

Section 7 - Update 2007

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1. Introduction

We have tried to incorporate most of the new information included in the second edition of the toolkit but due to space constraints we have been unable to include everything.

However, all new sample documents are featured as well as the full version of the information to support children living with parental substance misuse and domestic violence.

We envisage that you insert this new section into the back of your current toolkit binder. A full version of the new toolkit (second edition) is available to purchase or download for free at www.gldvpstellaproject.org.uk

2. Supplement to section 2 – drug & alcohol information

2.1 Facts and statistics

Alcohol:

Department of Health definitions of hazardous, harmful and dependent drinking define:

- Sensible drinking: no more than 3-4 units a day for men and 2-3 units a day for women
- Binge drinking: 8 or more units of alcohol for men and 6 or more units for women on their heaviest drinking day in the past week
- Hazardous drinking: drinking above recognised 'sensible' levels and likely to result in harm should present drinking habits persist
- Harmful drinking: drinking above 'sensible' levels which causes harm to the psychological or physical well being of the individual
- Alcohol dependence: drinking above 'sensible' levels and experiencing harm and symptoms of dependence

- 21% of Londoners are reported to be drinking to harmful or hazardous levels. 5% (approximately 370 000 people) of adult Londoners are dependent drinkers compared to 3.6 % of adults across the whole of England¹

- Between 2000/01 and 2003/04 there was a 30 per cent increase (from just over 5000 to just over 7000) in the number of alcohol-related hospital admissions in London²

- Statistics suggest that parental alcohol misuse plays a role in approximately a quarter to a third of all known cases of child abuse³

Drugs:

- 71% of people entering Tier 3 and 4 drug treatment 2004/2005 in London and England were men and only 29% were women⁴
- In a comprehensive research study focusing on drug use amongst Black and minority ethnic communities in the UK, the largest concentration of female respondents reporting drug use is South Asian (29%)⁵
- London has the highest proportion of Class A drug users of any region of England and Wales. 5.2% of 16-59 year olds in London reported using a Class A drug compared to 3.4% across England and Wales⁶
- Over the period 1998-2005/06 men consistently report higher levels of drug use compared to women. 13.7% of men reported using any drug in the past year compared with 7.4% of women⁷

2.2 Drugs Policy

The Stella Project has created a sample drugs policy for domestic violence services working with survivors who are using drugs and accepts that a woman may need to use on the premises. It covers the steps that a refuge must legally take to operate within the law.

This can be found online at:

http://www.gldvp.org.uk/module_images/SampleDrugsPolicyFINAL.pdf

The main points of the sample policy are:

- Supplying or manufacturing drugs from the building is not allowed
- Any suspected drug use, supply or manufacturing in the building will be challenged. However, the refuge is not obliged to stop a woman using illegal substances in her room, unless they are cannabis or opium.

- The law for cannabis and opium is different to other drugs. If residents use these anywhere on the premises actions taken to address this have to be more assertive
- All women should report prescribed medicine use to staff and store them in a safe place
- Staff are prohibited from holding onto substances for residents, even if they are prescribed by the doctor
- Anyone whose behaviour is offensive or disruptive when affected by substance use will be challenged and treated in accordance with the refuge's general conduct and anti-social behaviour policy

The Stella Project policy draws on a sample policy created by Kevin Fleman/KFx available at www.ixion.demon.co.uk

Emergency drug/alcohol support

There are no drug/alcohol agencies which provide 24 hour assistance. Therefore if a woman arrives at a refuge and requires emergency assistance with regards to drug use e.g. severe withdrawal symptoms, you should contact the out of hours GP service or take her to A&E who may be able to prescribe some emergency symptom relief. It is unlikely they are able to provide emergency/immediate prescribing of drugs and if methadone is provided it will be at a low level.

Therefore, she may require extra support overnight or through the weekend until she can get access to full prescribing. You should contact your local DAAT team to inquire as to the fastest route in your area for providing services such as prescribing. You may wish to consider setting up a protocol with your local GP for prescribing the interim with the local drug agency picking up prescribing as soon as they re-open.

City Roads Crisis Intervention operates a 24 hour crack cocaine and opiates helpline **t: 020 7278 8671/2**

Saneline offer practical information, crisis care and emotional support to anybody affected by mental health problems. **t: 0845 7678 000** (charged at local rates) 1pm – 11pm every day.

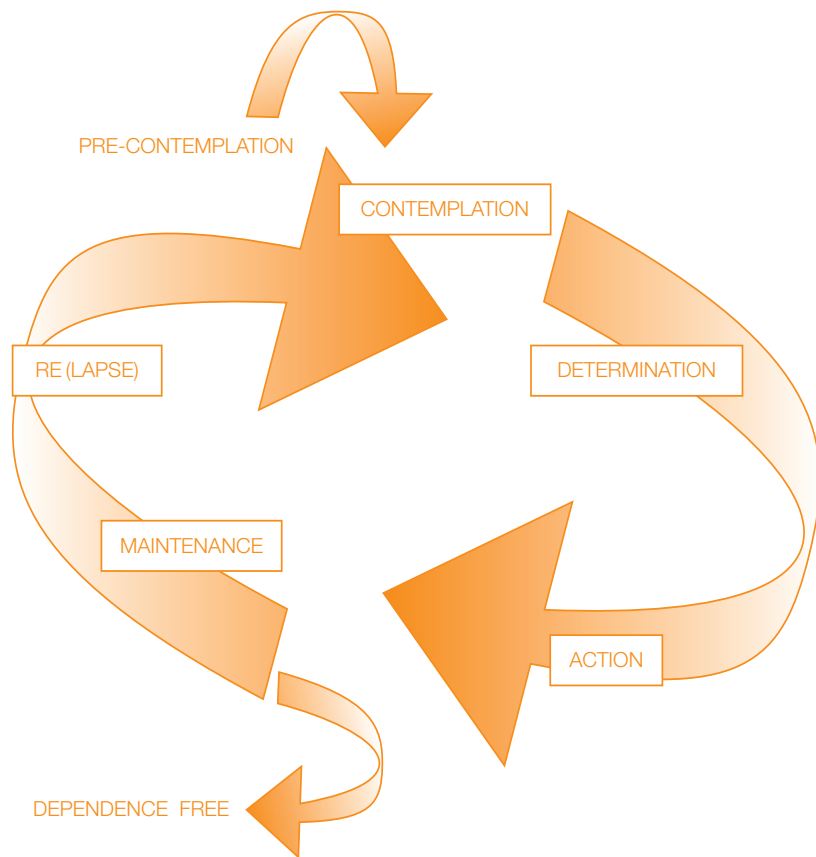
2.3 Safety for domestic violence survivors using substances

Safety Planning should address specific issues relating to a survivor or perpetrator's use of substances. Some additional issues you may wish to address include:

- Response survivors may receive from services/police etc. when they make calls under the influence of alcohol/drugs
 - Staying safe when services arrive - some women see this as a safe opportunity to challenge their partner/become more aggressive themselves when the police are there - this then impacts on them being seen as the aggressor and taken less seriously
 - How will they implement their safety plan if they are drinking? Often good safety plans can go out of the window as soon as a person is intoxicated
 - What provisions are made for children when using/drinking or when the violence happen?
 - Detox/withdrawal/relapse on the part of the perpetrator can be dangerous times in terms of safety
 - Consideration of which drug/alcohol services to access – do not use one where their partner attends
 - Altering routes/times if their partner is aware of their attendance at a alcohol/drug service; using a panic alarms; making sure phone is charged
 - Anticipating partner's substance use – how to keep safer when they have been using/drinking
 - Consideration of how a survivor's drinking/using may impact on their ability to protect themselves - they are more likely to fight back and receive worse injuries etc.
- The location of where a survivor goes to use/drink – how does this impact on safety?
 - Discussion of harm minimisation – e.g. learning to self inject safely, smoking rather than injecting (a drug/alcohol agency will be able to provide such harm minimisation support)
 - If considering leaving – where will they get supply of drugs – do they need emergency prescribing?
 - It is also empowering for a survivor to realise that their abuser wants them to continue in their dependency to substances and to plan for such interference with their treatment
 - Vulnerability/safety when entering new relationships due to drinking/drug use

2.4 Cycle of Change

The Cycle of Change theory[®] can be useful in understanding the different stages involved in addressing drug and alcohol misuse and the different types of support you as a practitioner can give along the way.



People have to move through each stage in succession in order to successfully reduce and/or stop using substances and most people attempting to stop using drugs and/or alcohol move around the cycle several times before they become dependent free.

Resistance to change is usually characteristic of the wrong intervention at the wrong time.

Characteristics of each stage and how you can provide support are listed below. Remember that as domestic violence practitioners you already use similar skills and knowledge with your service users and the same approaches can be used to address substance use and tip the balance in favour of change.

PRE-CONTEMPLATION

Being unaware of a problem, being in denial and minimising problem, and presenting excuses for why they should be using are all signs of this stage; a user is not considering change and is unlikely to take action soon.

How to help?

Raise awareness of the problem in a non-judgemental manner and emphasise the possibility of change; you may have to agree to disagree about the severity of the problem; help to do a self assessment to help increase survivors perception of risk and safety; help survivor to make link between their substance use and experiences of violence and abuse and any mental ill health symptoms; provide details of local drug/alcohol agencies.

Prescriptive advice can be counterproductive and can create resistance to change.

CONTEMPLATION

Substance user may see some of the negative consequences of substance use but is ambivalent towards change; seesaw of considering and rejecting change; *"I am not addict – I could quit if I want to"*.

How to help?

Normalise ambivalence and help to weigh up reasons for both sides and tip the balance in favour of change; reinforcing and giving further reflection to help clarify the seesaw or ambivalent feelings; emphasising the survivor's free choice, responsibility and self efficacy for change; use clients' language and goals; if you can talk positively about drug/alcohol agencies and individual workers – accessing these services may seem more appealing.

DETERMINATION/PREPARATION

Motivated to make change and looking for ways to change; this is a window of opportunity - only open for short time.

How to help?

Acknowledge the significance of choice and affirm ability to seek treatment and change despite the difficult road ahead; suggest choices for action and help survivor decide most appropriate, achievable path; probe survivor's thinking/worries/fears about options; if survivor is fearful about attending a new service, suggest a drug/alcohol worker comes to them at an agreed location.

ACTION

The person is actively doing things to change and modify behaviour but is not yet stable.

Often thought of as a therapeutic process; doing things to make a change.

How to help?

Cheering on; support survivor in steps to make change; reinforcing that feelings and difficulties are normal part of treatment journey; reflecting back to goals; make plans for possible interference of treatment by partner; let her know that relapse is normal and it will not jeopardise your relationship.

MAINTENANCE

A person continues to maintain behavioural change on a long term basis.

Sustaining change; preventing relapse; learning different skills that need to change.

How to help?

Helping client to identify and use strategies to prevent relapse e.g. finding activities to keep busy, new sources of pleasure, different ways to seek adrenalin high.

