Final Report

Linkage of Domestic Violence and Substance Abuse Services

May 28, 1999

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Abstract

Linkage of Domestic Violence and Substance Abuse Services

It is well established that substance abuse and domestic violence are linked with each other for male batterers, and there is evidence of a domestic violence–substance abuse relationship for victims as well. Substance abuse and domestic violence services are not typically linked with each other by programs, or if such service linkage does exist, it tends to be ad hoc and poorly developed.

For the current study, computer-assisted telephone interview surveys were conducted of national samples of programs offering domestic violence and substance abuse services to identify how often and in what ways these two program types provide the complementary service. Domestic violence and substance abuse program directors recognized that many of their clients had the complementary problem, and high percentages of the two program types screened for the complementary problem. One-quarter of domestic violence program directors reported providing substance abuse services to their clients, and 54% of substance abuse program directors reported that they provide domestic violence services. Domestic violence program directors had less favorable attitudes than substance abuse program directors toward providing complementary services. Substance abuse program directors also were more likely than domestic violence program directors to think that substance abuse is implicated in domestic violence, and they were more optimistic that substance abuse treatment can reduce future domestic violence among treated offenders.

Logistic regression analyses were conducted of the relationships between a variety of program and director characteristics and attitudes and complementary service linkage. Many of the relationships were inconsistent and difficult to interpret. Program directors who estimated that the complementary problem was more prevalent among their clients were more likely to direct programs that provide complementary services. A number of the factors expected to distinguish programs that did and did not provide complementary services, however, were unrelated to linkage or were related in unexpected ways to linkage.

The report also identifies some implications of the study and recommends that a demonstration/evaluation of complementary services for victims of domestic violence be developed and implemented.

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TABLES

1. INTRODUCTION

The association between alcohol use and domestic violence has been well established by past research, and there is growing evidence that drug use is associated with domestic violence. As detailed in the next section, a majority of domestic violence incidents involve alcohol and/or drugs. The clearest evidence is that alcohol is a risk factor for domestic violence *offending*. Although the etiology is complex, males who assault their intimate partners have frequently been drinking prior to the violence, and these men often have alcohol problems. There is also some evidence that alcohol and drug use are implicated in domestic violence *victimization*, although the nature of this relationship is multidimensional and may be more complex than the substance use–domestic violence offending relationship. Substance use/abuse by women can

- increase the risk of being victimized by one's domestic partner,
- be an aftereffect of domestic violence victimization, and
- inhibit the capacity of domestic violence victims to protect themselves.

In short, alcohol and drug use are implicated in domestic violence in a variety of ways. Past research has paid much less attention to the relationship of substance use to domestic violence victimization than to the effects of substance use on domestic violence offending. We focus on both offending and victimization in this report.

Given the substance abuse–domestic violence relationship, one might logically expect that substance abuse services would be integrated into programmatic responses to the domestic violence problem by shelters and other domestic violence programs. And given the common co-occurrence of substance use and domestic violence, one might think that substance abuse treatment programs would attend to the violent behavior or victimization of their clients during substance abuse treatment. But in practice, domestic violence and substance abuse programs do not usually address the complementary problem. There are notable exceptions and things are currently changing, but most programs do not integrate domestic violence and substance abuse services.

A number of reasons can explain why substance abuse treatment and domestic violence programs do not typically integrate services for the complementary problem:

- human services programs in the United States have traditionally had a "single problem" focus,
- the philosophies that guide domestic violence and substance abuse treatment services differ and make service integration difficult, or even inappropriate, and
- domestic violence and substance abuse are each complex problems requiring a range of responses, so that dealing with both problems may exceed the programmatic and financial resources available to most programs.

But in spite of these challenges, there are very good reasons to consider integrating domestic violence and substance abuse programming, the most important ones being that client needs may be better served, and client outcomes might be improved by doing so.

This report describes a project funded by the National Institute of Justice (NIJ) that surveyed national samples of domestic violence programs and substance abuse treatment programs to determine whether and in what ways the two program types provide services for the complementary problem (i.e., whether domestic violence programs provide substance abuse services, and whether substance abuse treatment programs address domestic violence). We conducted surveys of national samples of domestic violence and substance abuse programs to determine how often, and in what ways, the programs provided the complementary service. We asked program directors what barriers they saw to providing the complementary service, and we collected attitudinal data that we hypothesized are associated with the tendency to link the two kinds of services. We also collected information about the program directors (age, education, etc.), their programs (staffing, budget, etc.), and the services their programs provide. The results of the surveys are reported in Chapter 4.

In the next chapter, we discuss the relationship between alcohol and drug use to being a domestic violence offender and to domestic violence victimization. We also discuss complexities of the substance abuse–domestic violence relationship and factors identified in past studies that help account for the relationship. The limited previous work on the linkage of domestic violence and substance abuse treatment services also is reviewed.

In Chapter 3, we describe the study methodology, including sampling of domestic violence and substance abuse treatment programs for the computer-assisted telephone interview

(CATI) survey, the survey instrument that was used, the data collection methodology, and the program eligibility and response rates. Descriptive survey findings are provided in Chapter 4, including program and program director characteristics, client characteristics, services provided by programs, whether and how programs link domestic violence and substance abuse services, program director attitudes toward the substance abuse–domestic violence relationship and service linkage, and barriers to service linkage. Chapter 5 presents our multivariate analysis of the survey data for the two program types and for victims and offenders. We analyze the relationship of program and program director factors, and program director's attitudes toward domestic violence service linkage to provision of complementary services, and to reasons why such linkage is not provided. Chapter 6 provides a summary of findings and a discussion of the study's implications. Copies of the two survey instruments are included in Appendices A and B, and Appendix C contains logistic regression results.

2. LITERATURE REVIEW

In this chapter, we review previous literature regarding the

- relationship of alcohol and drugs to domestic violence, and
- linkage of domestic violence and substance abuse treatment services, and barriers to such linkage.

We examine separately the relationship of alcohol and drugs to domestic violence *offending* (battering) and the relationship of substance abuse to domestic violence *victimization.* The literature on alcohol and domestic violence offending is extensive, but previous work on the *drug* use-domestic violence offending relationship is sparse. The literature on alcohol and drug use and domestic violence victimization also is limited. Limited, too, is previous study of the linkage of domestic violence and substance abuse treatment services, due mainly to the infrequency of such linkage in practice.

2.1 Alcohol, Drugs, and Battering

The prevalence of the domestic violence problem began to be more visible with the publication of the results of the first national survey of family violence in 1980 (Straus, Gelles, & Steinmetz, 1980). This survey indicated that 16% of those surveyed reported some kind of violence between spouses in the previous year, and 28% reported marital violence at some time during the marriage.[1] The 1985 National Family Violence Survey found very similar levels of family violence (Straus & Gelles, 1990). These two national surveys are important reasons why so much attention has been paid to the domestic violence problem over the past two decades. The surveys have been analyzed extensively and have stimulated additional research on domestic violence.

From the outset of systematic study of family violence, the association of drinking to male against female domestic assault was apparent. In a review of the literature from the 1970s,

[1]The current study primarily addresses male against female domestic violence (commonly referred to as "battering") even though the National Family Violence Surveys indicate that female partners often commit violence against their male partners. Male violence against their female domestic partners is more prevalent and more likely to result in serious injury to the victim, so we focused on male battering in this study.

Hamilton and Collins (1981) estimated that 25% to 50% of male against female domestic violence events involved drinking males and that men who were violent against their partners were disproportionately likely to have alcohol problems. More recent reviews of the literature have shown similar findings (Frieze & Browne, 1989, pp. 192-196; Lee & Weinstein, 1997, pp. 347-350).

Barnett and Fagan (1993) examined drinking patterns among 181 men who were married or cohabiting in the past 12 months. Four groups were studied: maritally violent counseled (n=43), maritally violent uncounseled (n=46), nonviolent unhappily married (n=42), and nonviolent satisfactorily married (n=50). The men who had been maritally violent drank more than the nonviolent men, and they were different from their nonviolent counterparts specifically on the larger *amount* of alcohol consumed and their drinking for emotional reasons.

Female victims of domestic violence are sometimes interviewed about their experiences. Victims interviewed for the National Crime Victimization Survey (NCVS) are asked to report whether they think the offenders who assaulted them had been drinking alcohol. Among those who were assaulted by their intimate partners (spouse, former spouse, boyfriend, girlfriend), the victims reported that *two-thirds* of the offenders had been drinking (Greenfeld, 1998, p. 3). This percentage is substantially higher than for victims who were assaulted by nonmarital relatives (50%), acquaintances (38%), and strangers (31%). Surveys of jail and prison inmates also indicate substantial percentages of inmates reporting that they were drinking before they committed the offenses that resulted in their incarcerations. A 1991 survey of jail inmates indicates that 41% of those incarcerated for violent offenses were drinking before the offense (Greenfeld, 1998, p. 26), and 37% of prison inmates interviewed in 1991 who were incarcerated for violent offenses reported being under the influence of alcohol (or drugs and alcohol) at the time they committed the offense (Beck et al., 1993, p. 26). These inmate data are not presented separately for intimate and other kinds of violence.

Some literature on the evaluation of male batterer treatment also provides evidence that alcohol use is a risk factor for domestic violence offending. Gondolf and his colleagues evaluated batterer interventions in four sites. Longitudinal data for 350 men who participated in batterer treatment showed that a batterer's drunkenness after program entry was associated with the risk of re-assault (Jones & Gondolf, 1997).

A recent study of domestic violence before and after alcoholism treatment examined the effects of behavioral marital therapy (BMT) on subsequent involvement in domestic violence and the relationship of drinking to domestic violence. A study of 75 alcoholics and their wives indicated that BMT reduced the use of violence in the 2 years after treatment (O'Farrell, Van Hutton, & Murphy, 1999). The study also found that the alcoholics whose drinking had remitted did not have elevated domestic violence behavior in comparison to a matched control group, but that the alcoholics who relapsed had elevated domestic violence levels.

The literature addressing the *drug* use-domestic violence offending relationship is limited but growing. Kantor and Straus (1989), analyzing the 1985 National Family Violence Survey, found that husband's drug use was associated with both minor and severe violence against the female domestic partner. Lee and Weinstein (1997) reported a relationship between higher Addiction Severity Index (ASI) scores and battering among a cocaine abuse treatment population in Philadelphia. In a summary of a survey of domestic violence victims who came to the attention of the police in Memphis, Brookhoff (1997) reported that 92% of the offenders had used drugs and/or alcohol on the day of the assault, and 67% of the assailants had used a combination of cocaine and alcohol. In another study, Miller (1990) reported that an alcohol/drug interaction effect contributed to the level of violence against their spouses by a group of parolees.

Bennett, Tolman, Rogalski, and Srinivasaraghavan (1994) studied domestic abuse in a sample of 63 married, cohabiting, or divorced men in an alcohol/drug treatment program. This sample of men had high self-reported rates of physical and psychological abuse of their partners. An estimated 21% of the men had been arrested for battery against a female domestic partner, and 27% had an order of protection or restraining order against them. This study found no relationship between the quantity or frequency of alcohol use or severity of alcohol dependence and abuse of their domestic partners; however, a history of drug use, particularly cocaine, and an early onset of drug- and/or alcohol-related problems were significantly associated with abuse of one's partner.

Moffitt (1997) reported on analyses of severe partner violence in a longitudinal sample of 961 young adults in Dunedin, New Zealand. An interesting finding of this study was that the women were more likely than the men to say they used severe (19% vs. 6%) and minor (37% vs. 22%) violence against their male partners. There was no alcohol–drug relationship to violence

found for the women, but the men who were violent reported more symptoms of alcohol dependence and drug abuse than did their nonviolent peers.

Amaro, Fried, Cabral, and Zuckerman (1990) surveyed pregnant women and their experiences with violence. They found that the male partner's drug use was associated with the violent victimization of the pregnant women, even after controlling for age, marital status, education, and a history of violence in the 3 months before pregnancy.

2.2 Covariates of Substance Abuse and Battering

The research on substance abuse and domestic violence has identified a number of factors that covary with or mediate the substance abuse–domestic violence offending relationship. For example, Kantor and Straus (1989) conducted a multivariate analysis of the 1985 National Family Violence Survey and found that drunkenness and drug use by husbands were associated with minor violence against their partners and that husbands' drug use was associated with severe violence against their partners. But other factors also were relevant. In particular, low family income and a history of the father hitting the mother in the wife's family of origin were significantly associated with minor and severe violence against the female partner.

Hotaling and Sugarman (1986) reviewed the domestic violence literature between 1970 and 1985 and evaluated 52 case comparison studies (i.e., studies that included both violent and nonviolent male partners) to look at risk markers for husband-to-wife violence. Their review identified several consistent risk factors, one of which was alcohol use by the husband. The other risk factors were income, education, occupational status, assertiveness, being sexually aggressive against a wife or partner, using violence against children, and witnessing violence in the home while a child or adolescent.

Kantor (1997) found that ethnicity was systematically associated with assaultive behavior by husbands against wives in analyses of the 1992 National Alcohol and Family Violence Survey. Rates of wife assault were high among Puerto Rican and Mexican-American families in comparison to Mexican, Cuban, and Anglo families. But when husband's average daily drinking was introduced into the analyses, similar patterns of alcohol-related marital assaults were seen regardless of ethnicity.

A common finding in the alcohol-domestic violence research is an association between *patterns* of alcohol consumption, individual factors, and violence against one's domestic partner (Collins, 1993; Leonard, 1993). In two studies, Leonard and his colleagues identified several patterns (Leonard & Blane, 1992; Leonard & Senchak, 1992):

- risky drinking (high alcohol dependence score) was associated with marital aggression among men with high levels of negative affect,
- risky drinking patterns were highly associated with marital aggression among highly hostile subjects, and
- heavy drinking was associated with marital aggression among men dissatisfied with their marital situation.

It is clear from this and other research that the etiology of domestic violence is complex and involves multiple factors in addition to use of drugs and alcohol.

2.3 Causal Relationship of Substance Abuse and Domestic Violence Offending

The empirical evidence of an alcohol-domestic violence association is clear: A high percentage of domestic violence incidents involve alcohol and/or drug use by the offender, and domestic violence offenders are disproportionately likely to have substance abuse problems. The causal contribution of alcohol and drug use to domestic, however, violence is more controversial. The application of strict scientific causality criteria to the research literature on alcohol, drugs, and violence leads to the conclusion that it cannot be concluded that alcohol and drug use are *causally* related to violence (Collins & Messerschmidt, 1993; Lipsey, Wilson, Cohen, & Derzon, 1997). But the absence of good evidence for concluding that substance use is causally related to domestic violence offending does not necessarily mean that no such relationship exists. A more reasonable conclusion is that substance use contributes to domestic violence in complex and conditional ways (Pernanen, 1991). In fact, when substance abuse's explanatory power is examined along with other domestic violence etiological factors, it is not usually found to be quantitatively strong (Collins & Messerschmidt, 1993; Pernanen, 1991). Cognitive, situational, social, and cultural factors usually contribute along with alcohol and drugs (Collins, Kroutil, Roland, & Moore-Guerra, 1997).

Two factors found to be associated with the substance abuse–domestic violence relationship complicate making causal inferences:

- expectations on the part of some drinkers that drinking leads to violence (expectancy effects), and
- drinker's use of alcohol as an excuse for acting violently (deviance disavowal).

An important body of psychological research has demonstrated that drinking creates the expectation among some drinkers that they will act aggressively as a result of their consumption of alcohol (Bushman & Cooper, 1990; Lang, Goeckner, Adesso, & Marlatt, 1975; Taylor & Gammon, 1975; also see review in Fagan, 1990, pp. 264-270). The deviance disavowal perspective suggests either that alcohol is consumed before acting violently and is used as an excuse for the violence, or that alcohol use is offered as an excuse after the fact in an attempt to deflect personal responsibility for the violence (Coleman & Straus, 1983; Collins & Messerschmidt, 1993). Expectancy effects and deviance disavowal further complicate efforts to untangle an already complicated etiological picture.

2.4 Alcohol, Drugs, and Domestic Violence Victimization

There are two major questions in connection with the relationship of substance abuse to the victimization of women by their domestic partners:

- Do alcohol and drug use increase the risk that a woman will be assaulted by her partner (substance abuse → domestic violence victimization)?
- To what extent is substance abuse a *consequence* of domestic violence victimization (domestic violence victimization → substance abuse)?

Although research addressing these questions has only been published since the mid-1980s, there is evidence that substance abuse is *both* a risk factor for being assaulted by a domestic partner and a consequence of such victimization (substance abuse ↔ domestic violence victimization) and that each of these relationships is etiologically complex. But answering the above questions

with confidence is not yet possible because most of the research that has been done has fundamental limitations and study findings are inconsistent.

2.5 Substance Abuse as a Risk Factor for Victimization

The New York City Department of Health studied all female homicide victims aged 16 or older in New York City for the 1990 to 1994 period (Wilt, Illman, & BrodyField, n.d.). Medical examiner reports, including autopsy, crime scene and police reports, and medical history documents, were examined for each of 1,159 victims. Among all victims, autopsy results indicated that

- 24% tested positive for alcohol,
- 28% tested positive for cocaine or its metabolites,
- 45% of those testing positive for alcohol also tested positive for cocaine or its metabolites, and
- 5% tested positive for opiates.

Among the 54% of homicides where a motive was known, 49% were classified as intimate partner homicides (IPH) or family homicides (FH).[2] IPH and FH victims were *less likely* than other kinds of victims to test positive for cocaine, opiates, and marijuana. They were about as likely as other kinds of homicide victims to test positive for alcohol.

These epidemiological data do not allow causal inferences about the role of victim's alcohol and drug use in female homicide, but the prevalence of alcohol and drugs found in the New York City Department of Health study's victims suggests that substance use is a risk factor worth serious analysis. However, the fact that drug use is less frequent among IPH and FH victims, and that alcohol use is about equally involved in all homicide types, suggests that alcohol and drug use are not uniquely important risk factors for homicides involving IPH and FH victims.

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[2]Intimate partner homicides were ones committed by a current or former intimate partner. Family homicides were those in which the offender was related by blood or marriage.

In their review of 52 case comparison studies, Hotaling and Sugarman (1986) found that the only consistent risk factor for domestic violence victimization was witnessing violence in the parental home while a child or adolescent. Alcohol abuse by wives was *not* related to their victimization. Drug abuse by wives was inconsistently related to domestic violence victimization; three of the five studies examining the drug abuse–domestic violence relationship found that drug abuse was significantly associated with being a victim of violence by one's domestic partner.

Kantor and Straus (1989) analyzed the 1985 National Family Violence Survey data using a multivariate approach. Drug use and drunkenness of both husbands and wives were included in the models, along with family income, violence approval norms, and father against mother violence in the wife's home of origin. Separate models were estimated for minor violence (slapping, pushing, etc.) and serious violence (punching, kicking, etc.) by husbands against wives. The wife's drunkenness was associated with minor violence against her, but not with serious violence, suggesting heavy drinking by the wife may be a risk factor for minor domestic partner assault.

Kantor and Asdigian (1997a) examined gender differences in alcohol-related spousal violence using data from the 1992 National Alcohol and Family Violence Survey. Interview data for 1,446 nonabstainers (73% of the total sample) were analyzed to address the effect of the wife's drinking on alcohol-related aggression by the husband. Included in the model were an alcohol expectancy scale, violence legitimation, family income, husband's age, wife's use of violence, husband's usual number of drinks consumed, and wife's usual number of drinks consumed. The only variable accounting for statistically significant variation in the husband's use of violence against the wife after drinking was the wife's usual number of drinks consumed. The authors noted that alcohol-related assaults on wives are more likely when both partners were heavy drinkers, and they speculated that marriages between heavy drinkers may be discordant, conflict-ridden relationships with a high likelihood of assaults. In another chapter, however, Kantor and Asdigian (1997b) questioned the notion that women's intoxication provokes assaults by their husbands. They argued that the temporal precedence of the woman's drinking has not been established in previous work, that alternative explanations for the association between women's drinking and victimization by her partner are possible, and that some previous research has not found such a relationship.

In two chapters, Miller (1990, 1996) interpreted the empirical relationship sometimes observed between women's drinking and their violent victimization. In her own work, she examined the interrelationships between alcohol and family violence in two samples: (a) alcoholic women and a comparison sample of women from the community, and (b) a sample of New York State male parolees and their spouses or partners. Miller found that women victim's alcohol problems were associated with their experiences of spousal violence, but she noted the complexity of the relationship particularly given that when drinking or alcohol problems are associated with victimization, it is usually the case that both domestic partners have been drinking. Miller (1990, 1996) suggested some explanations for the relationship of drinking and domestic violence victimization:

- Women who drink heavily violate traditional notions of their role and may thus make violence against them seem more socially acceptable.
- Alcohol negatively affects cognitive capability and may result in drinking women exercising poor judgment and placing themselves at risk of violent victimization.
- Some drinking contexts (such as bars) are risky and may expose women to an increased risk of victimization.

Brewer, Fleming, Haggerty, and Catalano (1998) examined the relationship between drug use and domestic violence victimization among 82 women in methadone treatment for opiate addiction. A relationship was found between heavier use of crack cocaine, other forms of cocaine, tranquilizers, and being hit by one's partner. No statistically significant relationship was found between use of heroin, marijuana, and alcohol and domestic violence victimization. Brewer et al. (1998) offered three possible explanations for the relationship between crack/other cocaine use and victimization:

- A woman's cocaine use is an indicator of her male partner's cocaine use, and it is the male partner's cocaine use that is associated with his violence against his partner.
- Domestic violence arises from disputes between the partners over drugs and money.

- Cocaine use by women is associated with having multiple sexual partners, and her known or suspected infidelity precipitates violence by males against his cocaine-using partner.

Brewer et al. (1998) did not present evidence in favor of any one of these three explanations, and their small sample size prevented multivariate analysis of the cocaine use–domestic violence relationship that might have shed further light on the etiology of the relationship.

Stark and Flitcraft (1991) asserted that alcohol and drug abuse are not important factors in the onset of domestic abuse against women; they noted that substance abuse is rather a consequence of victimization. They also acknowledged, however, that female alcoholism contributes to the onset of violence in a small percentage of cases (Stark & Flitcraft, 1991, p. 141).

A firm inference that a woman's drinking and/or drug use increases the likelihood that she will be assaulted by her spouse is not justified, although several studies have found such an empirical relationship. There is evidence from the above research that the drinking of *both* spouses is relevant to the risk of family violence. The issue also is in doubt due to methodological limitations of previous work, particularly the lack of longitudinal research designs that permit making causal inferences, especially on the question of the temporal ordering of substance abuse and domestic violence victimization in relationship to each other.

2.6 Substance Abuse as a Consequence of Victimization

There is growing evidence that violent victimization is a risk factor for later substance abuse among women. The best evidence of such a relationship is for *childhood sexual abuse* and elevated rates of alcohol abuse and dependence in adulthood (see Crowell & Burgess, 1996, pp. 73-84; also see the review in Wilsnack, Plaud, Wilsnack, & Klassen, 1997, pp. 260-262). There is also evidence that being a battered woman increases the likelihood of having alcohol and drug problems. The Hotaling and Sugarman (1986, p. 118) review of 52 studies concluded that substance abuse is a *consequence* of battering, not a cause of it.

Stark and Flitcraft (1991, p. 140) concluded that "battering appears to be the single most important context yet identified for female alcoholism, possibly associated with 50 percent of all female alcoholism." These authors also concluded that the rate of drug abuse is no higher for

abused women prior to victimization, but the risk of drug abuse becomes nine times higher after an abusive episode (Stark & Flitcraft, 1991, p. 141).

Miller and Downs (1993) studied women in alcoholism treatment, domestic violence shelters, mental health centers, drinking and driving classes, and in the community (n=472). The women in domestic violence shelters, as expected, had the highest frequency of domestic violence experiences, but the women in alcoholism treatment experienced a high rate of severe violence at the hands of their pretreatment partners (41%). The household women had the lowest rate (9%). In the Barnett and Fagan (1993) study of maritally violent men discussed in Section 2.1, the spouses or partners of the violent men did not differ in general alcohol use, but they drank larger amounts than did the spouses/partners of the nonviolent men. This study also found that 48% of the female partners of the violent men "drank as an aftermath of the violence" (Barnett & Fagan, 1993, p. 19).

Wilsnack et al. (1997, pp. 262-263) discussed the work of Kilpatrick and his colleagues regarding alcohol abuse as a consequence of victimization. Kilpatrick, Edmonds, and Seymour (1992) interviewed more than 4,000 adult women about their violent victimization experiences. Rape victims who had experienced rape-related post-traumatic stress disorder (PTSD) were much more likely than nonvictims to report two or more alcohol-related problems. Almost four of five rape victims reported getting intoxicated for the first time after having been raped. Follow-up interviews of the same sample of women indicated that experiences of violent victimization were more likely to precede and predict alcohol dependence than the reverse (Kilpatrick, Resnick, Saunders, Best, & Epstein, 1994).

2.7 Summary of Past Research on the Substance Abuse–Domestic Violence Relationship

The current state of knowledge concerning the relationship of substance use/abuse and domestic violence can be summarized as follows:

- Alcohol use, and probably drug use, are risk factors for male against female domestic violence offending.
- The alcohol/drug–domestic violence offending relationship is etiologically very complex, and multiple factors are relevant.

- Alcohol and drug use may be risk factors for female domestic violence victimization, but the evidence is currently insufficient to support such a conclusion. This possible relationship is probably much weaker than the alcohol/drug–domestic violence *offending* relationship and is etiologically complex.

- There is growing evidence that substance abuse is sometimes a consequence of domestic violence victimization, but more research is needed and the etiological pathways have not been examined.

Additional research on the substance abuse–domestic violence *offending* relationship should have an etiological focus. Additional epidemiological and correlational work on this topic is unnecessary given the large number of such studies already done. Much more research on the substance abuse–domestic violence victimization relationship is needed. This work should focus on both substance use/abuse as a risk factor for victimization and on substance abuse as a consequence of domestic violence victimization.

