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Foreword

Since its launch in 2002 the Stella Project has worked emphatically to improve understanding and practice across the domestic violence and alcohol and drug sectors in London. The first edition of this unique toolkit was published in 2004 to address concerns about the lack of consistent thinking and response to these complex issues. It provided basic information, advice and sample documents for practitioners and service managers to enable them to respond to people using their services safely and appropriately.

When it was first published the toolkit was widely welcomed and demand for it has remained constant. Since then there has been increased awareness of the links between domestic violence and substance misuse and much progress in the development of collaborative and integrated service provision.

This progress is matched by a commitment across the sectors for continued improvements. I am pleased that the Stella Project has been able to update the toolkit and offer more guidance and examples of what works and I am especially pleased that much of this is based on first hand experience of agencies taking on this innovative work.

This updated edition features more examples of assessment forms and guidance on risk management as well as guidance on working with perpetrators in drug/alcohol treatment and supporting children living with parental substance misuse and domestic violence. You will also find more examples of policies and strategic partnership working which can be emulated within your own agency and local area.

I commend those working to address these complex issues and am sure that this updated toolkit will provide essential guidance and support that will ultimately increase the safety of survivors and their children.

Prof Sue Atkinson FFPH CBE
Chair, Greater London Alcohol and Drugs Alliance (GLADA)
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1. Background

1.1 How the Stella Project began

“Safety and support for all through the development of inclusive and responsive services for people affected by drugs, alcohol and domestic violence”

As the leading agency addressing drug and alcohol related domestic violence and abuse, the Stella Project works across all 33 London boroughs for positive, sustained improvement in the way services are delivered to survivors, their children and perpetrators of domestic violence affected by problematic substance use.

The Stella Project is a partnership between the Greater London Domestic Violence Project (GLDVP) and the Greater London Alcohol and Drug Alliance (GLADA). The GLDVP works to end domestic violence across the capital by supporting direct service providers and promoting joint working.

GLADA, established by the Mayor of London in 2002, is a strategic network of organisations and agencies concerned with the problems caused by drugs and alcohol in London.

During 2002, discussions between GLDVP and GLADA identified gaps in the current service provision for both survivors and perpetrators of domestic violence who are problematic substance users.

GLDVP and GLADA therefore decided to create the Stella Project in order to find positive and creative ways to work towards more inclusive service provision.
The Stella Project works firmly from the perspective that there is not a simple causal link between substance misuse and domestic violence; drug or alcohol use should never be accepted as an excuse for violent or abusive behaviour and neither should survivors’ substance use be used to justify the use of violence against them.

“Today is not about barriers, its about bridges...Today is not about feeling entrenched in our disciplines and resistant to change; it is about daring to hear the other view, however uncomfortable this might be. It is about focusing on the women and children who we work with and for asking if there is something we are missing or something we could do better.”

Dr Sarah Galvani - University of Birmingham at the Stella Project Launch Seminar

1.2 The toolkit

The Stella Project launch in 2002 initiated a dialogue between domestic violence and drug and alcohol agencies and discussed ways to improve practice and collaborative work between sectors.

The creation of the toolkit stemmed from the recommendation to develop guidance, models of good practice and training for front line workers in both sectors. The first edition of the toolkit was published in 2004 and met with overwhelming interest and demand.

900 hard copies were distributed to front line workers across the UK in domestic violence projects, drug and alcohol agencies, social services, homelessness charities, children’s charities and the police and Crown Prosecution Service. The publication has also proved popular as a download from the GLDVP website.

Since the publication of the first edition, there has been increased awareness of the links between domestic violence and substance misuse and much progress in the development of collaborative and integrated service provision.

As a consequence there is the need for further guidance and advice to support these developments. We are now fortunate to be in a position to offer more guidance and examples of what works based on first hand experience of agencies taking on this innovative work.
2. Overview

2.1 Who should use this toolkit?

This toolkit is primarily for front-line workers and managers in the drugs, alcohol and domestic violence fields, but it could be used by anyone who works with survivors experiencing domestic violence or those perpetrating domestic violence who are also problematic substance users.

2.2 How to use the toolkit

This toolkit is designed to be used as a reference rather than be read cover to cover. Many of you will only pick it up when you have a client with you who needs immediate support or information. The toolkit is clearly divided into sections to help you find the information you need quickly.

Each section stands alone and case studies and what works examples have been included throughout the text, enabling you to also use the toolkit as a workbook.

“Stop discriminating! Stop being judgemental! Stop making excuses! Feel the fear and do it anyway! Take women with substance misuse issues into refuges and work with them. Develop more women only substance misuse services – gender specific spaces might help women to make that first step to disclosing that she is experiencing domestic violence. We need more services that work with women and children. We also need more services that focus on children as survivors in their own right. Some of this will take a while. Some of it can happen quite quickly.”

Marai Larasi – Director of the Nia Project

2.3 What is the purpose of this toolkit?

The purpose of this toolkit is to:

- Help workers increase safety for survivors and their children experiencing domestic violence
- Enable staff to provide options to drug and alcohol users both as survivors and perpetrators of domestic violence
- Support staff across the drugs, alcohol and domestic violence fields to work with this client group
- Encourage networking and partnership working across the sectors
- Provide practical, adaptable tools which enable organisations to implement changes in policy and practice

Throughout this toolkit, we have attempted to be as gender neutral as possible in that we have not automatically assumed that all victims/survivors are female or that all perpetrators are male. In some instances however, we have not been gender neutral.

This is mostly because some of our knowledge about domestic violence is indeed gendered. For example, we know that leaving a violent relationship is extremely dangerous for heterosexual women. However, the evidence does not suggest that the reverse is true so it would be misleading to state that leaving is a particularly dangerous time for all victims.

We have also been gendered when presenting research findings that derive from studies that have only focused on female victims/male perpetrators or referring to gender-specific services such as domestic violence perpetrator programmes.

Finally, in some instances, to reduce cumbersome grammatical constructs, we have referred to victims as female and perpetrators as male in recognition of the fact that this is true in the overwhelming majority of cases. However, this is not meant to imply that this is always the case.
3. Overview of current provision

3.1 Current provision

Drug, alcohol and domestic violence agencies often serve the same client base. However, while numerous services deal specifically with domestic violence or substance misuse, few organisations in the UK are currently equipped to provide the range of services needed by survivors or perpetrators of domestic violence who also experience problematic substance use.

Differing models of working, time restraints and philosophies mean that drug, alcohol and domestic violence services often do not work together as effectively as they could.

3.2 Similarities in the client groups

Many similarities do exist for those who experience problematic substance use and those who experience domestic violence. Clients with these individual issues may experience:

- Feelings of isolation, guilt, shame, low self-esteem
- Experience of trauma
- Initial denial of the problem
- Reluctance to seek out support systems due to fears of negative consequences e.g. losing children or housing
- Fears of rejection from community and family
- Magical thinking; “if I ignore the problem, it might go away, it might stop”
- Difficulty in decision making or making decisions that may not appear to others as logical

- Efforts at reducing alcohol or drug use or escape from violence are sabotaged by the partner as a mechanism of control, and substance use may even be encouraged or forced
- Repeated attempts to change the substance or relationship before making lasting changes

As well as these client similarities, substance misuse programs and domestic violence projects both:

- Work with an overlapping client base
- Focus on safety for clients
- Tackle social exclusion and work towards breaking down client isolation
- Conduct risk assessment and screening

3.3 Working together

The Stella Project believes that the similarities identified above make working together both feasible and essential.

Not only can resources be pooled but outcomes for the survivor and perpetrator are more likely to be positive if approached in an integrated holistic way.

Joint working across the domestic violence and drug and alcohol sectors is therefore the logical way forward.

Myth:
Alcoholics and drug addicts are nothing like me, my family or friends

Fact:
There is no ‘look’ or ‘personality’ of drug or alcohol users, they are as diverse as society itself
4. Making the links

4.1 Perpetrators and drug and alcohol use: are they responsible for their violence?

Understandings of the reasons and causes of substance misuse and domestic violence are varied. Many organisations believe problematic substance use to be a cause of a perpetrator’s violence. Within these sorts of organisations, a perpetrator’s substance use may be addressed, with the intention of reducing their use of violence.

Many organisations however see the use of substances as a ‘disinhibitor’ which gives a perpetrator the belief that they will not be held accountable or responsible for their violent behaviour. The Stella Project strongly supports the view that substance use does not cause domestic violence.

4.2 Survivors and substance use: are they causing or simply coping with violence?

There are also differences in the ways organisations understand women’s substance use. Some organisations believe that there is some causal link between a woman’s use of substances and her experiences of domestic violence.

Other organisations may see the misuse of substances (both legal and illegal) as a way for women to cope with their experience of domestic violence. This view is supported by research in the U.S. and Britain.

Drug and alcohol use is often present in violent relationships. This can manifest itself in multiple ways, for example the perpetrator may:

- Act as supplier and use access to substances as a form of control
- Force their partner to use substances
- Threaten to disclose their partner's use of substances to the authorities, particularly where there are children in the family who the mother fears will be taken away
- Limit access to information or treatment
- Use their partner's earnings to buy substances
- Take out frustrations and aggression on a partner during a detoxification phase
- Sabotage a partner’s attempts to stop using or enter into treatment

Women who are problematic substance users are often excluded from services. For instance refuges often find it difficult to support women who use substances. As a result this group of women are particularly vulnerable to long-term experiences of domestic violence and possibly homelessness as they have fewer options of where to go to find help, support or safety.

The primary presenting issue often masks additional needs for instance if a client presents with substance misuse problems, any domestic violence issues are usually submerged and vice versa. This is partly due to the secrecy and shame that surrounds both issues as well as fear of being misunderstood or excluded from services.

Myth:
Survivors who use drugs and alcohol deserve or provoke violence from their partner

Fact:
No-one deserves abuse. Survivors who use drugs and alcohol often say they do so to cope with violence from their partner

“If a substance misuse agency ignores a woman’s safety – she may never get sober. If domestic violence providers ignore her drug use she may never be safe. Can we really keep affording to keep taking the risk?”

Marai Larasi – Director of the Nia Project
4.3 Domestic violence and substance use facts and statistics

Although substance use does not cause domestic violence, there is a clear link between the two.

- A recent UK study showed that 51% of respondents from domestic violence agencies claimed that either themselves or their partners had used drugs, alcohol and/or prescribed medication in problematic ways in the last five years.

- Almost two thirds of survivors drawn from domestic violence agencies in the same study showed that they began their problematic substance use following their experiences of domestic violence.

- Another UK study of 60 women using crack cocaine found that 40% reported being regularly physically assaulted by a current partner and 75% being physically assaulted by a current or past partner.

- In a study of inner London treatment agencies in 2000, 30% of women reported physical violence from their current partner although this figure is estimated to be higher due to women’s fear and difficulty in disclosing their experiences of violence and abuse.

- A US study reports that 60% of women accessing drug or alcohol services (n = 360) reported current or past domestic abuse.

- The Yale trauma study showed that abused women are 15 times more likely to use alcohol and 9 times more likely to use drugs than non-abused women.

- Findings from a review of the British Crime Surveys revealed that 44% of domestic violence offenders were under the influence of alcohol and 12% affected by drugs when they committed acts of physical violence.

- A number of studies have found that the perpetrator’s use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober.

- A small scale study in the UK showed that all of the women interviewed about the role of alcohol in their partner’s abuse had also experienced violence and abuse from their partner when he had not been drinking.

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

You may feel reluctant to work with this client group but your organisation is probably already working with clients who have complex needs. Although you may not be knowingly working with this client group it is statistically likely you are.

5.1 Domestic violence workers are encouraged to take into account:

- If you ignore drug or alcohol issues your client may be less able to leave a violent partner, in greater danger of more severe violence and more likely to have ineffective criminal justice system intervention

- She may be more likely to lose her children, less likely to benefit from counselling and less likely to be admitted to a refuge or provided with permanent housing

- Working in partnership with drug and alcohol agencies will reduce your workload, increase your confidence that you are working effectively, improve outcomes and reduce repeat victimisation

- “Supporting People” sees working across sectors and in partnership as positive and good value for money

- There may be possible sources of funding for your agency to support drug and alcohol work

- Often the perpetrator’s use of substances has a significant effect on women and children. Careful consideration needs to be given to how these issues will affect the sort of support women may require from both your service and others

5.2 Drug and alcohol workers are encouraged to take into account that:

- Studies into women and drug use find an extremely high correlation between the experiences of abuse and substance use. Violence and abuse are not always past issues; there is a high likelihood that a woman using drugs may be living with a violent partner

- Men who present as drug users need to be asked about their offending behaviour or capacity for violence. It is possible your client is putting others at risk with his behaviour

- Attempting to address a survivor’s substance use without also giving support in relation to their experiences of violence is unlikely to be effective. You cannot expect better results if you fail to look at their situation holistically

- Many survivors use drugs and alcohol as a strategy to cope with the violence they experience. Addressing their substance use without acknowledging the effects of violence on their lives can increase their feelings of vulnerability and their ability to remain engaged with treatment

- Women face a risk of escalated domestic violence if a perpetrator finds out they have been trying to access services

- Addressing a perpetrator’s drug/alcohol use alone will not reduce their abusive behaviour. If treatment is able to reduce the severity of the violence it does not address the complex dynamics and power and control which underpin domestic violence. Therefore, work which specifically addresses such dynamics should accompany a treatment plan

- Many survivors choose to stay with their violent partners if they know that they are on a drug or alcohol programme because they believe it will increase their safety. However, the stress of withdrawal and/or relapse of the violent partner may increase their violence
6. Key messages

In order to provide your clients with key messages, it is essential to view your clients holistically and individually. Remember that each client’s experience of substance use and violence is highly individual. Your clients have many strengths to build upon, it will have taken much courage and resourcefulness to have survived this far.

