others admit to hitting and punching but report that they would never use a weapon (Ptacek, 1987).

The escalation in the severity of violence over time does not represent a batterer's "loss of control" over the violence, as the analogy to addictions would suggest. Instead, violence may get worse over time because increasing the intensity of the abuse is an effective way for batterers to maintain his control over their partners and prevent them from leaving. The violence may also escalate because most batterers experience few, if any, negative consequences for their abusive behavior. Social tolerance of domestic violence thus not only contributes to its existence, but may also influence its progression and batter ers' definitions of the acceptable limits of their abuse.

INTERVENTIONS WITH SUBSTANCE ABUSING BATTERERS

Batterers who are also alcohol or other drug involved need to address both problems separately and concurrently. This is critical not only to maximize the victim's safety, but also to prevent the battering from precipitating relapse or otherwise interfering with the recovery process. True recovery requires much more than abstinence. It includes adopting a lifestyle that enhances one's emotional and spiritual health, a goal that cannot be achieved if the battering continues.

Self-help programs such as Alcoholics Anonymous promote and support emotional and spiritual health and have helped countless numbers of alcoholics get sober. These programs, however, were not designed to address battering and are insufficient in motivating batterers to stop their abuse. Accordingly, a treatment plan for chemically dependent men who batter must include attendance at program designed specifically to address the attitudes and beliefs that support batterers' behavior.

IMPACT OF CO-DEPENDENCY TREATMENT ON BATTERED WOMEN

Most often, the partners of batterers in chemical dependency treatment are themselves directed into self-help programs such as Al-Anon or co-dependency groups. Like other traditional treatment responses, however, these resources were not designed to meet the needs of victims of domestic violence and often inadvertently cause harm to battered women.

The goals of Al-Anon and co-dependency treatment typically include helping family members of alcoholics to get "self-focused", practice emotional detachment from the substance abusers, and identify and stop their enabling or "co-dependent" behaviors, that is, to stop protecting their partners from the harmful consequences of addiction. Group members are encouraged to define their personal boundaries, set limits on their partners' behaviors, and stop protecting their partners from the harmful consequences of the addiction. While these strategies and goals may be very useful for women whose partners are not batterers, for battered women such changes will likely result in an escalation of abuse, including physical violence.

Battered women are often very attuned to their partners' moods as a way to assess their level of danger. They focus on their partners' needs and "cover up" for them as part of their survival strategy. Battered women's behaviors are not symptomatic of some underlying "dysfunction," but are the life-saving skills necessary to protect them and their children from further harm. When battered women are encouraged to stop these behaviors through self-focusing and detachment, they are, in essence, being asked to stop doing the things that may be keeping them and their children most safe.

Battered women whose partners are chemically dependent should be given accurate and complete information about available resources so that they can make informed choices and set realistic expectations about the potential benefits of these different sources of help. It is critical that they understand the purposes of Al-Anon and co-dependency groups and the limitations of these forums as sources of accurate information regarding safety-related concerns. They should also be advised of the availability of local domestic violence programs and referred to these services for assistance. Empowering women with accurate information will help them make

decision that best meet their individual needs.

IMPACT OF TRADITIONAL ADDICTIONS TREATMENT ON CHEMICALLY DEPENDENT BATTERED WOMEN

Although the vast majority of battered women are not alcohol or substance abusers, those who are confront a system that is ill-equipped to deal with their needs, particularly their need for safety. Often, intakes to treatment programs do not include an assessment for adult domestic violence. Even when domestic violence is identified, it is often assumed that treatment for the substance abuse must occur before the victimization can be addressed.

One of the concerns with the "sobriety first" approach is that it does not consider the increased risk of violence that a woman's recovery may precipitate. Batterers often are resistant to their partners' attempts to seek help of any kind, including substance abuse treatment. In response, they may sabotage the recovery process by preventing victims from attending meetings or keeping appointments, or they may increase the violence in order to reestablish control. Many chemically dependent battered women leave treatment in response to the increased danger or are otherwise unable to comply with treatment demands because of the obstacles constructed by their partners. Even if a battered woman is able to complete a treatment program, being revictimized is predictive of relapse (Haver, 1987).

An additional concern with the "sobriety first" approach is that it does not recognize the relationship between the substance use and a battered woman's victimization. Many battered women report that they began to use substances as a way to cope with unremitting danger and fear. Often, these women report that they had sought help repeatedly from the traditional social service and legal systems, but received inadequate or negative responses. In fact, many chemically dependent battered women are addicted to sedatives, tranquilizers, stimulants and hypnotics, drugs that were prescribed by the health care providers from who they sought help (Flitcraft & Stark, 1988).

Whatever the drug of choice, substance-using battered women often report that the substances helped them cope with their fear and manage the daily activities of their lives in the face of ongoing abuse and danger (Minnesota Coalition for Battered Women, 1992). These are women who may be particularly resistant to engaging in a recovery process until they are confident that they can achieve genuine safety from the violence. For these women, an intervention framework that requires "sobriety first" is an approach that is almost destined to fail.

LACK OF INFORMATION IN DOMESTIC VIOLENCE FIELD

Traditional addictions treatment approaches are insufficient to meet the needs of battered women, both those whose partners are addicted and those who themselves have a substance abuse problem. In many ways, the services typically provided by the domestic violence service system are equally inadequate to meet the needs of women affected by both problems.

Chemically dependent battered women often have very limited or no access to safe

shelter through the emergency domestic violence shelter network because of their addiction. While admission and discharge policies must consider the safety needs of all sheltered residents, policies that prohibit access by chemically dependent battered women and that often are based on misconceptions about addiction, cut off many women from a vital resource. Even when admission criteria do not categorically exclude chemically dependent battered women from services, domestic violence programs do not conduct appropriate screening for substance abuse and regularly fail even to minimally evaluate the addiction treatment needs of sheltered battered women (Bennett & Lawson, 1994).