2.8 Linkage of Domestic Violence Services and Substance Abuse Services

Clinical judgment and logic suggest that domestic violence and substance abuse services should be linked for both male offenders and women victims of domestic violence. Substance abuse treatment effectiveness and relapse risk are likely to be impacted negatively if substance abuse treatment providers do not deal with the consequences of violence suffered by women substance abuse treatment clients. Failure to address the substance abuse problems of women domestic violence victims may increase their risk of further victimization after they leave treatment (Center for Substance Abuse Treatment [CSAT, 1994; Fazzone, Holton, & Reed, 1997). But substance abuse treatment programs do not usually have formal ways to address family violence issues, and many programs ignore the issue altogether (Collins et al., 1997).

Linking substance abuse and domestic violence services is part of a more general set of issues associated with violence against women and women's health (Buehler, Dixon, & Toomey, 1998; The Commonwealth Fund, 1998; Flitcraft, 1993; Langford, 1996; Rosenberg & Mercy, 1991; Stark & Flitcraft, 1991). A variety of actions have been suggested that should be done by the health care system to identify and respond to domestic violence and the associated health

problems that often accompany such victimization (e.g., depression, chronic pain, substance abuse):

- Develop screening inserts into Research in Brief protocols and proactive screening of women who come to hospital emergency rooms and by women's personal physicians to uncover domestic violence.
- Train health care staff to recognize domestic violence.
- Document domestic violence that is reported to health care workers.
- Develop bridges between service delivery systems to coordinate services for the multiple needs of domestic violence victims.
- Refer victimized women to hot lines, social workers, shelters, and other community organizations that can provide help.

There is evidence that these and other initiatives are increasingly being implemented.

Domestic violence programs do not usually deal with the substance abuse problems of the women they serve. There are multiple reasons why this is the case:

- The primary foci of domestic violence programs for women are safety and shelter.
- There is a concern that focusing on the substance abuse of women victims might encourage "victim blaming."
- Resources are typically very limited within domestic violence programs.
- Programmatic expertise in substance abuse treatment usually does not exist in domestic violence programs.

Another option for dealing with the substance abuse problems of women domestic violence victims within domestic violence programs is referral to substance abuse programs. This option, however, is often not pursued for some of the above reasons and because of philosophical differences between the two program types. Domestic violence programs sometimes view the treatment philosophy of substance abuse programs as inappropriate for their clients because it does not emphasize safety and empowerment of women victims.

Treatment programs for batterers do not usually provide substance abuse treatment. In fact, there is often explicit resistance to the inclusion of substance abuse treatment as a part of treatment for batterers because of the strong emphasis on batterer accountability, a high priority in batterer treatment. There is a concern that inclusion of the substance abuse component with its emphasis on alcohol and drug abuse as a disease or disorder might shift attention away from the idea that battering is voluntary behavior, and offenders should be held strictly accountable for their violent behavior (Healey, Smith, & O'Sullivan, 1998, p. 6).

Bennett and Lawson (1994) surveyed domestic violence and substance abuse treatment programs in Illinois in an attempt to determine how often domestic violence and substance abuse treatment service are linked and the barriers to such linkage. Their survey included 139 individuals in 22 domestic violence programs, and 244 individuals in 53 substance abuse treatment programs in Illinois. The program-level response rate was 47% for domestic violence programs and 35% for substance abuse treatment programs. The main findings of their survey were as follows:

- Formal *screening* for the cross problem (substance abuse screening by domestic violence programs, and domestic violence screening by substance abuse programs) was rare and tended to be unsystematic; an exception was substance abuse screening by programs for male batterers.
- The presence of in-house expertise for the cross problem was uncommon, and when it did exist, it tended to be superficial.
- Approximately 70% of the two program types said they had some kind of formal linkage agreement with the other program type, but only 20% of the substance abuse program directors said they met sometimes or frequently with the other program type, and 70% of the domestic violence program directors said they met with the substance abuse treatment programs.
- Almost one-quarter of the substance abuse treatment programs said they never made referral to domestic violence programs, and 5% of the domestic violence programs reported never making referrals to substance abuse treatment programs.

This survey was conducted in a single State and did not have a high response rate, but its findings are consistent with anecdotal evidence about the extent and features of linkage (Collins et al., 1997).

CSAT (1994) compiled guidelines in a manual for the treatment of women with substance abuse problems. This manual dealt only superficially with the domestic violence issue. In a list of "critical components" of substance abuse treatment for women, the domestic violence problem is not mentioned, and a later discussion that makes reference to the domestic violence problem of women substance abusers does not deal substantively with the integration of services to address the violence issue (CSAT, 1994, pp. 81-95). In a later CSAT monograph (No. 25 in a series of Treatment Improvement Protocols [TIPs]), Fazzone et al. (1997) dealt explicitly with the dual problems of substance abuse treatment and domestic violence. This monograph, based on the conclusions of a consensus panel of domestic violence experts, asserted that failure to deal explicitly with domestic violence in substance abuse treatment interferes with substance abuse treatment effectiveness and contributes to relapse. The document further recommended that substance abuse treatment programs screen all their clients for past and current domestic violence and sexual abuse and that domestic violence programs also do so when possible.

The 1997 CSAT protocol recommended models for *systemic reform* and *community linkages.* Recommended *systemic reforms* include the following:

- linkages between substance abuse treatment and domestic violence at the human services system level;
- creation of mechanisms for interagency cooperation at the State level;
- efforts to provide holistic services to address needs for housing, child care, mental health, legal services, vocational services, and other services, including an emphasis on physical and emotional safety for women victims; and
- State and Federal support for demonstration projects to test the feasibility of changing the current systems to formalize collaboration and linkage.

Similar recommendations are made in Collins et al. (1997), including the adoption of a case manager model to coordinate the two kinds of services in the current absence of integrated programs.

Recommended linkages at the *community* level in the CSAT protocol include program cooperation, organizational linkages, and credentialing of substance abuse treatment providers on domestic violence issues, such as safety planning and domestic violence legal issues.

Treatment programs for batterers are more likely than substance abuse treatment programs and domestic violence programs for women victims to deal with *both* the substance abuse and violence problems. It is still uncommon to have programs for batterers integrate substance abuse and batterer treatment, but often batterer programs will include a substance abuse assessment. A recent set of recommendations developed for batterer treatment suggests that substance abuse assessment and treatment be part of a coordinated set of responses (Healey et al., 1998, pp. 79-84).

There is evidence of meaningful reform in the substance abuse–domestic violence area. Healey et al. (1998, pp. 115-138) summarized State guidelines that indicate critical thinking about the integration of substance abuse and batterer treatment. For example, 13 States mandate that substance abuse treatment may not be a replacement for batterer treatment, although some States do allow concurrent substance abuse and batterer treatment.

There are good reasons for substance abuse and domestic violence programs to address both problems—at least to the extent of screening female and male clients for the complementary problem. No research literature supports linking the two kinds of services, but there is significant clinical judgment support for doing so. One is tempted to conclude that linking domestic violence and substance abuse services is desirable. But very little is known systematically about the difficulties of such linkage, about optimal ways to provide linked services, and about the impact of linkage on subsequent victimization, offending, and substance abuse.

Based on a national survey of substance abuse treatment and domestic violence programs, this report documents what the two program types are doing currently with regard to linkage of the two service types, what some of the difficulties of linkage are, including barriers associated with attitudes about the substance abuse and domestic violence phenomena and appropriate interventions to address the problems. After discussing the survey methodology in the next chapter, we present in Chapter 4 the results of the national survey of programs we conducted. This information provides a foundation for the guidance we offer for domestic violence–substance abuse service linkage initiatives in the final chapter of the report.

3. METHODOLOGY

3.1 Overview

In this chapter, we describe our instrumentation, sampling, and data collection activities. Specifically, this chapter details the development and pretest of our survey questionnaires, the construction of sampling frames and the selection of national samples of domestic violence and substance abuse treatment programs, our computer-assisted telephone interviewing (CATI) data collection procedures, and the response rate results of our data collection efforts.

3.2 Instrument Development

Two questionnaires were used in this study: the Domestic Violence Program Directors' Questionnaire and the Substance Abuse Program Directors' Questionnaire (see Appendices A and B, respectively, for the final versions of these instruments). The instruments focused on collecting information about program directors, the programs and services provided, whether complementary substance abuse or domestic violence services were provided, barriers to provision of complementary services, program director's attitudes about providing complementary services, and their beliefs about the substance abuse–domestic violence relationship. Initial drafts of these instruments were prepared by Research Triangle Institute (RTI) staff. In the spring and summer of 1997, RTI project staff refined the questionnaires for field use.

Because the Substance Abuse Program Directors' Survey went into data collection first, RTI project staff initially focused on finalizing it before completing their work on the Domestic Violence Program Directors' Questionnaire. Between March and April 1997, the instrument for substance abuse treatment providers was (1) shortened to address concerns about CATI programming and interviewing costs, and (2) reformatted for CATI administration. A paper-and-pencil version of the instrument was pretested in late March 1997. Using the hard-copy questionnaire, RTI staff made pretest calls to approximately 10 substance abuse programs randomly selected from the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, 1995 (Substance Abuse and Mental Health Services Administration [SAMHSA], 1996). This pretest uncovered several problems in the questionnaire, including

unsuitable terminology, inappropriate or missing response options, and incorrect or missing skip patterns. Following the pretest, changes were incorporated into the questionnaire to address these problems.

Additional modifications were made to the Substance Abuse Program Directors' Questionnaire in June 1997, following the start of data collection. Although we would have preferred to avoid altering the questionnaire during data collection, observations by the data collection manager and feedback from interviewers revealed additional problems worthy of attention, many of which could be easily remedied. A number of these problems called for expanding the CATI software's numeric response ranges, increasing the CATI software's flexibility to handle inconsistent responses to several questionnaire items, inserting/revising interviewer instructions for handling these items, modifying skip logics, and adjusting wording.

In preparation for interviewing domestic violence program directors in August 1997, the draft version of the Domestic Violence Program Directors' Questionnaire was refined by RTI project staff in June 1997. We incorporated relevant revisions that were made to the Substance Abuse Program Directors' Questionnaire (discussed above) and made additional changes to (1) include separate questionnaire items, where appropriate, about domestic violence victim and offender clients, (2) remove items that were duplicated elsewhere in the instrument, and (3) where appropriate, make the instrument comparable to the Substance Abuse Program Directors' Questionnaire on an item-by-item basis. Because the final domestic violence questionnaire differed from the substance abuse questionnaire in wording only, RTI staff did not conduct a pretest of the former. At different points of time in its development, however, the Domestic Violence Program Directors' Questionnaire was reviewed by three substantive area experts:

- Dr. Brenda A. Miller, Director and Senior Scientist at the Research Institute on Addictions in Buffalo, New York, who has studied domestic violence and substance abuse;
- Ms. Anne Menard, Director of the National Resource Center on Domestic Violence in Harrisburg, Pennsylvania; and
- Ms. Nancy Durburow of the Pennsylvania Coalition Against Domestic Violence (PCADV) in Harrisburg, Pennsylvania.

Suggestions and comments for revisions from these individuals were incorporated into the instrument.

Although dissimilarities between the two program types made some differences between the two questionnaires necessary, the structure and much of the content of each survey instrument were very similar. The final version of each questionnaire was broken down into the following six sections:

- **Respondent Information.** Program directors were asked to provide demographic information about themselves, their job responsibilities, and the length of time at their present position and in their field.

- **Organization Information.** Questions were included regarding the auspices of the program and the length of time the program has been in operation. In addition, the program's complete contact information (address and phone number) was obtained.

- **Budget, Personnel, and Service Volume Information.** Questions were asked about the program's annual budget; the number of people who work at the program; the educational background of its employees; and the number, type, and demographic characteristics of clients who are served by the program.

- **Services Offered.** Questions in this section focused on the types of services and networking the program provides to clients and the frequency at which these services are provided.

- **Service Linkage Information.** Program directors were asked about whether clients are screened for substance abuse problems/domestic violence; whether complementary services are provided to clients in need; if not, why the program does not provide complementary services; as well as what complementary services the program would provide if more resources were available.

- **Barriers to Service Linkage.** This section asked about conceptual/ attitudinal and resource barriers to service linkage. For example, program directors were asked about their attitudes about the relationship between domestic violence and substance abuse problems and about the linkage of domestic violence and substance abuse services. In addition, directors were asked about the problems they would expect or have experienced (e.g., financial, lack of training) in working with a complementary program.

3.3 Sampling of Substance Abuse Treatment and Domestic Violence Programs

Two separate lists were obtained for the sampling of domestic violence and substance abuse programs: the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, 1995 (SAMHSA, 1996) and a draft version of the 1997 National Directory of Domestic Violence Programs maintained by the National Coalition Against Domestic Violence (NCADV, 1997). Stratified probability samples of the two program types were selected from these lists. The sampling procedures used for the substance abuse programs are presented in greater detail below.

3.3.1 Substance Abuse Treatment Programs

The National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, 1995 lists 12,766 alcoholism and drug abuse treatment facilities and contains information obtained from the 1995 Uniform Facility Data Set (UFDS) survey conducted by SAMHSA. Working from this directory, we constructed a sampling frame of substance abuse treatment programs that were considered to be potentially eligible for our study.

Eligibility criteria required that a substance abuse program provide residential or ambulatory alcoholism services or both alcohol and drug abuse services to at least 100 clients in 1996.[3] Programs that only provide drug abuse services, detoxification services, or methadone services were considered to be ineligible, as were programs that only provide services to youths, public inebriates, and clients who tested positive for the human immunodeficiency virus (HIV). Programs in the U.S. Territories also were excluded.

Prior to selecting a sample from the frame, an attempt was made to remove ineligible programs from the frame using information collected in UFDS. We also identified potential duplicate programs. Because the potentially duplicate programs (identified by telephone numbers) appeared to be separate programs operating under one agency at more than one address or different types of programs at the same address, we opted not to remove these programs from the frame. Instead, duplicate programs, closed programs, and any remaining ineligible programs

[3]A minimum clientele size was imposed in an attempt to eliminate programs from our sample that did not serve many clients. A consequence of this eligibility criterion was that small programs were excluded disproportionately from the sample.

were identified during interviewer telephone screening. (See below for more information on telephone screening.)

The final sampling frame of substance abuse programs contained 9,685 programs. The frame was stratified into three groups according to whether the program offered residential services only, outpatient services only, or both or unknown. A stratified random sample of 1,100 programs was selected, allocated in proportion to the number of programs in each stratum.

After data collection, sampling weights were constructed and adjusted for nonresponse. Weighting class adjustments were used with separate adjustments within each stratum.

3.3.2 Domestic Violence Programs

Using the draft version of the 1997 National Directory of Domestic Violence Programs, we constructed a sampling frame of domestic violence programs for our study. The directory contained the name, address, and telephone number of 2,031 domestic violence programs, but it did not include other information about the programs, such as type of service provided.

To be eligible for our study, domestic violence programs had to provide services to either domestic violence victims or offenders and have served at least 50 clients in 1996.[4] Because the draft version of the 1997 National Directory of Domestic Violence Programs did not contain this information, we were unable to eliminate ineligible programs before we selected a sample of programs from the frame. By examining address information for programs with the same telephone number, however, we were at least able to identify in advance apparent duplicates in the directory. Duplicate records and programs in the U.S. Territories were eliminated from the frame prior to sample selection. Closed programs as well as additional duplicate and ineligible programs were identified later by telephone interviewer screening.

The final sampling frame contained 1,970 domestic violence programs. An unstratified simple random sample of 800 programs was selected for the survey. After data collection, sampling weights were constructed and adjusted for nonresponse using weighting class adjustments within classes defined by the four U.S. Census regions.

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[4]As with the substance abuse treatment programs, a minimum clientele size was imposed to eliminate programs from our sample that did not serve many clients. Again, a consequence of this eligiblity criterion was that small programs were excluded disproportionately from the sample.

3.4 Data Collection Procedures

The two questionnaires used in this study were administered to staff of sampled substance abuse treatment and domestic violence programs during different time periods in 1997, with a slight overlap in data collection during the month of September 1997. Data collection for the substance abuse program sample began on April 27th and continued through September 30th. Data collection for the domestic violence program sample began on August 27th and ended on October 31st. The following sections detail the data collection procedures that RTI survey staff employed for both samples.

3.4.1 Interviewer Training

RTI's Telephone Survey Unit (TSU) operates three shifts—day, evening, and weekend. For this study, the majority of interviewers trained were on the day shift, with a few from the evening shift to cover West Coast calls. No weekend shift interviewers were trained.

In April 1997, prior to the start of data collection, telephone interviewer training materials were developed that included a comprehensive training manual and mock interviews. The training manual covered study background, telephone interviewer responsibilities, data collection time line and procedures, quality control measures, and question-by-question specifications. Practice cases were set up within the CATI system for the interviewers to access the mock interviews.

The initial interviewer training on the substance abuse questionnaire was conducted by the data collection manager on April 27, 1997, and followed the standard RTI telephone survey training agenda. Six telephone interviewers and five telephone supervisors were trained. Project staff were introduced to the interviewers, and a thorough background of the study was provided. The interviewers then were shown a demonstration interview using an overhead projector. During this demonstration, each question within the questionnaire was discussed in detail, and the question-by-question specifications within the manual were reviewed. During training, each interviewer was logged on to his or her own terminal, so all could follow the exercises. Mock interviews then were conducted with the data collection manager as the respondent, and the interviewers taking turns asking questions. Between mock interviews, short lectures were presented on how to contact respondents, trace respondents, answer respondent questions, and

handle refusals. Each mock interview incorporated exercises to practice procedures discussed in the previous lecture.

To increase production, a second group of interviewers was trained on May 15, 1997. This training session followed the initial session agenda outlined above and included an additional 10 interviewers and 1 telephone supervisor.

Telephone interviewers were trained on the domestic violence questionnaire on August 27, 1997, using the same training format outlined above. Along with the original supervisors and eight of the interviewers trained on the substance abuse questionnaire, seven additional interviewers were trained to work on the domestic violence questionnaire.

3.4.2 Procedures for Computer-Assisted Telephone Interviewing

Questionnaire Administration. At the beginning of each TSU shift, the project telephone interviewers logged onto the CATI system and accessed the substance abuse or domestic violence cases specified to be called during their shift. RTI's CATI automated scheduler keeps track of all calls made for each project and prioritizes these calls on the appropriate day and at the appropriate time. For each case accessed, the CATI software displayed the program name, address, and phone number. The interviewer dialed the number and attempted to contact the selected program.

Once an RTI telephone interviewer called and reached a person at a program, his or her duty was to first identify the program director and then obtain their cooperation.[5] Although lead letters were sent to all program directors 2 weeks prior to data collection, some program directors did not receive them. If a program director required that we send the letter before he or she would participate in the interview, the interviewer recorded the program's fax number and scheduled a callback to complete the interview. The fax information then was forwarded to a telephone supervisor, who faxed the lead letter to the prospective respondent.

During the interview, if the respondent was not able to provide the detailed information asked for in the "Budget, Personnel, and Service Volume Information" section of the questionnaire, that section was skipped, the balance of the interview was completed, the

[5]In the event that a program director was unable to participate or preferred that another person respond to the study, another staff person in the program who was familiar with that program's operations was identified to serve as the respondent. Although we refer to respondents as "program directors" in this report, it should be noted that some of the respondents were other program administrators, service providers, or other program employees.

respondent's fax number was obtained at the end of the interview, and a callback was scheduled to collect the rest of the information. Again, this fax information was forwarded to a telephone supervisor, who faxed the respondent a hard copy of the budget-related questions.

According to the responses entered by the interviewer, RTI's CATI system automatically recorded an outcome for each attempted call. These outcomes were used to create data collection status reports that were sent to and reviewed by TSU project staff on a daily basis.

Resolving Data Collection Problems. RTI's CATI software includes an interactive problem reporting system in which the telephone interviewer can enter any problem that arises during data collection. These problems were electronically forwarded to TSU supervisors, the CATI programmer, and the data collection manager on a daily basis, where they were reviewed and resolved.

Handling Refusals. If a respondent initially refused to complete the interview, RTI's CATI system placed the case in a refusal queue for a trained refusal converter to call at a later time. The standard amount of time between the first and second attempt was 1 to 2 weeks. If the second attempt failed, the CATI system automatically coded the case a final refusal.

Program Tracing. If an interviewer encountered a wrong or disconnected number, he or she first contacted the selected program's local directory assistance to find out if the program had a new number. If directory assistance had no new number for the program, it was coded as a "Pending Unable to Locate" and passed on to the data collection manager. Using the national directories of domestic violence and substance abuse treatment programs we obtained for sampling, the data collection manager called other programs in the same town as the selected program to try to find out if the program had closed or if it had moved. If this was unsuccessful, the case was coded a final "Unable to Contact."

Quality Control Measures for Interviewing. To ensure that standards were met, TSU supervisors monitored interviewer performance, including application of proper interviewing techniques, production rates, and the number of refusals experienced. The supervisor discussed performance concerns with interviewers. In addition to the monitoring of performance standards related to production and response rates, other procedures were implemented to aid in ensuring that the data collected met quality standards. Two major procedures for this purpose were silent monitoring and regular debriefing meetings. Telephone supervisors and the data collection manager monitored approximately 10% of all calls made by the project's interviewers. The

telephone supervisor shared the results with the interviewers monitored and worked with the interviewers to ensure quality interviewing. Additionally, the data collection manager met regularly with interviewers and supervisors to exchange information, address problems and their resolution, and discuss such issues as refusal aversion/conversion techniques.

3.5 Data Collection Results

3.5.1 Final Disposition Profile of Sample

Table 3.1 summarizes the final call dispositions for the 1,100 substance abuse treatment programs and 800 domestic violence programs sampled for the study. Overall, we obtained usable completed or partial interviews from 691 substance abuse and 606 domestic violence programs.

Table 3.1 Final Disposition Profile of Substance Abuse and Domestic Violence Program Samples

Final Disposition	Substance Abuse Programs *n* (%)	Domestic Violence Programs *n* (%)
Completed Interview	670 (61%)	598 (75%)
Partial Interview Included in Analysis Excluded from Analysis	24 (2%) 21 3	9 (1%) 8 1
Ineligible Site Site Closed Duplicate Site Screened as Ineligible	262 (24%) 29 3 230	67 (8%) 10 3 54
Refusal	75 (7%)	26 (3%)
Unable to Contact Site/ Time Exhausted	48 (4%)	52 (7%)
Unable to Locate Site	20 (2%)	48 (6%)
Language Barrier	1 (0%)	0 (0%)
Total	1,100	800

3.5.2 Discussion of Ineligible Programs

A total of 262 substance abuse programs and 67 domestic violence programs were determined to be ineligible. As Table 3.1 indicates, three of these for each program type turned out to be the same site as another sample member, and 29 substance abuse and 10 domestic violence programs were found to be closed (i.e., no longer in operation). Additional ineligible programs were identified by a set of screener questions that telephone interviewers administered prior to the questionnaire.

Of the 1,100 substance abuse programs sampled, we were able to administer the set of screener questions to 948 programs to determine if these programs were eligible for the study. A total of 68 of these programs reported that they do not provide either residential or ambulatory alcoholism services and were therefore coded as ineligible. An additional 78 substance abuse programs were determined to be ineligible because they only provide detoxification services (17), methadone services (5), services for youths (44), services for public inebriates (9), or services for HIV-positive persons (3). A total of 82 additional substance abuse programs were screened out because they reported that they did not serve at least 100 clients in 1996, and 2 other programs were coded ineligible for other reasons. Overall, of the 948 programs we screened, 230 (or 24%) were determined to be ineligible.

Of the 800 domestic violence programs sampled, we were able to administer a set of screener questions to 675. A total of 27 of these programs did not provide services to either domestic violence victims or offenders; as a result, we considered them to be ineligible for the study. An additional 27 programs were determined to be ineligible because the programs reported that they did not serve at least 50 clients in 1996. Overall, of those domestic violence programs we formally screened, 54 (or 8%) were determined to be ineligible.

3.5.3 Calculation of Response and Refusal Rates

Using the information contained in Table 3.1, response and refusal rates were calculated for each program type. To determine the response rates, the number of partial and completed interviews combined was divided by the total number of eligible programs. Eligible programs were defined as all programs except those that were found to be closed or duplicates or determined to be ineligible via the screener questions administered to some programs (discussed

above). For domestic violence programs, the response rate calculation was (598+9)/800-(54+10+3), or 82.8%. For substance abuse programs, the calculation was (670+24)/1,100 - (230+29+3), or 82.8%.

To determine a refusal rate for each program type, the number of refusals was divided by the total number of eligible programs. The refusal rates for domestic violence and substance abuse programs were 3.6% and 9.0%, respectively.

4. DESCRIPTIVE FINDINGS

4.1 Analytic Goals and Approach

In this chapter, we examine our national samples of substance abuse and domestic violence programs. One purpose of our statistical analyses was to describe and compare substance abuse and domestic violence programs with regard to their directors and clients, their financial and staffing resources, the services they provide, and their activities, perceptions, and attitudes concerning service linkage. Another aim of our survey analysis was to identify factors associated with linked services and to determine the comparative importance of different factors to service linkage for the two program types. To accomplish these goals, we conducted two types of analyses: descriptive bivariate analyses and a series of logistic regression analyses. The bivariate findings are presented in this chapter, and the logistic regression findings are in Chapter 5.

As discussed earlier in Section 3.3, the data were weighted within sampling strata to reflect the probability of selection. Using SAS statistical analysis software, chi-square and *t*-tests of statistical significance were used to assess whether domestic violence and substance abuse treatment programs differed. Tables 4.1 through 4.8 contain the results of these analyses and are discussed below. For continuous numeric variables, we present both the mean and median; it should be noted that the difference between these two measures suggests that some of these variables have a skewed distribution.