To survivors of violence:
- You are not alone, support is available
- There is life after abuse
- You are not responsible for the violence you experience and should not be blamed for it

To perpetrators of violence:
- Domestic violence is a range of abuse (not just physical) which is an attempt to control and manipulate a partner or ex partner
- Domestic violence is unacceptable. You are responsible for your violence and abuse
- Substance use, anger and trauma do not explain or excuse violence
- Domestic violence is a crime

To drug or alcohol users:
- You have the right to decide how to manage your drug or alcohol use
- You can have access to support, information and treatment that suits your individual needs
- Services should support you to limit the level of harm caused to yourself and others due to your drug and alcohol use

7. Minimum standards

Survivors of violence:
- Survivors should be able to choose the support they want and who provides it
- Women in violent situations often leave their relationship several times, before the break is permanent. Workers can support women in making their own choices in their own time, in a space they feel comfortable
- Women-only and women-led services must be available to all clients who wish to access them, whenever possible
- Treatment and other interventions should not be dependent on a survivor’s relationship and their current level of safety
- Survivor’s experiences of domestic violence and abuse can be defined in terms of trauma. Post Traumatic Stress Disorder is common among survivors
- Survivors must not be sent back to where the violence has been occurring
- Women experiencing domestic violence should never be asked to participate in couple or family counselling or mediation. Raising the issue of violence in this manner may actually increase her danger
- Always validate survivors’ experiences if they disclose violence, recognise and name abusive behaviour and respect their choices of what to do about it
- Ensure all survivors are provided with information about how to access help for domestic violence
**Drug and alcohol users:**
- Clients require a non-judgemental and safe environment to enable them to disclose substance use.
- Drug and alcohol assessments are helpful in making decisions about care, treatment or support.
- Substance users need a variety of treatment options.
- Clients reducing their substance use or becoming drug free may relapse on several occasions. This is very common and clients should be supported through this, rather than criticised or excluded.

**Worker and agency responses:**
- Clients should not be denied services due to issues with domestic violence or substance misuse.
- Clients need to be consulted about the interventions they find supportive and effective.
- Only refer violent men to perpetrator programmes which are members of the Respect network.
- Staff can enable clients to make choices about their own lives and to take control of decisions.
- Be clear about confidentiality boundaries at all times.
- Clients should be encouraged to speak freely with workers about substance use or domestic violence without it affecting service provision.
- Prescription medication should not be given without counselling and other therapeutic support.
- Early detection of substance use or domestic violence could provide a client with greater safety and options. Services may find it beneficial to carry out routine questioning for both issues after receiving training.
- Services need to be accessible to all potential clients. This includes provision for children, as well as disability access and access to interpreters where relevant.
Section 1 footnotes


3 ibid

4 Bury, C et al., 1999. An examination of the needs of women crack users with attention to the role of domestic violence and housing, Report for the Lambeth, Southwark and Lewisham Health Authority in collaboration with the National Addiction Centre and the Brixton Drug Project.


1. Drug and alcohol information

1.1 Definitions

The Stella Project defines substance misuse as:

“The use of substances (such as illegal drugs, prescription medicines or alcohol) in such a way that results in harm to the individual user or to the wider community. The range of harms includes problems for physical health, psychological health, violence, financial problems, family problems or social problems.”

1.2 Types of substances

Substances are often referred to in relation to their illegality or their effects on the users. In this section substances are described as depressants, stimulants or hallucinogens and include both illegal and legal drugs.

These materials have been provided to The Stella Project under licence from HIT. For further information contact Lynne Hannah tel: 0151 949 5344 www.hit.org.uk

Further information about substances can be found at: www.ixion.demon.co.uk or www.talktofrank.com

Depressants
Depressants all have the effect of slowing down the heart rate and generally provide the user with a sense of calm. Depressants reduce the activity of the central nervous system, leading to a sense of relaxation, drowsiness, and lowered inhibitions. Cannabis is included in this section, although it can also have hallucinogenic properties.
Alcohol can be measured in units. Alcoholism is made by fermenting fruits, vegetables or grains and includes beers, lagers, wines, spirits and ciders. Alcohol can cause accidents and violence. Drinking at home as measures may be more generous. Heavy alcohol use over long periods can cause liver and brain damage. Each year, there are over 30,000 alcohol-related deaths in the UK. Drinking alcohol can be very expensive.

**WHAT IS ALCOHOL?**
- Alcohol is a depressant drug which slows down body reactions and the working of the brain.
- Small amounts usually help people to relax.
- How you feel depends on your mood and the situation. If you already feel down, alcohol tends to make you feel worse.
- Women who are pregnant or trying to become pregnant should not drink more than 1 or 2 units of alcohol once or twice a week.
- Alcohol can cause accidents and violence.
- Feeling less embarrassed and being confused when drunk can already feel down, alcohol tends to make you feel worse.

**WHAT ARE THE EFFECTS OF ALCOHOL?**
- Alcohol is a depressant drug which slows down body reactions and the working of the brain.

**WHEN YOU SHOULD T DRINK**
- Any amount of alcohol will affect judgement and co-ordination.
- Keep a note of how much alcohol you drink each week.
- Your body needs time to recover from drinking alcohol. Allow yourself two or three alcohol-free days a week.

**SENSIBLE DRINKING**
- The government guidelines on safer drinking are complex.
- Consumption of 1 unit a day by most men and 2 units a day by most women will not cause significant health problems.
- Keep a note of how much alcohol you drink each week.
- Your body needs time to recover from drinking alcohol. Allow yourself two or three alcohol-free days a week.

**ALCOHOL AND THE LAW**
- It is illegal to give alcohol to a child under 5 years of age.
- It is illegal to licence to sell alcohol to under-18s.
- 16-year-olds can drink alcohol (but not spirits) in a public place if they are having a meal.
- The police have the power to confiscate alcohol from anyone under the age of 18 who drinks in public.
- Some town and city centres have introduced bye-laws that make it an offence to drink alcohol on the streets.
13: BENZODIAZEPINES (MINOR TRANQUILLISERS, SLEEPING TABLETS)

Benzodiazepines usually come in tablet or capsule form and each brand can be prescribed in different strengths. For example, diazepam is available in 5mg, 10mg and 20mg tablets. The different brands of benzodiazepines are usually of different strengths. For example, 1–2mg of lorazepam is equivalent to 10mg of diazepam.

**WHAT ARE BENZODIAZEPINES?**
- Benzodiazepines are sedative drugs that are prescribed by doctors to reduce anxiety, to promote sleep or to act as a muscle relaxant.
- They are also used illicitly (without prescription) to offset the effects of stimulant drugs or with other ‘downer’s drugs such as alcohol and heroin.

**WHAT ARE THE EFFECTS OF BENZODIAZEPINES?**
- Benzodiazepines can release the symptoms of stress and anxiety and promote calmness, relaxation and sleep.
- They can become ineffective. They may stop working as ‘sleeping pills’ after only 2 weeks of continuous use and no longer control anxiety after 4 months of regular use.

**WHAT ARE THE PROBLEMS ASSOCIATED WITH BENZODIAZEPINES?**
- Some users experience depression, nightmares and confusion.
- Benzodiazepines can cause physical dependence. Users may find they need to take larger doses to get the same effect.
- Withdrawal symptoms can last for weeks or even months after stopping taking benzodiazepines. Symptoms vary from one person to another and include anxiety, sleeping problems, nausea, panic attacks and occasionally convulsions.
- Overdose is rarely fatal unless benzodiazepines are mixed with other ‘downers’ such as alcohol or heroin.

**WHAT ARE THE RISKS OF INJECTING?**
- Injecting benzodiazepines is dangerous. Risks include septicaemia and abscesses. Starting injecting equipment can spread HIV and hepatitis.

**COMING OFF BENZODIAZEPINES**
- DON’T STOP SUDDENLY. Even though some people have no trouble stopping, it is best to come off gradually. Ask your doctor or drug service for advice.
- Changing from shorter-acting benzodiazepines to longer-acting ones, such as diazepam, is often helpful.
- Many people find that changes in their diet, increased exercise and relaxation techniques can reduce withdrawal symptoms.

**SOME TIPS FOR SAFER BENZODIAZEPINE USE**
- See your doctor before getting a repeat prescription.
- Don’t use for long periods. It is recommended that users take benzodiazepines for no more than 2–4 weeks.
- If you take them as ‘sleeping tablets’, leave 2–3 nights per week benz-o-free.

**BENZODIAZEPINES AND THE LAW**
- Benzodiazepines are Class C drugs.
- It is illegal to possess any benzodiazepine, including temazepam and Rohypnol, without a prescription.
- The maximum sentence for the unauthorised possession of benzodiazepines is 2 years in prison and/or an unlimited fine.
- The maximum sentence for the unauthorised supply of benzodiazepines is 14 years in prison and/or an unlimited fine.

**WHAT IS HEROIN?**
- Heroine is a pain-killing drug made from the opium poppy.
- Other opiates with a similar effect include morphine, codeine, methadone, palfium, deconal and pentodine.
- Most street heroin in the UK is in the form of brown powder.
- Heroin costs £20–£30 for half a gram.

**HOW IS HEROIN USED?**
- Heroin can be snifted, smoked (inhalated) or injected.
- The effects are similar, but each method has its own risks.
- Smoking is safer as the dose can be more easily regulated.

**WHAT ARE THE EFFECTS OF HEROIN?**
- Heroin is a sedative drug. It relaxes the brain and slows down the heart and breathing.
- The user feels physically and mentally calm.
- At high doses the user can become drowsy and fall asleep.

**WHAT ARE THE PROBLEMS ASSOCIATED WITH HEROIN?**
- If the user takes too much heroin, they can overdose – their breathing stops.
- The purity of heroin can vary, making it difficult to gauge the strength.
- The risk of overdose increases if other drugs are used at the same time, especially sedative-type drugs such as alcohol, methadone and tranquillisers.
- Anyone using heroin regularly may experience:
  - tolerance – a need for larger doses to get the same effect
  - withdrawal symptoms – runny nose, sweats, chill and cramps, if the drug is stopped
  - a psychological craving for the drug.

**WHAT ARE THE RISKS OF INJECTING?**
- Injecting is the most dangerous way of using heroin because:
  - the possibility of overdose increases because the drug reaches the brain very quickly
  - impurities are introduced directly into the bloodstream, and this can cause septicaemia and other infections
  - sharing injecting equipment can spread hepatitis and HIV, the virus that causes AIDS.

**WHAT HELP IS AVAILABLE FOR HEROIN USERS?**
- Counselling, advice and support can help users.
- Other options include methadone and buprenorphine prescribing, community or in-patient detoxification and residential rehabilitation.
- Injecting drug users can get free injecting equipment and advice from a syringe exchange scheme or pharmacist.

**HEROIN AND THE LAW**
- Heroin is a Class A drug.
- The maximum sentence for possessing heroin is 7 years in prison plus an unlimited fine.
- The maximum sentence for supplying heroin (including giving some to a friend) is 7 years in prison plus an unlimited fine.
- Anyone using heroin regularly may experience:
WHAT IS METHADONE?
• Methadone has been manufactured to mimic many of the effects of opiates such as heroin.
• Methadone is usually prescribed to reduce the risk of illicit drug use by people who take heroin.

WHAT ARE THE EFFECTS OF METHADONE?
• Methadone is a much longer-acting drug than heroin. Users can take it once a day and usually will be free of withdrawal symptoms for 24 hours.
• It can give feelings of well-being and absence of stress, less intense than heroin but longer lasting.
• Side-effects of methadone include constipation, sweating and itchy skin.

WHY IS IT PRESCRIBED?
• Methadone will reduce acute withdrawal symptoms and will satisfactorily some of the need to take heroin.
• It has been prescribed safely for many years.

DOES METHADONE WORK FOR EVERYONE?
• Methadone is not a magic cure that helps anyone taking heroin.
• Methadone is more likely to be helpful if it is used alongside:
  • support from family and friends;
  • counselling and advice from drug services.

METHADONE AND THE LAW

WHAT IS METHADONE?
• Methadone is a Class A drug – it can only be legally possessed if it has been prescribed for you.

WHAT ARE THE PROBLEMS ASSOCIATED WITH METHADONE?
• Methadone can be a dangerous drug.
• Fatal overdose can occur if methadone is taken with other destroyer-type drugs such as alcohol, heroin and tranquillisers.
• People should only take the amount prescribed for them by a doctor. A small amount can kill an adult who is not used to taking it most days of the week. A tiny amount can kill a child. Methadone should be stored safely away from children.
• Like heroin, methadone is physically addictive. Both drugs are very hard to get off. Some users say the withdrawal symptoms from methadone last longer than heroin – however, they may not be so severe.

WHAT IS TOBACCO?
• Tobacco contains the stimulant drug nicotine, which increases pulse rate and blood pressure.

HOW IS TOBACCO USED?
• Tobacco is usually smoked in cigarettes, cigars and pipes.

WHAT ARE THE EFFECTS OF SMOKING?
• Coughs, chest and breathing problems, and bad breath are very common amongst smokers.
• Regular long-term users have much greater risk of developing lung and some other cancers, heart disease, circulatory problems, bronchitis and ulcers.
• Each year about 120,000 people die prematurely from smoking-related illnesses in the UK.
• Smoking during pregnancy can damage an unborn child. It can result in low birth weight and other complications.

TOBACCO AND THE LAW

WHAT ARE THE EFFECTS OF TOBACCO?
• Tobacco is physically addictive.
• Some people smoke occasionally, but most smokers smoke regularly. They may feel relaxed, antivirus and depressed without a cigarette.
• Coughs, chest and breathing problems, and bad breath are very common amongst smokers.
• Regular long-term users have much greater risk of developing lung and some other cancers, heart disease, circulatory problems, bronchitis and ulcers.
• It is not illegal to smoke at any age.
• It is illegal to sell tobacco to young people under 16 years of age.

STIMULANTS

Stimulants increase a person’s heart rate and the activity of the central nervous system. Stimulants can also increase a users’ level of energy and sense of well being.
WHAT ARE THE EFFECTS OF COCAINE AND CRACK?

- Cocaine powder is usually sniffed up the nose. It can also be injected. Crack is smoked. The effects are similar, but each method has its own risks.
- When cocaine is snorted, the effects come on gradually and peak after 15–30 minutes.
- When cocaine is injected, the effects are felt immediately but wear off very quickly.
- When crack is smoked, the effects are felt almost immediately and much more intensely.

WHAT ARE THE PROBLEMS ASSOCIATED WITH COCAINE AND CRACK?

- Cocaine or crack can be detected in urine for up to 3 days.
- The maximum sentence for supplying cocaine or crack (which includes giving some to a friend) is 7 years in prison plus an unlimited fine.
- The effect that makes MDA different from other drugs is the increase in body temperature. Taking real ecstasy will cause a rise in body temperature. In a small number of individuals this rise in body temperature – together with the hot environment of a club, energetic dancing and not drinking water – has resulted in death.
- If taking ecstasy in a club, take breaks from dancing and sip water regularly (about a pint an hour). Water will only prevent dehydration – it is not an antidote to other things that can go wrong as a result of taking ecstasy.
- Users often feel ‘down’ a few days after taking MDA. This is partly caused by MDA’s action on the brain, lack of sleep and a suppressed appetite, so it is important to get plenty of sleep and eat healthily.
- From January 1997 to December 2003 there were about 200 deaths associated with ecstasy.
- The majority of deaths have been caused by ecstasy-induced heat stroke. Taking real ecstasy will cause a rise in body temperature. In a small number of individuals this rise in body temperature – together with the hot environment of a club, energetic dancing and not drinking water – has resulted in death.
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ECSTASY AND THE LAW

- Ecstasy is not addictive. However, the drug can often take on great importance in people’s lives.
- Many users report they have had the best time they have ever had in their lives.
- However, taken too often, it can lose its special appeal and users may take more to try and prolong the effects or may move on to other things.