RELAPSE

A person returns to pattern of behaviour that they have begun to change and hence returns to one of the first three stages.

Slip up – steps backwards; challenge is to start again and not get demoralised; use relapse as an opportunity to grow.

How to help?

Help prepare for and expect relapse; avoid demoralisation; urge them to get back onto the track and not to give up; clarify consequences and what can be learned from the relapse.

2.5 Further information for practitioners delivering domestic violence perpetrator programmes

Statistics and information

- Research based on small scale studies in London and Nottinghamshire found that 63% of men attending domestic violence perpetrator programmes reported that they had substance misuse problems⁹
- Gondolf's multi-site evaluation of perpetrator programmes has shown that the man's drunkenness after programme intake made him 3 times more likely to re-assault his partner than a man who did not get drunk. If the man was drunk nearly every day, he was 16 times more likely to re-assault than those who seldom or never drank¹⁰
- Alcohol is likely to contribute to intimate partner violence in a variety of ways. Levels of consumption relate to the likelihood and severity of violence. Alcohol appears to be particularly important in escalating existing conflict¹¹
- Reducing substance use (including alcohol) may reduce levels of physical injury but has not been shown to reduce the actual occurrence of domestic violence (i.e. non physical abuse such as psychological and sexual violence)¹²

“It is important for workers to be clear that the alcohol does not cause his violence. He will have been violent and abusive when sober and he will certainly not have been violent every time he has been drinking.”

Phil Price, Domestic Violence Intervention Programme, East London

What to do when you identify a perpetrator who has a substance use problem

- **Undertake further detailed assessments of drug/alcohol use**

It is helpful for workers to understand how often a perpetrator uses, what he uses, when he uses and where. This will allow him to develop a greater understanding of his situation and identify which interventions are most appropriate.

See pg 81 for further questions or assessment tools which will enable you to do this. This could also be undertaken in conjunction with a drug/alcohol worker.

Detailed assessment is important to determine which substance misuse treatment is most suitable and in order to advise his partner about the nature of the drug/alcohol problem and implications for their safety planning.

- **Establish if he wish to address his substance use and refer him to an appropriate service**

Ideally substance use and violence should be dealt with concurrently. However, in some cases it may be necessary for a man to address his substance misuse before attending a perpetrator programme. Don't just refer him to a substance misuse service and expect the violence and abuse to cease. However, an effective drug/alcohol treatment intervention may reduce the seriousness of the violence.

As drunkenness after and during programme intake is a strong indicator of future re-assault, risk may be reduced by periodically monitoring men's alcohol use or treatment compliance.

- **Establish contacts with local alcohol and drug services**
Details of local services across London can be found at www.ldan.org.uk. Contact your local Drug Alcohol and Action Teams in the boroughs in which you work and ask for a copy of their referral guide which will detail all services in their boroughs.

- **Educate him where appropriate about the lack of a causal link between alcohol and drugs**

“If he knows he is much more likely to be aggressive when drinking - then the decision to drink is a decision to be violent.”

Phil Price, Domestic Violence Intervention Programme, East London

Allow him to discuss his view of the relationship between the two. This will give you more insight into his thinking and more information to work with. The focus of all perpetrator work is encouraging the abuser to recognise his own ability to control his violence. In relation to drug/alcohol use perpetrators should be encouraged to:

- Explore and dispel beliefs that the substance use alone causes the violence
- Acknowledge his use of violence/abuse whilst sober
- Acknowledge that he is not always violent whilst being substance affected
- Understand that entering into a drug/alcohol treatment programme will not be sufficient to stop the violence and abuse

According to Respect's Perpetrator Programme Accreditation Standards, all staff working on domestic violence perpetrator programmes should receive basic drug and alcohol training. Screening of all perpetrators for drug/alcohol use should be standard and staff are recommended to make links with local drug/alcohol agencies and make referrals where appropriate.

For more information on these standards contact Neil@respect.uk.net

3. Supplement to section 3 - domestic violence

3.1 New definition

The Government's new definition of domestic violence is as follows:

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'¹³

This definition includes violence such as female genital mutilation (FGM), so-called 'honour' crimes, forced marriage and acts of gender based violence.

Defining domestic violence has always been problematic. It must be emphasised that the above definition is insufficiently complex to understand domestic violence in its entirety and functions only as a monitoring mechanism.

Whatever form it takes, domestic violence is rarely a one off incident, and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim.¹⁴

3.2 Why stay in an abusive relationship?

It is commonly asked why women stay in a relationship if the abuse is so bad. However, perhaps it is more appropriate to reframe the question to focus on the perpetrator and ask why doesn't he stop the abuse and why doesn't he leave?

Below are listed a wide range of issues to consider for survivors; each will be more or less relevant to your service user. It is also important to consider that Black and minority ethnic and refugee women's experiences may be further compounded by racism and discrimination; furthermore the experiences of Lesbian, Gay, Bisexual and Transgender survivors will also be compounded by additional discrimination and complexities.

Common reasons survivors give for remaining in violent relationships include: fear of increased injury, danger or murder – often based on threats made by the perpetrator; stalking/abduction; loss of drug supply; isolation or rejection from community, friends and family; loss of home, income, pets, possessions and reduced standard of living; negative impacts on children – loss of school, friends, community, relationship with father/family; grieving for loss of partnership; feelings of guilt and self-blame; fear of losing children/having children removed; continued or increase use of drugs or alcohol; loss of group/location for using/drinking; and being unable to access drug/alcohol service due to partner accessing same service.

"My ex-boyfriend were a control freak, he were a lot older, and I were a lot younger at that stage, and I think he wanted to be in control more. He was always in control of the drugs, like. He'd get the drugs and he put it on the spoon, he'd cook it up, he'd draw the drugs up into the pin and that and like he wanted to be controlling me, always had to inject me."

(Survivor's voice)^A

3.3 Key pieces of new legislation

Domestic Violence Crime and Victims Act (2004)

- **Section 1:** amends the Family Law Act 1996 to make breach of a non-molestation order a criminal offence, punishable by up to five years of imprisonment.
- **Section 3:** definition of 'cohabitants' to include same sex couples and extends provisions to include non-cohabiting couples (not enacted – but enacted under the Civil Partnerships Act (2005))
- **Section 4:** makes couples who have never cohabited or been married eligible for non-molestation and occupation orders, under the Family Law Act 1996
- **Section 5:** creates a new offence of causing or allowing the death of a child or vulnerable adult. This establishes criminal responsibility for members of a household where they know a child or vulnerable adult is at significant risk of serious harm
- **Section 9:** establishes domestic violence murder reviews (not yet enacted)
- **Section 10:** common assault is an arrestable offence [not enacted – but common assault is arrestable under the Serious Organised Crime and Police Act (2005)]
- **Section 11:** allows a court to make a restraining order when the defendant has been acquitted of the offence
- **Section 12:** will enable courts to impose a restraining order when sentencing for any offence, on conviction and also on acquittal

Sexual Offences Act 2003

Overhaul of the previous law on sexual offences.

There is now a:

- New definition of rape which now includes oral penetration
- New offence of sexual assault. This replaces indecent assault
- New offences of assault by penetration and causing a person to engage in sexual activity
- New definition of consent. The onus is now on the perpetrator to show that he took steps to find out that the victim was consenting

Rights of Women www.rightsofwomen.org.uk can give more advice and information about the civil and criminal law and can be contacted on 020 7251 6577. The website also gives more in depth information regarding the law and details of training courses on domestic violence and the law.

Using Treatment Outcomes Profiles (TOP) and Care Planning to address domestic violence

We know that many victims (and perpetrators) will not disclose experiences of domestic violence at initial assessments. However, disclosures might be made later when you have established more of a relationship with the service user.

The answers to some of the TOP questions/monitoring could alert a practitioner to the possibility of domestic violence and therefore could provide the opportunity to explore the issue further. Questions on mental, physical health, quality of life, social circumstances and offending could all open a window of opportunity to address domestic violence with service users.

For example, a question about quality of life and relationships with partner and family could be followed by a question about whether your service user is frightened of anyone at home or whether they have done anything they regret towards a partner when they are using/drinking.

3.4 Risk assessment and management

Assessing Risk

If someone has problems with their substance use or is the victim of violence they are potentially at risk of harm. Harm can be experienced physically, emotionally, financially and socially. A risk assessment can highlight potentially dangerous risks your client may be facing and indicate any areas of additional support they may require.

As a drug/alcohol worker you will already complete a lengthy risk assessment form. As standard you should include a question about experiences of violence. If your service user is indicating experiencing violence or abuse from a partner or family member you should ask further questions:

- *“Is the violence worsening in nature?”*
- *“Has your partner been more controlling lately and/or attempted to isolate you?”*
- *“Do you feel unsafe to go home?”*
- *“Are you planning to leave your partner or have you recently separated?”*
- *“Has your partner attempted to choke or strangle you?”
(a high proportion of women who are murdered are strangled by their partners)*
- *“Has a weapon been used against you? E.g. a household instrument used as a weapon”*
- *“Has violence occurred whilst you were pregnant?”*
- *“Have you been forced to have sex or perform a sexual act against your will?”*
- *“Have children been injured during a domestic violence incident?”*
- *“Does your partner force you to use drugs/alcohol?”*

Answering yes to any of these questions could mean your service user is at a high level of risk. It is important that you work with a domestic violence professional to complete a thorough risk assessment as soon as possible.

If your service user does not wish to speak to a domestic violence worker you should respect these choices and not force this option. However, you should consider undertaking a full risk assessment to determine whether you should refer and share information to your local MARAC (see pg 23).

Domestic violence cases can be highly complex with fragmented information shared across several different services. Joint information sharing and development of a risk management strategy is far more effective and prevents you as a lone worker or agency carrying the sole responsibility for victim/survivor (and their children’s) safety.

Remember:

Risk assessments are not foolproof and they only give an indication of risk at that particular point in time. Victim/survivor assessment of danger is the most reliable indicator of risk.¹⁵ If she feels he will be violent again, chances are that he will. Nevertheless, you should be aware that women often minimise the risk as a way of coping so a denial/hope that he will not be violent again is not as reliable. Other research suggests that assaults committed whilst intoxicated are also a relatively reliable indicator of future risk of serious violence.¹⁶

An example of a risk assessment can be found on pg 92.

High Risk Cases - when should I override requests for confidentiality?

Upon initial assessment it is standard practice to explain the limits of confidentiality. Domestic violence comes under the duty to share information if a service user is deemed a risk to themselves or others.

If you determine your service user to be at a high level of risk then you are obligated to override confidentiality and share information with a domestic violence professional without consent. If you are concerned for your service user’s immediate safety upon leaving your service you should call the police.

If having undertaken a risk assessment you deem your service user to be at a high level of risk you should refer to your local MARAC coordinator and be prepared to share information on a need to know basis. It is best practice to tell your service user this is what you are doing whether you have obtained their consent or not.