4.2 Program Director Characteristics

Table 4.1 summarizes demographic and other characteristics of directors of each program type. A number of statistically significant differences were observed. As expected, our results indicated that domestic violence programs were more likely to have a female director. On average, directors of substance abuse programs were slightly older in age and were more likely than domestic violence program directors to have graduate degrees. Compared to domestic violence program directors, substance abuse program directors held their present position for about a year longer and had been in their field for about 4 years longer. Regarding job

Table 4.1 Program Director Characteristics

Characteristic	Domestic Violence Programs (n=606; N=1,774)	Substance Abuse Programs (n=691; N=7,027)
Gender* **		
Female	93.9%	49.7%
Male	6.1%	50.3%
Mean (Median) Years of Age* **	43.3 (44)	47.0 (47)
Race* **		
Alaskan Native	0.3%	0.0%
American Indian	1.9%	2.0%
Asian or Pacific Islander	2.1%	.7%
Black, not of Hispanic Origin	3.2%	7.9%
Hispanic	2.9%	3.6%
White, not of Hispanic Origin	86.6%	80.1%
Other	2.9%	4.4%
Education* **		
Less Than College	22.8%	13.2%
College (including some postgraduate)	37.8%	19.7%
Master's	36.3%	55.5%
Doctoral	3.0%	11.4%
Major Job Responsibilities		
Administrative	94.2%	93.9%
Fund-Raising***	71.6%	35.8%
Clinical/Direct Services to Clients**	66.1%	72.9%
Supervision of Employees	90.9%	92.6%
Coordination with Other Programs	97.5%	96.2%
Public Relations*	92.7%	88.9%
Other*	39.6%	32.8%
Mean (Median) Years in Present Position* **	4.9 (3.5)	6.0 (5)
Mean (Median) Years in Field* **	10.8 (10)	14.7 (14)

* Program differences significant at the .05 level.
** Program differences significant at the .01 level.
*** Program differences significant at the .001 level.

responsibilities, domestic violence program directors were more likely to be involved with fund-raising and public relations; substance abuse program directors were more likely to provide clinical or direct services to clients. Nonetheless, with the exception of fund-raising, an overwhelming majority of directors of *both* program types were involved in all job responsibilities we asked about.

4.3 Program Characteristics

The public/private status, fiscal and staffing resources, and clientele size of substance abuse and domestic violence programs are compared in Table 4.2. Nearly all (90%) of the domestic violence programs were private/not-for-profit agencies, whereas only slightly over half of the substance abuse programs reported they were private/not-for-profit. Another third of the substance abuse programs were public or private/for-profit programs. Both substance abuse and domestic violence programs had been in operation for approximately 17 years.

On average, substance abuse programs operated with two and a half times as many full-time employees as domestic violence programs (25 vs. 10) and with an annual budget of over $1.8 million compared to the approximately $550,000 budget observed for domestic violence programs. Directors of both program types were asked about the percentage of their program's total operating budget that came from government, private, and other funding sources. Overall, domestic violence program directors most often reported larger percentages from Federal and State funds, whereas substance abuse program directors most often reported larger percentages for State funds and client fees. Our analyses showed statistically significant differences in funding sources between the two program types. Compared to domestic violence programs, substance abuse programs were less likely to be funded by Federal Government funds, private foundations/agencies, private donations, and other sources. Domestic violence programs, on the other hand, were much less likely to receive funds from client fees.

Although domestic violence program directors reported smaller operating budgets and fewer full-time staff, overall we found that their programs' clientele size was significantly larger than that of substance abuse programs. This may be because domestic violence programs sometimes provide service to adults and children, and because the length of service provision for domestic violence programs is shorter, allowing more clients to be served.

Table 4.2 Program Characteristics

Characteristic	Domestic Violence Programs (*n*=606; *N*=1,774)	Substance Abuse Programs (*n*=691; *N*=7,027)
Corporate Status***		
Public	6.2%	18.1%
Private—not for profit	90.5%	56.0%
Private—for profit	0.2%	17.8%
Other	3.0%	7.9%
Mean (Median) Years in Operation	16.9 (17)	17.6 (17)
Mean (Median) Annual Budget***	$547,615 ($300,000)†	$1,831,040 ($550,000)†
Funding Source—Mean (Median) Reported Percentage		
Federal Government funds**	22.4% (18%)†	18.2% (0%)†
State government funds	31.4% (30%)†	28.0% (20%)†
County government funds	7.4% (2%)†	8.7% (0%) †
Other local government funds***	4.1% (0%)†	1.9% (0%)†
Private foundation/agencies***	12.0% (7%)†	2.1% (0%)†
Private donations***	9.0% (5%)†	2.2% (0%)†
Client fees (incl. reimbursement from private insurance)***	1.8% (0%)†	33.6% (15%)†
Other***	12.1% (0%)†	5.4% (0%)†
Mean (Median) Number of Full-Time Employees***	10.1 (7)	25.4 (10)
Mean (Median) Number of Clients per Year***	1,374.1 (700)	693.2 (300)

* Significant at the .05 level.
** Significant at the .01 level.
*** Significant at the .001 level.

† 10% or more of cases responded "don't know" to or refused to answer questionnaire item.

4.4 Client Characteristics

Table 4.3 outlines demographic and other characteristics for the clients of both program types. As expected, domestic violence program directors reported that the majority (85%) of their clients were female; on average, two-thirds of the clients of substance abuse programs were male. Compared to substance abuse program directors, domestic violence program directors reported that their clientele was made up of a smaller proportion of non-Hispanic black clients (as well as larger proportions of non-Hispanic white and American Indian clients), of individuals younger than 18 years of age, and of persons with an annual income of less than $15,000. In contrast, substance abuse program directors indicated that their clientele was comprised of a larger percentage of clients over the age of 26 years and of individuals with annual salaries greater than $15,000. Substance abuse treatment clients were older and had higher incomes.

Substance abuse program directors were asked about the proportion of their clients who are court ordered and who are voluntary. We asked the same question of domestic violence program directors with specific regard to their domestic violence offender clients. On average, substance abuse program directors reported a close-to-equal split between the two client types (58% were voluntary clients). In contrast, domestic violence program directors reported that only about a quarter of their offender clients were voluntary. We did not ask about involuntary domestic violence clients because courts rarely mandate that victims seek treatment.

4.5 Services Provided by Programs

Table 4.4 shows the kinds of services provided by domestic violence programs. A very large majority of the domestic violence programs provide victim support/assistance/counseling to victims, services to children, and legal advocacy; 88% of the programs provide shelter services. Slightly more than 30% domestic violence programs provide batterer programming. On average, more than two-thirds of the clients of domestic violence programs were adult victims, one-fourth were children of victims, and an average of 1 in 20 was a batterer. Approximately 37% of program clients were shelter residents.

Domestic violence programs provide a variety of networking services. Almost all programs had hotlines and provided information about and referrals to other agencies. About

Table 4.3 Client Characteristics

Characteristic	Domestic Violence Programs (*n*=606; *N*=1,774), %	Substance Abuse Programs (*n*=691; *N*=7,027), %
Gender —		
Mean (Median) Reported Percentage		
Female***	84.8 (95)†	33.0 (30)
Male***	15.2 (5)†	67.0 (70)
Race/Ethnicity —		
Mean (Median) Reported Percentage		
Alaskan Native	0.8 (0)†	0.6 (0)
American Indian**	6.1 (1)†	3.6 (1)
Asian or Pacific Islander**	3.5 (1)†	1.7 (0)
Black, not of Hispanic Origin***	16.7 (10)†	26.3 (20)
Hispanic	10.1 (4)†	11.0 (5)
White, not of Hispanic Origin***	62.9 (67)†	56.9 (60)
Years of Age —		
Mean (Median) Reported Percentage		
≤ 17***	18.8 (14)†	7.0 (1)
18-25	22.0 (20)†	21.4 (20)
26-34***	28.3 (30)†	33.4 (30)
35-44***	16.2 (15)†	24.2 (25)
≥ 45***	7.5 (5)†	13.6 (10)
Annual Income —		
Mean (Median) Reported Percentage		
≤ $5,000	37.0 (30)†	35.6 (25)†
$5,001-15,000***	36.5 (35)†	30.6 (25)†
$15,001-35,000***	17.3 (12)†	24.4 (20)†
≥ $35,001***	4.5 (1)†	9.3 (5)†
Referral Source —§	(offenders only)	
Mean (Median) Reported Percentage		
Court Ordered	76.0 (90)	41.9 (40)‡
Voluntary	23.9 (10)	58.1 (60)‡

* Significant at the .05 level.
** Significant at the .01 level.
*** Significant at the .001 level.

† 10% or more of cases responded "don't know" to or refused to answer questionnaire item.
‡ Due to a CATI skip pattern error, data are missing for 7% of substance abuse cases.
§ Because this item differed in the substance abuse and domestic violence questionnaires, the statistical significance of the difference in the percentages observed for the two program types was not tested.

Table 4.4 Services Provided by Domestic Violence Programs

Characteristic	Percentage (*n*=606; *N*=1,774)
Types of Services Provided†	
Victim Support/Assistance/Counseling (individual or group)	98.8
Shelter Services	87.8
Child Services	90.3
Legal Advocacy for Victims	89.3
Batterer Programming	31.1
Other	68.7
Client Breakdown — Mean (Median) Reported Percentage	
Adult Victims	69.1 (70)
Batterers	4.6 (0)
Children	25.7 (24)
Other	0.7 (0)
Proportion of Victim Clients Who Are Shelter Residents — Mean (Median) Reported Percentage	37.2 (25)‡
Types of Networking Provided†	
Hotline/Crisis Intervention	96.3
Information About Other Agencies	99.0
Referrals to Other Agencies	99.2
Transportation	87.5
Legal Advocacy/Advice	91.4
Other	56.9

† These categories of services/networking types were included in the wording of the relevant questionnaire items. Respondents were not provided with specific definitions for these categories.

‡ Reported by programs that provide shelter services (*n*=532).

90% of domestic violence programs provided transportation services and legal advocacy networking. More than half of them also said they provided *other* kinds of networking services.

Table 4.5 indicates that all of the substance abuse treatment programs we interviewed said they provided alcoholism services, and almost all programs provided drug abuse treatment services. In other words, contemporary substance abuse treatment programs do not specialize in dealing with either alcohol *or* drug services; they deal with *both* alcohol and drug abusers.

Very high percentages of substance abuse treatment programs provided individual and group drug/alcohol counseling, cognitive/behavioral counseling, family counseling, and aftercare. Slightly less than half of programs provided children's services, and more than 60% of the programs said they provided *other* kinds of services.

Approximately 56% of the substance abuse program directors interviewed ran outpatient programs, 12% directed residential-only programs, and 27% were in charge of both residential and outpatient programs. Four percent of programs did not fit the outpatient, residential, or hybrid (both outpatient and residential) program types.

In comparison to the domestic violence programs, where 96% of programs provided hotline networking services, only 52% of substance abuse programs provided such networking. Substance abuse treatment programs also were less likely to provide transportation and legal advocacy networking services. These differences were found to be statistically significant at the .001 level. As with the domestic violence programs, almost all substance abuse treatment programs provided information about and referrals to other agencies.

4.6 Service Linkage Activities

Our survey collected information on programs' service linkage activities, including whether domestic violence and substance abuse programs screen clients for the complementary problem, provide complementary services, or have a relationship with a complementary program. The results of these data are summarized in Table 4.6.

Substance abuse program directors were asked whether their programs screen clients to determine if they are either domestic violence offenders or victims. Domestic violence program directors were asked whether their programs screen victim and offender clients for substance abuse problems. We found that the majority of *both* program types screen for the complementary

Table 4.5 Services Provided by Substance Abuse Treatment Programs

Characteristic	Percentage (*n*=691; *N*=7,027)
Alcoholism Services	100.0†
Drug Abuse Services	96.8
Types of Services Provided‡	
Individual Drug/Alcohol Counseling	96.8
Group Drug/Alcohol Counseling	95.8
Family Counseling	86.9
Cognitive/Behavioral Counseling	82.3
Vocational/Employment Counseling	44.8
Aftercare	89.0
Children's Services	46.8
Other	62.3
How Services Are Provided	
Outpatient	56.3
Residential	12.3
Hybrid (Both Outpatient and Residential)	27.1
Other	4.3
Types of Networking Provided‡	
Hotline/Crisis Intervention	52.1
Information About Other Agencies	90.9
Referrals to Other Agencies	98.7
Transportation	49.9
Legal Advocacy/Advice	25.9
Other	33.4

† For a program to be eligible to participate in the study, it had to provide either outpatient or ambulatory alcoholism services.

‡ These categories of services/networking types were included in the wording of the relevant questionnaire items. Respondents were not provided with specific definitions for the categories.

Table 4.6 Domestic Violence–Substance Abuse Linkage Activities

Activity	Domestic Violence Programs (n=606; N=1,774), %	Substance Abuse Programs (n=691; N=7,027), %
Screen for Complementary Problems		
Offenders*	58.1	59.8
Victims***	62.3	72.4
Standard Screening Form (Domestic Violence)/Procedures (Substance Abuse)†		
Offenders	87.5	56.9
Victims	76.4	50.5
Reported Percentage of Clients with Complementary Problem — Mean (Median)		
Offenders***	60.6 (60)	26.3 (20)‡
Victims	35.8 (30)‡	33.1 (25)‡
Provide Complementary Service		
Offenders***	19.2	49.3
Victims***	26.0	52.1
Complementary Counselors on Staff* **	25.8	54.3
Contract with Outside Counselor	16.1	15.0
Formal Referral Arrangements with Complementary Program	47.3	45.7
Informal Referral Arrangements with Complementary Program	85.6	82.6
Ever Had Relationship with Complementary Program	79.5	70.6§
Current Relationship with Complementary Program**	80.8	67.2§
Reasons for Not Providing Complementary Service to Offenders		
Lack of Experience in Complementary Field	47.1	41.8
Limited Staff Resources	64.3	57.9
Limited Financial Resources***	69.6	52.6
Complementary Services Are Better Provided Independent of Program*	57.1	46.7
Not Part of Agency/Program Mission	73.0	64.6‡
No Need for Complementary Services***	2.0	47.4
Other***	23.0	6.4
Reasons for Not Providing Complementary Service to Victims		
Lack of Experience in Complementary Field***	59.5	34.3
Limited Staff Resources***	71.7	53.3
Limited Financial Resources***	75.7	53.0
Complementary Services Are Better Provided Independent of Program	54.4	47.6
Not Part of Agency/Program Mission	66.5	61.9‡
No Need for Complementary Services***	3.2	46.7
Other***	20.3	8.0

* Significant at the .05 level.
** Significant at the .01 level.
*** Significant at the .001 level.

† Because this item differed in the substance abuse and domestic violence questionnaires, the statistical significance of the difference in the percentages observed for the two program types was not tested.

‡ 10% or more of cases responded "don't know" to questionnaire item, refused to answer, or are otherwise missing data.

§ This questionnaire item was added to the substance abuse CATI instrument during data collection. Results for substance abuse programs are based on responses provided by < 20% of the substance abuse sample.

problem.[6] A similar proportion (approximately 60%) of substance abuse and domestic violence programs screened substance-abusing clients to determine if they are domestic violence offenders and screened offender clients for substance abuse, respectively. Substance abuse programs, however, were more likely to screen clients for domestic violence victimization than domestic violence programs were to screen victim clients for substance abuse (72% vs. 62%). We also asked domestic violence program directors if their program used a standard form to screen for the complementary program; for directors of substance abuse programs, we asked if their program used standard screening procedures. Our results show that domestic violence programs were more likely to use a standard form than substance abuse programs were to employ standard screening procedures. In part, this probably reflects a greater availability of standard substance abuse screening instruments. The domestic violence field has not yet developed screening techniques that are tested and in widespread use. Within both program types, standard screening was used more often for domestic violence offenders than for victims.

As shown in Table 4.6, domestic violence program directors, on average, estimated that about 36% of their victim clients had substance abuse problems, and substance abuse program directors estimated that 33% of their clients were domestic violence victims. In contrast, our results revealed that the average proportion of offender clients that domestic violence program directors estimated to have substance abuse problems (61%) was significantly higher than the average proportion of clients that substance abuse program directors estimated to be victims of domestic violence (26%). Although domestic violence programs were more likely than substance abuse programs to currently have a relationship with a complementary program, domestic violence programs were less likely to *provide* complementary services to both offender and victim clients than substance abuse programs were to provide complementary services to substance-abusing clients who were determined to be domestic violence offenders or victims.

When asked why their program does not provide complementary services, the reasons most often cited by domestic violence program directors included "limited staff resources," "limited financial resources," and that the provision of complementary services is "not part of their agency/program's mission." The reasons most often cited by substance abuse program

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[6]This finding is based on only the percentage of program directors from each program type who reported that their program regularly screens for the complementary problem. Respondents were *not* asked about the percentage of their *staff* who routinely screen, nor about the percentage of *clients* who are routinely screened, for the complementary problem.

directors were the same. In addition, the following differences were observed for the two program types. Domestic violence program directors more often indicated "lack of experience in complementary field" as a reason for not providing complementary services to victims. Substance abuse programs, on the other hand, were significantly more likely to cite the reason that there is "no need for complementary services" for both victims and offenders.

From those respondents who indicated that they do not provide complementary services because of limited financial resources but would provide such services if more resources were available, we asked for the types of complementary services that would be provided (data not shown in a table). The large majority (ranging from 92% to 96%) of these domestic violence programs (n=239) indicated that they would provide the following substance abuse services to victims: on-site counseling, on-site case management, referral under formal arrangements, and referral to Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). On the other hand, most (between 62% and 84%) of these domestic violence program directors reported that they would *not* provide on-site detoxification, short-term residential treatment, or on-site drug testing. When we asked directors of the domestic violence programs that provide batterer services what substance abuse services they would provide to domestic violence offenders (n=56), the results were very similar.

The majority (ranging from 85% to 94%) of substance abuse program directors who said that they would provide domestic violence victim services if more resources were available (n=126) reported that in-house counseling, case management, and referral to other agencies/programs would be provided. Approximately half (53%) of the substance abuse program directors indicated that they would provide legal advocacy to domestic violence victims, but only 38% said that they would provide shelter services. Of those substance abuse program directors who said that they would provide domestic violence offender services (n=133), most (between 83% and 96%) reported that in-house counseling, case management, and referral to other agencies/programs would be provided.

4.7 Perceptions Concerning Service Linkage

Program directors were asked whether they are interested in continuing or beginning to work with a complementary program and about problems they had experienced or would expect

to experience with service linkage. These results are presented in Table 4.7. Overall, the overwhelming majority of both domestic violence and substance abuse program directors were interested in continuing or beginning to work with a complementary program, although compared to substance abuse program directors, domestic violence program directors were more likely to express interest. Among the experienced/expected problems most often noted by domestic violence program directors were that "complementary programs lack training in the domestic violence field" (63%), "financial burdens" (56%), and "difference in treatment philosophy" between the two program types (47%). Most often, substance abuse program directors cited "lack of complementary programs/services in the area" (37%), "difference in treatment philosophy" (35%), and "difficulty in arranging reimbursement" (34%). Another noteworthy finding is that substance abuse program directors were more likely to communicate "do not know complementary service system" as an experienced/expected problem or that they had experienced or expected no problems at all.

We asked respondents whether they strongly agree, agree, disagree, or strongly disagree with four attitudinal statements about service linkage. These statements also are contained in Table 4.7. Overall, our results suggest that domestic violence program directors were more skeptical of service linkage than directors of substance abuse programs. For example, slightly over half of domestic violence program directors strongly agreed or agreed to the statement, "Complementary services are better provided elsewhere." Less than one-third of substance abuse program directors agreed to the same statement.

Our analyses examined whether program directors thought that their program should be expected to provide complementary services under current State funding levels or with increased State funds. Domestic violence program directors were significantly more likely to indicate that programs should not be expected to provide complementary services to substance-abusing domestic violence victims under current State funding levels. Substance abuse program directors, however, were more likely to indicate that with an increase in State funding, programs could be asked to provide such complementary services.

Table 4.7 Perceptions Concerning Service Linkage

Perception	Domestic Violence Programs (n=606; N=1,774), %	Substance Abuse Programs (n=691; N=7,027), %
Would Like to Begin/Continue Working with Complementary Program to Develop More Integrated Services for Substance-Abusing Battered Women*‡	91.9	79.2
Problems Expected/Experienced Working with Complementary Service§		
Difference in Treatment Philosophy ***	46.6	35.4
Complementary Program Lacks Training in Field***	63.2	20.4
Do Not Know Complementary Service System***	19.0	26.9
Lack of Complementary Programs/Services in Area	34.6	36.9
Financial Burdens	56.1	—
Difficulty in Arranging Reimbursement	—	33.9
Other	30.4	28.4
None***	14.8	31.0
Substance Abuse Treatment Programs Can Effectively Integrate Programs for Victims (Percent Strongly Agreeing or Agreeing)***	69.6†	94.8
Best if Substance Abuse Treatment for Violent Male Takes Place Outside Domestic Violence Program (Percent Strongly Agreeing or Agreeing)	77.3	—
Complementary Services Are Better Provided Elsewhere (Percent Strongly Agreeing or Agreeing)***	50.1	30.2
Philosophies of Domestic Violence Programming and Substance Abuse Treatment Are Inconsistent with Each Other (Percent Strongly Agreeing or Agreeing)***	40.2†	18.8
Given Current State Funding Levels, Programs Should Not be Expected to Provide Complementary Services to Substance-Abusing Domestic Violence Victims (Percent Strongly Agreeing or Agreeing)***	70.2	41.4
With an Increase in State Funding, Programs Could Be Asked to Provide Complementary Services to Substance-Abusing Domestic Violence Victims (Percent Strongly Agreeing or Agreeing)***	81.7	93.4

* Significant at the .05 level.
** Significant at the .01 level.
*** Significant at the .001 level.

† 10% or more of cases responded "don't know" to questionnaire item, refused to answer, or are otherwise missing data.
‡ Prior to the substance abuse questionnaire being changed during data collection, this question only asked if respondent would like to *begin* working with a complementary program.
§ Prior to the substance abuse questionnaire being changed during data collection, this question only asked about *expected* problems.

4.8 Attitudes About the Relationship Between Substance Abuse and Domestic Violence

We asked respondents about how often they thought that cases of domestic violence were linked to alcohol and drug use/abuse. We observed the following results. Only a small percentage of directors of both program types (5.8% of domestic violence; 1.3% of substance abuse) answered "a little of the time" or "none of the time" (data not shown in a table). Although the majority of directors of both program types responded at least "some of the time," substance abuse program directors were significantly more likely to respond "a lot of the time" (87.4% vs. 64.3%).

Table 4.8 presents additional data we examined regarding program directors' attitudes and perceptions concerning the relationship between domestic violence and substance abuse, such as whether domestic violence victimization increases the chances of victim substance abuse, substance use increases the chance that men or women will assault partners, and substance use is used as excuse by men who assault their partner or by women to stay in violent relationships. For each statement listed in the table, we asked each program director whether she or he strongly agreed, agreed, disagreed, or strongly disagreed. Although in many cases the majority of both domestic violence and substance abuse program directors strongly agreed or agreed, substance abuse program directors were more likely to, and the observed difference between substance abuse and domestic violence program directors was statistically significant for each statement.

Overall, the majority of substance abuse directors conveyed the belief that substance abuse and domestic violence were related. This response pattern was less consistent for domestic violence program directors. For instance, less than half of domestic violence program directors did not agree to the statements, "drinking/drug-using woman increases risk she will be assaulted by partner" and "women use their male partner's drinking to stay in violent relationships."

The comparison of domestic violence and substance abuse program directors' responses to the item for "Drinking/Drug Use Used as Excuse by Men Who Assault Partner" is especially informative. This is the only factor where a higher percentage of domestic violence program program directors than substance abuse program directors agreed or strongly agreed with the statement (99% vs. 95%). This finding can be interpreted to indicate that domestic violence program directors were more skeptical that substance use is a "real" cause of domestic violence, and that it is more often an excuse for assaulting one's spouse, or an after-the-fact attempt to

Table 4.8 Perceptions of Substance Use–Domestic Violence Relationship: Percentage of Program Directors Strongly Agreeing or Agreeing to Selected Statements

Statement	Domestic Violence Programs (n=606; N=1,774), %	Substance Abuse Programs (n=691; N=7,027), %
Victimization Increases Chances of Alcohol/Drug Problem***	76.6	87.2
Drinking/Drug Use Increases Chances Men Will Assault Partners***	75.9	98.5
Drinking/Drug Use Increases Chances That Some Women Will Assault Partners***	65.0	96.3
Drinking/Drug Use by Both Increases Likelihood of Violence***	87.2	98.5
Drinking/Drug Using Woman Increases Risk She Will Be Assaulted by Partner***	45.4	86.1
Drinking/Drug Use Used as Excuse by Men Who Assault Partner***	98.6	94.7
Substance Abuse Treatment for Violent Male Partner Can Reduce Future Violence***	49.4	91.2
Woman's Use of Alcohol Keeps Her Stuck in Violence Relationships***	50.7	82.2
Women Use Their Male Partner's Drinking to Stay in Violent Relationships***	32.6	60.2

* Significant at the .05 level.
** Significant at the .01 level.
*** Significant at the .001 level.

deflect responsibility by batterers. This difference of view may be important to linkage of services, particularly linkage initiatives that require cooperation between the two kinds of programs.

4.9 Summary of Descriptive Findings

The following points summarize the findings for the national samples of domestic violence and substance abuse treatment programs.

- Domestic violence program directors were much more likely than substance abuse program directors to be female (94% vs. 50%). Substance abuse program directors were more likely to have a graduate school

education and have been in the substance abuse field an average of 4 years longer than the domestic violence program director.

- Nearly 90% of domestic violence programs were private, not-for-profit agencies, and only 6% were public agencies. Only 56% of substance abuse programs were run by private, not-for-profit agencies, 18% for-profit, and another 18% were public.

- The mean annual budget for substance abuse programs ($1.8 million) was about three times higher than the mean annual budget for domestic violence programs. About 54% of the funding for domestic violence programs came from Federal and State sources, and 46% of substance abuse treatment programs' funding came from these sources. Substance abuse programs got an average of 34% of their income from insurance payments and client fees. Only 2% of domestic violence program income came from these sources.

- Substance abuse programs had an average of 25 full-time staff compared to 10 per domestic violence program. Domestic violence programs served an average of almost 1,400 clients annually compared to about 700 for substance abuse programs. Substance abuse clients were somewhat older and had higher incomes than domestic violence clients. Approximately 85% of domestic violence clients were female compared to about one-third of substance abuse clients.

- An estimated 76% of batterers were court-ordered to domestic violence treatment; only 42% of substance abuse clients were court-ordered to treatment.