IS ECSTASY ADDICTIVE?

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- However, taken too often, it can lose its special appeal and users may take more to try and prolong the effects or may move on to other things.

ECSTASY AND THE LAW

- Ecstasy is a Class A drug.
- The maximum sentence for possessing ecstasy is 7 years in prison plus an unlimited fine.
- The maximum sentence for supplying ecstasy (including giving a tablet to a friend) is life imprisonment and an unlimited fine.
- MDMA can be detected in the urine for about 2–4 days.
Khat is a green-leafed plant that has been used for its stimulant properties for centuries across parts of Africa and Arabia. The main active ingredients are cathinone and cathine. The plant remains potent for only a few days after it has been picked. It is regularly imported fresh into the UK from Kenya and Ethiopia.

WHAT IS KHAT?
• Khat contains stimulant drugs. The main active ingredients are cathinone and cathine.
• Older members of Somali– and to a lesser extent Ethiopian, Kenyan and Yemeni– communities are associated with using khat in the UK. There are occasional reports of younger members of these communities and other people also using khat. It is sold mainly at greengrocers and other shops in the communities where the plant isosal.
• A bunch of khat costs about £6.00.

HOW IS KHAT USED?
• The fresh leaves and small stems are chewed to a pulp and then spat out.
• A khat chewing session usually fulfils an important social function similar to the use of caffeine and alcohol in Europe. A khat session may last 3–5 hours.
• Khat can also be brewed into a ‘tea’. Some dried preparations of the drug are available in the UK. It is likely that they have a milder effect because its potency quickly declines once the plant has been picked.

WHAT ARE THE EFFECTS OF KHAT?
• Considerable chewing is needed to get any effect. For this reason, it is thought unlikely that other groups in the UK not culturally used to the drug will begin using khat.
• The effects may vary depending upon the freshness of the khat.

WHAT ARE THE PROBLEMS ASSOCIATED WITH KHAT?
• The majority of people who use khat do not experience serious problems.
• Psychological dependence can occur. A minority of people who use regularly – most days of the week – may feel anxious and uncomfortable if asked to stop using the drug, and they may experience psychological withdrawal problems.
• As with other drugs, these problems are likely to be greater amongst groups experiencing other difficulties, such as poverty and racism.
• Khat chewing can lead to a sore mouth that may put the user at risk of infections.
• There is some evidence that excessive khat chewing may increase the risk of leukaemia and cancer in the mouth.

KHAT AND THE LAW
• The khat plant is currently not illegal to use, possess or sell in the UK.
• Speed costs £5–£10 for a gram.
• Speed usually only contains about 4% amphetamine sulphate.
• Speed costs £3–£10 for a gram.

WHAT ARE AMPHETAMINES?
• Amphetamines are stimulant drugs which come as powder (sulphate), tablets or more rarely as paste.
• Amphetamine use can also trigger underlying long-term health problems in some people.

WHAT ARE THE EFFECTS OF AMPHETAMINES?
• They produce sensations of alertness, confidence and well-being, and increased levels of energy and stamina.
• They lessen the desire to eat or sleep.
• They lessen the desire to eat or sleep.
• The effects come on gradually and last longer than with other methods.
• Sniffing amphetamines takes effect faster than swallowing them, but it can damage the nose.

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• Sniffing amphetamines takes effect faster than swallowing them, but it can damage the nose.

WHAT ARE THE RISKS OF INJECTING?
• Injecting is the riskiest method of using amphetamines. Clean needles and syringes should always be obtained from a pharmacist or needle exchange scheme.
• Behaviour can become more compulsive as users chase the ‘rush’ that is produced by injecting.
• The dose reaches the brain almost immediately, increasing the possibility of overdose.
• Impurities are introduced directly into the bloodstream and can cause septicaemia and other infections.
• Repeated injections can damage veins, leading to thrombosis and abscesses.
• Sharing injection equipment can spread hepatitis and HIV, the virus that causes AIDS.

AMPHETAMINES AND THE LAW
• Amphetamines are Class B drugs.
• The maximum sentence for possessing illicit amphetamines is 5 years in prison and an unlimited fine.
• The maximum sentence for supplying illicit amphetamines (including giving some to a friend) is 14 years imprisonment and an unlimited fine.
• It is not illegal to possess amphetamine that has been prescribed for you.
• Excessive use of amphetamines can cause short-term mental health problems such as paranoia and psychosis. This can happen sooner if paste is used.
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• Amphetamine use can also trigger underlying long-term health problems in some people.
10: ANABOLIC STEROIDS

WHAT ARE ANABOLIC STEROIDS?
- Anabolic steroids (AS) are synthetic derivatives of the male hormone, testosterone.
- AS are not the same as corticosteroids (such as cortisone and prednisolone) which are medically prescribed to treat asthma and skin disorders or as anti-inflammatory. Corticosteroids have no muscle-building or masculinising effects.

HOW ARE ANABOLIC STEROIDS USED?
- They may be taken orally or by injection into a muscle, never a vein.
- Stacking refers to the practice of taking several drugs simultaneously. This is common among anabolic steroid users and can also involve the use of drugs other than steroids. Stacking increases the risks and harms caused.
- Cycling refers to the typical pattern of anabolic steroid use where drugs are taken in cycles of a number of weeks followed by a drug-free period.

WHAT ARE THE EFFECTS OF ANABOLIC STEROIDS?
- Physical problems:
  - increased water retention;
  - osteoporosis;
  - heart attacks;
  - stroke;
  - abnormal liver function;
  - increased liver activity;
  - changes in fertility.

- Psychological problems:
  - mood swings and irritability;
  - paranoia;
  - depression;
  - sleep disorders;
  - hallucinations;
  - increased aggression.

- Additional effects for males:
  - baldness, development of breast tissue, shrinking testicles, decreased sperm production.

- Additional effects for females:
  - growth of facial hair, changes in the menstrual cycle, decreased breast size, enlargement of the clitoris, deeper voice.

ANABOLIC STEROIDS AND THE LAW
- AS are Class C drugs.
- It is illegal to possess anabolic steroids for personal use.
- It is illegal to manufacture, to supply or to import and export them with the intent to supply. The maximum sentence is 14 years in prison and/or an unlimited fine.

WHAT ARE THE PROBLEMS ASSOCIATED WITH ANABOLIC STEROIDS?
- Physical problems:
  - increased water retention;

7: SOLVENTS (GLUE, GAS AND AEROSOLS)

WHAT ARE SOLVENTS?
- Solvents are substances that are inhaled to get ‘high’.
- They include glue, lighter fuel, petrol, aerosols and nail-varnish remover.

WHAT ARE THE EFFECTS OF SOLVENTS?
- The effects of solvents are similar to alcohol.
- Users feel drowsy and unsteady on their feet.
- Inhalation causes the drug to take effect very rapidly, causing a euphoric ‘rush’.
- The effects wear off quickly, within 30-45 minutes.

WHAT ARE THE PROBLEMS ASSOCIATED WITH SOLVENTS?
- Solvents can cause disorientation and sometimes unconsciousness.
- Each year about 100 young people die after using solvents in the UK.
- Most and more of the deaths are a direct result of the solvents’ effect on the body, especially lighter fuel.

- Sniffing can have an effect on the heart – physical exertion or fright can then cause heart failure.

- Deaths can also result from indirect causes such as:
  - choking on vomit whilst unconscious;
  - accidents as a result of being in an isolated or dangerous place;
  - suffocation through a plastic bag placed over the head.

- Lasting problems from solvent use are rare.

SOLVENTS AND THE LAW
- It is not illegal to use solvents.
- In England, Wales and Northern Ireland it is illegal for a shop ‘knowingly’ to sell solvents for the purpose of inhalation, to young people under 18 years old.
- In Scotland, Common Law has the same effect but there is no age limit. Sales to people over 18 years have resulted in prosecution.
Hallucinogens

Hallucinogens are natural and synthetic drugs where the primary effect is to distort the senses and thereby altering an individual’s perceptions, thoughts and feelings.

LSD can come dropped onto a sugar cube, in capsules, in gelatin sheets or strips, tablets, tiny tablets (microdots) or on blotting paper. Almost all LSD sold in the UK in recent years has been on blotting paper or cardboardsheets, cut into 5mm squares with printed images.

6: LYSERGIC ACID DIETHYLAMIDE (LSD, ACID, TRIP)

WHAT IS LSD?
• Lyseric Acid Diethylamide (LSD) is a hallucinogenic or psychedelic drug.
• LSD costs £3–£4 for a ‘trip’.

HOW IS LSD USED?
• LSD is almost always swallowed.
• LSD is usually described as a ‘trip’ because it is like a journey to another place. Usually the user knows the effects so can be ‘untethered’. Genuine hallucinations are rare with LSD. The experience may be broken up into four ‘phases’:
  * The Onset – Thirty minutes to an hour after being taken, colours appear sharper and moving objects leave traces behind them. Repeated pattern may be seen with the eyes closed.
  * Plateau – Over thesecond hour, the effects become more intense. Patterns are visible with the eyes open. Fantastic visions can appear from nowhere – from shapes in smoke to lines on the palm of the hand.
  * The Peak – Two hours after being taken, a high is reached. Tripplers may feel that they are in a different world. For some this is profound and mysterious, but for others it can be very frightening.
  * The Crescendo – Five or six hours after taking the drug, the sensations begin to subside. After eight hours, the trip is usually over, although some residual effects may remain until after sleep.

WHAT ARE THE EFFECTS OF LSD?
• LSD can trigger underlying mental health problems and produce delusions, paranoia and schizophrenia-like states.
• Users often report feeling sick even when they have taken ‘proper’ magic mushrooms.
• LSD can also produce extreme anxiety states or panic attacks, not only while under the influence of the drug, but for some time afterwards.
• LSD use may result in changes in the personality of the user.
• LSD can impair judgement. Users should not drive or operate machinery while under the influence of LSD.
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• LSD can impair judgement. Users should not drive or operate machinery while under the influence of LSD.
• A magic mushroom ‘trip’ tends to last about four hours, as opposed to eight hours or more with LSD.

WHAT ARE THE PROBLEMS ASSOCIATED WITH LSD?
• There are no known physical health problems associated with LSD use.
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WHAT CAN I DO IF SOMEBODY IS HAVING A ‘BAD TRIP’?
• If they become uncontrollable or hysterical, call a doctor or take them to a hospital. Remember though, hospital can make people more anxious and panicy, so use this as a last resort.
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9: PSILOCYBIN (MAGIC MUSHROOMS)

WHAT IS PSILOCYBIN?
• Psilocybin is a psychedelic drug, with effects similar to those of LSD.

HOW ARE MAGIC MUSHROOMS USED?
• Magic mushrooms can be eaten raw, mixed with food or made into a beer and swallowed.
• They can be eaten fresh, or dried and kept for later use.
• Usually a dose of 5–10 mushrooms will have a noticeable effect; 20–30 mushrooms will cause a strong ‘trip’.

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WHAT ARE THE PROBLEMS ASSOCIATED WITH MAGIC MUSHROOMS?
• The biggest danger associated with magic mushroom use is probably misidentification. Some mushrooms are poisonous and cause stomach pains, vomiting and diarrhoea.
• Users often report feeling sick even when they have taken ‘proper’ magic mushrooms.
• However, if you continue to feel unwell, go straight to hospital. Take a sample of the mushroom with you to help with identification.
• Magic mushrooms can cause ‘bad trips’ or panic attacks and should not be used when you are alone. A friend can provide reassurance or help if poisonous mushrooms have been accidentally taken.
• They can impair judgement, causing accidents. Do not drive while under the influence.
• There are no known long-term consequences of using magic mushrooms.

MAGIC MUSHROOMS AND THE LAW
• It is illegal to grow, gather or possess magic mushrooms which contain psilocin or psilocybin as they are a Class A drug.
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WHAT IS KETAMINE?
- Ketamine is an anaesthetic drug legally produced for use in human and animal medicine.
- Ketamine also has psychedelic or hallucinogenic effects. There has been small-scale recreational use of the drug in the UK and other parts of the world for many years.
- More recently, the drug has been used in the UK on the dance scene.
- Often clubgoers have taken ketamine mistakenly thinking it was ecstasy.
- The price of ketamine can vary enormously.

HOW IS KETAMINE USED?
- A tiny amount of powder is an active dose. Ketamine can be snorted up the nose, injected or swallowed. The method of use will influence the effects.
- When ketamine is snorted, the effects begin in a few minutes and last for about 15–30 minutes.
- When swallowed, the effects usually begin in 15 minutes and last for about 1–3 hours.
- When injected, the effects begin within a minute and last for about 1–3 hours.

WHAT ARE THE EFFECTS OF KETAMINE?
- It can be stimulating, creating feelings of increased energy and euphoria. Other effects can include floating sensations, numbness, loss of time, nausea and loss of control or disconnection from the body.
- Users report feeling as though they had travelled to other worlds - with ‘out-of-body’ and spiritual experiences, recall of memories and insights into the nature of existence – and believing they had died. The user may not know that the effects are ‘unreal’ until the drug has worn off.
- Users may experience blurred vision and difficulty in moving and speaking.
- Unlike LSD and magic mushrooms, ketamine does cause genuine visual and auditory hallucinations.

WHAT ARE THE PROBLEMS ASSOCIATED WITH KETAMINE?
- Ketamine should not be used with alcohol and other sedative-type drugs as this dramatically increases the risk of problems.
- Users may feel confused or disorientated, and not realise they are hallucinating. These consequences could be particularly frightening if the user had thought they were taking ecstasy.
- There is the possibility of accidental injuries whilst under the influence of ketamine. The risk of injury is likely to increase if the drug is used in a public place.
- Ketamine use has been linked with a wide range of mental health problems including anxiety, panic attacks, post-traumatic stress, persistent perceptual changes, depression, insomnia and suicide.
- There is some evidence that some users develop compulsive use over prolonged periods. This is limited scientific evidence of the long-term consequences of ketamine use.
- Injecting ketamine can cause damage to veins, leading to abscesses and thrombosis. The sharing of injecting equipment can spread hepatitis and HIV.
- There are no confirmed reports of fatal overdoses associated with the drug.