In all cases where there is indication of violence or abuse you should:

- Believe what the victim/survivor is telling you and do not blame them
- Do not tell them what to do
- Give details of services and offer to make a referral
- Discuss with your line manager
- Be aware that risk can change and monitor this in care planning
- Record what actions you took

3.5 The role and effectiveness of Multi-Agency Risk Assessment Conferences (MARACs)

The role of the MARAC is to facilitate, monitor and evaluate effective information-sharing to enable appropriate actions to be taken to increase public safety. The aims are:

1. To share information in order to increase the safety, health and well-being of victims – adults and their children.
2. To determine whether the perpetrator poses a significant risk to any particular individual or to the general community and to reduce this risk.
3. To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm by the perpetrator.
4. To reduce repeat victimisation within a multi-agency context.
5. To improve agency accountability and responses to domestic violence.
6. To improve support for staff involved in high risk domestic violence cases.

The responsibility to take appropriate actions rests with individual agencies; it is not transferred to the MARAC.

MARACs usually focus on high risk victims as indicated through the use of risk assessment and management process. By sharing information, agencies get a better picture of victims' situations and so develop responses that are tailored to the needs and goals of individual victims and their children. Safe information-sharing also allows agencies to manage the perpetrator in ways that reduce risk.

It is important that MARACs co-ordinate their work with LSCBs, MAPPAs and local systems to safeguard vulnerable adults.

Evaluation of MARACs:

- 42% of victims experienced no repeat incident and there were no police callouts in the 12 months following their case being heard at the MARAC
- Those who did suffer repeat victimisation typically called the police at a less severe level of abuse than had previously been the case, reflecting improved confidence in the services received and a significant step towards the goal of earlier intervention
- The combined work of Independent Domestic Violence Advisors, improved policing and the MARAC process have increased reporting of domestic violence from just over 150 cases/month to over 300 cases/month in 3 years
- The level of reported repeat victimisation to MARAC agencies has dropped from 32% to below 10%
- The number of children referred to the Social Services for extra support has increased from 5% to 50% of cases
- The impact on attrition is significant: the number of victims refusing to make a complaint and withdraw support to proceed to court has dropped from just under 60% to under 5%

Source: Specialist Domestic Violence Court Manual, Home Office, 2006

MARAC attendance and decision making

Those attending the MARAC should have the authority within their agencies to prioritise the actions that arise from the MARAC and to be able to make an immediate commitment of resources to those actions.

The victim does not attend the meeting, nor does the perpetrator, or the Crown Prosecution Service. The victim is usually informed that their situation will be discussed by the MARAC, unless doing so would jeopardise the victim's safety.

On average the MARAC will spend about 10 minutes per case. This does underline the importance of the role of the IDVA within the process.

The MARAC would usually be chaired by an officer from either the police or probation services. This is normally someone with the rank of Detective Inspector or equivalent. Contact your local Domestic Violence Coordinator for more information.

Protocols on information-sharing will have to be drafted and adopted by all agencies.

3.6 Information Sharing

Always share information to protect the safety of a survivor and their child(ren). If it is not for this reason, then do not share it. Information should not be shared for the sake of sharing information.

Detailed guidance on sharing information in a multi-agency context is available in the service provider resources section of the GLDVP website www.gldvp.org.uk

3.7 Working with domestic violence perpetrators within drug/alcohol services

In-depth work with perpetrators around their use of violence is a specialist field and holds potential for extreme danger. As such, it should only be attempted by trained professionals. The links between domestic violence and substance misuse are controversial, complex and a much under-developed area of debate.

However, given the fact that a perpetrator may not be engaged with specialist perpetrator services there are things you can do as substance misuse practitioners to partially address the abuse safely and effectively. This section focuses on identification of perpetrators, giving safe messages to clients and referrals to appropriate agencies.

Facts and statistics

- Findings from a review of the British Crime Surveys revealed that 44% of domestic violence offenders were under the influence of alcohol and 12% affected by drugs when they committed acts of physical violence
- Home Office research on domestic violence offenders (n = 336) showed 73% had used alcohol prior to the offence, with 48% seen as 'alcohol dependent'¹⁷
- Alcohol is likely to contribute to intimate partner violence in a variety of ways. Levels of consumption relate to the likelihood and severity of violence. Alcohol appears to be particularly important in escalating existing conflict¹⁸
- A number of studies have found that the perpetrators use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober¹⁹
- Evaluation of perpetrator programmes has also shown that a man committing violence whilst drunk is one of the most influential risk markers of future violence²⁰
- A small scale study in the UK showed that all of the women interviewed about the role of alcohol in their partner's abuse had also experienced violence and abuse from their partner when he had not been drinking²¹

- Reducing substance use (including alcohol) may reduce levels of physical injury but has not been shown to reduce the actual occurrence of domestic violence (i.e. non physical abuse such as psychological and sexual violence)²²

Why do this work?

Duty of Care/Social Responsibility:

Drug and alcohol workers have a social responsibility to address all the complex needs of a service user associated with drug and alcohol use, which may include the perpetration of domestic violence.

If the project is working with both partners, there is a duty of care to ensure the safety and well-being of the service user who is a victim/survivor of domestic violence. Challenging domestic violence could increase the ability to motivate change in a service user. One of the motivations for change is the perpetrator's awareness of the harm they are causing to others.

The actions of workers may help to improve the safety of a victim of domestic violence (including children) and ultimately prevent serious injury or death. There is a responsibility to share information if a service user is deemed at risk of harm to others.

Legal responsibilities:

Under section 17 of the Crime and Disorder Act there is a responsibility to take 'reasonable' action to prevent a crime which includes acts of domestic violence. This applies to voluntary sector agencies carrying out the duties of Responsible Authorities such as PCTs, Local Authority and the police.

Disclosure of domestic violence may result in increased risk for any children in the household and an effective agency response would therefore aid in more effective child protection responses.

Any agencies which are funded from the statutory sector have a positive duty to uphold rights in the Human Rights Act.

Alcohol and Domestic Violence: Myths and Realities

Myth:

Alcohol misuse causes domestic violence

Reality:

There is no simple causal relationship between alcohol use and domestic violence. Not all people attending alcohol treatment are abusive or violent towards a partner nor do the majority of domestic violence incidents take place when the perpetrator was drinking or using drugs.

This implies that there is a much more complex relationship which takes place combining the physiological effects of alcohol (or other substances) and other cultural and social factors such as the belief in using violence against women, expectations of gender roles and feelings of entitlement within relationships.

In small scale studies of domestic violence survivors, the women reported that the level of aggression of their partner depended on a number of variables in addition to the alcohol e.g. pre-drinking mood; aggression and worries; environmental factors; personality specific factors; and individual goals of drinking.²³

Myth:

For abusers who drink – there is a clear pattern that relates the abusive behaviour to their drinking

Reality:

A small scale study in the UK showed that all of women interviewed about the role of alcohol in their partner's abuse had also experienced violence and abuse when their partner had not been drinking. It is important to remember that even when physical violence only takes place with alcohol use, often emotional, psychological, financial and sexual abuse takes place in its absence.

Myth:

Alcohol treatment alone will address the abuse adequately

Reality:

Even if treatment is able to reduce the severity of the violence it does not address the complex dynamics and power and control which underpin domestic violence. Therefore, work which specifically addresses such dynamics should always accompany a treatment plan.

Myth:

Abusers lose control when drunk

Reality:

The Stella Project does not support the view that abusers lose control when perpetrating abuse – whether this involves substances or not.

Women report that even when their partners have seemed “uncontrollably drunk” during a physical assault they routinely exhibit the ability to stop the abuse when there is an outside intervention e.g. children, police.

Abusers exhibit control over which area of the bodies they direct their assault even when drunk. The majority of abusers only target their abuse and violence at one person – their partner.²⁴

Practice issues

Routine questioning for possible perpetrators of domestic violence

Perpetrators of domestic violence are unlikely to present to your service and disclose their violence as a problem with which they need help.

In drug and alcohol services they are more likely to associate their violence as a negative effect of their substance use. Alternatively perpetrators may refer to their violence as an 'anger management issue.' Within your general assessments under the sections which deal with risk of harm to others you should include some questions to ascertain whether your service user has ever been abusive towards a partner. **Sample questions are outlined on pg 145 in the first edition of the toolkit.**

It is important to begin any conversations about abuse by explaining that these are routine questions asked to every person who accesses the service.

If a man has stated that domestic abuse is an issue, these are useful questions to ask:

- ***“It sounds like your behaviour can be frightening; does your partner say they are frightened of you?”***
- ***“How are the children affected?”***
- ***“Have the police ever been called to the house because of your behaviour?”***
- ***“Are you aware of any patterns – is the abuse getting worse or more frequent?”***
- ***“What worries you most about your behaviour?”***
- ***“It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would you like to assist you make these changes?”***

What do I do if I know my client is perpetrating domestic violence?

It is important to find a balance between challenging the abusive behaviour whilst maintaining the development of the therapeutic relationship. Be especially careful if he is under the influence of alcohol or other substances and do not engage with him about his violence at such times.

Any discussions about abuse and violence should emphasise that there is no excuses for the behaviour. Any other approach is in danger of colluding and condoning the abuse. It should be made clear that the substance use is not to blame and no-one deserves to be abused.

Also be aware of the barriers to him acknowledging the abuse and seeking help (such as shame, fear of child protection process, self justifying anger etc.)

You may find the following approaches useful:

- Give him positive feedback on disclosing his use of violence, this will allow him to further explore and reflect on the problems with his use of violence. Be positive that he can change
- Help your service user to explore the links between the substance use and the abuse – when did the abuse and violence first start, what were the circumstances. Allow him to talk to support analysis of his attitudes, values, insights, defensiveness, powers of self analysis and commitment to change
- Do not back him into a corner and expect an immediate honest disclosure about the extent of the abuse
- Explore how he uses his behaviour to control and manipulate his partner and explain that domestic violence is a range of behaviours not just physical. Is it possible for him to empathise?
- Ask him what effects his violence has upon himself and explore if this is how he would like to continue. Be aware that deep down he is probably unhappy about the abuse

- Ask him to focus on the effects the abuse has on his children and partner, their family and friends. Allow him to think of the issue from another point of reference
- Does he show a desire to change? If not broach the subject with him in future sessions
- Have you established whether there are child or adult protection issues that need reporting? Does your organisation have a protocol for dealing with this?
- Tell him that you may contact his partner and provide her with information and offer support
- If he does wish to change encourage him to phone the Respect phone line on **0845 122 8609** or consider referring him to a perpetrator programme.
- Contact Respect for a list of perpetrator programs in your area. Contact a program and discuss the support they can provide to both the perpetrator and their partner

As with substance treatment, the most effective intervention takes place if an abuser acknowledges the problem and wishes to change.

“It is important for workers to be clear that the alcohol or drugs does not cause his violence. He will have been violent and abusive when sober and he will certainly not have been violent every time he has been drinking.”