- Services provided by the two kinds of programs differed. Domestic violence programs emphasized victim support, shelter services, child services, and legal advocacy. Substance abuse programs emphasized individual and group substance abuse counseling, family counseling, and aftercare. About 56% of substance abuse programs were outpatient programs.

- Similar percentages of domestic violence and substance abuse programs screened offender clients for the complementary problem, but substance abuse programs were more likely to screen their victim clients for domestic violence than domestic violence programs were to screen victims for substance abuse.

- Domestic violence program directors estimated that 61% of their offender clients had a substance abuse problem. On average, substance abuse program directors thought that 26% of their clients were domestic violence offenders.

- The most common reasons given by both program director types for *not* providing complementary services were limited staff and financial resources, and that provision of such services is "not part of the agency/program mission."

- An estimated 19% of domestic violence program directors said they provided substance abuse services to offenders, and 26% of them said they provided these services to victims. Roughly 50% of substance abuse program directors said they provided domestic violence services to offenders, and approximately the same percentage of substance abuse directors said they provided these services to victims.

- An estimated 81% of domestic violence programs said they had a current relationship with a complementary program; 67% of substance abuse programs responded positively to this question.

- Domestic violence program directors had less favorable attitudes toward complementary services than did directors of substance abuse programs on several dimensions.

- Substance abuse program directors were more likely than domestic violence program directors to think substance abuse was implicated in domestic violence offending and victimization, and more optimistic that substance abuse treatment for the violent male partner could reduce future domestic violence.

In the next chapter, we attempt to understand the complexities of complementary service linkage by conducting a series of multivariate analyses.

5. MODELING THE LINKAGE OF DOMESTIC VIOLENCE AND SUBSTANCE ABUSE SERVICES

As discussed in the earlier literature review, until recently, linkage of domestic violence and substance abuse services has been uncommon. The issues surrounding domestic violence–substance abuse service linkage are quite complicated and include

- level of financial and expert resources available to programs to provide complementary services;
- philosophical and programmatic factors guiding domestic violence and substance abuse treatment that can discourage and complicate linkage attempts; and
- perceptions about the domestic violence–substance abuse relationship that influence whether and how domestic violence and substance abuse services are linked.

Domestic violence and substance abuse service linkage is further complicated because domestic violence and substance abuse treatment programs are likely to differ from each other on the above factors, and because linkage issues will also vary according to whether domestic violence *victims* or *offenders* are a focus.

During our interviews with program directors, we asked questions about their attitudes toward linking domestic violence and substance abuse services and about their beliefs regarding the substance abuse–domestic violence relationship (see previous chapter). We hypothesized that these program director attitudes would affect whether and how the programs they directed would provide the complementary service (i.e., whether domestic violence program directors would provide substance abuse services to their clients, and whether substance abuse program directors would provide domestic violence services to victims and offenders).

We asked domestic violence program directors whether they strongly agreed, agreed, disagreed, or strongly disagreed with the following statements:

- Substance abuse services for battered individuals are better provided someplace other than domestic violence programs.

- Substance abuse programs can effectively integrate services for domestic violence victims.
- The philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other.
- Given current State funding levels, domestic violence programs should not be expected to provide services that substance-abusing victims of domestic violence need.

We asked substance abuse program directors a similar set of questions. For example, we asked the substance abuse program directors whether they agreed with the statement: Domestic violence services for substance abusers are better provided someplace other than substance abuse programs.

Because we thought that program directors' beliefs about the nature of the substance abuse–domestic violence relationship might influence whether their programs would provide complementary services, we included a set of questions about the relationship. We asked domestic violence program directors whether they agreed, strongly agreed, disagreed, or strongly disagreed with the following statements:

- Being a victim of violence increases the chances of the victim developing an alcohol or drug problem.
- Drinking/drug use increases the likelihood that some men will assault their partners.
- Drinking/drug use increases the likelihood that some women will assault their partners.
- When both partners are drinking or using drugs, the likelihood of violence between them is increased.
- A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner.
- Drinking/drug use is sometimes used as an excuse by men for assaulting their partner.
- Substance abuse treatment for the violent male partner can reduce the likelihood of future violence.

- Substance abuse treatment programs can effectively integrate programs for victims of domestic violence.
- A woman's use of alcohol keeps her stuck in violent relationships.
- Women use their male partners' drinking to stay in violent relationships.

An analogous set of questions was asked of the substance abuse program directors. Copies of the questionnaires are included in Appendices A and B.

Not all of the program director attitudinal questions were included in all models. For example, the statement that being a victim of domestic violence increases chances that a woman will develop a substance abuse problem was included in the domestic violence program analyses for *victims*, but not for *offenders*. Conceptually, it was not appropriate to consider the risk of developing a substance abuse problem as a result of being a domestic violence victim in models analyzing domestic violence–substance abuse service linkage for offenders. Moreover, as noted below, there was insufficient variation in program directors' responses to some items to support analyses.

To understand the factors associated with domestic violence–substance abuse service linkage, we conducted a series of logistic regression analyses. Two categories of dichotomous dependent variables were examined:

- six types of service linkage provided by programs (e.g., the program does or does not screen clients for the complementary problem); and
- five reasons why programs do *not* provide linked services (e.g., because of the absence of expertise dealing with the complementary problem).

Separate models are estimated for domestic violence and substance abuse treatment programs, and for victims and offenders. Thus, we will be reporting the results of 44 models (11 dependent variables listed above x 2 (separate models for domestic violence and substance abuse treatment programs) x 2 (separate models for victims and offenders) = 44.

The regressions models included several sets of factors as independent variables, including

- program director characteristics,
- program characteristics,
- program director attitudes about service linkage, and
- program director beliefs about the substance abuse-domestic violence relationship.

For simplicity of presentation, we present a series of matrices where statistically significant relationships between variables (at or below the .05 level) are indicated by plus (+) and minus (-) signs. A plus sign in a cell indicates a direct (positive) relationship between independent and dependent variables, and a minus sign indicates an indirect (negative) relationship between independent and dependent variables. Cells containing no sign indicate no statistically significant relationship was found between variables. Detailed regression results with odds ratios and levels of statistical significance are provided in Appendix C.

The reader will note that effective sample sizes are indicated in the tables and that these numbers are variable—particularly between victims and offenders. The major reason for this disparity is that a majority of domestic violence programs do not provide offender services, and these programs are not included in models that examine complementary service linkage for offenders.

5.1 Service Linkage for Victims in Domestic Violence Programs

Table 5.1 shows the logistic regression results when the set of six linkage activities are regressed in separate models on the set of independent variables (program director characteristics, program characteristics, program director attitudes about linkage, and program director attitudes about the substance abuse–domestic violence relationship). Table 5.1 presents the results for domestic violence programs and refers to linked services for *victims* of domestic violence.

Table 5.1 Substance Abuse Services for Victims in Domestic Violence Programs

Explanatory Variables	Screens Victim Clients for Substance Abuse Problems (*n*=424)	Provides Substance Abuse Services to Victim Clients (*n*=427)	Has Certified Substance Abuse Counselor on Staff (*n*=425)	Contracts with Outside Substance Abuse Counselor (*n*=427)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=426)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=426)
Director and Program Characteristics						
Male			+			
Tenure in field (years)		+	+	+	+	−
Graduate school			+	−		
# of full-time employees	+			−		
Provides shelter services	+		−		+	
Directors' Attitudes About Service Linkage						
% of victim clients with substance abuse problems	+	+		+	+	
Substance abuse services for battered individuals are better provided someplace other than domestic violence programs		−	−			
Substance abuse treatment programs can effectively integrate programs for domestic violence victims					+	
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other						
Given current State funding, domestic violence programs should not be expected to provide services that substance-abusing domestic violence victims need		−	−			+
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time						
Being a victim of violence increases chances of the victim developing an alcohol or drug problem					−	
Drinking/drug use increases likelihood that women will assault their partners						
When both partners are drinking or using drugs, the likelihood of violence between them is increased	+				+	
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner						
A woman's use of alcohol keeps her stuck in violent relationships	+		+		−	+

= Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

The only program director characteristic consistently associated with substance use service linkage for domestic violence victims is years in the domestic violence field. Program directors with longer tenure in the field directed programs that were more likely to provide four of the six complementary services. The negative relationship seen for years in the field and "*informal* arrangements with a substance abuse program" can be considered consistent with the first four direct relationships; having an informal relationship with a substance abuse program is a weak form of linkage and may in fact indicate a lack of real commitment to service linkage.

Some program directors' attitudes about providing complementary services were associated with linkage in the predicted directions. Domestic violence directors who thought that substance abuse services were better provided outside of domestic violence programs were significantly less likely to direct programs that provided substance abuse services to victims and had a certified substance abuse counselor on staff. Domestic violence program directors who thought that substance abuse programs can effectively integrate services for domestic violence victims were more likely to have formal arrangements with programs to refer clients.

The findings for the domestic violence–substance abuse treatment *inconsistent philosophy* variable are surprising. Program directors who said that domestic violence and substance abuse treatment philosophies are inconsistent with each other were *not* significantly less likely to direct programs that linked the two kinds of services. On the other hand, program directors who thought that domestic violence programs should *not* be expected to provide substance abuse services due to funding limitations tended to direct programs that were less likely to provide substance abuse services to victims and to have a substance abuse counselor on staff. The direct statistically significant relationship between the funding variable and having an informal arrangement with substance abuse program may not be inconsistent. This form of linkage is a "low budget" approach to linkage and so may indicate an attempt to provide low-cost complementary services. It is typically more costly to actually provide services, have a staff counselor, and have a formal relationship with another program than it is to have an informal relationship with another program.

Some program director beliefs about the substance abuse–domestic violence relationship were associated with service linkage. Program directors' estimates of the percentage of domestic violence victim clients who had substance abuse problems were associated with four linkage activities. Domestic violence programs that screened clients for substance abuse, provided

substance abuse services, contracted with an outside substance abuse counselor, and had formal arrangements with a substance abuse program tended to be operated by program directors who thought that high percentages of their victim clients had substance abuse problems.

Directors who thought that being a victim of domestic violence increased chances of developing a substance abuse problem were less likely to direct programs that provided or arranged for substance abuse services for victims. On the other hand, program directors who agreed with the statement that when both partners are drinking, the likelihood of violence between them is increased, were more likely to direct programs that screen victims for substance abuse problems and have a formal arrangement with a substance abuse program. Moreover, program directors who agreed that a woman's use of alcohol can keep her stuck in a violent relationship directed programs that screened for substance abuse services, had a certified substance abuse counselor on staff, and had an informal relationship with a substance abuse program. There was an inconsistency, however, in the findings for this variable. Program directors who thought that alcohol use can keep women stuck in violent relationships also directed programs that were *less* likely to have formal arrangements with a substance abuse program. Interpretation of this inconsistency is not possible from these data.

5.2 Reasons for Not Providing Linked Services to Victims

The next set of regression models focus on domestic violence–substance abuse service linkage from a different perspective. We look at the relationship between program director and program characteristics, and the program directors' attitudes toward linkage and the substance abuse–domestic violence relationship to reasons for *not* providing linked services to victims. The hope is that this alternative focus will provide additional insights into the reasons why services are and are not linked. Table 5.2 provides the results. No results are given for the "no need for such services" variable because of its limited distribution. Only 14 program directors reported this reason.

Male directors of domestic violence programs were less likely than female directors to say that their programs did not provide substance abuse services because of lack of expertise in substance abuse and due to limited staff resources. Male and female domestic violence program directors did not differ in the other three reasons for not linking domestic violence and substance abuse services. Domestic violence program directors with longer tenure in the field were less

Table 5.2 Reasons Why Domestic Violence Programs Do Not Provide Substance Abuse Services to Victims

Explanatory Variables	Reasons for Not Providing Substance Abuse Services to Victims				
	Lack of Expertise in Substance Abuse (*n*=313)	Limited Staff Resources (*n*=313)	Limited Financial Resources (*n*=313)	Substance Abuse Services Are Better Provided Independent of Domestic Violence Programs (*n*=313)	Not Part of Agency/ Program Mission (*n*=313)
Director and Program Characteristics					
Male	–	–			
Tenure in field (years)	–		+		
Graduate school				–	
# of full-time employees			–		
Provides shelter services		+	+		
Directors' Attitudes About Service Linkage					
% of victim clients with substance abuse problems				–	
Substance abuse services for battered individuals are better provided someplace other than domestic violence programs			–	+	+
Substance abuse treatment programs can effectively integrate programs for domestic violence victims	+	+		–	
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other		–		+	
Given current State funding, domestic violence programs should not be expected to provide services that substance-abusing domestic violence victims need		+	+		
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time					
Being a victim of violence increases chances of the victim developing an alcohol or drug problem				–	
Drinking/drug use increases likelihood that women will assault their partners	+				
When both partners are drinking or using drugs, the likelihood of violence between them is increased				+	+
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner		–	–		
A woman's use of alcohol keeps her stuck in violent relationships	+	+			

= Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

likely than those with shorter tenure to say their programs did not link services due to lack of substance abuse expertise, but directors with longer tenure were more likely to say they did not link services because of limited financial resources. Domestic violence program directors with a graduate degree were less likely than directors without graduate degrees to say that linked services were not provided because such services are better provided independent of domestic violence programs.

Program size, measured by the number of full-time employees, was negatively related to the limited financial resources reason for not linking services. Domestic violence programs that provided shelter services were significantly more likely that their counterparts to say linked services were not provided because of limited staff and financial resources.

Each of the program director attitudes about service linkage was significantly related to two of the reasons for not providing substance abuse services to domestic violence victims. Directors who felt that substance abuse services for victims were better provided elsewhere than at domestic violence programs were less likely than those disagreeing with that statement to say that they did not link services due to limited financial resources. On the other hand, domestic violence program directors who thought substance abuse services should be provided elsewhere than in domestic violence programs were more likely than their counterparts to say such services should be provided independent of domestic violence programs and that providing substance abuse services was not part of their agency's mission.

Domestic violence program directors thinking that *substance abuse programs* can effectively integrate programs for domestic violence victims were significantly more likely to say that their programs did not provide such services because of a lack of expertise and due to limited staff resources. Domestic violence program directors believing that domestic violence and substance treatment philosophies are inconsistent with each other were less likely to attribute limited staff resources as a reason for not linking services and were more likely to say that they did not provide linked services because such services are better provided independent of domestic violence programs. As expected, when program directors endorsed the notion that domestic violence programs should not be expected to provide substance abuse services to victims due to current State funding, they were more likely to say they did not provide linked services because of limited staff and financial resources.

Some of the variables describing various aspects of the substance abuse–domestic violence relationship were significantly related to reasons for not providing complementary domestic violence and substance abuse services. No results are given for the general statement that domestic violence and substance abuse were linked some or a lot of the time because of the limited distribution of the responses to this statement. Close to 100% of the domestic violence program directors agreed with this statement.

Domestic violence program directors endorsing the statement that when both partners are drinking the likelihood of violence between them is increased were significantly more likely than other program directors to say that their programs did not provide substance abuse services because such services were better provided independent of domestic violence programs and because these services were not part of their agency's mission. Program directors who believed that a woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner were less likely than their counterparts to say that their program did not provide linked substance abuse services because of limited staff and financial resources. Finally, domestic violence program directors who believed that a woman's use of alcohol keeps her stuck in violent relationships were more likely than their counterparts to give lack of expertise in substance abuse and limited staff resources as reasons for not providing linked substance abuse services to victims of domestic violence.

5.3 Service Linkage for Offenders in Domestic Violence Programs

Table 5.3 shows the logistic regression results for the relationships between program director and program characteristics, directors' attitudes about service linkage, directors' attitudes about the substance abuse–domestic violence relationship, and the six service linkage indicators for *offenders*.

There were no consistent patterns between the program-level characteristics and service linkage. Domestic violence program directed by males were significantly more likely to screen male batterers for substance abuse and to provide substance abuse services to batterers. Program directors with longer tenure in the domestic violence field were significantly more likely to direct programs that have certified counselors on staff and to have formal arrangements with other programs to refer offenders in need of substance abuse treatment. Program directors with graduate degrees were significantly *less* likely to direct programs that provide substance abuse

Table 5.3 Substance Abuse Services for Offenders in Domestic Violence Programs

Explanatory Variables	Screens Offender Clients for Substance Abuse Problems (*n*=146)	Provides Substance Abuse Services to Offender Clients (*n*=148)	Has Certified Substance Abuse Counselor on Staff (*n*=149)	Contracts with Outside Substance Abuse Counselor (*n*=149)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=148)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=149)
Director and Program Characteristics						
Male	+	+				–
Tenure in field (years)	–		+		+	
Graduate school		–			–	
# of full-time employees	+		+		+	
Directors' Attitudes About Service Linkage						
% of offender clients with substance abuse problems			–			
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	+	–				
It is best if substance abuse treatment for a violent male partner takes place outside the family violence program					+	
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time	▨	▨	▨	▨	▨	▨
Drinking/drug use increases the likelihood that some men will assault their partners					–	
When both partners are drinking or using drugs, the likelihood of violence between them is increased	–		+	–		
Drinking/drug use are sometimes used as an excuse by men assaulting their partner	▨	▨	▨	▨	▨	▨
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence			+		+	–
Women use their male partners' drinking to stay in violent relationships	–	+				

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

services to offenders and to have formal arrangements with other programs to do so. Program size, measured by number of full-time employees, was positively associated with screening offender clients for substance abuse, having a certified substance abuse counselor on staff, and having *formal* arrangements with other programs to refer offender clients in need of substance abuse treatment.

Perceptions regarding the percentage of domestic violence offender clients having substance abuse problems were negatively associated with having a certified substance abuse counselor on staff.

Program directors' attitudes about complementary service linkage were weakly and inconsistently associated with providing linked services for offenders. Domestic violence program directors who thought that the philosophies of domestic violence and substance abuse treatment are inconsistent with each other were *more* likely to screen offender clients for substance abuse, but *less* likely to provide substance abuse services to offenders. Program directors who thought that substance abuse treatment for violent male partners should take place outside domestic violence programs were significantly *more* likely to direct programs that have formal arrangements with other programs to refer offender clients in need of substance abuse services. This is a relationship that one would logically expect to observe.

Two of the directors' attitudes about the substance abuse–domestic violence relationship could not be included in the offender regression models because almost all the directors agreed with the statements that domestic violence is linked to substance abuse some or all of the time, and almost all also agreed that drinking and drug use are sometimes used as an excuse by men for assaulting their partners. The two items dealing directly with the idea that alcohol and drug use are risk factors for domestic violence (drinking/drug use increases the likelihood that some men will assault their partners, and when both partners are drinking or using drugs the likelihood of violence between them is increased) were inconsistently associated with linkage. There were three negative relationships and one positive relationship.

The belief that substance abuse treatment for the violent male partners can reduce future violence was directly associated with having a certified substance abuse counselor on staff and with having formal referral arrangements with other programs to refer offenders in need of substance treatment.

5.4 Reasons for Not Providing Linked Services to Offenders

Table 5.4 shows the relationships between our sets of program and attitudinal factors and the reasons for not providing substance abuse services to offenders. The most consistent relationship observed is that between program directors' perceptions about the percentage of offender clients with substance abuse problems and four reasons for not providing substance abuse services to offenders. Directors who estimated that higher percentages of offenders had substance abuse problems were more likely to endorse the following reasons for not providing substance abuse services to offenders:

- a lack of expertise in substance abuse,
- limited staff resources,
- limited financial resources, and
- providing substance abuse services is not part of their agency's mission.

The inconsistent domestic violence–substance abuse philosophy factor does not distinguish program directors who did and did not endorse any of the five reasons for not providing substance abuse services. Not surprisingly, directors who said it was best if substance abuse treatment for the violent male partner takes place outside of the family violence program were also more likely to endorse two reasons for not providing services: Substance abuse services are better provided independent of domestic violence programs, and providing such services are not part of the domestic violence agency mission.

Domestic violence program directors who agreed with the notions that when both partners are drinking, the likelihood of violence between them is increased and substance abuse treatment for the violent male partner can reduce the likelihood of future violence were significantly more likely to say their programs did not provide substance abuse services to offenders because of limited staff and financial resources. One way to interpret these findings is to say that many program directors recognized the need and potential value of substance abuse treatment for males who are domestically violent, but they were constrained in providing such services by resource limitations.

Table 5.4 Reasons Why Domestic Violence Programs Do Not Provide Substance Abuse Services to Domestic Violence Offenders

Explanatory Variables	Reasons for Not Providing Substance Abuse Services to Offenders				
	Lack of Expertise in Substance Abuse (*n*=118)	Limited Staff Resources (*n*=118)	Limited Financial Resources (*n*=118)	Substance Abuse Services Are Better Provided Independent of Domestic Violence Programs (*n*=118)	Not Part of Agency/ Program Mission (*n*=118)
Director and Program Characteristics					
Male		–			
Tenure in field (years)	–				–
Graduate school			–		
# of full-time employees					
Directors' Attitudes About Service Linkage					
% of offender clients with substance abuse problems	+	+	+		+
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other					
It is best if substance abuse treatment for a violent male partner takes place outside the family violence program			–	+	+
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time	▨	▨	▨	▨	▨
Drinking/drug use increases the likelihood that some men will assault their partners					
When both partners are drinking or using drugs, the likelihood of violence between them is increased		+	+		
Drinking/drug use are sometimes used as an excuse by men assaulting their partner	▨	▨	▨	▨	▨
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence		+	+		
Women use their male partners' drinking to stay in violent relationships					

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

5.5 Service Linkage for Victims in Substance Abuse Programs

This section begins our discussion of complementary service provision by substance abuse treatment programs. Table 5.5 presents the results of our logistic regression analyses of six kinds of linkage for victims of domestic violence. Male directors of substance abuse treatment programs were less likely to provide domestic violence services to victims and to contract with an outside domestic violence counselor to provide these services. Tenure in the substance abuse field was associated with four linkage activities. Directors in the field for a longer period were more likely than directors with shorter tenure to

- screen victims for domestic violence victimization,
- provide domestic violence services to victims,
- have a trained domestic violence counselor on staff, and
- have formal arrangements with other programs to refer their clients who are in need of domestic violence services.

Having a graduate degree was inconsistently associated with linkage. Directors with a graduate degree were more likely to screen substance abuse clients for domestic violence victimization, to provide domestic violence services, and to have *informal* referral arrangements with other programs to refer domestic violence victims. Substance abuse program directors with a graduate degree, however, were less *likely* to have a trained domestic violence counselor on staff or to contract with an outside domestic violence counselor. The number of full-time employees also was inconsistently associated with domestic violence service for victims in substance abuse treatment. Larger programs were *more* likely to provide these services, have a trained domestic violence counselor on staff, and have formal referral arrangements with other programs to provide such services. On the other hand, programs with a higher number of full-time employees were less likely than programs with fewer employees to contract with an outside domestic violence counselor and have *informal* referral arrangements with other programs.

Table 5.5 Domestic Violence Services for Victims in Substance Abuse Programs

Explanatory Variables	Screens Clients for Domestic Violence Victimization (*n*=564)	Provides Domestic Violence Services to Victim Clients (*n*=561)	Has Trained Domestic Violence Counselor on Staff (*n*=560)	Contracts with Outside Domestic Violence Counselor (*n*=563)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=562)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=560)
Director and Program Characteristics						
Male		−		−		
Tenure in field (years)	+	+	+		+	
Graduate school	+	+	−	−		+
# of full-time employees		+	+	−	+	−
Provides residential services	−			+	+	
Directors' Attitudes About Service Linkage						
% of clients who are domestic violence victims	+	+	+	+		
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs		−	−			+
Substance abuse treatment programs can effectively integrate programs for domestic violence victims	▨	▨	▨	▨	▨	▨
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other		−	+	+	+	−
Given current State funding, substance abuse programs should not be expected to provide services that substance-abusing domestic violence victims need	−	−	−	−	−	
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time	▨	▨	▨	▨	▨	▨
Being a victim of violence increases chances of the victim developing an alcohol or drug problem		+	+	−		+
Drinking/drug use increases likelihood that women will assault their partners	▨	▨	▨	▨	▨	▨
When both partners are drinking or using drugs, the likelihood of violence between them is increased	▨	▨	▨	▨	▨	▨
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner				+	+	
A woman's use of alcohol keeps her stuck in violent relationships	+		−	−	−	−

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

There was a fairly consistent direct relationship between substance abuse program directors' assessment of the percentage of their clients who are domestic violence victims and program provisions of domestic violence victim services. Directors who estimated that higher percentages of their substance abuse clients were also domestic violence victims were more likely to screen for domestic violence victimization, provide domestic violence victim services, have a trained domestic violence counselor on staff, and contract with an outside domestic violence counselor.

Substance abuse program directors who believed that domestic violence victim services were better provided apart from substance abuse programs were less likely to provide such services and less likely to have a trained domestic violence counselor on staff. These program directors who thought that domestic violence victim services should be provided outside substance abuse programs were *more* likely to have informal referral arrangements with outside programs. Substance abuse program directors who thought that the philosophies of domestic violence and substance abuse treatment were inconsistent were less likely to provide victim services, but they were more likely to direct programs that have trained domestic violence counselors on staff, contract with an outside domestic violence counselor, and have formal arrangements with other programs to refer clients.

Substance abuse treatment program directors who endorsed the idea that substance abuse programs should not be expected to provide domestic violence victim services because of current State funding arrangements were consistently less likely to screen or provide domestic violence services for victims.

The distribution of three of the six substance abuse–domestic violence relationship factors were insufficient to support analyses. About 95% to 98% of substance abuse program directors agreed with these statements. Program directors who believed that being a victim of violence increased chances that the victim would develop an alcohol or drug problem were more likely than those disagreeing with this statement to provide victim services, have a trained domestic violence counselor on staff, and have informal referral arrangements with other programs.

Directors who thought that women's use of alcohol keeps them stuck in violent relationships were more likely to direct programs that screen clients for domestic violence victimization, but were less likely to have on staff (or contract with) a trained domestic violence

counselor and to have formal or informal referral arrangements with other programs to provide services.