KETAMINE AND THE LAW
- The possession and use of ketamine is currently not illegal.
- Unauthorised manufacture or sale of ketamine is an offence under the Medicines Act.
- There is the possibility of accidental injuries whilst under the influence of ketamine. The risk of injury is likely to increase if the drug is used in a public place.
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1.3 Facts and statistics

Alcohol:
Department of Health definitions of hazardous, harmful and dependent drinking define:
- Sensible drinking: no more than 3-4 units a day for men and 2-3 units a day for women
- Binge drinking: 8 or more units of alcohol for men and 6 or more units for women on their heaviest drinking day in the past week
- Hazardous drinking: drinking above recognised ‘sensible’ levels and likely to result in harm should present drinking habits persist
- Harmful drinking: drinking above ‘sensible’ levels which causes harm to the psychological or physical well being of the individual

- Alcohol dependence: drinking above ‘sensible’ levels and experiencing harm and symptoms of dependence

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

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

- An estimated 920,000 children are living with parents experiencing serious drink problems. For many of these children, their parents’ drinking is a secret and they do not know where to turn for help

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

- Exposure to interpersonal traumatic events is associated with problematic alcohol use. A large scale US study showed that domestic violence during the first year of marriage was predictive of heavy episodic drinking one year later
2. Legal issues

Initially you may think that providing services, especially accommodation to women who use drugs or alcohol is a legal minefield. In reality, the law is quite clear on what guidelines individuals and services should follow when working with drug users. Don’t shy away from working with substance using women simply because you are unsure of the legal ramifications.

It is not illegal to discuss the details of a client’s substance misuse. This information should be used to inform the support and treatment that the client receives.

It is legal to talk about the effects of substances upon a person and safer methods of drug use. This type of discussion should aim to minimise the level of harm that substance misuse may cause an individual.

Myth:
Alcohol isn’t really a harmful drug; after all, it’s legal!

Fact:
Legal drugs can be just as, or even more, dangerous than illegal. Alcohol intoxication can lead to a lack of judgement, perception and the long term health effects can be fatal.

Drugs:
• 71% of people entering Tier 3 and 4 drug treatment 2004/2005 in London and England were men and only 29% were women.

• In a comprehensive research study focusing on drug use amongst black and minority ethnic communities in the UK, the largest concentration of female respondents reporting drug use is South Asian (29%).

• London has the highest proportion of Class A drug users of any region of England and Wales. 5.2% of 16-59 year olds in London reported using a Class A drug compared to 3.4% across England and Wales.

• Over the period 1998-2005/06 men consistently report higher levels of drug use compared to women. 13.7% of men reported using any drug in the past year compared with 7.4% of women.

• 50-90% of women within substance misuse programmes have experienced current or past physical, emotional or sexual abuse.

Sections 2.1 - 2.5 have been written by Release, a national charity committed to informing and advising the public about drugs, the law and human rights.

When working with either perpetrators or survivors of domestic violence it is possible they may use illegal drugs. This can present issues for workers in drop-in centres, residential projects and other services.

In this section we provide information about the legal status of the most commonly used controlled drugs and how this affects your position as a worker or manager.
2.1 Controlled drugs

The main piece of legislation which relates to drug use is the Misuse of Drugs Act 1971 (the “Act”). The Act creates the offences of possession, supply and production of controlled drugs.

All illegal drugs are controlled, but not all controlled drugs are illegal. We use the word "controlled" here for the sake of simplicity. It is not illegal to produce, possess or supply some controlled drugs in certain limited circumstances (i.e. under licence).

However, in relation to some controlled drugs, it is never legal to produce, possess or supply. The drugs which are controlled by the Act are listed according to their classification. They are classified under “Class A”, “Class B” or “Class C”.

The Class signifies the severity of the maximum sentence for offences relating to that drug. The most severe sentences are applied to Class A drugs.

It is illegal to possess, produce, supply or possess with intent to supply any controlled drug, unless you are licensed to do so. If you have a controlled drug in your possession, even if you are just holding on to it for someone else, you will be guilty of possession.

If you hand a controlled drug to someone else, even if you are just handing it to a colleague for them to deal with, you could theoretically be charged with supply.

For advice about how to deal with a situation where you come across a controlled drug, turn to “Frequently Asked Questions” on pg 49.

Custodial sentences, especially for supply (including giving or selling to friends), can be severe. Possession of even a small quantity of a controlled drug can lead to a charge for intent to supply. Surrounding factors other than quantity will be relevant when a court considers whether there was intent to supply.

The law allows judges a measure of discretion in how they direct juries to reach their verdict in this area. Sentences for drug offences depend upon the quantities involved, previous convictions and other relevant circumstances.

Some drugs are controlled under the Medicines Act 1968. This covers drugs such as Diazepam which it is legal to possess under prescription but not to supply to others. Many of these drugs are also controlled under the Misuse of Drugs Act. The most commonly used controlled drugs are pictured at the beginning of this section, together with details of their legal status.

2.2 Production, supply or use of drugs on premises

Personal liability
Section 8 of the Misuse of Drugs Act 1971 makes it illegal for occupiers of premises to knowingly permit on those premises:

- The production or attempted production of any controlled drug (s.8(a))
- The supply or attempted supply of any controlled drug (s.8(b))
- The preparation of opium for smoking (s.8(c))
- Smoking cannabis, cannabis resin or prepared opium (s.8(d))

“Occupiers of premises” includes anyone “concerned in the management of premises”. This includes managers of projects operating at residential or day centres and may include some employees.
2.3 Closure of premises

Part One of the Anti Social Behaviour Act 2003 (ASBA) came into force in January 2004. It creates new powers for the police and courts to close down premises that are associated with the production, supply or use of class A drugs and disorder or serious nuisance.

The process of closure of a premise starts by issuing a Closure Notice under the authority of a Police Superintendent on the basis of reasonable suspicion of Class A drug use, production or supply together with serious nuisance or disorder.

The Closure Notice must be served on parties with an interest in the premises. A Court hearing must take place no more than 48 hours after the Closure Notice is issued, to decide whether to make a Closure Order. During those 48 hours, it is an arrestable offence for anyone other than habitual residents to visit the premises. It is possible to seek a 14-day adjournment of the court hearing, however this will not be granted routinely.

If a Closure Order is made, the premises will be sealed for between 3 and 6 months. No-one will be allowed to enter the premises, regardless of any legal interest. It is possible to appeal a Closure Order. There is no provision for projects working with people who use drugs to be excluded from the exercise of these powers.

It must therefore be a concern for those working in such projects to guard against any such action being taken. Should this situation arise you will benefit from having co-operative relationships with the police, your local authority and your neighbours. You can mitigate against such action being taken by having a clear, written policy that details the legal position in relation to possession, use, production or supply of controlled drugs on your premises.

The policy should be displayed in a prominent place where clients and other visitors can see it, for example on the notice board in any “open” area. Clients and regular users of the service should also be provided with a copy. If action is taken against your premises, you should seek immediate legal advice.

2.4 Paraphernalia

The tools that are sometimes used to assist in taking drugs are commonly known as “paraphernalia”. These include hypodermic needles used for injecting, spoons used for mixing drugs for injection, snorting tubes such as rolled bank notes for snorting cocaine, and pipes or plastic bottles used for smoking.

The law has recently changed to make it legal to supply certain types of paraphernalia to drug users. Contact Release if you want to know more.

2.5 Frequently asked questions

If I find a client in possession of a controlled drug on the premises, what should I do?

First, you should establish whether your client has a legal right to possess the drug - i.e. on prescription. If not, you should ask your client to remove the substance from the premises or watch them dispose of it. You should also remind them of your drug policy and the illegalities of their drug possession. Give your client firm guidelines on what will and will not be tolerated on the premises.

Stella Project further comment:
In addition, refuge staff should explain to the woman that this will not automatically lead to eviction and take the opportunity to explore the woman’s substance use and provide advice and information on services that can help.

I have found a substance in the communal area of the premises which I think is a controlled drug. What should I do?

If the substances are prescribed medication and clearly labelled so the identity of the owner is known then they should be returned to the owner. The owner should be reminded to keep all medications on their person or in a locked cupboard. If the owner is not known then the drugs should be returned to a pharmacy.
If the substance is illegal then the only safe courses of action are to destroy the substance (this can be done most effectively by crushing and hovering it up if it is a solid) or to hand it straight to the police (and inform them beforehand). If you hold onto the drug or pass it to a colleague, you could theoretically be charged with possession and supply respectively.

Any decision should be made by a manager. It is useful in this type of difficult situation to have a clear, written policy for guidance. It would be a good idea to destroy the substance in the presence of another colleague (preferably a manager), and to make a written record.

**I have found a substance in a client’s room that I think is a controlled drug. Should I destroy it?**
If you are sure that your client is in possession of the drug illegally (i.e. without prescription) then yes. If you are not sure, you should ask the client about the substance first.

**Stella Project further comment:**
Removing any drugs from a woman’s room could have safety implications for that woman if she is holding onto the drugs for someone else or if she may return to a partner to get a further supply.

There are very few occasions when you would enter a woman’s room without her permission, so it is good practice to have the woman present if you do enter her room. In this case, if illegal drugs are found you can discuss this with her, remind her of the drugs policy and advise her to destroy the substance. This incident may also provide an opportunity to discuss her drug user further at the time or in a future keywork session. Remember that if cannabis is found and no action is taken, this could lead to liability under Section 8 of the Misuse of Drugs Act (see 2.2). If the woman shares a room with another resident or children then you have a duty of care to act. If the drugs are exposed to children then refer to the child protection policy and discuss findings with the woman. You should be supportive and non-judgemental and discuss the implications for parenting.

**Do I have to report it to the police?**
No. You are not obliged by law to report this to the police.

**What if someone informs me they are dealing drugs?**
You are not required by law to make a report to the police unless you are told about a specific crime that is about to be committed. You should be clear about your obligations of confidentiality in relation to your client. Your organisation should have a written policy in relation to confidentiality and in relation to drug use and supply on the premises. You should ensure that you are aware of these policies and understand them. It would also be sensible to inform your client about the illegalities of their activity and remind them of your organisation’s drug policy.

**What if you suspect or have been told by another client that someone is dealing illegal drugs from the premises?**
This is potentially a very serious situation as it could put you and your managers in danger of liability under Section 8 of the Misuse of Drugs Act 1971. However, before any action is taken, you should be sure to have some concrete evidence on which to base any investigation. You should inform your supervisor of the allegations (or your suspicions) immediately. Your organisation should have a written policy as to the action to be taken in these circumstances. Provided there is some concrete evidence giving rise to a reasonable suspicion, a thorough and fair investigation should be carried out without delay, and there should be some form of hearing in which the suspected party is given an opportunity to communicate their side of the story.

If the conclusion is reached that there has been supply on the premises, this should be treated very seriously e.g. permanent exclusion from your project. If the suspicion of supply is based on evidence that is not substantial enough to warrant an investigation (for example, a casual, one-off allegation without substantiation), it may be appropriate simply to make a note of the allegation and keep the situation under review.

**Stella Project further comment:**
A refuge has a legal requirement to take reasonable steps to stop the supply of illegal drugs taking place on the premises. It is important that residents know that if they are found to be dealing from the premises, then serious repercussions must follow such as a written warning or possibly eviction.
2.6 Drugs Policy

It is essential that all services have a drug policy that both staff and clients understand. This will provide a framework for safe inclusion of substance using clients within your services, ensure a consistent response and provide staff with the clarity and direction they need to support their work with service users.

Key issues to consider when writing or developing a drugs policy:

- That the use, production or sale of illegal drugs is unacceptable on the premises
- Commitment to working with substance using clients should be stated within your policy
- Alcohol use should also be addressed as a part of an organisation’s drug policy
- Your policy should include details of what behaviour is unacceptable and guidelines for dealing with this behaviour
- A drugs policy should highlight the support that is available and how to access it

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

http://www.gldvp.org.uk/module_images/SampleDrugsPolicyFINAL.pdf
3. Working with domestic violence survivors experiencing problematic substance use

Working with survivors who use drugs or alcohol needn’t be a stressful or resource intensive exercise. Even small agencies with few resources can incorporate basic policies and practices that provide an inclusive service. The section below will explore basic knowledge for working with drug and alcohol using women and also suggest some practice techniques you may find helpful.

Section 5 of the toolkit also contains a variety of helpful tools and techniques you can use with survivors.

The following section contains:

3.1 Facts and Statistics 57
3.2 Practice issues 59
3.2.1 Providing information on support services 59
3.2.2 Screening 61
3.2.3 Assessment 65
3.2.4 Documentation for client files 68
3.2.5 Risk 70
3.2.6 Crisis intervention and emergency drug/alcohol support 72
3.2.7 Safety & additional factors to consider when safety planning 73
3.2.8 HIV and Hepatitis 77

(continued overleaf)

The main points of the sample policy are:

• Supplying or manufacturing drugs from the building is not allowed

• Any suspected drug use, supply or manufacturing in the building will be challenged. However, the refuge is not obliged to stop a woman using illegal substances in her room, unless they are cannabis or opium. The resident is breaking the law by using drugs in her room, not the refuge

• The law for cannabis and opium is different to other drugs. If residents use these anywhere on the premises actions taken to address this have to be more assertive

• All women should report prescribed medicine use to staff and store them in a safe place

• Staff are prohibited from holding onto substances for residents, even if they are prescribed by the doctor

• Anyone whose behaviour is offensive or disruptive when affected by substance use will be challenged and treated in accordance with the refuge’s general conduct and anti-social behaviour policy

The Stella Project policy draws on a sample policy created by Kevin Fleman/KFx available at www.ixion.demon.co.uk
3.1 Facts and statistics about women, violence, drugs and alcohol

“Women who start drinking as a result of domestic violence... experience a range of awful feelings as a consequence of the violence, often compounded by a tremendous sense of shame and anger with themselves for drinking”.