Phil Price, Domestic Violence Intervention Programme, East London

Safety and basic risk assessment

If you are in contact with both partners, always see them separately when discussing violence and abuse.

If your information about the man's violence comes only from the woman, you MUST NOT use that to challenge the man. Her safety is paramount.

Offer alternatives to ‘couple work’ as such interventions are unlikely to be ineffective and even dangerous (**see pg 49**).

Be constantly alert to indicators of risk

Risk is not a static process and he is unlikely to disclose the level and extent of violence (particularly sexual violence) through direct questioning.

However, whilst completing your standard risk assessments and undertaking key working sessions with your service user you should be alert for the following indicators which have been found to be risk factors for domestic violence:

Domestic Violence Risk Identification checklist – for perpetrators

The following have been identified as factors associated with the perpetrator as increasing the risk of domestic violence. They do not provide a comprehensive reference for factors associated with victim vulnerabilities.

- History of violence and abuse
The strongest predictor that violence will occur in the future is if it has happened in the past. Indicators of particularly high risk to the victim include affirmative answers to the following: *Has the violence caused injuries? Have there been threats to kill, use of weapons? Choking or strangulation? Is the violence escalating? Has there been sexual violence/coercion/abuse? Has there been stalking, harassment, isolation of the victim? Jealous, controlling or obsessive tendencies?*
- Separation
Have the couple recently separated or is a separation imminent? It is often assumed that once the abusive partner is no longer present that the risk of violence ends. Yet research has consistently shown that it is the period following a couple's separation that poses the greatest threat to most women.
- Alcohol/drugs
Few researchers think there is a simple causal link between substance misuse and violent behaviour. Nevertheless, men's (especially recent and heavy) alcohol or drug misuse features among the most robust risk markers for violent recidivism and for inflicting serious injury to a victim.

- **Children's exposure**
In 90% of domestic violence incidents reported in the British Crime survey where children were present in the household, children were in the same or adjacent rooms. Whether or not children are directly exposed to the violence, we should also bear in mind that many men who assault their wives or partners are also directly physically or sexually violent to their children (estimates vary between 40-70% depending on the research).
- **Disputes over child contact**
In domestic violence homicide reviews in London, child contact has been proven to be a major factor in the majority of murders.
- **Mental health problems**
There is an established link between certain mental health problems such as attention deficits, including ADHD, anxiety, depression, post-traumatic stress, and personality disorders (especially borderline and anti-social personality) and an increased risk of domestic violence (especially when associated with a history of substance abuse).
- **Major life stresses**
E.g. bereavement, unemployment, homelessness, financial problems. The greater the number of individual, familial and social stressors individuals encounter, the greater the likelihood of domestic violence occurring.
- **Criminal record**
Men who have a history of anti-social behaviour or prior arrests, criminal convictions, or imprisonment for offences unrelated to violence are at increased risk of perpetrating violence in general, and domestic violence in particular.
- **History of generalised aggression**
Those who exhibit generally aggressive behaviour or who are violent to non-family members are among the most dangerous of domestically violent men; they are more likely to be severely and frequently violent, more likely to be sexually abusive, and more likely to murder their partner.

If you are in contact with the partner – issues to consider

- **Victim perceptions**
Is the victim afraid of further injury or violence? That the children will be hurt? Research has shown that victims' perceptions of risk tend to be accurate – the victim is, after all, the person who has been most closely associated with the perpetrator. A possible exception is where victims may minimise risk, for instance out of fear of the perpetrator or social services intervention or as a coping strategy.
- **Other victim vulnerability factors**
Pregnancy, poverty, health problems, imposed isolation by the perpetrator, disability, substance abuse, insecure immigration status, or dependency on the perpetrator in respect of these.

Consider sharing information

Communication with other agencies may be necessary to ensure the safety of his partner and children, particularly if he is not willing to engage with you around this subject.

You should consider seeking advice from the Respect helpline and/or contacting your local MARAC Coordinator (**see pg 23**) if you are concerned about the risk posed by an abuser.

Domestic violence cases can be highly complex with fragmented information shared across several different services – joint information sharing and development of a risk management strategy is far more effective and prevents you as a lone worker or agency carrying the sole responsibility for managing the behaviour of an abuser.

A model of good practice is to get permission to contact their partners if you feel their safety is at risk. For example, if the perpetrator has made threats to seriously harm his partner upon leaving the service.

Your agency could consider including a few sentences in your confidentiality agreement which give permission to contact a partner and passing on information to professionals with regards to acts of violence towards a partner or children.

Record disclosures

You should always make a note of when you asked and the response in the service user's records. You should also note what action you took in response to a disclosure. This information may be required if future criminal justice action is taken and could also be helpful in other circumstances (e.g. housing applications).

Refer to your line manager for guidance and support – you should not be expected to work with this issue on your own.

Referrals to perpetrator programmes

The Respect network accredits and supports perpetrator programmes with associated women's support services and works to a set of agreed standards.

As an organisation you need to ensure you have contacts with your local perpetrator program, so that your referrals are appropriate. When referring to perpetrator programmes you should look for programmes which are part of the Respect network as this will provide some reassurance about quality and safety.

More information about the content and philosophy of perpetrator programmes can be found at www.respect.uk.net and www.dvip.org

4. Supplement to section 4 - issues for both sectors

4.1 Supporting children living with parental substance misuse and domestic violence

Children are often forgotten when we consider the interventions required to work with domestic violence survivors and perpetrators. Most children who have witnessed violence in the home find it extremely upsetting.

Some evidence suggests children suffer trauma similar to Post Traumatic Stress Disorder as a result. In addition, children living with parental alcohol and drug misuse can suffer a range of physical, psychological and behavioural problems.

Despite limited data defining the number of children living with both domestic violence and parental substance misuse, it's clear that the two issues overlap.

Therefore there are likely to be significant numbers of children affected by the dual issues which may expose them to greater risks and increased levels of harm and present child protection issues.

The following section will provide information on how to support children living with the dual issues, including safety planning for children.

4.1.1 Key messages

“You see at one point...because they’d been going through so much, I started protecting them not letting them see what was going on and then it just got worse and they know. Especially when they turn around and say ‘oh but me dad had a drink he didn’t mean it, it’ll be alright won’t it, tomorrow...”

(Mother’s voice)

- Women who experience domestic violence, including those who use substances, are rarely ‘bad’ parents. Many women are able to manage their parenting role despite their substance use
- In assessments, focus should remain on how the non-abusive parent is able to meet the physical and psychological needs of the child when they are using substances
- Children’s services need to be an integral part of any responses rather than, as occurs far too often, an afterthought
- Workers need to feel confident in discussing and reporting potential or actual child abuse and neglect that may be occurring

4.1.2 Domestic violence, parental substance misuse and children - facts and statistics

- Over a one hundred day period an estimated 205,000 children will witness domestic violence²⁵ and at least 14 children will die from cruelty²⁶
- 29 children are known to have been killed in the last 10 years as a direct result of child contact arrangements²⁷
- At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs²⁸
- It is estimated that there are between 250,000-350,000 children of problem drug users in the UK – about one for every problematic drug user²⁹
- Children who grow up in families where there is domestic violence and/or parental alcohol or drug misuse are at an increased risk of significant harm³⁰
- Child Line report that 44% of children who called about a significant other’s alcohol misuse, had called primarily to talk about the physical abuse they had experienced. 29% who had called about significant other’s drug use reported physical abuse³¹
- 1 in 11 children are estimated to be living with a parent who is experiencing problems with their drinking³²
- Among the families that social workers have on their caseloads, 50-90% of cases include parents with drug, alcohol or mental health problems³³

4.1.3 The overlap between domestic violence, parental substance misuse and child abuse

Some aspects of abuse can be seen as both domestic violence and child abuse, it is important to remember that ‘association does not equal causation’. Just because two things are linked, it doesn’t mean that one causes the other.

Domestic violence is often associated with other risk factors such as poverty, substance abuse, child sexual and physical abuse, maternal depression and parenting style. Galvani has outlined the numerous parallels between the potential negative effects of parental alcohol problems and domestic violence and abuse on children.³⁴ (overleaf)

They are striking and outline the need for extra vigilance amongst professionals in detecting whether children are living with both issues and how this is affecting them.

Furthermore there are established links between experiencing child abuse and re-victimisation in later life,³⁵ and much has been written on the links between child abuse and the development of substance use problems in adulthood.³⁶

‘Grown ups think they should hide it and shouldn’t tell us but we want to know, we want to be involved and we want our mums to talk to us about what they are going to do, we could help make decisions’ (Child’s voice)³⁷

A clear distinction should be made between domestic violence and child abuse. Many children are themselves the direct target of abuse as well as experiencing indirect abuse through witnessing domestic violence. Both of these experiences can cause immense damage to children.

Parental alcohol problems	Domestic abuse
Social isolation, stigma and keeping secrets	Social isolation, stigma and keeping secrets
Emotional neglect and abuse	Emotional neglect and abuse
Behavioural changes or problems	Behavioural changes or problems
Developmental delay, including in utero	Developmental delay
Potential damage to the foetus from heavy drinking (Foetal Alcohol Spectrum Disorder – FASD)	Damage to foetus/miscarriage from physical abuse targeted at stomach
Psychological and/or psychiatric problems	Psychological and/or psychiatric problems
Poor supervision	
Inconsistent and poor quality care	Inconsistent and poor quality care
Overly punitive discipline	Overly punitive discipline
Child feeling fearful and responsible	Child feeling fearful and responsible
Disrupted play and leisure time	Disrupted play and leisure time
Disrupted routines, eg. school attendances	Disrupted routines, eg. school attendances
Low self esteem and confidence	Low self esteem and confidence
	Physical and sexual abuse
Disrupted attachment to parents	Conflicting loyalties towards parents
Difficulties in their adult relationships	Difficulties in their adult relationships

Taken from Galvani, S (2006) Safeguarding Children - working parental alcohol problems and domestic abuse, The Parent and Alcohol Project Paper Series, London: Alcohol Concern.

This is further compounded when one or both parents have problematic substance use. It is essential that organisations working with children have clear guidelines for dealing with disclosures of child abuse. Children need to feel they are being listened to and are safe. You need to be clear about what disclosure means in terms of child protection issues (see sec 4.1.9).

Common Assessment Framework

The Common Assessment Framework (CAF) aims to bring a standardised and more holistic approach to assessing and responding to the needs of children. It forms part of the Every Child Matters: Change for Children (DFES, 2004) strategy to achieve a greater focus on preventing things from going wrong in children's lives rather than dealing with the consequences once difficulties have arisen.

The CAF also aims to: promote early intervention; improve multi-agency working; consistency in undertaking assessments and referrals; reduction of bureaucracy for families by decreasing the amount and length of any further assessments.

A sample form and further guidance for implementation can be accessed at

<http://www.everychildmatters.gov.uk/deliveringservices/caf/>

All local authorities are expected to implement the CAF by the end of 2008.