5.6 Reasons for Substance Abuse Programs Not Providing Domestic Violence Victim Services

Male directors of substance abuse programs were more likely than female directors to endorse lack of expertise, limited staff resources, and limited financial resources as reasons for not providing services to domestic violence victims (see Table 5.6). Longer tenured program directors were less likely than their counterparts to give a lack of expertise, limited staff resources, and no need for such services as reasons why their programs did not provide domestic violence victim services. Similarly, directors with a graduate school education were less likely than directors with less education to say that lack of expertise and limited resources were reasons why they did not provide services to domestic violence victims. Directors who attended graduate school were also less likely to say that domestic violence victim services are better provided independently of substance abuse treatment programs.

Larger substance abuse treatment programs, measured by the number of full-time employees, were less likely than smaller programs to say that limited staff and financial resources, and there being no need for victim services as reasons not to provide complementary victim services. Substance abuse treatment programs that provided residential services were significantly more likely than programs not providing residential services to say that limited staff and financial resources were reasons for not providing victim services, and such program directors also more often endorsed the idea that domestic violence victim services were better provided independent of substance abuse treatment services.

The relationship between directors' perception of the magnitude of the domestic violence victimization problem among their substance abuse clients and reasons for not providing victim services was mixed. Directors who estimated the domestic violence victim prevalence problem to be lower were *less* likely to say that services were not provided because of lack of expertise, domestic violence services were better provided independent of substance abuse treatment programs, and that there was no need for such services. On the other hand, an assessment that victimization prevalence is higher was associated with giving limited staff and financial

Table 5.6 Reasons Why Substance Abuse Programs Do Not Provide Domestic Violence Services to Victims

Explanatory Variables	Reasons for Not Providing Domestic Violence Services to Victims				
	Lack of Expertise in Domestic Violence (*n*=259)	Limited Staff Resources (*n*=259)	Limited Financial Resources (*n*=259)	Domestic Violence Services Are Better Provided Independent of Substance Abuse Programs (*n*=259)	No Need for Such Services (*n*=259)
Director and Program Characteristics					
Male	+	+	+		
Tenure in field (years)	–	–			–
Graduate school	–	–	–	–	
# of full-time employees		–	–		–
Provides residential services	–	+	+	+	
Directors' Attitudes About Service Linkage					
% of clients who are domestic violence victims	–	+	+	–	–
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs		–	–	+	+
Substance abuse treatment programs can effectively integrate programs for domestic violence victims	▨	▨	▨	▨	▨
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other		–		–	
Given current State funding, substance abuse programs should not be expected to provide services that substance-abusing domestic violence victims need	–	–	+		
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time	▨	▨	▨	▨	▨
Being a victim of violence increases chances of the victim developing an alcohol or drug problem		+		–	–
Drinking/drug use increases likelihood that women will assault their partners	▨	▨	▨	▨	▨
When both partners are drinking or using drugs, the likelihood of violence between them is increased	▨	▨	▨	▨	▨
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner	–	+	+	+	+
A woman's use of alcohol keeps her stuck in violent relationships	+	+	+	–	–

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

resources as reasons for not providing domestic violence victim services to their substance abuse clients.

Substance abuse treatment program directors' attitudes about service linkage were not consistently associated with the reasons given for not linking substance abuse and domestic violence victim services. Directors who thought that services for domestic violence victims were better provided someplace other than substance abuse programs were *less* likely to give limited staff and financial resources as reasons for not linking services. They were *more* likely than directors who disagreed with this view to say that domestic violence services were better provided independent of substance abuse programs and to say there was no need for such services. Another apparent inconsistency is that directors who endorsed the statement that substance abuse programs should not be expected to provide services to domestic violence victims given current State funding were *less* likely to give lack of domestic violence expertise and limited staff resources as reasons for not providing services to victims, but they were *more* likely to give limited financial resources as a reason for not providing victim services.

Directors who agreed with the statements that a woman's drinking increases the chances that she will be assaulted by her partner, and who thought that a woman's drinking keeps her stuck in violence relationships, were more likely to give staff and financial resource limits as reasons for not providing victim services.

5.7 Service Linkage for Offenders in Substance Abuse Programs

Table 5.7 gives the results of the logistic regression analyses of service linkage for domestic violence offenders in substance abuse treatment programs. Substance abuse treatment programs directed by males were more likely to provide domestic violence services to offenders, but less likely to contract with outside counselors to provide these services. Number of years in the substance abuse field was directly related to

- screening clients for domestic violence offending,
- providing domestic violence services to offenders,
- having a trained domestic violence counselor on staff, and

Table 5.7 Domestic Violence Services for Offenders in Substance Abuse Programs

Explanatory Variables	Screens Clients for Domestic Violence Offending (*n*=574)	Provides Domestic Violence Services to Offender Clients (*n*=575)	Has Trained Domestic Violence Counselor on Staff (*n*=571)	Contracts with Outside Domestic Violence Counselor (*n*=574)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=573)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=571)
Director and Program Characteristics						
Male		+		−		
Tenure in field (years)	+	+	+		+	
Graduate school		+	−	−		+
# of full-time employees	−	+	+	−	+	−
Provides residential services				+	+	
Directors' Attitudes About Service Linkage						
% of clients who are domestic violence offenders	+	+	+			
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs	−	−	−			+
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	−			+		−
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time						
Drinking/drug use increases the likelihood that some men will assault their partners						
When both partners are drinking or using drugs, the likelihood of violence between them is increased						
Drinking/drug use are sometimes used as an excuse by men assaulting their partner						
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence	−	+	−	+		−
Women use their male partners' drinking to stay in violent relationships		−	−			

▥ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

- having a formal arrangement with other programs to refer clients in need of services.

Having a graduate degree was directly associated with providing domestic violence services to offenders, and to having informal arrangements with other programs to provide these services. But programs managed by a director with a graduate degree were *less* likely to have a trained domestic violence counselor on staff and to contract with an outside domestic violence counselor for offender services.

There were varied relationships between program employee size and the six linkage activities. Larger programs were *more* likely to provide services to offenders, have a trained domestic violence counselor on staff, and have formal arrangements with other programs to refer clients. On the other hand, larger programs were less likely to screen for domestic violence offending, contract with an outside domestic violence counselor, and have an informal arrangement with outside programs for referral of offender clients.

Substance abuse programs that offered residential services were more likely than programs not offering residential services to contract with an outside domestic violence counselor and to have formal referral arrangements with other programs.

Substance abuse program directors who thought that higher percentages of their clients were domestic violence offenders were more likely than those whose offender prevalence estimates were lower to screen for domestic violence offending, provide domestic violence services to offenders, and have a domestic violence counselor on staff.

Directors' attitudes about whether domestic violence services should be provided by substance abuse programs, and about the philosophical inconsistency of domestic violence and substance abuse programing, were typical of the regression findings we have been discussing (both positive, negative, and nonsignificant findings). Substance abuse directors who thought that domestic violence programming should be provided outside substance abuse programs were significantly less likely to screen clients for domestic violence offending, provide domestic violence services to offenders, and have a trained domestic violence counselor on staff. Directors' beliefs about the *location* of domestic violence programming were not significantly associated with contracting with an outside domestic violence counselor or with having formal arrangements with other programs to refer clients in need of domestic violence services. Finally, directors who thought that domestic violence programming should not take place within

substance abuse programs were more likely than their counterparts to direct programs that have *informal* arrangements with other programs for client referral.

Directors who believed the philosophies of domestic violence and substance abuse treatment programming were inconsistent with each other were less likely to screen clients for domestic violence offending and to have informal referral arrangements with other programs. But directors holding the "inconsistent philosophy" view were more likely than their counterparts to direct programs that contract with outside domestic violence counselors.

Substance abuse program directors who believed that substance abuse treatment for violent males can reduce the likelihood of future violence were more likely to direct programs that

- do not screen clients for domestic violence offending,
- do provide domestic violence services to offender clients,
- do not have trained domestic violence counselors on staff,
- do contract with outside domestic violence counselors, and
- do not have *informal* arrangements with other programs to refer clients.

Finally, substance abuse program directors who thought that women use their male partners to stay in violent relationships directed programs that were less likely to provide domestic violence services to offenders and less likely to have trained domestic violence counselors on staff.

5.8 Reasons for Not Providing Domestic Violence Programming to Offenders in Substance Abuse Treatment Programs

Table 5.8 displays the relationships between the set of independent variables we have been using and five reasons for not providing services to offenders. Male directors of substance abuse treatment programs were more likely than females to endorse each of the five reasons for not providing domestic violence services to offenders. Tenure in the field was negatively associated with three of the five reasons for not providing programming to domestic violence offenders. Directors with more years working in the substance abuse field were *less* likely than directors with fewer years of experience to say that limited staff resources was a reason for not

Table 5.8 Reasons Why Substance Abuse Programs Do Not Provide Domestic Violence Services to Offenders

Explanatory Variables	Reasons for Not Providing Domestic Violence Services to Offenders				
	Lack of Expertise in Domestic Violence (*n*=287)	Limited Staff Resources (*n*=287)	Limited Financial Resources (*n*=287)	Domestic Violence Services Are Better Provided Independent of Substance Abuse Programs (*n*=287)	No Need for Such Services (*n*=287)
Director and Program Characteristics					
Male	+	+	+	+	+
Tenure in field (years)		–		–	–
Graduate school	–			–	–
# of full-time employees					
Provides residential services				+	
Directors' Attitudes About Service Linkage					
% of clients who are domestic violence offenders		+	+		–
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs	–	–	–	+	+
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	–			–	
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time					
Drinking/drug use increases the likelihood that some men will assault their partners					
When both partners are drinking or using drugs, the likelihood of violence between them is increased					
Drinking/drug use are sometimes used as an excuse by men assaulting their partner					
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence				–	
Women use their male partners' drinking to stay in violent relationships	+			–	–

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

providing offender services, to say these services were better provided independently of substance abuse programs, and to say there was no need for such services. Programs directors who attended graduate school also were *less* likely than their counterparts to endorse three of the given reasons for not providing offender programming. Program size as measured by number of employees was unrelated to the five reasons for not providing services, and programs offering residential services differed from nonresidential programs only in their belief that offender domestic violence services should be provided independent of substance abuse programs.

Substance abuse program directors who estimated that higher percentages of their clients were domestic violence offenders were significantly more likely than their counterparts to say that limited staff and financial resources were reasons for not providing offender services. Directors who thought a higher percentage of their clients were domestic violence offenders, as expected, were less likely to think there was no need for offender services.

Substance abuse program directors who thought that domestic violence services for offenders were better provided outside substance abuse programs were less likely to say that lack of expertise and limited resources were reasons for not providing offender programming, but they were more likely to endorse the idea that offender programming should be provided independent of substance abuse programs and that there was no need for such services. Directors who agreed that philosophies of domestic violence and substance abuse programming are inconsistent were less likely to cite lack of domestic violence expertise and that domestic violence services are better provided elsewhere as reasons for not providing offender services.

Substance abuse program directors who thought that substance abuse treatment for the violent male partner can reduce future violence were less likely to say that domestic violence services were better provided independent of substance abuse programs. Program directors believing that women use their male partner's drinking to stay in violent relationships were significantly more likely to say that offender services should *not* be provided by substance abuse programs. But directors endorsing the same idea also were significantly *less* likely to say offender domestic violence programming should be provided independently of substance abuse programs and less likely to say there was no need for such services.

5.9 Complementary Services for Victims

In this section, we summarize and highlight the findings regarding the provision of substance abuse services to victims by domestic violence programs and the provision of domestic violence services to women in substance abuse treatment programs. We draw on the data provided in Tables 5.1 and 5.5 (complementary services to victims) and in Tables 5.2 and 5.6 (reasons for not providing complementary services to victims).

The program director's gender was not consistently associated with the six forms of complementary service provision across the two program types. Program director years' tenure in the field, however, was *directly* associated with programs' providing the complementary service, having a trained complementary counselor on staff, and having formal arrangements with other programs for client referral. This result held for both domestic violence and substance abuse treatment programs. Because these three forms of complementary service indicate a real commitment to complementary service linkage (in comparison to screening, outside contracting, and informal arrangements with other programs), their findings are particularly meaningful. Apparently, program directors with longer tenure in the domestic violence and substance abuse fields were more likely to recognize the need for and to institute programming to provide substance abuse services to domestic violence victims, and victim service to substance abuse treatment clients.

The findings for graduate school attendance were inconsistent across complementary service types and program types. Substance abuse program directors with some graduate school education were more likely than their counterparts to direct programs that screen clients for domestic violence victimization, provide victim services, and have informal referral arrangements with other programs. Substance abuse program directors with a graduate school education, however, were *less* likely to have a trained domestic violence counselor on staff or to contract with an outside domestic violence counselor.

Overall, the number of full-time employees in a program also was inconsistently associated with complementary service linkage, as was whether programs provide shelter or residential services. One exception is that substance abuse and domestic violence programs with a greater number of full-time employees were less likely to contract with outside complementary counselors. In the case of shelter/residential services, there was a statistically significant direct

relationship between these factors and having formal arrangements for client referral for both domestic violence and substance abuse programs.

There was a fairly consistent relationship between program directors' assessment of the percentages of their clients who have the complementary problem and the provision of complementary services to clients. Both domestic violence and substance abuse program directors who thought that higher percentages of their clients had substance abuse and victimization problems, respectively, were significantly more likely to screen clients for the complementary problem, provide the complementary service, and to contract with a trained outside counselor to provide the service. Apparently, the perceived magnitude of the complementary problem among clients influences directors to provide complementary services.

Program directors' attitudes about service linkage were not consistently associated with provision of complementary services. As expected, directors of both domestic violence and substance abuse treatment programs who endorsed the idea that the complementary service should be provided elsewhere than by their programs were significantly less likely than directors disagreeing with this statement to provide the complementary service and to have a trained complementary counselor on staff. Somewhat contrary to expectations, program directors who said that the philosophies of domestic violence and substance abuse treatment were inconsistent with each other did not avoid providing complementary services in several complementary service categories. Substance abuse program directors holding the inconsistent philosophy view in particular were significantly more likely to direct programs having a trained domestic violence counselor on staff, contract with an outside domestic violence counselor, and have formal arrangements with other programs to refer clients.

There was a fairly consistently *negative* relationship between endorsement of the view that programs should not be expected to provide complementary services given current State funding and provision of complementary services. Although this relationship was stronger for substance abuse programs than for domestic violence programs, both program types were less likely to (a) provide the complementary service and (b) to have a trained complementary counselor on staff.

The assessments of the substance abuse–domestic violence relationship by program directors did not generate consistent relationships with the complementary services:

- Directors who believed that being a victim of domestic violence increased chances of developing an alcohol or drug problem directed programs that were significantly more likely to provide domestic violence victim services, and to have a trained domestic violence counselor on staff.

- Domestic violence program directors who thought that a woman's use of alcohol keeps her stuck in violent relationships were significantly more likely to screen victims for substance abuse, to have a trained counselor on staff, and to have informal referral arrangements with other programs.

This last finding may be explained by the differing views held by the directors of the two program types. Substance abuse program directors holding this view, however, were significantly *less* likely to direct programs that have a trained domestic violence counselor on staff, contract with an outside domestic violence counselor, and have formal or informal referral arrangements with other programs. Directors of both program types holding this view were less likely to have formal referral arrangements with other programs.

The logistic regression analyses of the reasons for not linking domestic violence and substance abuse services did not generate the interpretable findings that the foregoing analyses did. These findings can be summarized as follows:

- Program director gender was inconsistently associated with the reasons for not linking services.

- Unlike with the relationship of program director tenure to complementary victim services, this factor was not as strong a correlate of reasons for not linking services.

- Substance abuse program directors who had some graduate school education were significantly less likely to say that their programs did not link services because of a lack of expertise, limited staff and financial resources, and because domestic violence services were better provided independent of substance abuse treatment programs.

- Directors of programs with larger numbers of full-time employees were less likely than directors of smaller programs to say they did not provide complementary services because of limited financial resources.

- Directors of programs that provided shelter or residential services were more likely to say they did not provide complementary services because of limited staff and financial resources.

- Most directors' attitudes about the domestic violence–substance abuse relationship were inconsistently associated with the five reasons for not providing complementary services. One exception was that directors who endorsed the notion that alcohol keeps women stuck in violent relationships were significantly more likely to say their programs did not provide complementary services because of lack of expertise and limited staff resources. Another exception is that directors who agreed that being a domestic violence victim increases the chances that the victim will develop a substance abuse problem were less likely to say that their programs do not provide complementary services because these services are better provided elsewhere.

5.10 Complementary Services for Offenders

When the regression findings for complementary offender services are considered for both domestic violence and substance abuse treatment programs, a few patterns emerge. As with the victim services, program director gender was not consistently associated with provision of complementary services. And consistent with the findings for program director tenure and provision of complementary victim services, years in the field were associated with providing complementary services to offenders in four of the six service categories. Graduate school attendance by program directors was not consistently associated with complementary offender services. Residential substance abuse programs were more likely than nonresidential programs to contract with an outside domestic violence counselor and to have formal arrangements with other programs for referring offender clients in need of services. Substance abuse program directors' perceptions of the percentage of clients with the complementary problem were associated with programs providing complementary services, although this relationship was less consistent for offender clients than it was for victim clients.

Substance abuse program directors who thought that offender domestic violence service needs ought to be provided someplace other than in substance abuse programs were significantly *less* likely to direct programs that screen clients for domestic violence, provide such services, and have a trained domestic violence counselor on staff.

The relationships between the belief that domestic violence and substance abuse treatment philosophies are inconsistent with each other and the provision of complementary services are difficult to interpret. Some of the relationships were statistically significant, but the

significant findings were both positive and negative and inconsistent within and across program types.

The program directors' perceptions of the substance abuse–domestic violence relationship also were not associated systematically with the provision of complementary services. Lack of variation in program directors' responses to the questions prevented inclusion of several of these variables in the analyses, and most of the relationships produced inconsistent findings. One exception was that program directors who believed that substance abuse treatment for the violent male partner can decrease the risk of future violence were significantly more likely than directors who disagreed with the statement to direct programs that provided complementary services in 4 of the 10 complementary service categories:

- substance abuse programs provided domestic violence offender services,
- domestic violence programs have a trained substance abuse counselor on staff,
- substance abuse programs contract with an outside domestic violence counselor, and
- domestic violence programs have formal arrangements with outside programs to provide substance abuse services to offenders.

For both domestic violence and substance abuse programs, however, a belief in the violence reduction potential of substance abuse treatments for offenders was inversely associated with having *informal* referral arrangements with other programs.

There are some notable summary findings from the analyses of reasons for not providing complementary services for offender clients at domestic violence and substance abuse programs:

- Being a male program director was significantly associated with all five reasons for not providing complementary services for substance abuse programs (but not for domestic violence programs).
- Directors of both program types who estimated that higher percentages of their clients had the complementary problem were significantly more likely than their counterparts to say that they did not provide complementary services because of limited staff and financial resources.

- Program directors' attitudes about service linkage and the substance abuse–domestic violence relationship were inconsistently associated with the reasons analyzed for not providing complementary services.

In the next chapter, we attempt to interpret our findings and to draw some implications from the results.

6. INTERPRETATION AND IMPLICATIONS

The purposes of this study were to

- identify the prevalence of complementary substance abuse–domestic violence linkage of services by substance abuse and domestic violence programs, and examine the forms of complementary service linkage provided by the two program types;
- compare substance abuse and domestic violence programs in the prevalence and type of service linkage provided;
- identify reasons why substance abuse and domestic violence programs do and do not link these two forms of service; and
- attempt to identify factors that facilitate and impede complementary substance abuse–domestic violence service linkage.

Computer-assisted interviews with national samples of directors of substance abuse and domestic violence programs generated findings on all four of these study purposes.

The study was largely successful in achieving the first three goals. The findings presented in Chapters 4 and 5 provided detailed information about the fairly high proportions of programs that provide complementary services and identified the somewhat less favorable attitudes of domestic violence program directors toward linkage. Sometimes financial or staff resources were given as reasons for not providing complementary services, but other reasons also were relevant, such as program directors' attitudes about integrating services, and in connection with the substance abuse–domestic violence relationship. The logistic regression analyses reported in Chapter 5 also identified factors associated with complementary service linkage when variation accounted for by program, director, and attitudinal factors were considered together. These multivariate analyses were informative but, as discussed in the next section, did not generate the kind of clear implications that we hoped would result.

6.1 Interpretation of Findings

The most useful information generated by this study may be the descriptive data for the national sample of domestic violence and substance abuse treatment programs (see Table 4.6). These data show clearly that directors of domestic violence and substance abuse programs agreed that their clients frequently had the complementary problem. Domestic violence program directors thought that 36% of their victim clients had substance abuse problems and 61% of their offender clients had substance abuse problems. Substance abuse program directors thought that 33% of their clients were domestic violence victims and 26% were domestic violence offenders. The data also indicate clearly that substantial percentages of programs provided some complementary services. For example, 62% of domestic violence programs screened victims for substance abuse, and 58% of these programs screened offenders for substance abuse; moreover, 72% of substance abuse programs said their programs screened their clients for domestic violence victimization, and 60% screened their clients for committing violence against their intimate partners. Smaller percentages of programs actually provided complementary services: 19% to 26% of domestic violence programs provided substance abuse services for offenders and victims, and about half of substance abuse programs provided domestic violence services for victims and offenders.

We had hoped that our survey data would provide some clear guidance for linkage of domestic violence and substance abuse services at the programmatic level. Our hypotheses have been confirmed regarding program director and program characteristics. Also, program directors' attitudes about service linkage and the substance abuse–domestic violence relationship were found in the logistic regression analyses to have statistically significant associations with complementary service provision. The findings did not provide, however, much specific direction for those who develop, fund, and operate domestic violence and substance abuse treatment programs. There are two *related* reasons why programmatic implications are difficult to identify in the findings:

- Many of the multivariate findings were inconsistent with each other and thus are difficult to interpret.
- The design and implementation of complementary domestic violence and substance abuse services require the simultaneous consideration of

multiple organizational, resource, clinical, and contextual issues that make the task very complex.

A few examples will illustrate the difficulties associated with finding programmatic guidance in the study findings.

As discussed earlier, we found a fairly consistent direct relationship between program directors' perceptions of the prevalence of the complementary problem among their clients and their provision of complementary services—particularly for domestic violence victims (see Tables 5.1, 5.3, 5.5, 5.7). The data also showed that domestic violence program directors were less likely to provide substance abuse services for victims *in house* (as part of their programs) if they endorsed the idea that given current State funding, they should not be expected to provide substance abuse services. This finding is what one would expect. Program directors' beliefs about State funding and not linking services were consistent. Domestic violence program directors who endorsed the view that State funding was a reason why they should not be expected to provide substance abuse services were not significantly less likely than their counterparts to direct programs that contracted with outside substance abuse counselors and to have formal arrangements with other programs to refer clients. These directors also were significantly more likely to have informal referral arrangements with other programs. On the surface at least, these empirical relationships are inconsistent. One would expect that program directors who thought they should not have to provide complementary services would *not do so*.

It is probable that this response pattern from domestic violence program directors is attributable to the comparative costs of providing complementary services to victim clients in the different ways. Providing such services within the structure of their programs would use substantial staff and financial resources that are comparatively costly than if complementary services are provided by contract employees or other programs to which clients are referred. These findings illustrate both points above about the apparent inconsistency of findings and the complexity of linking domestic violence and substance abuse services.

Another illustration of the apparent inconsistency of findings and the complexity of linkage issues in practice is found in the analyses of the effects of the belief that the philosophies of domestic violence and substance abuse programming are inconsistent with each other. An estimated 40% of the domestic violence program directors and 19% of the substance abuse program directors agreed or strongly agreed with this statement. We expected that our logistic

regression analyses would show an inverse (negative) relationship between the belief that domestic violence and substance abuse programming philosophies are inconsistent and the provision of complementary services. But this is not what we found. The relationships were variable. There was no statistically significant relationship between the philosophical inconsistency view and provision of complementary services, there was a positive statistically significant relationship between these factors, and there was a negative relationship between them (see Tables 5.1, 5.3, 5.5, 5.7). Clearly, the relationship is more complex than our analyses considered, probably varying by multiple factors (interaction terms) that were not considered in our analyses. It is likely that program directors *jointly* considered such factors as the prevalence of the complementary problem, resource availability, and different options for providing complementary services in conjunction with the inconsistent philosophy factor.

6.2 Study Limitations

This study has several important methodological limitations that future research in this area should consider:

- **Sampling frames.** Although the lists we used in sampling domestic violence and substance abuse programs—the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, 1995 and the 1997 National Directory of Domestic Violence Programs—were recent in publication and national in scope, it is likely that these lists did not include all domestic violence and substance abuse treatment programs in the country (NCADV, 1997; SAMHSA, 1996). Programs that were not affiliated with any State or national coalition or that do not receive State or Federal funding may have been excluded from these lists. As a result, our findings may not be generalizable to all domestic violence and substance abuse treatment programs in the country. Future studies on domestic violence and substance abuse programs may benefit from examining the completeness and representativeness of these lists and identifying additional sampling resources.

- **Clientele size as a criterion for study eligibility.** As mentioned earlier in this report, domestic violence programs that served fewer than 50 clients in 1996 and substance abuse treatment programs that served fewer than 100 clients in that year were excluded from our sample. These restrictions were imposed to prevent the sampling of programs that did not serve many clients. A consequence of this strategy, however, is that small programs were omitted disproportionately from our sample. Small programs are

disproportionately likely to serve less densely populated areas or to serve special populations, such as racial/ethnic minorities.

- **Questionnaire design.** Many of the questionnaire items in both the domestic violence and substance abuse program questionnaires were closed-ended. Although this format was necessary for the kind of interviewing we did (telephone interviews conducted by non-expert interviewers) and helped to control the time required to administer the interview, using this type of question format has disadvantages. For example, more descriptive information about the type of complementary services provided by programs or about the reasons that programs do not provide linked services could have been obtained by the use of open-ended questions. Future studies aimed at collecting more in-depth information should consider alternative data collection methodologies and question formats.

6.3 Effectiveness of Linkage

In a sense, the research conducted here is incomplete. We examined the prevalence and form of substance abuse–domestic violence services linkage and attempted to identify the factors associated with their linkage. Other information to address the *effectiveness* of providing complementary substance abuse and domestic violence services is needed before extensive plans to move the substance abuse service providers and domestic violence service providers toward complementary service linkage. There is a logic in the idea that the value of complementary services should be established before promoting the development of such programming.