Nicola Saunders, Drug and Alcohol Services London (DASL)

- Survivors in violent situations may turn to substance use as a form of self-medication and relief from the pain, fear, isolation and guilt that are associated with violence. Evidence also exists to show that a male partner often introduces women to drug use

- Women’s reliance on others to administer injections means they have less control over their drug use

- Social isolation can produce further dependence on a partner and attempts at sobriety or reducing substance use may be threatening to a controlling partner. Some violent men will actively encourage women to leave treatment – that is if they are allowed to access services in the first place

- The probability that a woman will engage with treatment decreases if doing so will anger her perpetrator

- A U.S. study of refuges revealed that as many as 42% of women use alcohol or other drugs

- A one week screening period of women in domestic violence agencies in East and West London (n=80) revealed that 44% reported their own problematic substance use

- A UK study of 60 women using crack cocaine found that 40% reported being regularly physically assaulted by a current partner and 75% being physically assaulted by a current or past partner
3.2 Practice issues

The focus of your work is likely to be around increasing safety for survivors of violence. This is likely to also involve minimising the harm associated with substance use. Minimising the risks to survivors will already be part of your work; substance use is simply an additional risk factor. As with violence, there are practical steps which can be taken to increase safety.

3.2.1 Providing information on support services:

One of your key responsibilities as a refuge worker is to provide your client with comprehensive and confidential information on the support and services available to them. Examples include information about drug and alcohol support agencies, information on different substances, counselling and other support services as well as general information on issues such as housing, benefits and so on.

While your clients may feel able to ask for some of this information, it may be difficult for them to speak about issues related to substance misuse due to fear of losing their refuge place or children or of not being believed.

It is therefore a good idea for you to provide basic information on drugs and alcohol to all your new clients as a matter of course. You can also ensure that there are leaflets/posters/information cards available throughout your organisation e.g. in toilets, living areas etc. Your local Drug and Alcohol Action Team (DAAT) will be able to provide you with such information – contact details can be found on pg 319.

You could consider inviting a drug/alcohol worker to a house meeting in order to introduce themselves and raise the issue generally about drug/alcohol use.

—

“...wanted me to go and cop [get cocaine]. I refused to. I told him I did not feel like smoking that day, I was hungry. He did not feed me. We had money for food but he wanted to use it for crack. And when I didn’t, he commenced pushing me down on the floor and just kicked me until I stopped moving”

(Survivor’s voice)
### 3.2.2 Screening

Screening for substance use is an opportunity to start discussions on how substance use can impact on safety, health and well-being. Remember that screening is different from assessment which uses more thorough and comprehensive tools and should be accompanied by a care plan.

Specialist drug and alcohol workers are best placed to undertake more thorough assessments. However, as a domestic violence worker you are in a position to ask some screening questions.

Domestic violence services often routinely assess clients for a variety of issues, including mental health, financial or benefits issues and familial relations. As part of this assessment you could include some questions around substance use.

Screening should not be used primarily as a method of exclusion but rather a tool which allows you to provide for the multiple needs of your clients. It is important to introduce the questions in a way that helps to normalise the issue.

For example:

“**As well as talking about domestic violence and abuse, we are also asking all service users about drug and alcohol use because this is very common. You may have seen our posters out in the waiting room. We will not automatically exclude you from our service because of drug and alcohol use.”**

**OR**

“**Because we care about your well being we will ask you about whether anyone in the home uses drugs or alcohol. We ask everyone this because we want everyone to be as safe as possible. This will help us to provide the best possible support for you.”**

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**When providing information to clients always remember:**

- Information should be readily available to clients and workers in anonymous spaces

- If clients request information staff should make the utmost effort to acquire and explain this information

- Don’t assume everyone can read, make sure you ask if clients require additional support

- Not everyone’s first language is English. Provide information in a variety of languages where possible. FRANK has leaflets available in a variety of community languages [www.talktofrank.com](http://www.talktofrank.com)

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“Oh I do think that one good way to reach women in refuges is to try to link with the refuge and offer to attend house meetings/residents meetings once a month to introduce the substance use service - have a chat with the women about the links and just get yourself known and build up some relationship/trust. I know the turnover is often quite quick but if it’s a regular thing you just get known by women and staff and are much more likely to receive referrals.”

*Michelle Robson, Domestic Violence and Substance Misuse worker at Drug Alcohol Services London (DASL)*
Key questions:

- Assume drug and alcohol use
  “How much alcohol do you consume each day? What sorts of substances do you use?”

- Normalise the drug use
  “Some people find that the use of drugs and alcohol help them cope with the abuse – does drinking or using drugs help you cope with your situation?”

- Ask in the context of specific stresses
  “What do you use to cope with the violence/pain?”

- Identify the cause of a specific health concern
  “You are saying you are having breathing difficulties/feeling depressed and agitated/constant sore mouth, some drugs can cause that …”

- Ask about the partners relation to the drug use
  “Does your partner ever make you feel you have to use drugs or alcohol? If so how often and when has this occurred?”

What Works: the nia project
The nia project has been offering support to women and children experiencing violence and abuse for over 30 years. While the nia project has a long history with LB Hackney (our host borough), the organisation works pan-London and to some extent nationally.

The organisation provides temporary safe accommodation, support and advocacy to women and children fleeing domestic violence; and individual and group-based support to survivors.

The nia project also employs Hackney-based IDVAs (Independent Domestic Violence Advocate) and a pan-London ISVA (Independent Sexual Violence Advocate), as well as therapeutic support for children and young people and specialist services for women involved in prostitution, women with substance misuse issues and BMER women and children.

The nia project also offers training and awareness-raising on a range of topics related to gender violence to communities and professionals across all sectors.

nia project training courses for professionals have received accreditation from Royal Holloway, University of London and the organisation has been recognised as a model of best practice with a 2005 Mayor of London Award of Distinction in recognition of outstanding and innovative work to further the aims of the London Domestic Violence Strategy and to make London a safer place.

In developing specialist services for women with substance misuse issues the nia project recognises links between domestic and sexual violence and substance misuse and has taken steps to respond to the needs of this often marginalised client group.

As part of our service, we have a substance misuse worker who works specifically with women with drug and alcohol issues and developing partnership working with external agencies.
3.2.3 Drug and alcohol assessments

If a survivor has disclosed drug or alcohol use, in order for you to provide the right level of support, it is important to try and build up a picture of drinking or drug use and to determine if it is problematic.

Ideally a comprehensive assessment should be completed by a specialist drug/alcohol worker however there may be circumstances where it is more appropriate for the domestic violence worker to do this e.g. survivor does not wish to speak to someone else, drug / alcohol worker unable to attend service.

Different domestic violence organisations may require different assessments, depending on the level of support your organisation will be providing for clients.

Generally an assessment should include:
- The type of drugs/alcohol used, with a focus on the main substance used
- How much is used?
- How long have they been using?
- How are the substance(s) used?
- When are the substance(s) used e.g. what time of day, with whom?
- Is the client physically dependent on the substance e.g. do they describe physically withdrawing from substances?

More detailed assessments will ask about any issues involved with health, family, work or criminal activities. It is suggested that full assessments should be used in refuges to gauge how a woman’s use will impact on the shared living environment.

Contact:
Claire Colley,
colley@niaproject.plus.com
t: 020 7683 1277

For example, we work closely with drug/alcohol agencies in building more appropriate referral pathways and assessments for women with multiple and complex support needs.

The nia project is now one of only a few organisations to provide specialist support to women with substance misuse issues who have experienced domestic or sexual violence and/or are involved in prostitution.

This is a service area that we aim to expand over the coming months and years, as we believe that it is essential that women who misuse substances and experience gender violence must be listened to, understood and supported.
Questions need to be raised around the following areas:

**Current use:**
- What are you using?
- Separately or with other substances?
- How much do you use per day/week?
- Describe a typical day
- What makes you start or stop using?

**Mental Health:**
- What are your moods like?
- Do you have a history of psychological or psychiatric problems?
- Have you ever self harmed or tried to commit suicide?

If a client indicates they have a mental health problem or you suspect from these questions they do, you should seek assistance from a mental health organisation. **Pg 209** outlines a process for this.

**Personal safety:**
- What plans do you make for your children when you are drinking or using substances?
- How do you control your use?
- What helps control your use?
- Tell me about the positive things going on in your life

**Change:**
- Have you tried to reduce your substance use in the past?
- What has or hasn’t worked for you in the past?
- Would you like to reduce the problems with your drug use?

- Have you made plans for this?
- Have you talked to anyone about this?

**Challenges:**
- What things could get in the way of changing your drug use?
- Is your partner getting involved?
- Who will support you?
- How will you manage parenting while this is happening?

**Overdoses:**
- Do you ever pass out or lose your memory as a result of drinking or drug use?
- Have you ever overdosed?
- Could you tell me about these incidents?

**Physical Health:**
- Has your use affected your physical health?
- Have you had a recent check up?
- When you don’t use do you have withdrawals?

**Livelihood:**
- How much does your drug use cost you?
- How does your use affect your workplace performance?
- Is your accommodation stable?

**Legal:**
- Have you been or are you in trouble with the authorities?
- Are you facing current convictions?
Possible signs of alcohol or drug use
- Smell of alcohol
- Signs of IV drug use (tracks, bruising, scabs etc)
- Unusual or extreme behaviour
- Nodding off
- Extreme forgetfulness
- Overtly alert
- Slurred or rapid speech
- Staggering
- Tremors
- Glassy eyed/pupils dilated or constricted
- Unable to sit still
- Disorientated or confused for no apparent reason
- Argumentative, defensive or angry at questions about substance use

Note that some of these signs are conducive to mental and physical health problems and may not be indicative of drug or alcohol use.

Screening tools and a drug and alcohol assessment form can be found on pg 264 onwards.

Remember no one expects you to be a drug and alcohol expert. Whenever possible refer your client to a drug and alcohol agency for assessment and treatment.

If it appears that a client becomes physically ill when they are not using, you should consider asking questions directly related to their dependency (see pg 267).

3.2.4 Documentation for client files

This following section is taken from Refining the Routes, Domestic Violence and Substance Misuse: Policies, Procedures and Protocols for Partnership working in Camden, 2007 available from www.camden.gov.uk/domesticviolence

It is important to keep accurate, concise, relevant and up to date records. All notes should be written during the session with the client, agreed by the client, and signed and dated. Any documentation will include the nature of the routine inquiry, the client responses, the worker’s response including discussion of options and information-giving, risk assessment, any injuries that have been noted, any referrals made, any safety plans, and scheduled follow-up appointments.

Even if substance misuse is not identified as an issue, it should still be documented that the worker inquired about it, and the client response. If the worker did not inquire about substance misuse as part of a Substance Misuse Routine Inquiry Policy, this should also be documented with the reasons why this did not occur.

Possible reasons could relate to issues of safety. For example, if the client was accompanied by someone else, if it was not possible to speak in a confidential setting, or if the client left before the appointment was completed.
3.2.5 Considering risk

As domestic violence workers you will already be familiar with carrying out risk assessments with your service users.

For a survivor who is using substances you should consider some additional questions to allow you to assess the full extent of the risk faced by the survivor:

- Have you ever overdosed or lost your memory as a result of your substance use?

- What are your drug/alcohol using habits? Could any of these be risky for you? E.g. sharing injecting equipment, drinking to the point of losing consciousness, using a variety of substances at one given time?

- When you are intoxicated who cares for your children?

If the service user complains of any pain, numbness, seizures and blackouts, recent near overdoses, heart pains or bruising or swelling around injection sites, it will be beneficial for the service user to see a medical professional. Remember as with domestic violence, risk assessment for drug and alcohol use should be on-going.

People in crisis are in a state of change and so are their circumstances. A survivor's use of substances may increase with a return to the partner or with increased episodes of violence. Risk assessments should therefore be continually updated and advice sought from a drug/alcohol professional around safety and harm minimisation.

Key points to consider in screening and assessments include:

- Portraying the substance use as expected or functional normalises her behaviour and will help build trust in disclosing any problems.

- Practitioners should always be open to the possibility that a woman may be using substances and be alert for signs (see pg 69). Ask questions when appropriate in keywork sessions. It is important to give the woman the support and time necessary to share her history with staff.

- Assessments need to be on-going and relate to changes clients may be experiencing e.g. a relapse in drug or alcohol use and return to her partner. She may then be facing a possible risk related to her drug use as well as the risk of violence.

- A woman may not disclose substance use immediately and may be in denial which. Denial is the most frequent response to questions about drug/alcohol misuse. See pg 82 for advice on how to address this.
3.2.6 Crisis intervention and emergency drug / alcohol support

In addition to the crisis/emergency line your service may operate, you could also give your service user details of other helplines which specifically address substance or mental health related issues.

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

Saneline offer practical information, crisis care and emotional support to anybody affected by mental health problems t: 0845 767 8000 (charged at local rates) 1pm – 11pm every day.

Emergency drug/alcohol support
There are no drug/alcohol agencies which provide 24 hour assistance. Therefore if a woman arrives at a refuge and requires emergency assistance with regards to drug use e.g. severe withdrawal symptoms, you should contact the out of hours GP service or take her to A&E who may be able to prescribe some emergency symptom relief.

It is unlikely they are able to provide emergency/immediate prescribing of drugs and if methadone is provided it will be at a low level. Therefore, she may require extra support overnight or through the weekend until she can get access to full prescribing.

You should contact your local DAAT team (see pg 319) to inquire as to the fastest route in your area for providing services such as prescribing.

You may wish to consider setting up a protocol with your local GP for prescribing the interim with the local drug agency picking up prescribing as soon as they re-open.

3.2.7 Safety for domestic violence survivors using substances

Although survivors may be using substances, safety is still the priority issue. Additional safety issues to bear in mind for this client group include:

- Some survivors’ drug or alcohol use could make it difficult for them to assess the severity of the violence they are experiencing. Their substance use may be ‘dulling’ both the physical and mental pain they are in
- Survivors who are using substances may be too ashamed or embarrassed about their substance use to access services
- Some women may feel they cannot disclose their substance use problem for fear of not being given access to refuge accommodation
- Trust is paramount. Problem drug-using women caring for their children fear automatic referral to social services departments if they disclose their drug use
- Some survivors may have had previous bad experiences with substance misuse agencies which may hinder their choice to engage with new services

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

- The response survivors may receive from services/police etc. when they make calls under the influence of alcohol/drugs
- Staying safe when services arrive - some women see this as a safe opportunity to challenge their partner/become more aggressive themselves when the police are there - this then impacts on them being seen as the aggressor and taken less seriously
• How will they implement their safety plan if they are drinking? Often good safety plans can go out of the window as soon as a person is intoxicated

• What provisions are made for children when using/drinking or when the violence happens?