The Parenting and Alcohol Project has produced an evidence base for assessing the potential impacts of parental alcohol misuse on children within the framework of the CAF. They are presented in a series of tables which are accessible and easy to understand.

Parental Alcohol Use and the Common Assessment Framework, The Parenting and Alcohol Project, Alcohol Concern, 2006 available to download at www.alcoholandfamilies.org.uk

4.1.4 Protective factors and building resilience in children

In recent years focus has been on identifying why some children are able to be resilient to the impact of negative childhood experiences such as parental substance misuse and domestic violence. Research seems to indicate that some children can grow up with many forms of difficult circumstances without developing significant problems.³⁸

Resiliency is defined as **“...the ability to overcome adversity, survive stress and rise above disadvantage.”**³⁹

There are certain protective factors which can be fostered which make it more likely that a child can become resilient.

“Protective factors make it more likely that a child can overcome this risk because they provide a more positive setting. Resilience makes this more likely because it equips the child with a set of skills and feelings that enable him (or her) to be forward looking and to bounce back from adversity.”⁴⁰

Studies have shown that a central key element of helping children thrive in difficult circumstances is feeling as though they have choices and are in control of their lives. This can be done through the identification of goals and aspirations and the strategies needed for achieving them.

Resilient children may appear to be less vulnerable, however it is still important to offer services and support as levels of resilience and protective factors can change at various developmental stages and transitions.

Researchers have identified some key ways that practitioners can help children and young people develop the attributes associated with resilience.⁴¹

Working directly with children, practitioners can help enable children to:

- Maintain positive family routines

- Remove themselves from the disruptive behaviour of the problem parent or parents (where domestic violence is present in the family, evidence shows that the negative effects on children and the problems they face as a result can dramatically improve once they are away from the perpetrator of abuse)
- Disengage from the disruptive elements of family life
- Engage with stabilising people outside the family
- Develop 'confidants' outside the family
- Engage in stabilising activities (schools, clubs, sports, culture, religion) within which the child can develop a sense of self and self-esteem
- Receive early interventions
- Develop a desire to be, and pride in being, a survivor

Practitioners can also help mothers and non-abusive care givers to:

- Ensure that young children have age-appropriate opportunities outside the family
- Experience warm, supportive, nurturing relationships with their parents and with other caregivers
- Ensure that mothers and carers have access to all benefits to which they are entitled, as well as to local opportunities that will promote their economic security. Focusing on financial strategies can help ensure that women and children are not trapped in violence because of their economic circumstances

“So we’d talk occasionally but I was too scared of what to say because if it ever got back I knew that I’d be the one that got in trouble.” (Child’s voice)⁴³

4.1.5 Guidance for drug/alcohol agencies

Practice Guidance

The Advisory Council on the Misuse of Drugs states that assessing and meeting the needs of a client’s children should be an integral part of reducing drug related harm. It recommends that substance misuse agencies should become family friendly with an emphasis on meeting the needs of women and children.⁴² A number of key tasks should remain the focus of work to support children affected by parental substance use:

- Reducing and stabilising the parents drug and alcohol use as far as possible (this may require supporting the mother around issues of domestic violence)
- Discussing safety at home (from both parental drug use and domestic violence and abuse)
- Liaising with families’ health visitors
- Ensuring the child is registered with a GP and immunised
- Checking the child receives early years and school education
- Liaising with the local child protection team if harm to the child is suspected
- Involvement of relevant non-statutory agencies with the aim of collectively meeting the needs of children e.g. domestic violence agencies

Whether your agency works only with adult service users or includes children and families, practitioners need to take the following measures:

- Identifying and asking about domestic violence and abuse and intervening where children are suffering abuse or are at risk of abuse
- Be clear that the service users’ safety is the priority rather than their drinking or drug using goal. Practitioners may have fears that this will frighten their clients away from treatment but if it is routine part of assessment alongside other personal questions involving health and risk then this is unlikely to be an issue

- Staff commitment to referring the adult and children to domestic violence specialists as well as a commitment to monitoring and supporting their progress. Once the safety of the children and parent is established it is more likely that they will feel able to talk about the links between domestic violence, abuse, their drug/alcohol use and subsequent thoughts feelings and behaviour
- Be alert to possible domestic violence at all stages of your work with parents and/or families – not just at the assessment stage
- Be aware of the language of domestic abuse and ask for clarity from children who use phrases such as *“I’ll be in trouble”* or *“daddy can get really angry”*
- Be aware that children also fear that the information they disclose will lead to their removal from the home or may make their current situation worse. Children may fear the consequences of revealing violence or illegal activity such as drug use – particular if they have been threatened by the abuser
- Be aware that risk is not a static process and can change rapidly. Missed appointments, drug and alcohol relapse or disengagement with the service could indicate ongoing experiences of domestic violence
- Be aware that child contact disputes where domestic violence is present can be potentially very dangerous as some fathers may use contact with the children as a route to further abuse them and their mother

Research exploring the characteristics of families who had disengaged with a London based family alcohol service found that in the majority of cases, domestic violence was clearly identified.⁴⁴

The table on the next page is taken from Galvani, S. (2006) Safeguarding Children: working with parental alcohol problems and domestic abuse, The Parenting and Alcohol Project Paper Series, London: Alcohol Concern

Adult only interventions	Family and children interventions
1. being aware of domestic abuse and identifying the risk to the parent and their children, as it arises during the adult intervention	1. being aware of domestic abuse and identifying the risk to the parent, and their children, as it arises during the intervention
2. supporting, or challenging, the drinking parent (depending on whether they are victim or perpetrator respectively)	2. supporting, or challenging, the drinking parent (depending on whether they are victim or perpetrator respectively)
3. assessing and exploring the domestic abuse and the parent’s awareness of its impact on themselves, their parenting and the children, and what they would like to happen about it	3. assessing and exploring the domestic abuse and the parent’s awareness of its impact on themselves, their parenting and the children, and what they would like to happen about it 3a. assessing and exploring the domestic abuse and the child’s awareness of its impact on themselves and their parents and what they want to happen about it
4. identify any child protection concerns, seeking advice if needed, and the consult agency procedures if the child is at risk	4. identify any child protection concerns, seeking advice if needed, and consult agency procedures if the child is at risk
5. referrals to relevant specialist agencies (with or without consent as appropriate), offering support to the specialist agency and parent through the referral and specialist intervention process	5. referrals to relevant specialist agencies (with or without consent as appropriate), offering support to the child, parent and specialist agency through the referral and specialist intervention process
6. supporting the adult, including discussion about how their alcohol use is related to their suffering, or perpetration, of domestic abuse, and how both these behaviours affect their children. (This provides an educational opportunity to dispel some of the myths about the relationship between alcohol and domestic abuse.)	6. supporting the adult, including discussion about how their alcohol use is related to their suffering, or perpetration, of domestic abuse, and how both these behaviours affect their children 6a. supporting the child, including discussions (if age appropriate) about how their parent’s alcohol use is related to domestic abuse, and how it affects them. (For parent/s and children this provides an educational opportunity to dispel some of the myths about the relationship between alcohol and domestic abuse.)
7. discuss safety planning with the parent in relation to domestic abuse and alcohol use, a) when drinking and b) when sober	7. discuss safety planning with the parent, and children, in relation to the domestic abuse and alcohol use a) when parent/s drinking and b) when sober
8. provide relevant information including details of relevant agencies, websites, leaflets	8. Provide relevant information including details of relevant agencies, websites, leaflets 8a. ensure information is provided to children in age appropriate language and formats, eg. Videos, helplines, leaflets, web addresses

Child Contact

Making arrangements for children to keep in touch with the other parent after separation is often difficult, and in cases of domestic violence, contact can be potentially very dangerous. Some fathers may use contact with the children as a route to further abuse them and their mother.

- In more than one in eight domestic violence incidents the London Metropolitan Police note issues around child contact or residence⁴⁵
- In 1995 6.7% of contact orders applied for were refused. In 2004 0.7% contact orders were refused
- Women's Aid has compiled details of 29 children in 13 families who were killed between 1994 and 2004 as a result of contact (and in one case residence) arrangements in England and Wales⁴⁶
- In 2001 a survey involving 127 refuge organisations found that contact orders were granted to parents convicted of offences against children and to parents whose behaviour caused children to be placed on the Child Protection Register. In some of these cases unsupervised contact was granted or visits were ordered to take place at contact centres which had no facilities for supervision⁴⁷

Unfortunately there are a limited number of supervised contact centres in the UK. Contact should not be presumed to be in the best interests of the child if there has been domestic violence towards the mother.

• **Stephen's Place Children's Centre**

Stephen's place, a purpose built child friendly centre provides a range of work with children who have been exposed to violence including supervised contact, assessed contact and direct therapeutic intervention. **t: 020 8741 8020**

Couples and Network Therapies

The Stella Project believes that couples counselling or other network therapy is not appropriate if domestic violence is currently being perpetrated in the relationship. Many drug and alcohol agencies who are concerned about addressing domestic violence note that excluding such families from network therapies would exclude a significant proportion of their clients.

The Stella Project welcomes the development of detailed guidance on this issue but until this has been developed, it is simply too risky to work with families where any domestic violence or abuse has been disclosed.

This makes it all the more important to routinely inquire about violence and abuse in one to one sessions (and at later stages of the intervention). Professionals should also be aware of the indicators of abuse.

Working with domestic violence is a specialist area requiring a high level of understanding of the dynamics of abuse. There can be dangers of colluding with abuse by reinforcing that the perpetration of abuse stems from communication problems between couples or lack of anger management. This sends a message that the victim is somehow to blame for the domestic violence. The abuser is fully responsible for their behaviour and this is not determinate on the behaviour or actions of the partner or children.

Couple or family based interventions locate the problem of domestic violence as being within the family whereas research clearly shows us that it is connected to women's social, economic and political position within wider society. By seeking to intervene with the whole family, we are perpetuating the myth that domestic violence occurs in 'problem' families rather than it being a rooted in the fundamental inequality that exists between men and women.