To our knowledge, no evaluation of complementary substance abuse and domestic violence services has been conducted, and we know of no significant evaluation that is currently under way. It is also the case that linkage initiatives are currently being implemented, and it appears such initiatives are likely to become more common. This situation calls for two courses of action:

- assessments of linkage to identify optimal ways to design and implement these services, and
- the design and conduct of process and outcome evaluations to examine the effectiveness of linkage.

The current study is a partial response to the first point. We have established that many in the domestic violence and substance abuse fields believe there is a need for complementary services of these kinds and that many programs already link these services. Our study also has identified some of the factors that affect linkage. Findings on the last point make it clear that multiple factors are important and that linkage implementation is complex.

One of the factors not directly examined in this study that we believe helps account for some study findings and is partly responsible for the complexity of implementing linkage is the organization and funding of domestic violence and substance abuse services in the United States. Domestic violence and substance abuse services are usually the responsibility of separate private and public human service delivery systems. There is a long U.S. history of a *categorical* approach to delivery and funding of human services. The United States tends to compartmentalize social and behavioral problems, such as domestic violence and substance abuse, and other problems (e.g., mental health and economic) and to assign responsibility for dealing with these problems to separate entities. Independent social service bureaucracies are established and perpetuated by specialization, law, and public and private funding. Multiple constituencies develop interests in the continuation of such arrangements. At times, the arrangements do not match well the needs and interests of individual clients, including the related problems of substance abuse and domestic violence.

Although the linkage of substance abuse and domestic violence services has received little systematic attention, previous study of linking other kinds of services has taken place. An example is a study of national models for linking drug abuse treatment and primary (medical) care (Schlenger et al., 1992). This study examined nine different projects that attempted to link substance abuse and primary care. The nine linkage attempts varied considerably in form, ranging along a continuum from decentralized to centralized (see Schlenger et al., 1992, p. 267). A common linkage mechanism among the nine case study sites was the use of case managers or social workers to facilitate linking substance abuse and primary care services across different programmatic entities. The study identified a number of elements potentially important to service linkage (Schlenger et al., 1992, pp. 271-288).

- co-location of services,
- case management,

- philosophical congruence of providers,
- multidisciplinary approach to treatment,
- cross training of providers,
- communication among providers,
- important role of mental health,
- consistent therapeutic alliance,
- meeting clients "where they are,"
- structural assessments, and
- linked services versus linked systems.

This list represents an excellent set of factors that identify both important issues to address when attempting to design service linkages, as well as a number of mechanisms that can or should be incorporated into linkage. Not all the elements on the list should be considered "mandatory" because some items on the list represent linkage alternatives (e.g., co-location of services and case management). The 11 items can usefully be viewed as a checklist though for decisionmakers and programs to consider when substance abuse and domestic violence service linkage is being considered.

Not mentioned in the above list is the *financing* of linked services, an issue likely to be of high importance to programs. The source of funding to implement linkage will often be problematic, and the absence of funding to support linkage can make linkage difficult or impossible. Creativity in the generation of linkage dollars is likely often to be required if programs are to be successful in the provision of linked services. Creative funding solutions might include the acquisition of special focus grants to support linkage, development of relationships with complementary programs, and the use of volunteers and other modes of acquiring needed resources or services. One solution that can be implemented at a modest cost is the case manager approach, which might involve hiring a case manager whose mandate would be to identify clients in need and to develop ways to broker needed services for clients from existing programmatic resources. The case manager approach seems to fit the needs of service linkage, given the characteristics of the domestic violence and substance abuse service systems, and the individual service needs that are associated with this configuration of problems.

6.4 Suggestions for Linkage Demonstration and Evaluation

At the same time that attempts are made to better formulate and organize domestic violence and substance abuse service linkage, a demonstration/evaluation initiative to implement and assess linkage should be undertaken. We recommend an approach here that would be a useful first step toward establishing whether complementary domestic violence and substance abuse services improve client outcomes. Improved outcomes for victims would include reduced victimization, the reduction of substance abuse among victims, and improved family and economic circumstances. Improved outcomes for offenders would include effectively addressing the violent behavior and substance abuse problems to reduce the likelihood of future domestic violence.

Initially, we think that it would be appropriate that a demonstration/evaluation focus on linkage for *victims* of domestic violence. Attempting to assess linkage initiatives for both victims and offenders would be methodologically difficult and costly. Moreover, evaluations of domestic violence batterer treatment are currently under way, and it is appropriate to await those results before developing a research demonstration for substance abuse–domestic violence service linkage for batterers.

One of the major dimensions in the consideration of domestic violence–substance abuse service linkage for victims is where and how to deliver those services. In the current study, we looked at services provided as part of domestic violence programming and at some ways that the substance abuse treatment for victims could be provided by referral to other programs or by contract employees. Given some of the issues discussed earlier, such as resource limitations and domestic violence program directors' concerns about the philosophical inconsistency of domestic violence and substance abuse treatment, there is a rationale for designing alternative approaches to linkage that are integrated *within* existing programming or are provided by referral or contract. The referral/contract approach may be preferred by programs having limited resources and/or concerns about attempting to integrate substance abuse and domestic violence within the same program framework.

Before a research demonstration design can be fully developed, additional linkage program identification/specification is needed. In other words, linkage interventions must be identified that can be described in sufficient detail for implementation, which will require that some qualitative research to describe linkage programming be conducted. The most efficient

way to proceed along this line is to identify existing linkage initiatives for victims within both domestic violence and substance abuse programs. Two approaches will help locate existing programming:

- examine our national program database and identify programs currently providing complementary programming, and selectively follow up to gather information about the programming, and
- conduct interviews with informants in the domestic violence and substance abuse fields and ask them to identify programs currently providing complementary domestic violence and substance abuse services.

These two approaches will identify a range of complementary approaches from which a few well-articulated, logically grounded ones can be selected for study.

A modest initial demonstration/evaluation initiative would make sense, perhaps involving eight approaches:

- two domestic violence programs integrating substance abuse victim services into their current programming,
- two domestic violence programs arranging for substance abuse victim services through other programs,
- two substance abuse programs integrating domestic violence victim services into their current programming, and
- two substance abuse programs arranging for domestic violence victim services through other programs.

Inclusion of both process and outcome evaluation components will provide the most useful information.

The demonstration evaluation plan needs more detailed development and review, including assessment by domestic violence and substance abuse treatment experts who can speak to programmatic choices and feasibility issues. A reasonable activity to further the plan would be a 1- or 2-day conference that would include experts from the domestic violence and substance abuse treatment fields. In addition to NIJ, other agencies having an interest in this enterprise would probably include the Violence Against Women Office within the Office of Justice

Programs, the National Institute on Alcohol Abuse and Alcoholism, the Centers for Disease Control and Prevention, and the Center for Substance Abuse Treatment.

As discussed earlier, the domestic violence–substance abuse service linkage issue has already received considerable attention, so some of the necessary thinking and planning has already taken place. It would not take major resources to develop a viable evaluation plan. The research demonstration project itself would probably require $1 million to $2 million to conduct. This investment would likely pay substantial dividends for the domestic violence and substance abuse service delivery system. The current state of knowledge about the implementation and effects of linking these two kinds of services is rudimentary, and the costs of the related problems of substance abuse and domestic violence are high. Generating evaluation data that address implementation and effectiveness issues could advance the two fields and provide a foundation for reducing the very high individual and societal costs associated with these problems.

REFERENCES

Amaro, H., Fried, L.E., Cabral, H., & Zuckerman, B. (1990). Violence during pregnancy and substance use. American Journal of Public Health, 80, 575-579.

Barnett, O.W., & Fagan, R.W. (1993). Alcohol use in male spouse abusers and their female partners. Journal of Family Violence, 8(1), 1-25.

Beck, A., Gilliard, D., Greenfeld, L., Harlow, C., Hester, T., Jankowski, L., Snell, T., Stephan, J., & Morton, D. (1993, March). Survey of state prison inmates, 1991 (NCJ-136949). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Bennett, L., & Lawson, M. (1994). Barriers to cooperation between domestic-violence and substance-abuse programs. Families in Society: Journal of Contemporary Human Services, 75, 277-286.

Bennett, L.W., Tolman, R.M., Rogalski, C.J., & Srinivasaraghavan, J. (1994). Domestic abuse by male alcohol and drug addicts. Violence and Victims, 9, 359-368.

Brewer, D.D., Fleming, C.B., Haggerty, K.P., & Catalano, R.F. (1998). Drug use predictors of partner violence in opiate-dependent women. Violence & Victims, 13(2), 107-115.

Brookhoff, D. (1997, October). Drugs, alcohol, and domestic violence in Memphis (NIJ Research Preview, summary of videotape available as NCJ 163056). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Buehler, J., Dixon, B., & Toomey, K. (1998, October 16). Lifetime and annual incidence of intimate partner violence and resulting injuries—Georgia, 1995. Morbidity and Mortality Weekly Report, 47, 849-853.

Bushman, B.J., & Cooper, H.M. (1990). Effects of alcohol on human aggression: An integrative research review. Psychological Bulletin, 107, 341-354.

Center for Substance Abuse Treatment. (1994). Practical approaches in the treatment of women who abuse alcohol and other drugs (DHHS Publication No. SMA 94-3006). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration.

Coleman, D.H., & Straus, M.A. (1983). Alcohol abuse and family violence. In E. Gottheil, K.A. Druley, T.E. Skoloda, & H.M. Waxman (Eds.), Alcohol, drug abuse, and aggression (pp. 104-124). Springfield, IL: Charles C Thomas.

Collins, J.J. (1993). Alcohol and crime aetiology. In J. Russell (Ed.), Alcohol and crime: Proceedings of a Mental Health Foundation conference (pp. 22-32). London, England: Mental Health Foundation.

Collins, J.J., Kroutil, L.A., Roland, E.J., & Moore-Gurrera, M. (1997). Issues in the linkage of alcohol and domestic violence services. In M. Galanter (Ed.), Recent developments in alcoholism, Volume 13: Alcohol and violence (pp. 387-405). New York: Plenum.

Collins, J.J., & Messerschmidt, P.M. (1993). Epidemiology of alcohol-related violence. Alcohol Health and Research World, 17(2), 93-100.

The Commonwealth Fund. (1998, February). Addressing domestic violence and its consequences. New York: The Commonwealth Fund Commission on Women's Health.

Crowell, N.A., & Burgess, A.W. (Eds.). (1996). Understanding violence against women (Panel on Research on Violence Against Women, Committee on Law and Justice, Commission on Behavioral and Social Sciences and Education, National Research Council). Washington, DC: National Academy Press.

Fagan, J. (1990). Intoxication and aggression. In M. Tonry & J.Q. Wilson (Eds.), Drugs and crime (pp. 241-320). Chicago, IL: University of Chicago Press.

Fazzone, P.A., Holton, J.K., & Reed, B.G. (1997). Substance abuse treatment and violence (Treatment Improvement Protocol [TIP] Series No. 25, DHHS Publication No. SMA 97-3163). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Flitcraft, A. (1993). Physicians and domestic violence: Challenges for prevention. Health Affairs (Millwood), 12(4), 154-161.

Frieze, I.H., & Browne, A. (1989). Violence in marriage. In L. Ohlin & M. Tonry (Eds.), Family violence (Vol. 11 of M. Tonry & N. Morris [Series Eds.], Crime and justice: A review of research, pp. 163-218). Chicago, IL: University of Chicago Press.

Greenfeld, L.A. (1998, April). Alcohol and crime: An analysis of national data on the prevalence of alcohol involvement in crime (prepared for the Assistant Attorney General's National Symposium on Alcohol Abuse and Crime, Washington, DC, NCJ 168632). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Hamilton, C.J., & Collins, J.J. (1981). The role of alcohol in wife beating and child abuse. In J.J. Collins, Jr. (Ed.), Drinking and crime: Perspectives on the relationships between alcohol consumption and criminal behavior (pp. 253-287). New York: Guilford Press.

Healey, K., Smith, C., & O'Sullivan, C. (1998, February). Batterer intervention: Program approaches and criminal justice strategies (Issues and Practices in Criminal Justice, NCJ 168638). Washington, DC: National Institute of Justice.

Hotaling, G.T., & Sugarman, D.B. (1986). An analysis of risk markers in husband to wife violence: The current state of knowledge. Violence and Victims, 1, 101-124.

Jones, A.S., & Gondolf, E.W. (1997, August). Situational risk factors for re-assault among batterer program participants. Indiana, PA: Mid-Atlantic Addiction Training Institute.

Kantor, G.K. (1997). Alcohol and spouse abuse ethnic differences. In M. Galanter (Ed.), Recent developments in alcoholism, Volume 13: Alcohol and violence (pp. 57-79). New York: Plenum Press.

Kantor, G.K., & Asdigian, N. (1997a). Gender differences in alcohol-related spousal aggression. In R.W. Wilsnack & S.C. Wilsnack (Eds.), Gender and alcohol: Individual and social perspectives (pp. 312-334). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Kantor, G.K., & Asdigian, N. (1997b). When women are under the influence: Does drinking or drug use by women provoke beatings by men? In M. Galanter (Ed.), Recent developments in alcoholism, Volume 13: Alcohol and violence (pp. 315-336). New York: Plenum Press.

Kantor, G.K., & Straus, M.A. (1989). Substance abuse as a precipitant of wife abuse victimizations. American Journal of Drug and Alcohol Abuse, 15, 173-189.

Kilpatrick, D.G., Edmonds, C.N., & Seymour, A.K. (1992). Rape in America: A report to the nation. Arlington, VA: National Victim Center.

Kilpatrick, D.G., Resnick, H.S., Saunders, B.E., Best, C.L., & Epstein, J. (1994, June). Violent assault and alcoholic dependence among women: Results of a longitudinal survey. Paper presented at the annual meeting of the Research Society on Alcoholism, Maui, Hawaii.

Lang, A.R., Goeckner, D.J., Adesso, V.J., & Marlatt, G.A. (1975). Effects of alcohol on aggression in male social drinkers. Journal of Abnormal Psychology, 84, 508-518.

Langford, D.R. (1996). Policy issues for improving institutional response to domestic violence. Journal of Nursing Administration, 26(1), 39-45.

Lee, W.V., & Weinstein, S.P. (1997). How far have we come? A critical review of the research on men who batter. In M. Galanter (Ed.), Recent developments in alcoholism, Volume 13: Alcohol and violence (pp. 337-356). New York: Plenum Press.

Leonard, K.E. (1993). Drinking patterns and intoxication in marital violence: Review, critique, and future directions for research. In S.E. Martin (Ed.), Alcohol and interpersonal violence: Fostering multidisciplinary perspectives (Research Monograph No. 24, NIH

Publication 93-3496, pp. 253-280). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Leonard, K.E., & Blane, H.T. (1992). Alcohol and marital aggression in a national sample of young men. Journal of Interpersonal Violence, 7(1), 19-30.

Leonard, K.E., & Senchak , M. (1992). Alcoholic use and premarital violence among couples applying for a marriage license. Unpublished manuscript, Research Institute on Addictions, Buffalo, NY.

Lipsey, M.W., Wilson, D.B., Cohen, M.A., & Derzon, J.H. (1997). Is there a causal relationship between alcohol use and violence? A synthesis of evidence. In M. Galanter (Ed.), Recent developments in alcoholism, Volume 13: Alcohol and violence (pp. 245-282). New York: Plenum Press.

Miller, B.A. (1990). The interrelationships between alcohol and drugs and family violence. In M. De La Rosa, E.Y. Lambert, & B. Gropper (Eds.), Drugs and violence: Causes, correlates, and consequences (NIDA Research Monograph 103, DHHS Publication No. ADM 90-1721, pp. 177-207). Rockville, MD: National Institute on Drug Abuse.

Miller, B.A. (1996). Women's alcohol use and their violent victimization. In J.M. Howard, S.E. Martin, P.D. Mail, M.E. Hilton, & E.D. Taylor (Eds.), Women and alcohol: Issues for prevention research (Research Monograph No. 32, NIH Publication No. 96-3817, pp. 239-260). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

Miller, B.A., & Downs, W.R. (1993). The impact of family violence on the use of alcohol by women. Alcohol Health and Research World, 17, 137-143.

Moffitt, T.E. (1997, April). Partner violence among young adults (NIJ Research Preview, summary of videotape available as NCJ 154277). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

National Coalition Against Domestic Violence. (1997, September). 1997 national directory of domestic violence programs: A guide to community shelter, safe home and service programs (draft). Denver, CO: Author.

O'Farrell, T.J., Van Hutton, V., & Murphy, C.M. (1999). Domestic violence before and after alcoholism treatment: A two-year longitudinal study. Journal of Studies on Alcohol, 60, 317-321.

Pernanen, K. (1991). Alcohol in human violence. New York: Guilford Press.

Rosenberg, M.L., & Mercy, J. (1991). Introduction. In M.L. Rosenberg & M.A. Fenley (Eds.), Violence in America: A public health approach (pp. 3-13). New York: Oxford University Press.

Schlenger, W.E, Kroutil, L.A., Roland, E.J., Etheridge, R.M., Cox, J., Caddell, J.M., Woods, M.G., Fountain, D.L. (Research Triangle Institute), Brindis, C., & Blachman, L. (Institute for Health Policy Studies, University of California at San Francisco). (1992, November). National Evaluation of Models for Linking Drug Abuse Treatment and Primary Care: Linking drug abuse treatment and primary care: A casebook (prepared under Contract No. 283-90-0001). Rockville, MD: National Institute on Drug Abuse, Clinical Medicine Bramch, Division of Clinical Research.

Stark, E., & Flitcraft, A. (1991). Spouse abuse. In M.L. Rosenberg & M.A. Fenley (Eds.), Violence in America: A public health approach (pp. 123-157). New York: Oxford University Press.

Straus, M.A., & Gelles, R.J. (1990). Physical violence in American families: Risk factors and adalptations to violence in 8,145 families. New Brusnwick, NJ: Transaction.

Straus, M.A., & Gelles, R.J., & Steinmetz, S.K. (1980). Behind closed doors: Violence in the American family. New York: Anchor Doubleday.

Substance Abuse and Mental Health Services Administration. (1996, September). National directory of drug abuse and alcoholism treatment and prevention programs, 1995. Rockville, MD: Author.

Taylor, S.P., & Gammon, C.B. (1975). Effects of type and dose of alcohol on human physical aggression. Journal of Personality and Social Psychology, 32, 169-175.

Wilsnack, S.C, Plaud, J.J., Wilsnack, R.W., & Klassen, A.D. (1997). Sexuality, gender, and alcohol use. In R.W. Wilsnack & S.C. Wilsnack (Eds.), Gender and alcohol: Individual and social perspectives (pp. 250-288). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Wilt, S.A., Illman, S.M., & BrodyField, M. (n.d.). Female homicide victims in New York City: 1990-1994. New York: New York City Department of Health, Injury Prevention Program.

Appendix A

Domestic Violence
Program Directors' Questionnaire

Domestic Violence Program Directors' Introduction

Hello. My name is _____. I am calling from Research Triangle Institute in North Carolina. We are conducting a survey regarding domestic violence and substance abuse service linkage under a grant from the National Institute of Justice. Your agency has been randomly selected for this survey.

I need to speak with the program director or coordinator. Is she or he available?

01 Yes
02 No

(Hello. My name is _____. I am calling from Research Triangle Institute in North Carolina.)

We are conducting a survey of domestic violence and substance abuse program directors and coordinators to determine how often domestic violence programs provide substance abuse services, and how often substance abuse programs provide services to domestic violence victims or offenders. The study is funded by the National Institute of Justice, and will ask for information about your program, it's characteristics, and resources. We will also ask some questions about your beliefs concerning the advisability and feasibility of linking domestic violence and substance abuse services, and how this might be done.

Your agency has been randomly selected for this survey, and the interview will only take about 20 minutes. Your participation is voluntary, and will have no effect on any public funding your program may receive. You may refuse to answer any question. Your responses will be kept confidential and will not be individually reported or attributed to you or your program. At the end of data collection, a few programs may be asked to participate in a site visit.

If you are ready now, we can begin.

Domestic Violence Program Screener

First I have a few general questions to determine if your agency is eligible to participate.

A1a. Does your agency/program provide services to domestic violence victims?

01 Yes
02 No

A1b. Does your agency/program provide services to domestic violence offenders?

01 Yes
02 No

[IF 'NO' TO A1a AND A1b, GO TO INELIGIBLE. ELSE, CONTINUE]

A2. Does your agency/program provide shelter services for domestic violence victims?

01 Yes
02 No

A3. Did your agency/program serve at least 50 domestic violence victims and/or offenders in 1996?

01 Yes [GO TO Q1]
02 No

INELIGIBLE: **Based on your responses your agency is not eligible to participate in this survey. Thank you for your time. [CODE AS INELIGIBLE]**

If you have any questions about the survey, you may contact Dr. James J. Collins at 1-800-334-8571, extension 6452 or Dr. Wendy Visscher, from the Institutional Review Board, at 1-800-334-8571, extension 6028.

Respondent Information

Now I have a few questions about your background. We're asking these questions of all respondents in this study so that we will be able to describe our survey sample in general.

1. **What is your name?** _____

2. **What is your job title?** _____

3. **What are your major job responsibilities? (CODE ALL THAT APPLY)**

   - 01 Administrative
   - 02 Fund-raising
   - 03 Clinical/direct services to victims/offenders
   - 04 Supervision of employees
   - 05 Coordination with other programs
   - 06 Public relations
   - 07 Other (specify)_____
   - 08 Other (specify)_____

4. **How long have you worked in your present position?**

   ___ ___ yrs. [RANGE 0-50] ___ ___ mths. [RANGE 0-11]

5. **How long have you worked for this program/agency?**

   ___ ___ yrs. [RANGE 0-50] ___ ___ mths. [RANGE 0-11]

6. **How long have you worked in domestic violence or a related field?**

   ___ ___ yrs. [RANGE 0-50] ___ ___ mths. [RANGE 0-11]

7. **WHAT IS RESPONDENT'S GENDER?**

   - 01 Male
   - 02 Female

8. **What is your age?** _____ **yrs. [RANGE 18-70]**

9. **Which of the following best describes your race?**

01	Alaskan Native
02	American Indian
03	Asian or Pacific Islander
04	Black, not of Hispanic origin
05	Hispanic
06	White, not of Hispanic origin
07	Other (specify) _____

10. **What is the highest level of education you have completed?**

01	High school
02	Some college
03	College degree
04	Some postgraduate work
05	Master's degree (M.S., M.A., M.Ed., etc.)
06	Doctoral or doctorate degree (M.D., Ph.D., Psy.D., etc.)

Organization Information

Now I have a few questions about your domestic violence program.

NOTE: IF INFORMATION IS ALREADY FILLED IN, VERIFY IT, OTHERWISE ASK FOR THE AGENCY/PROGRAM NAME, ADDRESS AND PHONE NUMBER.

11. Name of agency/program: _____

12. Address: (street/avenue) _____

_____

(city, state, zip) _____

(county) _____

(phone number) _____

13. Is this agency/program:

01 Public,
02 Private—not for profit,
03 Private—for profit, or
04 Something else (specify)

_____

14. How long has this agency/program been in operation?

_____ **yrs. [RANGE 0-70]** _____ **mths. [RANGE 0-11]**

15. Does the program provide/offer:
CODE ALL THAT APPLY.

01 Victim support, assistance or counseling (individual or group)
02 Shelter services
03 Child services
04 Legal advocacy for victims
05 Batterer programming
06 Something else (specify)

_____

The following set of questions asks about your domestic violence program's total operating budget, sources of the operating budget, number of employees, staff's educational degrees, number of victims and offenders served per year and their demographics (gender, race, age and income). Your best estimate is okay. Do you have this information available?

01 **Yes [SKIP TO Q16]**
02 **No**

We will skip those questions for now and continue with the interview. When we finish, I will fax the questions to you so you can collect the information needed; we will call back in a day or two to get your answers.

Budget, Personnel, and Service Volume Information

16. What is the agency's/program's total operating budget for the current year?

19 __ (year) [RANGE 96-97] **$_____ (dollar amount) [RANGE 0-90 MILLION]**

NOTE: IF BUDGET IS IN THE MILLIONS, AT LEAST 7 DIGITS ARE REQUIRED.

17. What percentage of the total operating budget comes from each of the following sources? Your best estimate is okay, but the total must equal 100%.

IF RESPONDENT CANNOT BREAK OUT RESOURCES INTO THE CATEGORIES LISTED BELOW, SPECIFY THEIR CATEGORY/ CATEGORIES, ALONG WITH THEIR PERCENTAGE, UNDER OTHER.

Federal government funds	_____ %
State government funds	_____ %
County government funds	_____ %
Other local government funds	_____ %
Private foundations/agencies	_____ %
Private donations	_____ %
Client fees (including reimbursement from private insurance)	_____ %
Other (specify) _____	_____ %
Total	**100** %

[ERROR MESSAGE IF Q17 DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

18. How many of your employees (including contract employees) are: (FILL IN ALL THAT APPLY)

a: Full-time (more than or equal to 35 hours per week) ... ___ [RANGE 0-500]

b: Part-time (less than 35 hours week) ..... ___ [RANGE 0-500. IF 0, SKIP 18c AND DELETE IT FROM SCREEN]

c: How many full-time equivalent (FTE) positions do these part-time employees represent? (include fractions as decimals) ..... ___.___
[RANGE 0-500]

d: Others (including volunteers and students) ..... ___
[RANGE 0-500]

19. How many members of your staff have the following educational degrees?

a. Bachelor's degree [RANGE 0-250] ..... _____

b. Master's degree [RANGE 0-250] ..... _____

c. Ph.D., Psych. D., etc. [RANGE 0-250] ..... _____

d. M.D. [RANGE 0-250] ..... _____

e. Other (specify) [RANGE 0-250. IF 0, SKIP SPECIFY AND GO TO Q20] ..... _____

What other degrees does your staff have?