• Detox/withdrawal/relapse on the part of the perpetrator can be dangerous times in terms of safety

• Consideration of which drug/alcohol services to access – do not use one where their partner attends

• Altering routes/times if their partner is aware of their attendance at an alcohol/drug service; using a panic alarms; making sure phone is charged

• Anticipating partner’s substance use – how to keep safer when they have been using/drinking

• Consideration of how a survivor’s drinking/using may impact on their ability to protect themselves - they are more likely to fight back and receive worse injuries etc.

• The location of where a survivor goes to use/drink – how does this impact on safety?

• Discussion of harm minimisation e.g. learning to self inject safely, smoking rather than injecting (a drug/alcohol agency will be able to provide such harm minimisation support)

• If considering leaving – where will they get supply of drugs – do they need emergency prescribing?

• It is also empowering for a survivor to realise that their abuser wants them to continue in their dependency to substances and to plan for such interference with their treatment

• Vulnerability/safety when entering new relationships due to drinking/drug use

A sample safety plan can be found on pg 288.

What Works: Eaves Women’s Aid - Chamlong House
Chamlong House is a short term crisis refuge for women and children who have or are experiencing violence and abuse in Southwark.

The service is further targeted towards women with substance misuse, mental health, learning difficulties and women with male children up to 16 years. Access is available 24 hours with a maximum stay of 12 weeks.

Full support and advocacy is provided to all women and children while at the refuge, with 6-8 week resettlement support upon leaving the project.

Referrals are accepted from agencies within Southwark, as well as self referrals. The refuge receives a reasonable number of referrals of women with drug and alcohol misuse – many are identified through our initial referral and some once admitted to the project through a full assessment process. Partnership working has/is essential to appropriately meeting women needs.

Our experience of the past 18 months has been invaluable in identifying what has worked and not worked and lessons learnt for the future:

1. High staff turnover – many do not understand the full implications of working in a medium/high project of this kind and the realities of working with women in a very short space of time. Overwhelming paper work and responsibility for all refuge issues means staff become burnt out and disillusioned very quickly. Rot based work including night shift ‘sleep ins’ didn’t suit everyone which also resulted in high turnover.

2. Specialist worker and funding – the refuge was initially dependent on a specialist substance misuse worker. However problems with recruitment and then loss of funding placed greater emphasis on the mainstream refuge workers to develop more specialist skills around drugs/alcohol through appropriate training. Now all staff feel capable and confident to manage issues which arise relating to drug/alcohol use without the support of a specialist worker.
3. It is important to have a children’s worker. We have recently received funding for this post which is crucial as the workload for the other refuge workers is heavily increased when following up with children’s issues as part of their role.

4. Developing the links to partner agencies in the drug/alcohol field was crucial but time-consuming so it’s important to factor in time for partnership working.

5. We have been able to support women who are still using and who present with complex needs without too much disruption to staff and other residents.

To make a referral, please call our main number 0870 850 2642.

Further information can be obtained from:
Pat Blackford (Domestic Violence Services Manager)
t: 0870 850 2854; patricia.blackford@eaveshousing.co.uk

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3.2.8 HIV, Hepatitis (Hep) B & C

Many people associate drug use with infectious diseases such as HIV and hepatitis. HIV and Hepatitis C are blood borne viruses, meaning they are spread when there is contact between the blood of two people.

This means injecting drug users can contract HIV or hepatitis through sharing drug paraphernalia. Drug users are often aware of the risks and choose to use their own drug equipment and store and dispose of equipment safely.

Because HIV and Hepatitis B and C can be contracted in a variety of ways it is safer to assume that anyone could be a carrier, both staff and clients.

Organisations therefore need to have clear guidelines for staff about dealing with any blood spills (e.g. in an accident or emergency situation), handling needles, sharps bins and associated drug paraphernalia.

So what are HIV, Hepatitis B and C?

- HIV is a virus which can lead to AIDS, which is a disease that affects the body’s immune system. A positive HIV test does not mean that a person has AIDS

- Hepatitis is a word used to describe disease or inflammation of the liver. Hepatitis C, B and HIV are not contracted through:
  § Kissing, sneezing, coughing, hugging or other social contact
  § Sharing food or drinks
  § Sharing eating or cooking utensils
  § Toilet or shower facilities
  § There is no risk of contracting Hepatitis C, B or HIV from a mosquito or other blood-sucking insects

- Hepatitis B and C can be contracted in a variety of ways it is safer to assume that anyone could be a carrier, both staff and clients.
How can I contract HIV?
HIV may be transmitted when blood, breast milk, semen or vaginal fluid from an infected person enters the body of an uninfected person. This can happen through unsafe sex - anal, oral and vaginal. Sharing needles and injecting equipment contaminated with blood is the other primary method of contracting HIV. Injecting equipment could include needles, syringes, swabs, tourniquets or spoons.

How can I contract Hepatitis B?
Hepatitis B can be spread through unsafe sex - anal, oral and vaginal. There is a small risk that it can be spread to close members of a household through close contact such as contact with broken skin, kissing or sharing razors.

How can I contract Hepatitis C?
Hepatitis C can be contracted through re-using or sharing needles or any equipment when injecting drugs. Hepatitis C spreads very easily through sharing injecting drug equipment. Sharing once can be enough to become infected. Hep C can also be contracted through sharing contaminated personal hygiene equipment, such as razors or toothbrushes with an infected person.

Ten Tips for HIV, Hep B & C prevention
1. It is not necessary to keep people with Hepatitis B, C or HIV away from others.
2. Encourage safer sexual practices e.g. leave free condoms and safe sex information and advice in bathrooms.
3. Inform your clients of the risks associated with sharing needles or injecting drug use paraphernalia.
4. Front line staff should be immunised against Hep B. Ideally this would be provided in-house or employees could be reimbursed for their treatment at local GPs.
5. Avoid sharing of intimate equipment such as toothbrushes, razors, nail files.
6. Safely dispose of blood stained tissue, sanitary napkins and other dressings so they are not where people can touch them.
7. Wipe up blood spills using warm water and detergent. It is safer if people clean up their own blood spills.
8. Care is needed when dealing with blood (including minor injuries). This means hand washing, covering open sores or wounds, disinfecting surfaces etc and using gloves when cleaning wounds.
9. All services should have latex gloves on hand to deal with any contact they may have with blood in an emergency situation. These should be placed in a communal area and all staff and clients be made aware of where the gloves are kept.
10. If injecting equipment is found it should be disposed of as soon as possible. Needles and syringes should be disposed in an appropriate needle disposal bin; other paraphernalia should be placed in a separate plastic bag and placed at a refuse point.

Services should be aware that any of their clients or employees could possibly be carrying HIV, Hep B or C. Some PCTs offer free immunisation against Hep B for frontline workers.
3.3 Strategies for change

3.3.1 Giving survivors choices

Refuge and outreach practitioners report that one of the most over-riding factors which has helped to engage a survivor in discussions around substance use, is the non-judgemental approach of the keyworker.

“Most substance users at the time of referral are ready to accept help and support to overcome their problem. Don’t be judgemental - it blinds you from seeing a person and instead you see a problem first; they see through that. Work on building a trusting and honest relationship to enable them to express themselves honestly (if they relapse). After all they are individuals who deserve to be given an opportunity to make the most of life. Our job as support workers is to give the best SUPPORT, encouragement and acknowledgement we can. Don’t judge, don’t be scared, don’t give up, you may be that one person who makes a difference to someone’s life.”

Nikki Campbell, Domestic Violence Support Worker, Solace (formerly Camden Women’s Aid)

• The process of change is gradual and often slow

• If your client experiences domestic violence and substance misuse their lifestyle is likely to be extremely stressful and sometimes chaotic. Their confidence as a survivor may be low, perhaps magnified by the stigma of problematic substance use. In this state it may be difficult to find the confidence and foresight to instigate change

• It is important not to set unrealistic goals for clients who are negotiating life changes. For example if a specific service decides it will only work with a survivor if they seek treatment for their alcohol use

• Do not push a survivor into a decision they are not ready to make. This is exactly the sort of behaviour they are trying to escape from. In particular, it is important to note that women in refuges are immersed in crisis situations which often need to be resolved before they are able to address other issues such as their substance use. In fact, asking a woman to give up one of her coping mechanisms at such a time may well be counterproductive

• Any choices clients make around treatment or personal safety should be done in their own time. This allows people to feel empowered and in control of their life, hopefully allowing them to make positive decisions, about their future

“It’s like I’d drink to get rid of the pain and stop it hurting so much. Both emotionally but more at the time – it was more physically. Looking back in hindsight I can see that a lot of it was sheer terror of what was gonna happen and drinking enough kind of got rid of it but it was also the anaesthetic before the pain.”

Survivor’s voice

© Stella Project Section 2 - Drugs and Alcohol
3.3.2 Cycle of change

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

People have to move through each stage in succession in order to successfully reduce and/or stop using substances. Most people attempting to stop using drugs and/or alcohol move around the cycle several times before they become dependent free. Resistance to change is usually characteristic of the wrong intervention at the wrong time.

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

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

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

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

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

**DETERMINATION/PREPARATION**
Motivated to make change and looking for ways to change; this is a window of opportunity - only open for short time.
How to help?
Acknowledge the significance of choice and affirm ability to seek treatment and change despite the difficult road ahead; suggest choices for action and help survivor decide most appropriate, achievable path; probe survivor’s thinking/worries/fears about options; if survivor is fearful about attending a new service, suggest a drug/alcohol worker comes to them at an agreed location.

ACTION
The person is actively doing things to change and modify behaviour but is not yet stable; often thought of as a therapeutic process; doing things to make a change.

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

MAINTENANCE
A person continues to maintain behavioural change on a long term basis. Sustaining change; preventing relapse; learning different skills that are needed to change.

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

RELAPSE
A person returns to pattern of behaviour that they have begun to change and hence returns to one of the first three stages. Slip up – steps backwards; challenge is to start again and not get demoralised; use relapse as an opportunity to grow.

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

3.3.3 Implementing minimum standards
Organisations could consider working towards a set of practice standards to help inform and direct the development of their services for survivors and their children.

The Stella Project has created a model which can be found on pg 303 and adapted to the specific needs of agencies.

3.3.4 Interagency working and referrals
To meet the needs of this client group you may need to consider extending your partnership work. It is often assumed that interagency working is time consuming and complex but there are small scale changes which can be made that can be easily incorporated into existing work practices.

Some of these may be routine for you already such as agreeing to refer clients to a partner agency or simply ringing other agencies to enquire about services. You may have already established drug and alcohol agencies in your service directory.

There are always challenges to interagency working and as a worker you need to take into account the different approaches to practice.

For instance, you may need to explain to a drug and alcohol service the issues you have around confidentiality and the secrecy of your location.

Always offer to send information about your service, provide a named point of contact within your organisation and supply any telephone support numbers you can.

Pg 224 gives more information about partnership working.
3.4 Summary of key messages:

- Treat a survivor’s disclosure confidentially. Be non-judgmental - just because they drink or use drugs doesn’t make them a bad person or a bad parent.

- Contact a local drug or alcohol agency and obtain information about the services available. Don’t forget to provide basic information about the substances they use.

- Suggest a possible meeting with a local drug/alcohol worker either at the domestic violence service or at the drug/alcohol service. If you can talk about the service and or worker in a positive and familiar manner, they may be more likely to engage.

- Be aware and knowledgeable about possible risks from her drug/alcohol use e.g. using both alcohol and methadone/opiates together, visiting unsafe houses/places in order to obtain drugs and/or use.

- Respect their choices. They may feel that now is not the time to address their alcohol or drug use. Think about where they may be on the Cycle of Change (see pg 82) and adapt your response accordingly.

- Discuss ways in which they can reduce the level of harm caused by their substance use e.g. injecting practices, safety while drinking etc.

- Discuss their previous experiences of accessing drug/alcohol treatment and explore fears or worries about engaging with another service.

For refuge workers:

- **DO NOT EXCLUDE HER FROM YOUR SERVICE SIMPLY BECAUSE OF HER SUBSTANCE USE.** Instead discuss ways in which her use of substances might cause difficulties for your service and for others.

- Her safety should still be your paramount concern. If you need to consider excluding her from your service simply because of her behaviour when using substances offer other options including alternative sources of accommodation.

- Consider how her substance use will impact on your service. What time of the day will be the best time to work with her? Can you avoid her being victimised due to her drug or alcohol use?
Jenny is a twenty year old woman who entered your refuge three months ago. Her ex partner John is now on remand for drug related charges, Jenny’s relationship was fraught with violence and excessive alcohol use. Whilst in jail for the past two months, Jenny has visited John three times and writes to him regularly. You have noticed before and after visiting John, Jenny uses alcohol heavily. Jenny plans to attend John’s court appearance next week and you are concerned about her drinking and her emotional stability.

1. What support can you offer Jenny?
2. How does Jenny view her drinking?
3. How do you think Jenny’s relationship is related to her alcohol use?

Possible Solutions

Have you considered the key points to remember when working with this client group? (see pg 86).

1. What support can you offer Jenny?

As a refuge you are already supplying Jenny with accommodation and a dedicated key worker to support her stay. Do you have a full understanding of the level and extent of Jenny’s alcohol use? If not it is best to ask Jenny several questions and do a full drug and alcohol assessment. Alternatively, if Jenny is willing, a drug/alcohol worker could come to the refuge to speak to her.

If Jenny is drinking a large quantity on a daily basis, it is likely that she is physically dependent on alcohol. You could open up a conversation about her pattern of drinking and how it is related to health – for example her sleeping patterns.

You could also explore how Jenny’s relationship impacts on her use of alcohol. You could also consider where Jenny is on the Cycle of Change (pg 82) in order to determine how to support her best.

2. How does Jenny view her drinking?

You need to engage Jenny in a conversation in a comfortable and non-judgement environment. Ask Jenny if she believes her drinking to be a problem and if she would like further support around this. If so, refer her to your local alcohol service.

It is good idea to discuss with Jenny her fears around engaging with treatment service – has she had bad experiences before? Do not remove Jenny from your service simply because she is an alcohol user. Do not assume that just because Jenny drinks heavily on occasions that she will behave in a completely inappropriate manner. It is good practice to be clear with Jenny and all service users about what sort of behaviour is acceptable in the refuge - with or without alcohol. Firm boundaries should also be set about if and where Jenny can drink in the project. For example it may be okay to drink in her room, but not in the lounge or the children’s play area.