"It is critical that decision about couple work be based not on faith or familiarity with couples therapy as a therapeutic modality but on concrete data obtained from the couple on the detailed knowledge of risk assessment and the intricate dynamics of violent relationships."⁴⁸

Working with both a victim and abuser together can be dangerous for the following reasons:

- It is common for the victim to also minimise what is happening to them for fear of the consequences of disclosure and the hope that the relationship can be saved. In this context, such interventions will potentially unwittingly undermine rather than increase the safety of a vulnerable client⁴⁹
- The work is unlikely to be useful when one partner is fearful about how much they can disclose about the relationship. However skilful the therapist they will be unlikely to gain the open and honest thoughts and feelings of a victim while the abuser is in the same room. This can apply equally to the children who may suffer the consequences of speaking openly
- Reviewing violence and abuse with a couple in a session is not advisable due to the risks of retaliation if the victim discloses abuse
- The couple have a history with each other which means subtle and exclusive methods of communication – including non-verbal - may have developed which are not discernible to the therapist
- Research evidence from mediation, couple counselling and court welfare work all tells us that neither women or children fare well in any model which means they have to negotiate their safety in the presence of their abuser. Out of fear for the consequences if they do not, women frequently reach ‘agreements’ which are not in their best interests
- If the victim/survivor is the one with the substance use problem it is not helpful for more information about the complexity of their problems to be passed onto the abuser. It will only give the abuser more ammunition with which to control his partner
- It is noteworthy that in at least 20 US states, most of Australia and New Zealand, couple based interventions are expressly prohibited by law. In Australia, this was in part motivated due to the numbers of women killed by ex-partners when attending or leaving couple-based interventions⁵⁰

It could still be beneficial to work with the child (ren) and the non-abusing parent. This could include the wider family if it is safe to do so and where family members are supportive of the non-abusing parent. This should be done ideally in partnership with a domestic violence agency.

Relate are piloting a model of routine screening in one to one appointments and where there is a current risk of domestic violence (whether identified at initial assessment or during an intervention), couples therapy is not offered. Instead the victim/survivor is supported through one to one interventions.

Using this framework, brief work is also done with the abuser (one or two sessions) focusing on safety, conveying safe messages about responsibility for abuse and violence, and motivating them to move forward and change their behaviour. They also signpost or refer to domestic violence perpetrator programmes where available.⁵¹

4.1.6 Guidance for domestic violence agencies

The possibility of parental alcohol or drug use should always be considered given the link with domestic violence and the potential impact on children. However, it should not be automatically concluded that alcohol or drug use by the parent means that the children will have additional needs or there are parenting difficulties.

Focus should remain on whether the child's needs, both physically and emotionally, are being met by the non-abusive parent.

Domestic violence practitioners should be aware of the following risks posed to children living with parental drug/alcohol misuse:

- Use of family resources to finance dependency, characterised by inadequate food, heating, clothing etc.
- Exposing children to unsuitable care givers or visitors or total lack of supervision
- Children's absenteeism from school or other school related issues

- Children taking on the role of carer either for other siblings or the parent(s)
- Effects of drugs/alcohol which may lead to uninhibited behaviours e.g. inappropriate display of sexual and/or aggressive behaviour and reduced parental vigilance
- Unsafe storage of alcohol or drugs and prescribed medication could mean children having unsafe access to them
- Adverse impact of growth and development of unborn child e.g. Foetal Alcohol Syndrome

The Stella Project sample assessment form for domestic violence agencies contains some opening questions regarding children (see pg 78). The answers to these questions may indicate a need to ask further questions. Workers should seek examples from substance using parent as to how the emotional and developmental needs of children are being met.

E.g. does alcohol or drug use play a role in making family routines more difficult – preparing meals, taking children to school, helping with homework

Parental attitudes towards their own drinking or drug use will shape further questions. If they believe that their drinking/using is not impacting on their parenting capacity, questions should be asked around why any professional concerns are unjustified.

Whereas if parents recognise that their parenting capacity has been affected, professionals should ask what parents feel they should be doing differently, what they feel would help them to do this and whose help they would accept.

Suggested questions to ask:⁵²

- Does the child have regular contact with a non-drinking/using adult/carer?
- How discreet is the alcohol/drug misuse – do the children witness the behaviour or have they stumbled upon it by accident?

- How is the behaviour hidden or contained so that children are not affected?
- Have there ever been accidents as a result of drug/alcohol misuse and are the parents able to acknowledge risks and accept responsibility?
- How much time, energy, money and organisation is directed towards alcohol/drug related activity and what are the consequences for the children?
- Who looks after the children when alcohol is being sought or consumed?
- Are children ever taken to inappropriate places connected with drugs/alcohol where they might be placed at risk?
- Is the home used as a base for the alcohol/drug misusing group to which the parent may be attached?
- Does the alcohol/drug use lead to financial problems that mean the children have to go without basics?
- Does the alcohol/drug use come first so that other financial obligations are not met?

4.1.7 Specialist services and resources for children

Domestic violence specific

- **Children's Support Workers**

With the exception of refuges, few services operate for children who have experienced domestic violence within the home. Within a refuge children will be provided with some services. Although these will vary from refuge to refuge, most now have specialist children's workers.

- **Talking To My Mum: A Picture Workbook for Workers, Mothers and Children Affected by Domestic Abuse**

Children and young people and their mothers, who have lived with domestic violence often don't talk about the distressing events they have lived through together. Mothers often underestimate how much children already know.

Through work with women, children and children's workers some unique resource packs have been developed. "Talking to Mum" enables frontline domestic violence workers and mothers to focus on renewing the bond with their child(ren) after domestic violence in an activity based way.

Available to purchase online at

<http://www.jkp.com/catalogue/book.php/isbn/9781843104223>

- **Community Group Treatment Programme**

An integrated community group programme for children and their mothers who have experienced domestic violence.

The 12 weekly sessions are held in a community-based setting in which children can meet other children in the same situation as themselves, explore their feelings and learn how they can best protect themselves.

Core issues addressed are: validation of the children's experiences; understanding abuse; reducing self blame; safety planning; managing appropriate and inappropriate expressions of emotion.

Alongside the children's programme, mothers also attend a 12 week programme and are supported to understand how the violence has impacted on their child and how best to help them through the healing process.

For details of these groups and the training available please contact the GLDVP at: **t: 0207 785 3866; joanna.sharpen@gldvp.org.uk**

Children and Domestic Violence E-forum

This has been set up for all professionals working with children and dealing with issues relating to domestic violence. The forum is open to all professionals who have a relevant interest.

The e-forum provides:

- An opportunity to post messages/questions/information
- A database of relevant links
- The option to set up opinion polls
- Discussion forums
- Networking
- Latest updates on relevant events, policies, good practice etc.

To join the forum send an email to the address below (you do not need a yahoo account):

gldvp_frontlinechildrensworkers-subscribe@yahoogroups.co.uk

Specialised services to support children around parental drug/alcohol misuse

There are a few specialised drug and alcohol services which work with parents and their children and/or offer specific support to children.

When approaching these agencies or making a referral, it is important to ascertain their approaches to working with parents where domestic violence is involved e.g family and network therapy takes place without the abuser.

Some services are listed below.

- Drug Alcohol Services London (DASL) offers individual counselling to young people aged between 11-21 who have experienced both substance misuse & domestic violence in their family
t: 020 8257 3068;
f: 020 8257 3066;
services@dasl.org.uk
- Core Kids is a holistic therapeutic service for children, parents and families affected by problem substance use. The service aims to help children be safe and healthy, adults to be effective parents, and families to communicate. The service offers child and adolescent therapy (including complementary therapy)
t: 020 7258 3031;
f: 020 7402 1964;
grainne@coretrust.org
- ARP works in partnership with the NSPCC to provide the Family Alcohol Service (FAS). FAS works with families in Camden who are affected by a parent's or carer's alcohol use.

The service works with both the drinking and non-drinking family members, including the children, to look at the impact that alcohol is having upon their family and how changes can be made to minimize these harmful effects

t: 020 7383 3817

For a detailed list of family services working with parental substance use see www.adfam.org.uk

Websites specifically designed for young people around parental substance use and/or domestic violence

- STARS (Support Therapeutic, Advocacy and Outreach Services) National Initiative – support for children and young people living with parents using drugs
<http://www.parentsusingdrugs.org.uk>

- NSPCC website - for children and young people designed to give information about services and people that are there to help.
<http://www.worriedneed2talk.org.uk/htm>
- The Hideout – support for children and young people living with domestic violence. Includes a virtual tour of a refuge.
<http://www.thehideout.org.uk/>
- Interactive game and informative website for young people about issues including domestic violence, sexual bullying and sexual discrimination
www.respect4us.org.uk
- Website for young people providing free, confidential drugs information and advice 24 hours a day
www.talktofrank.com
- Get Connected - a free, UK wide, email and telephone helpline that finds young people the best help whatever the problem
www.getconnected.org.uk

4.1.8 Recognising diversity when supporting children

It is important to reflect on and respond to the additional needs that some children may have relating to their ethnicity, culture and/or religion.

For example, in some cultures where alcohol is forbidden, this may induce extra shame and stigma for children, particularly if their mother is drinking or using drugs.

This may also limit their information flow and awareness of drug/alcohol use. In addition, domestic violence can go unchallenged and colluded with due to particular cultural beliefs and expectations relating to family and gender roles.

For many communities, the home and community networks provide a shield from racism and discrimination.

This can lead to problems at home remaining hidden in an attempt not to bring the family and community into 'disrepute' and/or encouraging further discrimination and hostility.

Furthermore, choosing to leave the family home due to domestic violence or to overcome condemnation from the religious community can sometimes become a choice between different forms of abuse – domestic violence and racial harassment.⁵³

Ensuring children's voices are heard

Using creative tools such as play and drawing it is important to gauge the feelings of the child towards their parents drug or alcohol use. Questions about where children seek safety, comfort and protection should be asked alongside questions about fears, anxieties and hopes about their parents behaviour.⁵⁴

- What is it like when their parent(s) is under the influence of alcohol or drugs or arguing? What it is like when they are not?
- Do they have fears, anxieties and hopes about their parent's behaviour?
- What would they most like to be different or stay the same?
- Whom do they think is most affected by the alcohol/drug use or violence and how can they tell?
- To what extent do the children have caring responsibilities?
- What do they do when their parents are arguing, drinking or taking drugs?

4.1.9 Child protection and legal responsibilities

Any services that work directly with children should have a child protection policy. This should be cross referenced with the following:

- Domestic violence policy and procedures (substance misuse agencies)
- Drug and alcohol policy and procedures (domestic violence agencies)
- Vulnerable adults policy and procedures
- Confidentiality and information sharing policy and procedures

This policy should clearly state the process involved for reporting any suspicions or disclosures of child abuse or perceived harm to a child.

It is essential that a sense of safety and confidentiality is given to the client. Women are often worried that any disclosure of violence could lead to the removal of children.

Workers should assure clients that Social Services will only be informed if there is a realistic fear for the child's safety.

Drug and alcohol services need to ensure they ask basic questions about their client's family situation, such as children's names and ages. From this basis, workers are then able to further assess a child's safety, over a period of time.

Social Services are not always involved in families where there is domestic violence or substance misuse; their focus is largely on children who are at risk of 'significant harm'.

All practitioners have a duty to safeguard and promote the welfare of children. In many cases, this is a subjective assessment so the point at which a Social Worker will intervene varies between different Social Service Departments.

You will need to be aware of the risk factors associated with both domestic violence and substance misuse so that Social Services can be informed if a child is at risk.

Harm includes physical, emotional and sexual abuse, as well as neglect. However, children do not have to be in imminent danger to be referred.