_____

20. Approximately how many domestic violence victims and offenders does your agency/program serve a year?

_____ [RANGE 1-9999]

21. Of the victims and offenders your agency/program serves in a year, approximately what percentage are...?

01 Adult victims ..... _____%
02 Batterers ..... _____%
03 Children ..... _____%
04 Other ..... _____%

[IF 0, SKIP SPECIFY AND GO TO Q23]

SPECIFY_____

Total: ..... 100 %

[ERROR MESSAGE IF Q21 DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

[IF A2=NO, DK, RE, SKIP TO Q22a. ELSE, CONTINUE]

22. What percentage of the domestic violence victims you serve are overnight shelter residents?

_____%

[IF A1b=NO, DK, RE, SKIP TO Q23. ELSE, CONTINUE]

22a. Approximately what percentage of the domestic violence offenders you serve are. . . ?

01 Court ordered ..... _____ %
02 Voluntary ..... _____ %

Total: 100 %

[ERROR MESSAGE IF Q22a DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

23. Approximately what percentage of the domestic violence victims and offenders you serve are. . . ?

01 Male ..... _____ %
02 Female ..... _____ %

Total: 100 %

[ERROR MESSAGE IF Q23 DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

24. Approximately what percentage of the domestic violence victims and offenders you serve are. . . ?

01 Alaskan Native ..... _____ %
02 American Indian ..... _____ %
03 Asian or Pacific Islander ..... _____ %
04 Black, not of Hispanic origin .. _____ %
05 Hispanic ..... _____ %
06 White, not of Hispanic origin . _____ %

Total: ..... 100 %

(We recognize that some of your clients may be of mixed backgrounds. When this is the case, please classify them by the racial/ethnic group they most identify with.)

[ERROR MESSAGE IF Q24 DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

25. **Approximately what percentage of the domestic violence victims and offenders you serve fall within the following age ranges?**

IF RESPONDENT CANNOT BREAK OUT AGES INTO THE CATEGORIES LISTED BELOW, SPECIFY THEIR CATEGORY/CATEGORIES, ALONG WITH THEIR PERCENTAGE, UNDER OTHER.

01	17 years of age or younger	_____ %	
02	18-25	_____ %	
03	26-34	_____ %	
04	35-44	_____ %	
05	45 or older	_____ %	
06	Other (specify)	_____ %	[IF 0, SKIP SPECIFY AND GO TO Q26]

SPECIFY _____

Total: 100 %

[ERROR MESSAGE IF Q25 DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

26. **Approximately, what percentage of the domestic violence victims and offenders you serve fall within the following income categories?**

IF RESPONDENT CANNOT BREAK OUT INCOME LEVELS INTO THE CATEGORIES LISTED BELOW, SPECIFY THEIR CATEGORY/CATEGORIES, ALONG WITH THEIR PERCENTAGE, UNDER OTHER.

01	Below poverty level - $5000 or less per year	_____%	
02	Low income - $5001 - $15000 per year	_____%	
03	Middle income - $15001 - $35000 per year ..	_____%	
04	High income - $35001 or more per year	_____%	
05	Other (specify)	_____%	[IF 0, SKIP SPECIFY AND GO TO Q27]

SPECIFY _____

Total: 100%

[ERROR MESSAGE IF Q26 DOES NOT = 100%:

INVALID: TOTAL % NOT EQUAL TO 100%]

Services Offered

27. What types of *networking* does this agency/program offer? (CODE ALL THAT APPLY)

01 Hotline/crisis intervention
02 Information about other agencies
03 Referrals to other agencies
04 Transportation
05 Legal advocacy/advice
06 Any other services (specify)

SPECIFY_____

[IF A2=NO, DK, RE, SKIP TO Q34. ELSE, CONTINUE]

31. You mentioned earlier that you provide shelter services for domestic violence victims. Are there reasons why someone may be excluded from overnight shelter services?

01 Yes
02 No [SKIP TO Q32]

31.a. What reasons may cause domestic violence victims to be excluded from overnight shelter services? (CODE ALL THAT APPLY)

01 Psychiatric problems
02 Drug or alcohol use
03 Physical health problems
04 Other (specify)

SPECIFY_____

32. What is the average length of *overnight shelter* stay at your agency/program per domestic violence victim?

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q33]

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

32a. ENTER TIME FRAME:

01 Days
02 Weeks
03 Months
04 Years

33. What is the preferred or designated length of *overnight shelter* stay?

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q34]

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

33a. ENTER TIME FRAME:

01 Days
02 Weeks
03 Months
04 Years

[IF A1a=NO, DK, RE, SKIP TO 34e. ELSE, CONTINUE]

34. What is the average length of *nonresidential* involvement at your agency per domestic violence victim?

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q34b]

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

34a. ENTER TIME FRAME:

01 Hours/appointments/sessions
02 Days
03 Weeks
04 Months
05 Years

34b. What is the preferred or designated length of *nonresidential* involvement at your agency per domestic violence victim?

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q34e]

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

34c. ENTER TIME FRAME:

01 Hours/appointments/sessions
02 Days
03 Weeks
04 Months
05 Years

[IF A1b=NO, DK, RE, SKIP TO Q35. ELSE, CONTINUE]

34e. What is the average length of *nonresidential* involvement at your agency per domestic violence offender?

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q34g]

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

34f. ENTER TIME FRAME:

01 Hours/appointments/sessions
02 Days
03 Weeks
04 Months
05 Years

34g. What is the preferred or designated length of *nonresidential* involvement at your agency per domestic violence offender?

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35]

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

34h. ENTER TIME FRAME:

01 Hours/appointments/sessions
02 Days
03 Weeks
04 Months
05 Years

[IF A1a=NO, DK, RE, SKIP TO Q35g. ELSE, CONTINUE]

35. For the domestic violence victims you serve, what is the frequency of counseling services for:

a1. Individual counseling

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35b1]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

a2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

b1. Group counseling

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35c1]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

b2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

c1. Women and children counseling

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35d1]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

c2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

d1. Educational counseling

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35e1]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

d2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

f1. Any other counseling services (specify)

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35g]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

f2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

SPECIFY_____

[IF A1b = NO, DK, RE, SKIP TO Q36. ELSE, CONTINUE]

35g. For the domestic violence offenders you serve, what is the frequency of counseling services for:

g1. Individual counseling

_____ **[ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35h1]**

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

g2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

h1. Group counseling

_____ **[ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35i1]**

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

h2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

i1. Couples counseling

_____ **[ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35j1]**

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

i2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

j1. Educational counseling

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q35k1]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

j2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

k1. Any other counseling services (specify)

_____ [ALLOW RANGE OF 0-90,99. IF 0,99, DK OR RE, SKIP TO Q36]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

k2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

SPECIFY_____

Service Linkage Information

[IF A1a=NO, DK, RE, SKIP TO Q43. ELSE, CONTINUE]

36. The next questions are about the domestic violence victims you serve. Does this agency/program regularly screen domestic violence victims for substance abuse problems?

01 Yes
02 No (SKIP TO Q.39)

37. Do you use standard procedures to screen domestic violence victims for substance abuse problems?

01 Yes
02 No

38. In your opinion, how reliable are your procedures for identifying domestic violence victims who have substance abuse problems?

01 Very reliable
02 Moderately reliable
03 Not reliable

39. What percentage of the domestic violence victims you serve would you estimate have substance abuse problems?

_____%

40. Do you provide substance abuse services to domestic violence victims?

01 Yes (SKIP TO Q.42A)
02 No

41. **Why doesn't this agency/program provide substance abuse services for domestic violence victims? (CODE ALL THAT APPLY)**

01 Lack of expertise in substance abuse
02 Limited staff resources
03 Limited financial resources
04 These services are better provided independent of domestic violence programs
05 Not part of agency/program mission
06 No need for such services
07 Some other reason (please specify)

SPECIFY_____

[IF Q41=03, CONTINUE. ELSE, GO TO Q43]

42. **If more resources were available, would you provide substance abuse services for domestic violence victims?**

01 Yes
02 No [GO TO Q43]

NOTE: 'RESOURCES' MAY INCLUDE MONEY, TRAINING, MORE STAFF, ETC.

42a. **[IF Q40=YES] What substance abuse services do you provide for domestic violence victims?**

[IF Q40=NO, DK, RE] What substance abuse services would be provided for domestic violence victims?
(CODE ALL THAT APPLY)

01 On-site detoxification
02 On-site counseling
03 On-site case management
04 Referral under formal arrangements
05 Referral to AA/NA
06 Short term residential treatment (on-site)
07 On-site drug testing
08 Other (please specify)

SPECIFY_____

[IF A1b=NO, DK, RE, SKIP TO Q50. ELSE, CONTINUE]

43. **These next questions are about the domestic violence offenders you serve. Does this agency/program regularly screen domestic violence offenders for substance abuse problems?**

01 Yes
02 No (SKIP TO Q46)

44. **Do you use standard procedures to screen domestic violence offenders for substance abuse problems?**

01 Yes
02 No

45. **In your opinion, how reliable are your procedures for identifying domestic violence offenders who have substance abuse problems?**

01 Very reliable
02 Moderately reliable
03 Not reliable

46. **What percentage of the domestic violence offenders you serve would you estimate have substance abuse problems?**

_____%

47. **Do you provide substance abuse services to domestic violence offenders?**

01 Yes [GO TO Q49a]
02 No

48. **Why doesn't this agency/program provide substance abuse services for domestic violence offenders?**
(CODE ALL THAT APPLY)

01 Lack of expertise in substance abuse
02 Limited staff resources
03 Limited financial resources
04 These services are better provided independent of domestic violence programs
05 Not part of agency program/mission
06 No need for such services
07 Some other reason (please specify)

SPECIFY_____

[IF Q48=03, CONTINUE. ELSE, GO TO Q50]

49. **If more resources were available, would you provide substance abuse services for domestic violence offenders?**

01 Yes
02 No [GO TO Q50]

NOTE: 'RESOURCES' MAY INCLUDE MONEY, TRAINING, MORE STAFF, ETC.

49a. **[IF Q47=YES] What substance abuse services do you provide to domestic violence offenders?**

[IF Q47=NO, DK, RE] What substance abuse services would be provided to domestic violence offenders?
(CODE ALL THAT APPLY)

01	**On-site detoxification**
02	**On-site counseling**
03	**On-site case management**
04	**Referral under formal arrangements**
05	**Referral to AA/NA**
06	**Short term residential treatment (on-site)**
07	**On-site drug testing**
08	**Other (please specify)**

SPECIFY_____

50a. **Does your program have one or more certified substance abuse counselors on staff?**

01	**Yes**
02	**No**

b. **Does your program contract with an outside substance abuse counselor to provide services to the domestic violence victims and offenders you serve?**

01	**Yes**
02	**No [GO TO 50d]**

c1. **How often do you use this counselor?**

_____ **[ALLOW RANGE OF 1-90,99. IF 99, DK OR RE, SKIP TO Q50d]**

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

c2. **ENTER TIME FRAME:**

01	**Per day**
02	**Per week**
03	**Per month**
04	**Per year**

d. **Does your program have formal arrangements with other programs/agencies to refer the domestic violence victims and offenders you serve who need substance abuse services?**

01 Yes
02 No [GO TO Q50f]

e1. **How often do you refer the domestic violence victims and offenders you serve to these programs/agencies?**

_____ [ALLOW RANGE OF 1-90,99. IF 99, DK OR RE, SKIP TO Q50f]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

e2. **ENTER TIME FRAME:**

01 Per day
02 Per week
03 Per month
04 Per year

f. **Does your program have informal arrangements with other programs/agencies to refer the domestic violence victims and offenders you serve who need substance abuse services?**

01 Yes
02 No [GO TO Q51]

g1. **How often do you refer the domestic violence victims and offenders you serve to these programs/agencies?**

_____ [ALLOW RANGE OF 1-90,99. IF 99, DK OR RE, SKIP TO Q51]

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

g2. **ENTER TIME FRAME:**

01 Per day
02 Per week
03 Per month
04 Per year

Barriers to Service Linkage

51. Have you ever had any relationships with substance abuse programs?

01 Yes
02 No

51a. Do you currently have any relationships with substance abuse programs?

01 Yes
02 No

52. [IF Q51 OR Q51a = YES] Based on your program's experiences to date, would you like to continue working with substance abuse programs to develop more integrated services for substance-abusing battered women?

[IF Q51 AND Q51a = NO, DK, RE] Would you like to begin a dialogue with the people in your county who provide substance abuse services about working together to develop integrated services for substance-abusing battered women?

01 Yes
02 No [GO TO Q54]

[IF Q51 OR Q51a = YES, GO TO Q54]

53. Do you have any concerns about entering into a dialogue with people offering substance abuse services in your county?

01 Yes
02 No [GO TO Q54]

53a. What are your concerns?

54. **[IF Q51 OR Q51a = YES] What problems, if any, made it difficult for you to work with substance abuse programs?**

[IF Q51 AND Q51a = NO, DK, RE] What problems, if any, would you expect might make it difficult for you to work with substance abuse programs? (CODE ALL THAT APPLY)

01 Differences in treatment philosophy
02 Lack of domestic violence treatment training
03 We do not know the substance abuse service system.
04 There is a lack of substance abuse service programs/services in this area.
05 Financial burdens/issues
06 Any other problems (specify)
SPECIFY _____
07 I would expect no problems/We had no problems.

The following questions are about your perceptions of the relationship between domestic violence and substance abuse.

55. **In your opinion, how often are cases of domestic violence linked to alcohol and drug use/abuse?**

01 A lot of the time
02 Some of the time
03 A little of the time
04 Not at all

56. **For each of the following, please indicate whether you strongly agree, agree, disagree, or strongly disagree:**

a. **Being a victim of violence increases chances of the victim developing an alcohol or drug problem, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

b. **Drinking/drug use increases the likelihood that some men will assault their partners, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

c. **Drinking/drug use increases the likelihood that some women will assault their partners, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

d. **When both partners are drinking or using drugs, the likelihood of violence between them is increased**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

e. **A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

f. **Drinking/drug use are sometimes used as an excuse by men for assaulting their partner**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

g. **Substance abuse treatment for the violent male partner can reduce the likelihood of future violence**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

h. **It is best if substance abuse treatment for a violent male partner takes place outside the family violence program.**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

h1. **Substance abuse treatment programs can effectively integrate programs for victims of domestic violence.**

01 **Strongly agree**
02 **Agree**
03 **Disagree**
04 **Strongly disagree**

i. **A woman's use of alcohol keeps her stuck in violent relationships.**

01 **Strongly agree**
02 **Agree**
03 **Disagree**
04 **Strongly disagree**

j. **Women use their male partners' drinking to stay in violent relationships.**

01 **Strongly agree**
02 **Agree**
03 **Disagree**
04 **Strongly disagree**

57. **For each of the following statements, please tell me whether you strongly agree, agree, disagree, or strongly disagree:**

a. **Substance abuse services for battered individuals are better provided someplace other than domestic violence programs, do you:**

01 **Strongly agree**
02 **Agree**
03 **Disagree**
04 **Strongly disagree**

b. **The philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other.**

01 **Strongly agree**
02 **Agree**
03 **Disagree**
04 **Strongly disagree**

c. **Given current State funding levels, domestic violence programs should not be expected to provide services that substance-abusing victims of domestic violence need**

01 **Strongly agree**
02 **Agree**
03 **Disagree**
04 **Strongly disagree**

d. **With an increase in State funding, domestic violence programs could be asked to provide services to substance-abusing battered women**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

[IF BUDGET INFORMATION = NO, GO TO FAXEND. ELSE, GO TO END]

e1. **As part of our study, we will be contacting and interviewing domestic violence programs that deal only with offenders or batterers.**

[IF A1b=YES AND A1a=NO, DK, RE AND A2=NO, DK, RE] Are there any other batterer programs in your area that we could contact?

[ELSE] Are there any batterer programs in your area that we could contact?

01 Yes
02 No [SKIP TO e2]

Program Name _____

Telephone Number _____

Address _____

_____

Contact Person (Program Director) _____

e2. **That is all the questions I have for you. Thank you very much for your time and assistance.**

If you have any questions about the survey, you may contact Dr. James J. Collins at 1-800-334-8571, extension 6452 or Dr. Wendy Visscher, from the Institutional Review Board, at 1-800-334-8571, extension 6028.

FAXEND: That is all the questions I have for you right now. I need to make an appointment to call back in a few days to collect the rest of the information.

INTERVIEWER: COLLECT THE FAX AND NAME AND PUT ON A PROBLEM SHEET.

[GO TO APPOINTMENT SCREEN]

Appendix B

Substance Abuse Program Directors' Questionnaire

Substance Abuse Program Directors' Introduction

Hello. My name is _____. I am calling from Research Triangle Institute in North Carolina. We are conducting a survey regarding substance abuse and domestic violence service linkage under a grant from the National Institute of Justice. Your agency has been randomly selected for this survey.

I need to speak with the agency director. Is he or she available?

01 Yes [CONTINUE]
02 No [GO TO APPT. SCREEN]

Hello. My name is _____. I am calling from Research Triangle Institute in North Carolina. We are conducting a survey of domestic violence and substance abuse program directors to determine how often domestic violence programs provide substance abuse services, and how often substance abuse programs provide services to domestic violence victims or offenders. The survey will ask for information about your program, it's characteristics, clients and resources. We will also ask some questions about your beliefs concerning the advisability and feasibility of linking domestic violence and substance abuse services, and how this might be done. The study is funded by the National Institute of Justice. The interview will take about 20 minutes.

Your agency has been randomly selected for this survey. Your participation is voluntary, and your participation will have no effect on any public funding your program may receive. You may refuse to answer any question. Your responses will be kept confidential and will not be individually reported or attributed to you. The survey results will not identify you or your program. At the end of data collection, a few programs may be asked to participate in a site visit. If you have any questions about the survey, you may contact Dr. James J. Collins at 1-800-334-8571, extension 6452 or Dr. Wendy Visscher, from the Institutional Review Board, at 1-800-334-8571, extension 6028.

If you are ready now, we can begin.

01 Yes [GO TO SCREENER]
02 No [GO TO APPT. SCREEN]

Note to programmer re: APPT. Screen: I would like a place on the appt screen to record the directors name (I would also like that info. when entered on appt. screen to fill Q.1.).

Substance Abuse Program Screener

First I have a few general questions to determine if your agency is eligible to participate.

A. Does your agency/program provide:

1.	**Residential alcoholism services (inpatient services)**	**Y**	**N**
2.	**Ambulatory alcoholism services (outpatient services)**	**Y**	**N**
3.	**Drug abuse services**	**Y**	**N**
4.	**Only detoxification services**	**Y**	**N**
5.	**Only methadone services**	**Y**	**N**
6.	**Services only to youth**	**Y**	**N**
7.	**Services only to public inebriates**	**Y**	**N**
8.	**Services only to HIV positive persons**	**Y**	**N**

B. Did your agency/program serve at least 100 clients in 1996? **Y** **N**

PROG. NOTE: ***IF A1 & A2 are both NO then the program is not eligible***
IF A4, A5, A6, A7, or A8 is YES then the program is not eligible
IF B is NO then the program is not eligible

IF ELIGIBLE: **GO TO QUESTIONNAIRE.**

IF NOT ELIGIBLE: **Based on your responses your agency is not eligible to participate in this survey. Thank you for your time. [TERMINATE INTERVIEW...CODE AS INELIGIBLE]**

Respondent Information

1. What is your name?: _____

2. What is your job title? _____

3. What are your major job responsibilities? (CHECK ALL THAT APPLY)

   01 Administrative
   02 Fund-raising
   03 Clinical/direct services to clients
   04 Supervision of employees
   05 Coordination with other programs
   06 Public relations
   07 Other (specify)_____
   _____
   08 other (specify) _____
   _____

4. How long have you worked in your present position?

   ___ ___ yrs. ___ ___ mths.

   (PROGRAMMER NOTE: allow a range of 0-50 years and 0-11 months)

5. How long have you worked for this program/agency?

   ___ ___ yrs. ___ ___ mths.

   (PROGRAMMER NOTE: allow a range of 0-50 years and 0-11 months)

6. How long have you worked in substance abuse treatment or a related field?

   ___ ___ yrs. ___ ___ mths.

   (PROGRAMMER NOTE: allow a range of 0-50 years and 0-11 months)

7. WHAT IS YOUR GENDER?

   01 Male
   02 Female

8. What is your age? _____

(PROGRAMMER NOTE: allow a range of 18 - 70 years)

9. Which of the following best describes your race?

01 Alaskan Native
02 American Indian
03 Asian or Pacific Islander
04 Black, not of Hispanic origin
05 Hispanic
06 White, not of Hispanic origin
07 Other, specify _____

10. What is the highest level of education you have completed?

01 High school
02 Some college
03 College degree
04 Some postgraduate work
05 Master's degree (M.S., M.A., M.Ed., etc.)
06 Doctoral or doctorate degree (M.D., Ph.D., Psy.D., etc.)

Organization Information

NOTE: IF QUESTION ALREADY FILLED IN, VERIFY, OTHERWISE ASK THE QUESTION.

11. Name of agency/program: _____

12. Address: (street/avenue) _____

_____

(city, state, zip) _____

(county) _____

(phone number) _____

13. Is this agency/program:

01 Public,
02 Private—not for profit,
03 Private—for profit, or
04 Something else (specify)

_____

14. How long has the program been in operation? ___ ___ yrs. ___ ___ mths.

(PROGRAMMER NOTE: allow for a range of 0-70 years and 0-11 months)

15. Is the program:

01 Outpatient,
02 Residential,
03 Hybrid residential and outpatient, or
04 Something else (specify)

_____

The following set of questions asks about your substance abuse program's total operating budget, sources of the operating budget, number of employees, staff's educational degrees, number of clients served per year and client demographics (gender, race, age and income). Your best estimate is okay. Do you have this information available?

01 Yes [SKIP TO NEXT SECTION]
02 No

We will skip those questions for now and continue with the interview. When we finish I will fax the questions to you so you can collect the information needed; we will call back in a day or two to get your answers.

INTERVIEWER: COLLECT THE FAX AND NAME AND PUT ON A PROBLEM SHEET

Budget, Personnel, and Service Volume Information

16. What is the agency's/program's total operating budget for the current year?

19 _____ (year) $_____ (dollar amount)

(PROGRAMMER NOTE: allow 96 or 97 as a range for year and 0-90 million as a range for dollar amount)

17. What percentage of the total operating budget comes from each of the following sources? Your best estimate is ok, but the total must equal 100%. IF RESPONDENT CAN NOT BREAK OUT RESOURCES INTO THE CATEGORIES LISTED BELOW, SPECIFY THEIR CATEGORY/ CATEGORIES, ALONG WITH THEIR PERCENTAGE, UNDER OTHER.

Federal government funds	_____ %
State government funds	_____ %
County government funds	_____ %
Other local government funds	_____ %
Private foundations/agencies	_____ %
Private donations	_____ %
Client fees (including reimbursement from private insurance)	_____ %
Other (specify) _____	_____ %
Total	**100** %

18. How many of your employees (including contract employees) are:

a: Full-time (more than or equal to 35 hours per week) .. ___
(PROGRAMMER NOTE: allow for a range of 0-500)

b: Part-time (less than 35 hours week) ..... ___
(PROGRAMMER NOTE: allow for a range of 0-500)
(PROGRAMMER NOTE: if 18.b.= 0 then skip 18.c and delete it from the screen.)

c: How many full-time equivalent (FTE) positions do these part-time employees represent? (include fractions as decimals) ..... ___.___

d: Others (including volunteers and students) ..... ___
(PROGRAMMER NOTE: allow for a range of 0-500)

19. How many members of your staff have the following educational degrees?

a. M.D. (PROGRAMMER NOTE: allow for a range of 0-250)

b. Ph.D., Psych.D., etc. (PROGRAMMER NOTE: allow for a range of 0-250)

c. Master's degree (PROGRAMMER NOTE: allow for a range of 0-250)

d. Bachelor's degree (PROGRAMMER NOTE: allow for a range of 0-250)

e. Other (specify) (PROGRAMMER NOTE: allow for a range of 0-250. If 0, skip specify and go to question 20).

20. Approximately how many substance abusing clients does your agency/program serve a year?

(PROGRAMMER NOTE: allow for a range of 1 - 9999)

21. Do you provide services to the spouse/partner of substance abusing client?

01 Yes
02 No (SKIP TO Q23) deleted

22. Approximately what percentage of your clientele are. . . ?

01 Court ordered ..... _____ %
02 Voluntary ..... _____ %

Total: 100 %

23. Approximately what percentage of your clientele is. . . ?

01	Male	_____ %
02	Female	_____ %

Total: 100 %

24. Approximately what percentage of your clientele is. . . ?

01	Alaskan Native	_____ %
02	American Indian	_____ %
03	Asian or Pacific Islander	_____ %
04	Black, not of Hispanic origin .	_____ %
05	Hispanic	_____ %
06	White, not of Hispanic origin .	_____ %

Total: 100 %

(We recognize that some of your clientele may be of mixed backgrounds. When this is the case, please classify them by the racial/ethnic group they most identify with.)

25. Approximately what percentage of your clientele fall within the following age ranges?
IF RESPONDENT CAN NOT BREAK OUT AGES INTO THE CATEGORIES LISTED BELOW, SPECIFY THEIR CATEGORY/CATEGORIES, ALONG WITH THEIR PERCENTAGE, UNDER OTHER.

01	17 years of age or younger	_____ %
02	18-25	_____ %
03	26-34	_____ %
04	35-44	_____ %
05	45 or older	_____ %
06	Other (specify)	_____ %

(ADD SPECIFY FIELD)_____

Total: 100 %

26. Approximately, what percentage of your clientele fall within the following income categories?

IF RESPONDENT CAN NOT BREAK OUT INCOME LEVELS INTO THE CATEGORIES LISTED BELOW, SPECIFY THEIR CATEGORY/CATEGORIES, ALONG WITH THEIR PERCENTAGE, UNDER OTHER.