3. How do you think Jenny’s relationship is related to her alcohol use?

It appears that Jenny uses alcohol to cope with her fears and anxieties in her relationship. Is this how Jenny views her drinking? Can you have a conversation with Jenny about this? What additional support can you offer Jenny before or after visiting John? Perhaps arrange your key-work sessions the day before her visits and explore other ways she can deal with her anxieties. Raise the possibility that Jenny could avoid visiting John or reduce the number or frequency of those visits.
4. Drug and alcohol services

Drug and alcohol services vary a great deal in terms of their level of service provision and their frameworks for practice. This section below will look at the different types of services and interventions commonly used within the drug and alcohol sector.

4.1 Different types of drug and alcohol services

The National Treatment Agency has developed a four-tiered approach to substance misuse service provision. An explanation of these tiers is below.

**Tier 1: Non-substance misuse specific services that may have clients with drug and alcohol issues e.g. doctors, refuges, social services.**
Tier 1 services work with a wide range of clients including drug and alcohol users, but their sole purpose is not drug or alcohol treatment. The role of Tier 1 includes the provision of their own services plus screening drug users and referral to local drug and alcohol treatment services.

In these services, provision for those with drug and alcohol problems may also include assessment, services to reduce drug-related harm, and liaison or joint working with specialist drug and alcohol treatment services. Many domestic violence services would therefore be seen as Tier 1 projects.

**Tier 2: Open access drug and alcohol treatment services**
Tier 2 services provide accessible drug and alcohol specialist services for a wide range of drug and alcohol users referred from a variety of sources, including self-referrals. This tier is defined by its easy access services, and limited requirements of clients to receive services.

The aim of the treatment in Tier 2 is to engage drug and alcohol users in drug treatment and reduce drug-related harm. Tier 2 services do not necessarily require a high level of commitment to structured programmes or a complex or lengthy assessment process.

Tier 2 services include needle exchanges, drug (and alcohol) advice and information services, and ad hoc support, including harm reduction support. Specialist substance misuse social workers can provide services within this tier, including the provision of access to social work advice, childcare/parenting assessment, and assessment of social care needs.

**Tier 3: Structured community-based drug treatment services**
Tier 3 structured services include psychotherapeutic interventions and structured counselling (e.g. cognitive behavioural therapy), motivational interventions, methadone maintenance programmes, community detoxification, or day care provided either as a drug and alcohol-free programme or as a part of methadone treatment.

Tier 3 services require the client to receive a comprehensive assessment and to have a care plan, which is agreed between the service provider and client. The drug and alcohol user attending Tier 3 services will normally have agreed to a structured programme of care which places certain requirements on attendance and behaviour (e.g. a certain number of days or hours attendance per week with a programme review triggered if attendance becomes irregular).

**Tier 4: Residential services for problematic drug and alcohol users**
Tier 4 services are aimed at individuals with a high level of presenting need. Services in this tier include: in-patient drug and alcohol detoxification or stabilisation services; drug and alcohol residential rehabilitation units; and residential drug crisis intervention centres.
4.2 Theories and interventions underpinning the drug and alcohol sector

It is possible that in working with your clients and drug and alcohol services you will come across various models of practice. Below are some pointers to the basic theories underpinning contemporary drug and alcohol services.

**Abstinence:**
The aim of abstinence is to completely refrain from the use of any substances. Organisations such as Alcoholics and Narcotics Anonymous require abstinence as part of their self-help ethos.

**12 Step:**
People attending AA or NA are encouraged to follow a set of 12 guiding principles. Fundamental to moving through the 12 steps is the person completing the first step and accepting they are powerless to control their "addiction" or compulsion to drink or use drugs.

There is usually a spiritual element to this programme & people following it are encouraged to look to support from a "higher power", although some followers would say this can be optional. People are encouraged to get support from a "sponsor" who can be contacted at times of crisis and potential relapse.

**Harm Minimisation:**
Harm minimisation accepts that some people will choose to use drugs and alcohol and some of those people will develop problems with their substance use. It is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising the harms and hazards of drug use for both the community and the individual. This approach does not require abstinence.

**Social Learning:**
This is a psychosocial theory which understands problematic drug and alcohol use. It proposes that drug or alcohol use is learned and continues because the user gets some reward for doing so e.g. feeling high or relaxed.

This theory suggests that learned behaviour can be unlearned and works with people to change the way clients' view their drug and alcohol use. This theory proposes that anyone at anytime can develop a problem with alcohol or drugs, which may be in response to emotional distress such as a bereavement, redundancy, or domestic violence.

**Cognitive Behavioural:**
The underlying assumption is that how people think about their substance use plays an important role in the decision to use substances. The same thinking processes can be used to help individuals change their behaviour and reduce their drug use.

Cognitive behavioural therapy attempts to help clients to recognise, avoid, and cope with triggers or relapses in their drug use. This theory is often used in domestic violence perpetrator programmes.
5. Information for practitioners delivering domestic violence perpetrator programmes

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

*Phil Price, Domestic Violence Intervention Project, East London*

N.B. Information for drug and alcohol workers who are working with clients who are also perpetrating domestic violence can be found on pg 148. Be aware that in depth work with perpetrators in relation to their violence is a specialist field that requires the correct training and resources. If you meet a client who wishes to get help with ceasing their violence, a referral can be made via Respect (see pg 158 for contact details).

5.1 Statistics and information

- Research based on small scale studies in London and Nottinghamshire found that 63% of men attending domestic violence perpetrators programmes reported that they had substance misuse problems

- Gondolf’s multi-site evaluation of perpetrator programmes has shown that the man’s drunkenness after programme intake made him 3 times more likely to re-assault his partner than a man who did not get drunk. If the man was drunk nearly everyday, he was 16 times more likely to re-assault than those who seldom or never drank

- Alcohol is likely to contribute to intimate partner violence in a variety of ways. Levels of consumption relate to the likelihood and severity of violence. Alcohol appears to be particularly important in escalating existing conflict

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

It is important that your agency explores the frequent coexistence of domestic violence, drugs and alcohol in order to ensure that all staff understand the subtle ways in which a perpetrator may use his or his partner’s substance use as an explanation or justification for their violence. Some of the key ways that substances can be used in abusive ways include:

- Perpetrators may use the disinhibiting effects of substances as an excuse for their violence and abuse. e.g. ‘I’m not usually like that, but I was off my head’

- Alcohol in particular can act as a disinhibitor and as a pre-emptive justification for violence towards a partner. A man may drink when already frustrated or angry at his partner and then use the alcohol in order to wind himself up towards violence - should he then act violently he will have a ready made excuse for his behaviour
• A woman’s substance use can be presented as an excuse for violence by the perpetrator

• Perpetrators may control or withhold substances as a means of abuse

• Perpetrators may spend the family’s money on substances denying women and children money for vital goods or services

• Perpetrators may abuse their partner by forcing her to use substances against her will

• Perpetrators may sabotage women undergoing treatment for substance use

• Perpetrators may force their partner into prostitution to pay for drugs

It is essential that drug or alcohol use is not seen as an excuse for domestic violence.

5.2 How to ask about drug/alcohol use

It is ideal for all services to briefly screen all perpetrators for drug and alcohol misuse. A few open ended questions can help reveal if a client has problems with their substance use. Be aware that if a client reveals having some of these issues you may need to complete a full drug/alcohol assessment (see pg 268).

Alternatively you could refer them to a service that is able to do this. The brief assessment will help you to choose the best methods for working with your client.

You should approach this subject by explaining that all clients are asked these questions because of the wide prevalence of drug and alcohol use in society and that they will not automatically be excluded from the programme for disclosure of drug use.

Key questions:
• How much alcohol do you drink and which drugs do you take (legal and/or illegal)?

• Have you ever thought you should cut down on your drinking or drug taking?

• Do you ever get annoyed when people criticise your use?

• Do you ever feel guilty about your drinking or drug use?

• How does your partner feel about your drug/alcohol use?

• Do you think your drug/alcohol use is related to why you are here today?

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

Phil Price, Domestic Violence Intervention Project, East London
5.3 What to do when you identify a perpetrator who has a substance use problem

Undertake further detailed assessments of drug/alcohol use
It is helpful for workers to understand how often a perpetrator uses, what he uses, when he uses and where. This will allow the perpetrator and worker to develop a greater understanding of his situation and identify which interventions are most appropriate. See pg 268 for further questions or assessment tools which will enable you to do this. This could also be undertaken in conjunction with a drug/alcohol worker. Detailed assessment is important to determine which substance misuse treatment is most suitable and in order to advise his partner about the nature of the drug/alcohol problem and implications for their safety planning.

Establish if he wish to address his substance use and refer him to an appropriate service
Ideally substance use and violence should be dealt with concurrently. However, in some cases it may be necessary for a man to address his substance misuse before attending a perpetrator programme. Don’t just refer him to a substance misuse service and expect the violence and abuse to cease. However, an effective drug/alcohol treatment intervention may reduce the seriousness of the violence. As drunkenness after and during programme intake is a strong indicator of future re-assault, risk may be reduced by periodically monitoring men's alcohol use or treatment compliance.

Establish contacts with local alcohol and drug services
Details of local services across London can be found at www.ldan.org.uk Contact your local Drug Alcohol and Action Teams (see pg 319) in the boroughs in which you work and ask for a copy of their referral guide which will detail all services in their boroughs.

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

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

According to Respect’s Perpetrator Programme Accreditation Standards, all staff working on domestic violence perpetrator programmes should receive basic drug and alcohol training.

Screening of all perpetrators for drug/alcohol use should be standard and staff are recommended to make links with local drug/alcohol agencies and make referrals where appropriate.

For more information on these standards contact Neil@respect.uk.net
Section 2 footnotes


2 ibid


9 ibid


16 Bury, C. et al. 1999. An examination of the needs of women crack users with the attention to the role of domestic violence and housing. Report for the Lambeth, Southwark and Lewisham Health Authority in collaboration with the National Addiction Centre and the Brixton Drug Project.


18 Prochaska & DiClemente, 1983. The Transtheoretical Model


1. Domestic violence information

1.1 Definition

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

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

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

Defining domestic violence has always been problematic. It must be emphasised that the above definition is insufficiently complex to understand domestic violence in its entirety and functions only as a monitoring mechanism. Whatever form it takes, domestic violence is rarely a one off incident, and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim.

1.2 Statistics

- An analysis of 10 separate domestic violence prevalence studies by the Council of Europe showed consistent findings: 1 in 4 women experience domestic violence during their lifetime and between 6 – 10% of women experience domestic violence in a given year

- Repeat victimisation is common. 89% of those suffering four or more incidents are women. The results of the British Crime Survey (2006) found that domestic violence had the highest rate of repeat victimisation, with 42 per cent of victims being victimised more than once

- Domestic violence is chronically under-reported but research shows that it accounts for 15% of all violent incidents
1.3 Domestic violence ‘Power and Control Wheel’

Domestic Abuse Intervention Project, Duluth, Minnesota

The Power and Control Wheel was developed by women survivors of domestic violence in Duluth who had been abused by their male partners and were attending women’s education groups sponsored by the women’s refuge. This wheel illustrates some of the different abusive behaviours used by men toward women and may assist you in understanding the dynamics of domestic violence.

A conservative estimate of the economic consequences of domestic violence found that it costs at least £900m per annum in London

Domestic violence accounts for 16% of homelessness acceptances

A study conducted into service provision for perpetrators of domestic violence found that male perpetrators were significantly more likely than female perpetrators to possess or use weapons. Police intelligence also showed that one in five (21%) of the perpetrators in the study were suspected of use of or dealing drugs

Research conducted with male respondents to the Scottish Crime Survey (2000) found that men were less likely to have been seriously injured, less likely to have been repeat victims of domestic assault, and less likely to report feeling fearful in their homes. When retraced, the majority of the male victims of domestic violence were also perpetrators of violence (13 of 22). A significant proportion of the men re-interviewed (13 of 46) later said they had actually never experienced any form of domestic abuse

A study of 200 women’s experiences of domestic violence found that 60% of the women had left because they feared that they or their children would be killed by the perpetrator

Among women surveyed in the British Crime Survey (2003), domestic violence is highest among those who are separated

Women are at greatest risk of being killed when separating from a violent partner. A review of domestic violence murders in London found that 76% occurred after the victim had ended the relationship

Copyright Domestic Abuse Intervention Project
202 East Superior Street, Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org
2. Criminal justice issues

It is estimated that less than one in three incidents of domestic violence are reported to the police. This section outlines the legal issues to consider when working with both perpetrators and survivors of violence.

2.1 General criminal law

There is no crime of domestic violence. There are a range of criminal offences that may occur in a domestic violence situation:

- Common assault
- Assault occasioning actual bodily harm (ABH)
- Unlawful wounding or inflicting grievous bodily harm
- Wounding or causing grievous bodily harm
- Threats to kill
- Kidnapping
- Murder
- Range of sexual assaults

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

Myth:
Domestic violence is a private matter between couples

Fact:
Domestic violence is not a private issue, it is a crime that is often unreported and repeated

There are two ways survivors can access the legal system, either through the police (criminal law) or a solicitor (civil law).
The criminal law

If you call the police
Always call 999 in an emergency so the police can provide immediate help. They may arrest a violent perpetrator if they have committed a criminal offence. It is their decision whether to arrest or not and not the survivor’s.

The Metropolitan Police Service has a positive action policy in relation to domestic violence so an investigating officer should complete a 124D form (which involves conducting a risk assessment of the survivor) and justify the reasons why an arrest has not been made if there is the power to do so i.e. a criminal offence has been committed.

The police will then pass the case to the local police Community Safety Unit. Community Safety Units are the investigation teams for domestic violence (as well as race and homophobic crime). They can also support survivors in finding ways to keep safe. You can find their number through your local police station or in the phone book.

The police will take a statement from the survivor. The survivor should be given a copy of this statement and be given contact details for domestic violence support services. The survivor will be asked to sign their statement to say that it is true. The police will also gather other evidence that may be available such as medical records, statements from neighbours and they should also take photographs of any injuries sustained.

It is not possible for a survivor to press or withdraw the charges. It is a common myth that this is the survivor’s decision, but in fact only the police and the Crown Prosecution Service can decide whether to charge and prosecute. The only action the survivor can take is to withdraw their willing co-operation with the prosecution. If there is still enough evidence of the crime, the case may still go to court and the survivor may be compelled by law to give evidence.

If a violent partner is arrested
If they’re arrested they’ll be taken to the police station. If charged with a crime, they may be released on bail while the police complete their investigation. Usually, there’ll be conditions attached to the bail such as an order to stay away from and not communicate with the survivor either directly (e.g. in person or by phone) or indirectly (e.g. by sending messages via someone else). If they ignore these conditions, they can be arrested and may be kept in custody until the court case.