Section 120 of The Adoption and Children Act 2002 extended the legal definition of 'significant harm' to make it clear that harm includes ***“any impairment of the child’s health or development as a result of witnessing the ill-treatment of another person, such as domestic violence”***.

If you suspect a child is being abused or appears neglected you have a legal obligation to contact Social Services.

You should:

- Discuss your concerns with your manager. You and your manager may also wish to speak to Social Services prior to a referral. Most social services departments will run a 'duty social worker' scheme where professionals can contact them for informal advice. If you do speak to Social Services you should emphasize your concerns for the welfare of a child, rather than allegations of harm or abuse
- If after this discussion you still have concerns, you should consider referrals for the child and family. If you believe the child is at risk of harm, you should refer them to Social Services. In addition to Social Services and the police, the NSPCC also have powers to intervene. **NSPCC helpline: 0808 800 5000**
- If possible, discuss your concerns with the child in a manner that is appropriate to their age and understanding. Take care to ask open-ended questions and do not lead the child. Any referrals to Social Services should preferably be done with the consent of the non-abusing parent and where this is not possible, all practicable steps should be taken to ensure the non-abusing parent is aware of the referral so that they can make fully informed decisions about their own and their children’s safety

- If you refer by telephone, confirm the referral in writing within 48 hours. You should hear from Social Services within one day of sending the written referral
- Any disclosures of child abuse should be clearly documented in a designated secure place. The Children Act 2004 sets out the framework for helping and protecting children and sets out as its paramount principle, that all decisions affecting children should be demonstrably in their best interests. A fuller explanation of the Children Act and how it affects children can be found at: <http://www.bbc.co.uk/health/hh/kids19.shtml>

Further guidance on child protection procedures and policies can be found at <http://www.londoncpc.gov.uk/>

4.1.10 Government legislation and policy framework

Children Act 2004

The Act provides a legislative framework for the wider strategy for improving children's lives and developing effective and accessible services for all children. This includes universal services which every child accesses, and more targeted services for those with additional needs. The Act also provides the legal underpinning for Every Child Matters.

Every Child Matters

In 2003, the Government published a green paper called Every Child Matters. This was published alongside the formal response to the report into the death of Victoria Climbié.

It focused on 4 main themes:

- Increasing the focus on supporting families and carers
- Ensuring necessary intervention takes place before children reach crisis point and protecting children from falling through the net

- Addressing the underlying problems identified in the report into the death of Victoria Climbié (namely weak accountability and poor integration)
- Ensuring that the people working with children are valued, rewarded and trained

Every Child Matters has 5 universal aims for every child: be healthy; stay safe; enjoy and achieve; make a positive contribution; achieve economic well-being.

All 5 outcomes for children and young people can be affected by domestic violence and/or by parental substance use.

Hidden Harm: responding to the needs of children of problems drug users, Advisory Council on the Misuse of Drugs (ACMD) 2003

A key message from this inquiry from the Advisory Council on the Misuse of Drugs state that reducing harm to children from parental drug use should become a main objective of policy and practice and effective treatment of the parent can have major benefits for the child. By working together, services can take many practical steps to protect and improve the health and well being of affected children. The inquiry further recommends that drug and alcohol agencies should aim to become 'family friendly' with an emphasis on meeting the needs of women and children.

Local Safeguarding Children Boards

The establishment of local safeguarding children boards (LSCBs) is an important element of the improved safeguards for children put in place by the Children Act 2004. The LSCB and its activities are part of the wider context of children's trust arrangements. Each local authority should have an LSCB in place.

Models of Care for Alcohol Misusers, National Treatment Agency 2006

Regularly acknowledges the need to assess for the impact of alcohol problems on children and families and refers to domestic violence and abuse as one of the additional interlinking issues that needs to be addressed through coordinated interventions.

National Service Framework for children, young people and maternity services Department for Health 2004. Identifies 'relationship conflict' and alcohol and drug use as areas where parents may need early intervention and multi-agency support.

Vision for services for children and young people affected by domestic violence

Produced in 2006 this guidance offers a valuable template for those commissioning children's services.

4.2 Partnership working

Multi-Agency Protocols and Practice Guidance

- Camden Domestic Violence Forum Substance Misuse Sub Group have created a set of policies, assessment forms and referral charts for use by drug, alcohol and domestic violence agencies. Refining the Routes, Domestic Violence and Substance Misuse can be downloaded from <http://www.camden.gov.uk/domesticviolence>
- Nottinghamshire County Council in partnership with Nottinghamshire Drug and Alcohol Action Team have produced Good Practice Guidelines for Working with Survivors and/or Perpetrators of Domestic violence Who Also Use Alcohol and Drugs which can be downloaded from the Nottinghamshire Domestic Violence Forum website at: http://www.ndvf.org.uk/resources_26.php
- The Stella Project has created a sample Partnership Agreement document based on the model used by GLDVP and GLADA when the Stella Project began. This can be obtained by contacting the stellaproject@gldvp.org.uk

What Works: ARP Women's Alcohol Service - Domestic Violence and Alcohol Project

The ARP Women's Alcohol Service in partnership with the nia project (formerly Hackney Women's Aid) is in its 3rd successful year of offering service users specific help, information and support around the dual issues of domestic abuse and alcohol misuse.

The Project is funded by Safer Islington Partnership and consists of 2 workers – a DV and Alcohol Worker (2.5 days a week employed by ARP) and a DV Advocacy Worker (seconded from nia 1 day a week).

The DV and Alcohol Worker promotes partnership working and delivers training to agencies within Islington. This worker also maintains a small one to one caseload and facilitates a weekly group for WAS service users who are or have been affected by domestic violence.

The DV Advocacy Worker provides weekly information and referral sessions at WAS and carries a small caseload of clients who require more specific advocacy and practical support.

Our experience of working in partnership has been a very positive one. The familiar presence and expertise of the nia project worker onsite has allowed women to be referred more easily to domestic violence agencies.

The majority of clients who attend WAS have experienced domestic violence in their past but have never talked to anyone about this which has often to their alcohol misuse.

Dealing with both issues in one place has enhanced clients' recovery and served to prevent relapse with regards to domestic violence and alcohol.

The nia worker has benefited from being seconded to an alcohol agency in that she has undertaken alcohol awareness training and transferred learning back to staff at the nia project.

Quarterly meetings between the line managers of the nia project worker are held in order to review progress and deal with any issues. ARP strongly acknowledges the need for a service for women who have the dual issues of domestic violence and substance misuse and is actively looking for funding to increase the amount of work that can be done in this area, as well as seeking partners in relevant fields and devising protocols for partnership work.

Cordelia Mayfield, Team Manager- ARP Women's Alcohol Service
cmayfield@arp-uk.org

What Works: Camden Women's Aid (CWA) and Margerete Centre (South Camden Drug Service)

Jackie was 25 years old when initially referred to CWA via the police, after a neighbour made a complaint. She arrived at the refuge with serious immediate injuries and signs of burns and bruises at various stages of healing. She had been isolated from all families and friends for many years and her child was in care.

Jackie told the police she was addicted to heroin and wanted support coming off the drug. She had not had any contact with any substance misuse agencies previously as she had not been allowed to access help by her partner.

Jackie had been using before she met her abusive partner, but he had in her view, encouraged her use, kept her addicted and encouraged her to become involved in prostitution occasionally when they both needed money for drugs. She also stated she was using drugs to numb the pain and to feel closer to her partner.

Camden Women's Aid responses

Immediate assessment and link with GP for immediate prescribing

CWA were informed of Jackie's heroin use upon her arrival. Jackie knew she would not be able to use in the refuge and asked for help as she feared that she could not cope without access to any heroin.

The refuge worker undertook an immediate assessment around her drug use asking questions such as how much, how often, with whom, how did she finance this, had she ever overdosed and what were her withdrawal symptoms etc.

It became apparent that Jackie needed access to immediate prescribing of methadone, and the worker phoned a GP who agreed to prescribe an immediate prescription to cover the period of the weekend via a chemist.

In this way, Jackie only went one day without a prescribed dose, although withdrawal symptoms were quite apparent.

Joint care planning with a local drug and alcohol centre

In the meantime, CWA contacted the Margarete Centre, a local drug service offering a multi-disciplinary health and social care team of practitioners to discuss making a referral.

Jackie was encouraged to attend her first appointment herself, although it was made clear that her support worker would be happy to attend with her if she wanted it. The centre worked in partnership with CWA to manage Jackie's care plans.

The key worker from the centre would attend the refuge when needed, and there were weekly liaison meetings between CWA and the Margarete Centre to share information and discuss progress.

Advocating to Social Services on Jackie's behalf

The refuge worker advocated on behalf of Jackie with social services to help with the return of her child. This required further close liaison with the Margarete Centre. Jackie's mother made contact again and supported her in her attempts to get her child back.

Open, non-judgemental and accepting attitude towards drug use by CWA staff

Jackie required a lot of encouragement to access all the various support services and express herself with any sense of confidence.

The open, non judgemental and supportive approach towards her drug use was paramount to Jackie's ability to address the complexity of her problems.

Jackie knew she could be honest about her temptations to start using again and was encouraged to speak to staff and her key worker if she felt close to doing so.

She was told she could use the internal 24 hour crisis line provided by CWA during these lows periods and was also given the number of a 24 hour drug and alcohol support line.

Jackie knew that she would not be evicted if she did start using and that she would constantly be encouraged to take one step at a time.

By the time Jackie left the refuge a year later, her confidence and self worth had increased tremendously and she looked like a completely different woman.

She had reduced her script to much lower levels and was also having regular access to her child who was living with her mother.

She was clear that she needed to be re-housed somewhere where she would not be in contact with users or ex-users.

Her partner was sentenced to jail for serious assault. At no time did she pose a threat to other residents or staff in the refuge who were never aware of her drug use or history.

During her stay at the refuge Jackie felt she need to undergo a period of self healing and empowerment and CWA helped her to access a number of outside workshops who could support her with this.

Camden Women's Aid is now part of Solace - referrals can be made by telephoning **020 7428 9962**

4.3 Working at a strategic level – guidance for managers, service directors and commissioners

In order to encourage agencies from both sectors to develop this work and ensure it is embedded into practice, it is important that domestic violence, drugs and alcohol issues are addressed at a strategic level.

Local drug treatment plans, alcohol, domestic violence and community safety strategies should all feature commitments to address the dual issues. Local Area Agreements have become the main conduit for identifying funding priorities for local boroughs and it is therefore a key process with which to engage. This section aims to give examples of good practice which could be emulated in your own boroughs.

4.3.1 Local Area Agreements

Local Area Agreements (LAAs) are three year agreements that set out priorities for the local area agreed by central government and local authorities. They bring together or ‘pool’ funding streams and aim to deliver better outcomes for local people through enhanced partnership working and by identifying the specific needs of the community.