WE ARE REFERRING TO THE CLIENTS' INCOME ONLY NOT THE FAMILY INCOME

01	Below poverty level — $5000 or less per year	_____%
02	Low income — $5001 - $15000 per year	_____%
03	Middle income — $15001-$35000 per year	_____%
04	High income above — $35001 or more per year	_____%
05	Other (specify)	_____%

(ADD SPECIFY FIELD)_____

Total: 100 %

(PROGRAMMER NOTE: total must equal 100%)

Services Offered

27. What types of services does this agency/program offer? (CHECK ALL THAT APPLY)

- 01 Individual drug/alcohol counseling
- 02 Group drug/alcohol counseling
- 03 Family counseling
- 04 Cognitive/behavioral counseling
- 05 Vocational/employment counseling
- 06 Aftercare
- 07 Children's services
- 08 Any other services (specify)
  (PROGRAMMER NOTE: allow for up to 80 characters)

28. What types of networking does this agency/program offer? (CHECK ALL THAT APPLY)

- 01 Hotline/crisis intervention
- 02 Information about other agencies
- 03 Referrals to other agencies
- 04 Transportation
- 05 Legal advocacy/advice
- 06 Any other services (specify)
  (PROGRAMMER NOTE: allow for up to 80 characters)

29. Does this agency/program offer residential services to women?

- 01 Yes
- 02 No

30. Does this agency/program offer residential services to men?

- 01 Yes
- 02 No

[IF 29 AND 30 = NO, SKIP TO 34. ELSE, CONTINUE]

31. Are there reasons why a client may be excluded from residential services?

- 01 Yes
- 02 No (SKIP TO Q.32)

31a. Please explain: (PROGRAMMER NOTE: please allow for 3 lines of 80 characters each)

32. What is the average length of *residential* stay at your agency/program per client?

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q33)

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

32a. ENTER TIME FRAME:

01 Days
02 Weeks
03 Months
04 Years

33. What is the preferred or designated length of *residential* stay?

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q34)

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

33a. ENTER TIME FRAME:

01 Days
02 Weeks
03 Months
04 Years

34. What is the average length of *nonresidential* involvement at your agency per client?

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q34b)

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

34a. ENTER TIME FRAME:

01 Hours/appointments/sessions
02 Days
03 Weeks
04 Months
05 Years

34b. What is the preferred or designated length of *nonresidential* involvement at your agency per client?

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q35)

IF RESPONDENT SAYS THERE ARE DIFFERENT LENGTHS FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

34c. ENTER TIME FRAME:

01 Hours/appointments/sessions
02 Days
03 Weeks
04 Months
05 Years

35. What is the frequency of counseling services for:

a.1. Individual counseling for alcohol/substance abuse

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q35b)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99.

a.2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

b.1. Group counseling

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q35c)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

b.2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

c.1. Family counseling for alcohol/substance abuse

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q35d)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

c.2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

d.1. Educational counseling

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q35e)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

d.2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

e.1. Any other counseling services (specify)

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q36)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

e.2. ENTER TIME FRAME:

01 Per day
02 Per week
03 Per month
04 Per year

Service Linkage Information

36. Does this agency/program regularly screen clients to determine if they are domestic violence victims?

01 Yes
02 No [SKIP TO Q39]

37. Do you use a standard form to screen for domestic violence victims?

01 Yes
02 No

38. In your opinion, how reliable are your procedures for identifying clients who are victims of domestic violence?

01 Very reliable
02 Moderately reliable
03 Not reliable

39. What percentage of your clients would you estimate are victims of domestic violence?

(PROGRAMMER NOTE: allow for a percentage of 0-100)

40. Do you provide domestic violence services to clients who are victims of domestic violence?

01 Yes (SKIP TO Q.42a)
02 No

41. Why doesn't this agency/program provide services for victims of domestic violence? CODE ALL THAT APPLY

01 Lack of expertise in domestic violence
02 Limited staff resources
03 Limited financial resources
04 These services are better provided independent of substance abuse programs
05 Not part of agency/program mission
06 No need for such services
07 Some other reason (please specify) (PROGRAMMER NOTE: please allow for 80 characters)

PROGRAMMER NOTE: Ask Q.42 ONLY IF answer category 03 is checked in Q.41

42. If more resources were available, would you provide domestic violence services for victims?

01 Yes
02 No (SKIP TO Q.43)

42a. (IF Q40 = YES) What services do you provide for domestic violence victims?

(IF Q40 = NO, DK, RE)What domestic violence victim services would be provided? (CODE ALL THAT APPLY)

01 In-house counseling (outpatient basis)
02 Case management
03 Referral to other agencies/programs
04 Shelter
05 Legal advocacy
06 Other (please specify) (PROGRAMMER NOTE: please allow for 80 characters)

43. Does this agency/program regularly screen clients to determine if they are domestic violence offenders?

01 Yes
02 No [SKIP TO Q46]

44. Do you use a standard form to screen for domestic violence offenders?

01 Yes
02 No

45. In your opinion, how reliable are your procedures for identifying clients who are domestic violence offenders?

01 Very reliable
02 Moderately reliable
03 Not reliable

46. What percentage of your clients would you estimate are domestic violence offenders?

(PROGRAMMER NOTE: allow for a percentage of 0-100)

47. **Do you provide domestic violence services to clients who are domestic violence offenders?**

01 Yes (SKIP TO Q.49a)
02 No

48. **Why doesn't this agency/program provide services for domestic violence offenders? (CODE ALL THAT APPLY)**

01 Lack of expertise in domestic violence
02 Limited staff resources
03 Limited financial resources
04 These services are better provided independent of substance abuse programs
05 Not part of agency/program mission
06 No need for such services
07 Some other reason (please specify) (PROGRAMMER NOTE: please allow for 80 characters)

PROGRAMMER NOTE: Ask Q.49 ONLY IF answer category 03 is checked in Q.48

49. **If more resources were available, would you provide domestic violence services for offenders?**

01 Yes
02 No (SKIP TO Q.50)

49a. **(IF Q47 = YES) What domestic violence offender services do you provide?**

(IF Q47 = NO, DK, RE)What domestic violence offender services would be provided?
(CODE ALL THAT APPLY)

01 In-house counseling (outpatient basis)
02 Case management
03 Referral to other agencies/programs
04 Other (please specify) (PROGRAMMER NOTE: please allow for 80 characters)

50. **Does your program:**

a. **have one or more trained domestic violence counselors on staff?**

01 Yes
02 No

b. **contract with an outside domestic violence counselor to provide services to your clients?**

01 **Yes**
02 **No (SKIP TO 50.d.)**

c.1. **How often do you use this counselor?**

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q50d)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

c.2. **ENTER TIME FRAME:**

01 **Per day**
02 **Per week**
03 **Per month**
04 **Per year**

d. **have formal arrangements with other programs/agencies to refer your clients who need domestic violence services?**

01 **Yes**
02 **No (SKIP TO 50.f.)**

e.1. **How often do you refer clients to these programs/agencies?**

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q50f)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

e.2. **ENTER TIME FRAME:**

01 **Per day**
02 **Per week**
03 **Per month**
04 **Per year**

f. **have informal arrangements with other programs/agencies to refer your clients who need domestic violence services?**

01 **Yes**
02 **No (SKIP TO 51)**

g.1. **How often to you refer clients to these programs/agencies?**

_____ (ALLOW RANGE OF 0-90, 99. IF 0 OR 99, SKIP TO Q51)

IF RESPONDENT SAYS THERE ARE DIFFERENT FREQUENCIES FOR DIFFERENT SITUATIONS/CLIENTS, ASK THEM TO AVERAGE THEM.

IF RESPONDENT SAYS 'IT VARIES/DEPENDS' ENTER 99

g.2. **ENTER TIME FRAME:**

01 **Per day**
02 **Per week**
03 **Per month**
04 **Per year**

Barriers to Service Linkage

51. Have you ever had any relationships with domestic violence programs?

01 Yes
02 No

51a. Do you currently have any relationships with domestic violence programs?

01 Yes
02 No

52. (IF Q51 OR Q51a = YES) Based on your program's experiences to date, would you like to continue working with domestic violence programs to develop more integrated services for substance-abusing battered women?

(IF Q51 AND Q51a = NO, DK, RE)Would you like to begin a dialogue with the people in your county who provide domestic violence services about working together to develop integrated services for substance-abusing battered women?

01 Yes
02 No (SKIP TO Q.54)

[IF Q51 OR Q51a = YES, SKIP TO Q54]

53. Do you have any concerns about entering into a dialogue with people offering domestic violence services in your county?

01 Yes
02 No (SKIP TO Q.54)

53a. What are your concerns?
(PROGRAMMER NOTE: allow for 5 lines of 80 characters each)

54. **(IF Q51 OR Q51a = YES) What problems, if any, made it difficult for you to cooperate with domestic violence programs?**

(IF Q51 AND Q51a = NO, DK, RE)What problems, if any, would you expect might make it difficult for you to cooperate with domestic violence programs? (CODE ALL THAT APPLY)

01 Differences in treatment philosophy
02 Lack of substance abuse treatment training
03 We do not know the domestic violence service system
04 There is a lack of domestic violence service programs/services in this area.
05 Difficulty in arranging for reimbursement
06 Any other problems (specify)
(PROGRAMMER NOTE: allow for 2 lines of 80 characters each)
07 I would expect no problems/ We had no problems.

The following questions are about your perceptions of the relationship between domestic violence and substance abuse.

55. **In your opinion, how often are cases of domestic violence linked to alcohol and drug use/abuse?**

01 A lot of the time
02 Some of the time
03 A little of the time
04 Not at all

56. **For each of the following, please indicate whether you strongly agree, agree, disagree, or strongly disagree:**

a. **Being a victim of violence increases chances of the victim developing an alcohol or drug problem, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

b. **Drinking/drug use increases the likelihood that some men will assault their partners, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

c. **Drinking/drug use increases the likelihood that some women will assault their partners, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

d. **When both partners are drinking or using drugs, the likelihood of violence between them is increased**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

e. **A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

f. **Drinking/drug use is sometimes used as an excuse by men for assaulting their partner**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

g. **Substance abuse treatment for the violent male partner can reduce the likelihood of future violence**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

h. **Substance abuse treatment programs can effectively integrate programs for victims of domestic violence**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

i. **A woman's use of alcohol keeps her stuck in violent relationships.**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

j. **Women use their male partners' drinking to stay in violent relationships.**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

57. **For each of the following statements, please tell me whether you strongly agree, agree, disagree, or strongly disagree:**

a. **Domestic violence services for substance abusers are better provided someplace other than substance abuse programs, do you:**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

b. **The philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other.**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

c. **Given current State funding levels, substance abuse programs should not be expected to provide services that substance-abusing victims of domestic violence need**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

d. **With an increase in State funding, substance abuse programs could be asked to provide services to substance-abusing battered women**

01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

58. **To date, has managed care or restrictions on insurance coverage affected your program or its operation in any way (e.g., client recruitment, changes in length of stay, treatment approach)?**

01 Yes
02 No (SKIP TO Q.59)

58a. **Could you briefly describe the effects?**
(PROGRAMMER NOTE: allow for 4 lines of 80 characters)

59. **Over the coming year, do you expect managed care or restrictions on insurance coverage to affect your program operations in any way?**

01 Yes
02 No (SKIP TO Q.60)

59a. **Briefly describe the effects you anticipate.**
(PROGRAMMER NOTE: allow for 4 lines of 80 characters)

60. **Are any of the services currently received at your agency reimbursable through managed care or other insurance coverage?**

01 Yes
02 No

61. **Do you anticipate that linked substance abuse and domestic violence services would pose an obstacle to reimbursement under managed care or restrictions on insurance coverage?**

01 Yes
02 No [IF BUDGET INFORMATION = NO, GO TO FAXEND. ELSE, GO TO END]

61a. Briefly describe the outcomes managed care or restrictions on insurance coverage would have on the provision of linked domestic violence and substance abuse treatment services at your agency.

(PROGRAMMER NOTE: allow for 4 lines of 8 characters)

[IF BUDGET INFORMATION = NO, GO TO FAXEND. ELSE, GO TO END]

END: **That is all the questions I have for you. Thank you for your time and assistance.**

FAXEND: **That is all the questions I have for you right now. I need to make an appointment to call back in a few days to collect the rest of the information.**

INTERVIEWER: COLLECT THE FAX AND NAME AND PUT ON A PROBLEM SHEET

[GO TO APPOINTMENT SCREEN]

Appendix C

Logistic Regression Results

Table C.1 Substance Abuse Services for Victims in Domestic Violence Programs (Odds Ratios)

Explanatory Variables	Screens Victim Clients for Substance Abuse Problems (*n*=424)	Provides Substance Abuse Services to Victim Clients (*n*=427)	Has Certified Substance Abuse Counselor on Staff (*n*=425)	Contracts with Outside Substance Abuse Counselor (*n*=427)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=426)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=426)
Director and Program Characteristics						
Male	.958	1.570	3.107*	.703	1.037	.783
Tenure in field (years)	1.016	1.054*	1.040*	1.028*	1.034*	.975*
Graduate school	.789	1.026	1.350*	.620*	1.052	1.072
# of full-time employees	1.027*	.999	1.000	.965*	1.011	1.003
Provides shelter services	2.055*	1.111	.627*	1.219	1.947*	1.007
Directors' Attitudes About Service Linkage						
% of victim clients with substance abuse problems	1.017*	1.017*	1.003	1.017*	1.010*	1.006
Substance abuse services for battered individuals are better provided someplace other than domestic violence programs	.926	.711*	.751*	.736	.987	1.116
Substance abuse treatment programs can effectively integrate programs for domestic violence victims	.830	1.265	.882	1.173	1.392*	.944
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	.829	1.202	.965	.772	1.051	1.087
Given current State funding, domestic violence programs should not be expected to provide services that substance-abusing domestic violence victims need	.835	.569*	.512*	1.195	.771	1.683*
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time						
Being a victim of violence increases chances of the victim developing an alcohol or drug problem	.913	1.058	.915	1.015	.583*	1.268
Drinking/drug use increases likelihood that women will assault their partners	1.217	1.173	1.012	1.406	.920	.835
When both partners are drinking or using drugs, the likelihood of violence between them is increased	1.675*	.672	1.551	.674	2.420*	.736
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner	.969	1.038	1.136	1.169	1.102	1.170
A woman's use of alcohol keeps her stuck in violent relationships	1.383*	1.141	1.572*	.780	.691*	1.832*

* Significant at the .05 level.

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

Table C.2 Reasons Why Domestic Violence Programs Do Not Provide Substance Abuse Services to Victims (Odds Ratios)

Explanatory Variables	Reasons for Not Providing Substance Abuse Services to Victims				
	Lack of Expertise in Substance Abuse (*n*=313)	Limited Staff Resources (*n*=313)	Limited Financial Resources (*n*=313)	Substance Abuse Services Are Better Provided Independent of Domestic Violence Programs (*n*=313)	Not Part of Agency/ Program Mission (*n*=313)
Director and Program Characteristics					
Male	.176*	.449*	.603	.533	1.917
Tenure in field (years)	.949*	1.017	1.036*	.979	.983
Graduate school	.868	.811	.842	.581*	1.054
# of full-time employees	1.011	1.006	.965*	1.000	.993
Provides shelter services	1.103	1.711*	2.019*	1.392	.959
Directors' Attitudes About Service Linkage					
% of victim clients with substance abuse problems	.994	.994	1.002	.990*	.996
Substance abuse services for battered individuals are better provided someplace other than domestic violence programs	.959	.849	.655*	4.991*	1.808
Substance abuse treatment programs can effectively integrate programs for domestic violence victims	1.523*	1.662*	1.180	.585*	1.116
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	1.287	.715*	.809	1.399*	1.282
Given current State funding, domestic violence programs should not be expected to provide services that substance-abusing domestic violence victims need	1.047	1.859*	2.033*	.760	1.288
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time					
Being a victim of violence increases chances of the victim developing an alcohol or drug problem	1.020	1.238	1.142	.463*	.788
Drinking/drug use increases likelihood that women will assault their partners	1.424*	.991	1.376	1.122	.968
When both partners are drinking or using drugs, the likelihood of violence between them is increased	.851	.722	.920	2.085*	1.803*
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner	.848	.616*	.694*	1.368	1.190
A woman's use of alcohol keeps her stuck in violent relationships	1.786*	1.580*	1.314	.917	.866

* Significant at the .05 level.

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

Table C.3 Substance Abuse Services for Offenders in Domestic Violence Programs (Odds Ratios)

Explanatory Variables	Screens Offender Clients for Substance Abuse Problems (*n*=146)	Provides Substance Abuse Services to Offender Clients (*n*=148)	Has Certified Substance Abuse Counselor on Staff (*n*=149)	Contracts with Outside Substance Abuse Counselor (*n*=149)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=148)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Substance Abuse Services (*n*=149)
Director and Program Characteristics						
Male	5.021*	13.442*	1.344	1.019	.677	.414*
Tenure in field (years)	.951*	.998	1.061*	1.010	1.061*	1.048
Graduate school	1.110	.437*	.778	.592	.539*	1.509
# of full-time employees	1.043*	1.009	1.052*	.986	1.024*	.975
Directors' Attitudes About Service Linkage						
% of offender clients with substance abuse problems	1.010	.996	.989*	.999	1.004	.994
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	1.921*	.468*	1.402	.577	.816	.578
It is best if substance abuse treatment for a violent male partner takes place outside the family violence program	.870	.928	.680	1.433	1.775*	1.914
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time						
Drinking/drug use increases the likelihood that some men will assault their partners	1.679	1.342	.875	1.499	.497*	1.191
When both partners are drinking or using drugs, the likelihood of violence between them is increased	.242*	.907	3.061*	.207*	1.818	2.758
Drinking/drug use are sometimes used as an excuse by men assaulting their partner						
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence	1.669	1.778	1.971*	1.323	1.705*	.330*
Women use their male partners' drinking to stay in violent relationships	.552*	4.687*	1.188	.758	.949	1.911

* Significant at the .05 level.

= Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

Table C.4 Reasons Why Domestic Violence Programs Do Not Provide Substance Abuse Services to Domestic Violence Offenders (Odds Ratios)

Explanatory Variables	Reasons for Not Providing Substance Abuse Services to Offenders				
	Lack of Expertise in Substance Abuse (n=118)	Limited Staff Resources (n=118)	Limited Financial Resources (n=118)	Substance Abuse Services Are Better Provided Independent of Domestic Violence Programs (n=118)	Not Part of Agency/ Program Mission (n=118)
Director and Program Characteristics					
Male	.446	.378*	2.382	.566	2.113
Tenure in field (years)	.961*	1.014	1.012	.976	.954*
Graduate school	.709	.634	.296*	.743	1.724
# of full-time employees	.987	.990	1.004	1.014	1.006
Directors' Attitudes About Service Linkage					
% of offender clients with substance abuse problems	1.023*	1.017*	1.033*	1.004	1.014*
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	.836	1.371	1.021	1.088	1.087
It is best if substance abuse treatment for a violent male partner takes place outside the family violence program	.712	1.201	.348*	3.957*	2.514*
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time					
Drinking/drug use increases the likelihood that some men will assault their partners	1.014	.805	.479	1.052	1.096
When both partners are drinking or using drugs, the likelihood of violence between them is increased	.683	3.059*	3.063*	.649	.559
Drinking/drug use are sometimes used as an excuse by men assaulting their partner					
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence	1.490	1.777*	2.133*	.853	1.004
Women use their male partners' drinking to stay in violent relationships	.986	1.080	.863	1.022	.770

* Significant at the .05 level.

= Unable to include variable in model because of insufficient variation i n response (i.e., had at least one response category with 5% or fewer cases).

Table C.5 Domestic Violence Services for Victims in Substance Abuse Programs (Odds Ratios)

Explanatory Variables	Screens Clients for Domestic Violence Victimization (*n*=564)	Provides Domestic Violence Services to Victim Clients (*n*=561)	Has Trained Domestic Violence Counselor on Staff (*n*=560)	Contracts with Outside Domestic Violence Counselor (*n*=563)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=562)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=560)
Director and Program Characteristics						
Male	1.130	.791*	.998	.463*	.956	.997
Tenure in field (years)	1.020*	1.027*	1.016*	1.003	1.018*	.998
Graduate school	1.530*	1.249*	.800*	.455*	1.113	1.372*
# of full-time employees	.999	1.002*	1.005*	.995*	1.002*	.998*
Provides residential services	.803*	.992	1.084	1.189*	1.630*	1.006
Directors' Attitudes About Service Linkage						
% of clients who are domestic violence victims	1.018*	1.015*	1.005*	1.007*	1.001	1.002
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs	.958	.678*	.500*	1.068	1.022	1.373*
Substance abuse treatment programs can effectively integrate programs for domestic violence victims						
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	.922	.826*	1.295*	1.503*	1.170*	.685*
Given current State funding, substance abuse programs should not be expected to provide services that substance-abusing domestic violence victims need	.639*	.575*	.625*	.826*	.837*	.979
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time						
Being a victim of violence increases chances of the victim developing an alcohol or drug problem	1.131	1.858*	1.296*	.734*	.906	1.674*
Drinking/drug use increases likelihood that women will assault their partners						
When both partners are drinking or using drugs, the likelihood of violence between them is increased						
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner	.891	.986	.958	2.334*	1.851*	.987
A woman's use of alcohol keeps her stuck in violent relationships	1.453*	1.078	.527*	.714*	.777*	.753*

* Significant at the .05 level.

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

Table C.6 Reasons Why Substance Abuse Programs Do Not Provide Domestic Violence Services to Victims (Odds Ratios)

Explanatory Variables	Reasons for Not Providing Domestic violence Services to Victims				
	Lack of Expertise in Domestic Violence (*n*=259)	Limited Staff Resources (*n*=259)	Limited Financial Resources (*n*=259)	Domestic Violence Services Are Better Provided Independent of Substance Abuse Programs (*n*=259)	No Need for Such Services (*n*=259)
Director and Program Characteristics					
Male	1.583*	1.479*	1.259*	1.104	1.154
Tenure in field (years)	.954*	.983*	.991	.989	.951*
Graduate school	.595*	.759*	.793*	.749*	1.005
# of full-time employees	1.000	.993*	.996*	.998	.992*
Provides residential services	.783*	1.239*	1.218*	1.767*	1.015
Directors' Attitudes About Service Linkage					
% of clients who are domestic violence victims	.992*	1.006*	1.009*	.995*	.993*
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs	1.187	.609*	.405*	2.097*	2.137*
Substance abuse treatment programs can effectively integrate programs for domestic violence victims					
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	1.015	.761*	1.141	.788*	1.201
Given current State funding, substance abuse programs should not be expected to provide services that substance-abusing domestic violence victims need	.791*	.783*	1.276*	1.004	1.141
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time					
Being a victim of violence increases chances of the victim developing an alcohol or drug problem	1.257	1.306*	.899	.732*	.725*
Drinking/drug use increases likelihood that women will assault their partners					
When both partners are drinking or using drugs, the likelihood of violence between them is increased					
A woman who has been drinking or using drugs increases the chances that she will be assaulted by her partner	.641*	1.554*	2.213*	1.818*	1.304*
A woman's use of alcohol keeps her stuck in violent relationships	1.581*	2.260*	1.345*	.530*	.763*

* Significant at the .05 level.

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

Table C.7 Domestic Violence Services for Offenders in Substance Abuse Programs (Odds Ratios)

Explanatory Variables	Screens Clients for Domestic Violence Offending (*n*=574)	Provides Domestic Violence Services to Offender Clients (*n*=575)	Has Trained Domestic Violence Counselor on Staff (*n*=571)	Contracts with Outside Domestic Violence Counselor (*n*=574)	Has Formal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=573)	Has Informal Arrangements with Other Programs to Refer Clients in Need of Domestic Violence Services (*n*=571)
Director and Program Characteristics						
Male	1.022	1.271*	1.031	.458*	.972	.963
Tenure in field (years)	1.025*	1.033*	1.011*	1.002	1.014*	.999
Graduate school	.974	1.330*	.783*	.446*	1.022	1.389*
# of full-time employees	.998*	1.004*	1.006*	.995*	1.002*	.998*
Provides residential services	.985	.898	.967	1.397*	1.469*	1.015
Directors' Attitudes About Service Linkage						
% of clients who are domestic violence offenders	1.014*	1.024*	1.013*	.996	1.000	.999
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs	.749*	.471*	.500*	1.032	1.044	1.302*
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	.784*	.890	1.126	1.514*	1.088	.624*
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship						
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time						
Drinking/drug use increases the likelihood that some men will assault their partners						
When both partners are drinking or using drugs, the likelihood of violence between them is increased						
Drinking/drug use are sometimes used as an excuse by men assaulting their partner						
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence	.657*	1.333*	.537*	1.789*	1.068	.631*
Women use their male partners' drinking to stay in violent relationships	1.062	.825*	.790*	.950	.912	1.015

* Significant at the .05 level.

▥ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).

Table C.8 Reasons Why Substance Abuse Programs Do Not Provide Domestic Violence Services to Offenders (Odds Ratios)

Explanatory Variables	Reasons for Not Providing Domestic Violence Services to Offenders				
	Lack of Expertise in Domestic Violence (*n*=287)	Limited Staff Resources (*n*=287)	Limited Financial Resources (*n*=287)	Domestic Violence Services Are Better Provided Independent of Substance Abuse Programs (*n*=287)	No Need for Such Services (*n*=287)
Director and Program Characteristics					
Male	1.963*	1.174*	1.252*	1.897*	1.364*
Tenure in field (years)	1.007	.986*	.992	.893*	.976*
Graduate school	.738*	1.139	.998	.714*	1.182*
# of full-time employees	1.001	1.000	1.002	1.001	.995*
Provides residential services	1.050	.959	1.165	1.273*	.925
Directors' Attitudes About Service Linkage					
% of clients who are domestic violence offenders	.995	1.012*	1.015*	1.003	.994*
Domestic violence services for substance abusers are better provided someplace other than substance abuse programs	.778*	.735*	.513*	3.153*	2.063*
Philosophies of domestic violence programming and substance abuse treatment are inconsistent with each other	.702*	.846	1.062	.761*	1.067
Directors' Attitudes About Substance Abuse–Domestic Violence Relationship					
Cases of domestic violence linked to alcohol and drug use/abuse some or a lot of the time					
Drinking/drug use increases the likelihood that some men will assault their partners					
When both partners are drinking or using drugs, the likelihood of violence between them is increased					
Drinking/drug use are sometimes used as an excuse by men assaulting their partner					
Substance abuse treatment for the violent male partner can reduce the likelihood of future violence	1.091	1.042	.950	.508*	1.229
Women use their male partners' drinking to stay in violent relationships	1.192*	1.093	1.121	.652*	.844*

* Significant at the .05 level.

▨ = Unable to include variable in model because of insufficient variation in response (i.e., had at least one response category with 5% or fewer cases).