Despite the fact that domestic violence programs do not adequately assess battered women for substance abuse problems, these programs do refer women to chemical dependency treatment agencies more frequently than the reverse occurs, suggesting to some that domestic violence programs have a greater desire to forge cooperative relationships with these providers of substance abuse treatment (Bennett & Lawson, 1994). There are, however, alternative explanations that may account for the high referral rates by domestic violence programs. The lack of information and training on chemical dependency among domestic violence program staff and/or the existence of harmful attitudes and beliefs about chemically dependent women may impede the direct provision of supportive and empowering interventions by domestic violence advocates. The subsequent referrals may then become a way to shift difficult cases to another agency or to someone else’s caseload. Advocates often miss an important opportunity to interrupt the deadly progression of women’s alcohol or other drug addictions, problems that may significantly impair battered women’s efforts to get safe.

CREATING AN EFFECTIVE PARTNERSHIP

Meeting the needs of battered women who are affected by substance abuse requires an effective working relationship between the two service systems, a need consistently identified by workers in both fields, but an undertaking fraught with multiple obstacles to cooperation (Bennett & Lawson, 1994; Levy & Brekke, 1990; Rogan, 1985; Wright, 1985). The battered women's movement is a grassroots social change movement based on a socio-political analysis of domestic violence. The alcoholism field works from a medical model and provides treatment from a perspective that understands chemical dependency as a disease. The subsequent conflicts that emerge in attempts to coordinate services to individuals affected by both problems are predictable and legitimate. The differences in language and approach reflect the analyses and perspectives of two very different problems. They are differences, however, that can and must be reconciled.

Despite the disparities, both the substance abuse and domestic violence service systems are combating problems that each day threaten the lives and well-being of countless women, children, and men. Both systems are battling barriers rooted in social attitudes and traditions that interfere with the provision of effective services and that frequently lead to harmful responses to those seeking help. It is essential that providers work together to ensure that our respective responses promote victim safety, offender accountability, and recovery from addiction.

REFERENCES

Bennett, L., and M. Lawson. 1994. "Barriers to Cooperation Between Domestic Violence and Substance Abuse Programs." Families in Society: The Journal of Contemporary Human Services, pp. 244-86.

Flitcraft, A., and E. Stark. 1988. "Violence Among Intimates, an Epidemiological Review." In Handbook of Family Violence, ed. V.D. Van Hasselt, R.L. Morrison, A.S. Bellack, and M. Hersen, pp. 159-99. New York: Plenum.

Haver, B. 1987. "Female Alcoholics: IV. The Relationship Between Family Violence and Outcome 3-10 Years After Treatment." Acta Psychiatric Scandanavia 57:449-56.

Kantor, G.K., and M.A. Straus, 1987. "The ?Drunken Bum' Theory of Wife Beating." Social Problems 34:213-30.

Levy, A.J., and J.S. Brekke. 1990. "Spouse Battering and Chemical Dependency: Dynamics, Treatment, and Services Delivery." In Aggression, Family Violence and Chemical Dependency, ed. D. Finnegan, pp. 81-97. Binghamton, NY: Haworth.

MacAndrew, C., and R.B. Edgerton. 1969. Drunken Comportment: A Social Explanation. Chicago: Aldine.

Marlatt, G.A., and D. J. Rohsenow. 1980. "Cognitive Processes in Alcohol Use: Expectancy and the Balanced Placebo Design. In Advances in Substance Abuse Behavioral and Biological Research, ed.
Nancy K. Mello, pp. 159-99. Greenwich, CT: Jai.

Minnesota Coalition for Battered Women. 1992. Safety First: Battered Women Surviving violence When Alcohol and Drugs Are Involved. Minneapolis: Minnesota Coalition for Battered Women.

Ptacek, J. 1987. "Why Do Men Batter Their Wives?" In Feminist Perspectives on Wife Abuse , ed. K. Yllo and M. Bograd, pp. 133-57. Newbury Park, CA: Sage.

Rogan, A. 1985. "Domestic Violence and Alcohol—Barriers to Cooperation." Alcohol Health and Research World, pp. 22-27.

Straus, M.A., and R. J. Gelles. 1990. Physical Violence in American Families. New Brunswick, NJ: Transaction Books.

Wright, J. 1985. "Domestic Violence and Substance Abuse: A Cooperative Approach Toward Working with Dually Affected Families." In Social Work Practice with Clients Who Have Alcohol Problems, ed. E.M. Freeman, pp. 26-39. Springfield, IL: Thomas.

The relationship between domestic violence and substance abuse among women is well documented. As an outgrowth of that research, social scientists have become increasingly concerned with the long-term consequences of children witnessing violence. Researchers thus began to investigate the influence of various types of family and community violence, including not only spousal violence, but also child abuse and neglect, street violence, and gun crimes. Domestic violence, however, was viewed as most traumatic because the victims and the perpetrators are often people whom the child loves and depends on for care.

Pathbreaking research has indicated that children exposed to violence at an early age are likely to suffer severe emotional and psychological damage. They may come to see the world as dangerous and unpredictable. They may lose trust and repress feelings, which can directly affect their emotional development.

Today, research is just beginning to explore the connection between substance abuse and children witnessing violence. Early indications are that the relationship is multidimensional and complex. For instance, family violence often occurs when the perpetrator is under the influence of an intoxicating substance. Family violence may also lead to the subsequent use of alcohol or drugs or both.

This resource guide presents the very new and important research findings and information on the relationship between childhood exposure to violence and substance abuse.

Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health Services
Administration

Ruth Sanchez-Way, Ph.D.
Acting Director, Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services
Administration