They are driven by Local Strategic Partnerships who negotiate the targets and outcomes, in conjunction with central government, and are responsible for their delivery and monitoring. In order to ensure that the domestic violence and drug and alcohol agendas receive sustained priority in the future it is essential that specific indicators and targets are incorporated into LAAs.

Having specific indicators that address alcohol and drug related domestic violence would prove an efficient way for local boroughs to meet several of the new targets featured in the new National Performance Indicators which replace all existing performance indicators.⁵⁵

Examples of local areas which have included integrated targets include Suffolk County Council which aims to ‘reduce the number of domestic violence incidents related to alcohol misuse by 10% by 2008’ and Coventry City Council which aims to ‘reduce the number of incidents of alcohol related crime and disorder by x % by 2008.

For more information see the Women’s Aid briefing Local Area Agreements – what’s next?

http://www.womensaid.org.uk/landing_page.asp?section=00010001000900050017

What Works: Camden Local Area Agreement

Camden has used LAA funding for a specialist DV and Substance Misuse Development Worker. Camden’s LAA includes an indicator which commits the borough to achieve Level Three of the London Domestic Violence Strategy.

This includes improving joint working between the domestic violence and substance misuse sectors.

The success in gaining LAA funding for such specialist work was driven by Camden Safety Net, the local domestic violence service, who in 2004 commissioned research into how services in both the domestic violence and substance misuse sectors link together.

A recommendation from this report was for the post of a development coordinator to be set up who would initiate the development of referral pathways, integrated working policies in both sectors and training.

From August 2005 to March 2007, a development worker was in post and set up the Substance Misuse Sub Group of the Domestic Violence Forum which meets bi-monthly with a membership of 18 agencies.

In addition to training and the creation of a referral directory, the Group published the policies, procedures and protocols which were developed for Camden.

Refining the Routes, Domestic Violence and Substance Misuse can be downloaded from www.camden.gov.uk/domesticviolence

For hard copies and additional information on the group contact:

**Domestic Violence Strategy and Services Manager
Community Safety and Drugs Team**

t: 020 7974 6138

catriona.scanlon@camden.gov.uk

4.3.2 Alcohol, domestic violence strategies and drug treatment plans

Much of the innovative and collaborative practice which has been developed across London has been driven by the inclusion of the dual issues in local strategic plans. Below are some examples:

What Works: Greenwich Alcohol Strategy

Domestic violence accounts for 28.6% of all recorded violent crime in Greenwich. The Greenwich Alcohol Strategy was developed in 2004 and identified that the borough had one of the highest rates of alcohol related violent crime in London. In response, the strategy contains priorities to address alcohol related domestic violence.

Lead by the Alcohol Strategy Coordinator, a working group was developed in February 2007 to develop referral pathways between the local substance misuse and domestic violence agencies.

The first priority was to consider outcomes and undertake an audit of services using a set of model practice standards developed by the Stella Project (see pg 103-106 for model standards).

A multi-agency partnership training day was held shortly after where agencies were asked to consider 'signing up' to a negotiated set of standards. A monitoring system was put in place to determine which agencies were able to meet the standards and identify where further resources and support were needed.

Skills based training to each sector was delivered over the subsequent 5 months aiming to equip staff with the skills and confidence to meet practice standards.

Ongoing discussions between the DAAT and individual agencies have lead to the following developments:

- The DAAT Data Officer supporting the development of a drug and alcohol recording spreadsheet for Greenwich Women's Aid
- DAAT visits to all domestic violence agencies to distribute information

- Agreements to record victim and perpetrators of domestic violence within three substance misuse agencies (with this being formalised into an Service Level Agreement with one agency)
- Networking lunch organised for both sectors
- The commissioning of a package of further advanced training for 2008

One major need which has been identified is for a specialist outreach worker to provide support to each sector in order to help embed good practice within agencies and support staff in the development of their skills base and knowledge.

This is in recognition that training is only the first step in ensuring such multi-agency work is sustainable and effective.

What Works: Brent Local Drug Treatment Plan

The 2006/07 Adult Drug Treatment Plan for Brent states that the Drug Alcohol and Action Team is 'committed to working in partnership to meet the unmet need and to prioritise the delivery of services to key target groups including women, poly-drug users, pregnant drug users and underserved groups.'

The links between domestic violence and substance misuse is identified and is a key priority with pathways to appropriate provision to be developed. This commitment within the Treatment Plan resulted in the DAAT funding a Substance Misuse worker for the local Domestic Violence Advocacy Project and a further amount pledged for training and development work.

The success of addressing domestic violence with the priorities of the DAAT was due to the commitment and partnership working of the local Domestic Violence Coordinator and the Lead Manager for Substance Misuse in the Community Safety Team.

4.3.3 Importance of monitoring service responses and collecting data

Monitoring impact of work

Any work undertaken with individual agencies and at a multi-agency level should include clear procedures for monitoring the impact of new initiatives. One method of doing this would be to audit the local services to assess what they are currently doing and to form the basis of agreeing a set of practice standards against which each service can be measured.

Examples of such standards can be found at **pg 103-106** and can be adapted to the specific needs of the Local Authority. Some standards can be implemented quickly with limited resources (e.g displaying posters and agency position statement) whilst others may need further resources and this could form the basis of a discussion between strategic partnerships and individual agencies. Agencies could then be periodically reviewed against the agreed set of practices.

Data collection

Collecting data on the number of service users disclosing the dual issues can provide an evidence of need and help in obtaining funding from your local Community Safety Partnership to develop this work further. Agencies may wish to capture data within their current forms or spreadsheets or alternatively a separate sheet or form could be created to go alongside existing ones. An ideal evidence collection would comprise the following points (in addition to more generic data that agencies already gather about user demographics and children).

- Total number of service users questioned about domestic violence/substance use*
- Total number of service users questions about domestic violence/substance use and who disclosed domestic violence/substance misuse*
- Substance misuse by the abuser disclosed?
- Disclose upon assessment or during working relationship?
- Current or past domestic violence/substance misuse*?

- Type of substance use/domestic violence* experienced?
- Referral made to a dv/drug/alcohol* agency AND did the service user follow through?
- Referral received from a dv/drug/alcohol agency* AND did the client consequently engage with your service

*delete as appropriate⁵⁶

4.3.4 Guidance for drug and alcohol service managers and commissioners

Models of Care and relevance to clients experiencing or perpetrating domestic violence

The Models of Care for the Treatment of Adult Drug Misusers (Models of Care) was updated in 2006 and focuses more heavily on the holistic needs of the service user in the completion of treatment. If your service user is a victim of domestic violence, your service should be recognising how this may impact on their 'treatment journey' and address this in care planning and other interventions.

In the context of Models of Care, domestic violence services are classified as Tier 1 services.

Therefore in their work with survivors of domestic violence, these services will ideally be able to screen for drug problems, refer to drug treatment services, and even provide basic harm minimisation.

Treatment Engagement and Retention

The update refers to the commissioning of a range of services which support engagement in treatment including services for children of drug users, advocacy and support arrangements.

Managers are urged to recognise the important and valuable role domestic violence agencies can play in increasing some women's access to and engagement with treatment and the services they provide for their children.

Increasingly refuges are accepting women on scripts and the support they can give to a woman in successfully engaging in treatment should be recognised. More refuges would be willing to provide this role with support from local substance misuse agencies.

- **Assessment, care planning and integrated care pathways**

Assessing for domestic violence falls in line with the Models of Care which explicitly states that assessments should establish related or co-existent problems and risk factors such as experiencing harm from others or causing harm to others. Where domestic violence is identified this should be addressed in the care plan ideally working in partnership with a specialist domestic violence agency which can provide psycho-social support, access to safe housing and in some cases, children's support services.

Integrated care pathways should be able to provide access to a range of services and interventions that meet an individual's needs in a comprehensive way. Therefore, partnership working with domestic violence agencies should automatically form part of a response to a service user who is a victim or perpetrator of domestic violence.

- **Aftercare**

For survivors of domestic violence who have left structured treatment, it is essential for their safety, and in order to avoid relapse, that the wider issues of partner and family abuse are addressed.

The safety of the service user should be paramount in any aftercare initiatives particularly where they are returning to an abusive relationship. Domestic violence services also have a key role to play in providing aftercare through psychosocial interventions which cater for the variety of survivors' needs.

Drug/alcohol agencies can play a key role in delivering thorough and holistic aftercare if staff are appropriately trained on the issues of domestic violence from the perspective of both the survivor and the perpetrator.

This requires knowledge of positive screening and effective responses to disclosures of violence.

Models of Care also recommends that it may be beneficial to have link professionals from specialist drug services who can train and support Tier 1 professionals, in this case domestic violence services. Where the prevalence of substance use in domestic violence services is high, it may be beneficial to have a specialised liaison service to provide a co-ordinated response.

Further guidance and detail from Models of Care can be found at http://www.nta.nhs.uk/areas/models_of_care/default.aspx

Models of Care for Alcohol Misusers (MOCAM) builds on the foundations of the models for drug treatment and recognises the particular needs of drinkers with complex problems.

Guidance regarding the stepped care model states that particular needs may be identified in relation to the alcohol use requiring more complex and co-ordinated interventions.

Domestic violence is specifically mentioned in this context. Psycho-social treatments should include targeted interventions for certain groups (as reflected by the needs of the local population) and should respond to specific cultural and gender issues.

- **Brief Interventions**

Some simple steps can be taken to address the link between alcohol use and domestic violence in brief interventions and advice services. Practitioners need to be alert to the fact that a person's drinking may be related to their experiences of domestic violence which may affect the type of advice that is given. At a minimum, all clients should be issued with info of local domestic violence services alongside alcohol information.

- **Integrated Care Pathways**

Specific guidance is due to be published for vulnerable service users with complex needs such as those experiencing domestic violence. This should form part of a service user's integrated care pathway.

MoCAM outlines how the commissioning of alcohol treatment must meet certain criteria. In ensuring 'equal access to relevant alcohol assessment and treatment' (criterion 3) providers should consider the specific needs of the local population including groups traditionally marginalised from mainstream and other health services.

'Specific, targeted interventions may be required for locally and under-represented or hard to reach groups. Similarly, provider service level agreements should specify how a diverse range of needs are to be met in providing services that are relevant and appropriate for local need.'

Women and those affected by domestic violence are identified as potential 'locally identified' groups who should be given particular consideration.

MoCAM further emphasises the need to assess for domestic violence (as perpetrator and victim) and the impact this may have on significant others, particularly children.

For more information see

http://www.nta.nhs.uk/publications/documents/nta_modelsofcare_alcohol_2006_mocam.pdf

4.3.5 Guidance for domestic violence service managers

Outcome form for short term services

The DCLG has recently introduced a new monitoring tool which will apply to refuge and other services funded by Supported People such as outreach.

All services will therefore be required to identify whether each client has additional support needs associated with substance use and whether the service user is better managing their substance use as a result of the support they have received from the service.

It also gives an opportunity to state what difficulties there were in supporting a service user around their drug and alcohol issues such as problems accessing treatment services.