If the perpetrator pleads guilty the victim doesn’t have to go to court. They may however be asked to give a ‘victim impact statement’ to describe the effect the abuse has had on them. This would be considered when the court decides the sentence.

If the perpetrator pleads ‘not guilty’ the survivor may have to go to court to give evidence. If this happens it may be useful to contact your local Victim Support or an Independent Domestic Violence Advocacy Service (IDVA) who can answer any questions about the court process. IDVAs can also attend court with a survivor.

The Crown Prosecution Service may also have a meeting with a survivor before the court case to find out if there are things they can do to help them to give evidence, such as see if they are eligible for special measures (for example, a screen to be used in court) or for video recorded evidence to be given.

If the violent partner is harassing the survivor (calling repeatedly, coming round uninvited, etc.) a survivor can report it to the police and they can issue the perpetrator with a formal caution under the Protection from Harassment Act.

If the abuse does not stop after being cautioned, the perpetrator can be arrested and could face up to 5 years in prison. This makes it more powerful than an injunction and incurs no financial cost to the survivor.
Other things the police can do

- The police can give information about support agencies (e.g. Women’s Aid, Refuge, etc.)
- They can accompany/escort the survivor back to their home to collect belongings
- If a victim is injured the police can take them to a doctor
- They can take the victim and their children to a safe place such as a friend’s house or a refuge

2.2 The civil law

In addition to calling the police, there are also other legal avenues your client may want to explore under the civil law.

Family Law Act 1996 Part IV
Provides protection from physical, psychological, emotional and sexual abuse in the form of non molestation and occupation orders.

An injunction is a civil court order which can be used to help keep a survivor safe. It places legal restrictions on the perpetrator to try to prevent or limit any further violence. Injunctions normally last for 6 months but they can sometimes be extended.

Types of injunctions

Occupation order (sometimes known as ouster injunctions):
Regulates who can live in the family home and can also restrict the abuser from the surrounding area.

Non molestation order:
This injunction prohibits the abuser from threatening a survivor or their children. It can have specific instructions added to it (e.g. to stop someone telephoning a victim) and can prevent the perpetrator from coming within a certain area and/or using someone else to threaten. This order can be granted for six months or for an indefinite period.

Ex-parte injunction:
This is not a different order to the two above; ex-parte simply means that the perpetrator isn’t notified of the court hearing. They can only be used in an emergency. A problem with enforcing an ex-parte injunction is that it doesn’t come into force until a copy of the order has been physically handed to the abusive partner. If the partner makes themselves scarce and avoids service of the order, there can be a delay between the order being made and it coming into force.

Applying for an injunction:
If a survivor can afford it, or if they’re entitled to help with legal costs, then they can use a solicitor for the entire process of applying for an injunction. However, there are less expensive options available. For more information contact Rights of Women on 020 7251 6577.

- Injunctions can be very useful to show the perpetrator that the survivor is no longer prepared to accept their behaviour but they are only effective if the survivor is prepared to call the police if the perpetrator disobeys the terms of the injunction
- To apply for an injunction a survivor will have to go to court. A survivor can ask for their address to be kept secret
- If they’re worried about their partner’s presence, they can ask court officers to keep the abuser away from them
- Police Community Safety Units keep a copy of all injunctions with an attached power of arrest. However it is still a good idea for the survivor to keep their own copy

If a violent partner breaks the terms of the injunction:
If the perpetrator breaks the terms of the injunction the judge has the power to send them to prison, although a judge may just give a warning. If the injunction is violated, the survivor must inform the police or their solicitor as soon as possible.
2.3 Key pieces of legislation


- **Section 1**: amends the Family Law Act 1996 to make breach of a non-molestation order a criminal offence, punishable by up to five years of imprisonment

- **Section 3**: definition of ‘cohabitants’ to include same sex couples and extends provisions to include non-cohabiting couples [not enacted – but enacted under the Civil Partnerships Act (2005)]

- **Section 4**: makes couples who have never cohabited or been married eligible for non-molestation and occupation orders, under the Family Law Act 1996

- **Section 5**: creates a new offence of causing or allowing the death of a child or vulnerable adult. This establishes criminal responsibility for members of a household where they know a child or vulnerable adult is at significant risk of serious harm

- **Section 9**: establishes domestic violence murder reviews [not enacted]

- **Section 10**: common assault is an arrestable offence [not enacted – but common assault is arrestable under the Serious Organised Crime and Police Act (2005)]

- **Section 11**: allows a court to make a restraining order when the defendant has been acquitted of the offence

- **Section 12**: will enable courts to impose a restraining order when sentencing for any offence, on conviction and also on acquittal

Sexual Offences Act 2003

Overhaul of the previous law on sexual offences. There is now a:

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

Protection from Harassment Act (1997)

This can be used to stop an abuser from behaving in ways that aren’t actually criminal offences (e.g. uninvited visits) yet which are still distressing and intimidating. To use this, there needs to have been two or more incidents and survivors need to inform the police of the perpetrator’s harassing behaviour and the police will need to issue them with a formal caution.

If they continue to harass the survivor after this, the perpetrator can be arrested and could face up to five years in prison. Unusually, the Act contains both civil and criminal remedies for those experiencing harassment from another person and created two new offences of causing harassment and causing fear of violence. The criminal court can make a restraining order on conviction.


See pg 196-198.

Rights of Women [www.rightsofwomen.org.uk](http://www.rightsofwomen.org.uk) can give more advice and information about the civil and criminal law and can be contacted on 020 7251 6577. The website also gives more in depth information regarding the law and details of training courses on domestic violence and the law.
3. Working with drug & alcohol users experiencing domestic violence

Working with domestic violence survivors requires a great deal of patience and reassurance. Be prepared to spend time with them discussing their options and emotions. This section outlines the best ways to raise the issue of domestic violence and how you can offer support to survivors of domestic violence.

3.1 Important things to remember

- Confidentiality and security are crucial
- Be alert to the possibility of domestic violence. Most survivors do not ‘fit’ the stereotype of a ‘battered wife’
- The experience of violence within a relationship is often complicated by feelings of love towards the perpetrator and hope that they will change their behaviour. This means that there are very rarely simple solutions
- You will only ever get a ‘snap shot’ of the relationship not the whole picture. Survivors may minimise the levels of violence they are experiencing so it may appear to you as if their fear is exaggerated. Underestimating the level of danger present is a common coping mechanism used by survivors. The relationship is not static which means that the survivor’s attitude to themselves, the abuse and the abuser will change over time
- Dealing with abuse is a process and most survivors will try a variety of coping strategies to deal with it. Drug or alcohol use is a coping mechanism some will use

3.2 If a survivor approaches you for help, remember:

- The following issues must underpin your work on this issue:
  - confidentiality
  - security
  - giving them choices
  - non-judgemental attitude
- The survivor is not a problem, they have a problem
- Be open and approachable and trustworthy
- When they tell you, tell them you believe them, take them seriously, stress you do not see it as their fault and that you appreciate how difficult it can be to talk about it
• Don’t undermine them by making them feel inadequate for not seeking help earlier. Remember they may have sought help before and not been believed. Seek to build their confidence and empower them - it takes courage and strength to survive violence. Let them dictate the pace and congratulate them on every step they take.

• Listen to what the survivor says about what they want, about the danger as they see it. Most women only reveal a tiny proportion of the abuse they have suffered - only she knows how much danger she is in.

• Remember their problems may be compounded by racist reactions, language and cultural barriers or other reactions to their age, sexuality or disability from people to whom they turn for help.

• Do not give them your opinion, make judgements or apportion blame about the relationship. Your focus needs to be on safety.

• Explore choices and options with them, including ways of her increasing their safety, whether they leave or not.

• Be aware of the particular circumstances of your client. Some options may be less possible than others.

• Do not rush them into solutions or tell them what to do. This is what their abuser will probably have done.

• Don’t give up on them just because things are taking longer than you think they should. You may feel frustrated seeing your client hurt and abused but their actions and choices have to be their decision. They must not sense your frustration.

• Ask what they would like you and others to do. Be clear about what is possible, and how you can be of assistance.

• NEVER act as a go-between. This includes never helping the partner locate them if they have left - don’t pass on letters, messages or facilitate contact in any way. This puts you and her in danger.

• Make sure you have a basic understanding of the relevant issues including those outside your area of work e.g. domestic violence, substance use or mental health issues.

• Be factually correct or say you do not know and suggest some one who will. Don’t feel you are letting your client down by not knowing all the answers - a joint approach to finding things out may help to build their confidence.

• Survivors may find it easier to excuse or explain their partner’s behaviour by blaming drugs or alcohol. Yet, their partner remains responsible for their violence - drunk, high or sober.

Other steps to take:
• Ask for training on domestic violence.

• Contact your local refuge or other specialist domestic violence provider to see how you can work together.

• Put domestic violence on the agenda for discussion at your team meeting.

• Develop a policy for your organisation setting minimum standards expected of staff when dealing with domestic violence, including guidelines on confidentiality and security. Make sure you include clear definitions so that myths and stereotypes are tackled. Be clear how the policy will be monitored and evaluated. Set timescales for changes.

• Put up posters and stock leaflets with information about domestic violence and who to contact for help. Make sure that images and languages used reflect the local community and are not stereotypical.

• Review your services and consider how responsive you are and how responsive you could be to the needs of those experiencing domestic violence.

• Ensure that your services are accessible to survivors of all races, ages, cultures, abilities and sexualities.
• Try to think of the needs of your client and adapt your services accordingly. For example, if you provide advice sessions, can they talk to you in private? Is there somewhere children can play while your client talks to you or will they have to be careful what they say because the children might be listening? Do you run evening sessions for those who work?

• You may find it useful to undertake an ‘audit’ of your service to guide your agency in making your service more responsive to domestic violence victims and survivors. A tool can be found on pg 305 which incorporates model practice standards which you can adapt for your own service.

Minimum Standards

• Display domestic violence posters in all public areas for survivors and perpetrators

• Provide additional domestic violence information (e.g. leaflets, crisis cards). These should be provided in languages other than English

• Include information about domestic violence on the agency website

• Ensure relevant staff gain domestic violence training

• Have a specific staff policy in relation to domestic violence

• Have an individual within the agency with lead responsibility for domestic violence. This should be included in their job description

• Have a mechanism in place to monitor an agency’s response to domestic violence. This data should be collated and shared with relevant agencies.

Source: London Domestic Violence Strategy, 2005

What Works:

Ethnic Alcohol Counselling Hounslow – The Pukaar Project

The Pukaar Project, within EACH Specialist Counselling and Support Service, has been established for a number of years supporting Asian women and young girls experience violence and abuse.

It provides a culturally sensitive counselling, information and advocacy service through a team of specialist counsellors. This outreach service extends across the boroughs of Barnet, Brent, Ealing, Harrow, Hillingdon, Hounslow and Richmond Upon Thames.

The Project’s strength is its understanding and work with the complexities of culturally acceptable norms and beliefs and how this impacts women's experiences of violence, abuse and substance misuse and subsequently help seeking behaviour.

The method of working is through proactive outreach work at a community level and in partnership with statutory and voluntary organisations. This is to engage and retain women in services and treatment; women make up over 50% of EACH’s client base. The majority of clients are also able to receive therapy in their mother tongue.

EACH also offer training to the voluntary and statutory sector.

For more information contact Fozhia Raja at fraja@eachharrow.org.uk
3.3 Asking about domestic violence – survivors/victims

Routine questioning is a technique that service providers should adopt as a means of identifying domestic violence. All clients can be asked the same basic questions, regardless of their age, ethnicity, socio-economic background or sexuality.

Routine questioning will allow you as a worker to identify any safety concerns a survivor may have, obtain basic information about their current situation and increase their access to services and information.

Most women who experience violence will be hesitant to name their experience as domestic violence or will not realise this is what they are experiencing. Service users will be more receptive if you ask questions around the state of their relationship or their personal safety e.g. ‘Are you having problems at home?’ It is acceptable to ask direct questions, particularly if you comment on the frequency of domestic violence within the community or possibly your client group.

Don’t assume a service user will be offended or hostile about you asking about domestic violence. If they are angry or hostile it doesn’t mean you should not have mentioned it. They may come back later when they are ready to discuss.

All conversations should be conducted in private and you should state that all disclosures will be dealt with confidentially, unless child protection concerns are raised. If interpreters are used they should be trained in the questioning process and use appropriate translations of words used in the process. All translators should sign a code of conduct and confidentiality agreement.

Why ask?
In line with the NTA’s Models of Care, knowledge of how violence and abuse is interacting with a service user’s drug/alcohol use is imperative to provide adequate care planning and ensure an effective treatment journey. The experiences of violence and abuse may be severely impacting on your service user’s ability to engage and retain in treatment.

Common fears of workers:
• Not providing the right response or not dealing appropriately with a disclosure of violence
• Taking on the ‘other issue’ may impact on workloads
• Asking may increase the risk or emotional distress of a service user and impact on their ability to address their drug/alcohol use

Adequate training and support from a supervisor can go a long way towards addressing these fears. You are not expected to become specialist workers in this area and working in partnership with a local domestic violence agency will ensure your workload does not increase. By not asking you are increasing the risk to a victim or survivor (and their children) and possibly ignoring a major driver for their drug/alcohol use.

Initially your client maybe reluctant to inform you of the violence that is taking place. If you question clients, it is helpful to introduce the conversation with a phrase such as:

1. “We often find that people using this service may have experienced or perpetrated violence. This information can affect the different sorts of services we are able to offer. Do you mind if I ask some questions about this?”

2. “Because we care about your safety we will ask you about whether you are being hurt at home. We ask everyone this just because we want everyone to be as safe as possible”

3. “As well as talking about substance use issues we are also asking all clients about violence or abuse in the home because this is very common. You may have seen our posters in the waiting room”

How questions are asked is very important. Simply asking “are you a victim of domestic violence?” will not be adequate as most victims and survivors will not identify with these words. The Power and Control Wheel (pg 105) may help you in phrasing your questions.
Example questions include:

- “How do you and your partner work out arguments?”
- “Do arguments ever result in you feeling put down or bad about yourself?”
- “Has someone else who uses substances harmed or posed a threat to you or your children?”
- “What does your partner think about your substance use?”
- “Do you ever become frightened by what your partner says or does?”
- “Do arguments ever result in hitting, kicking or pushing?”
- “Has anyone ever been violent towards you? Who?”
- “Have you ever been forced to have unwanted sexual contact with your partner?”
- “Do you think there is a link between any of these problems and why you are here today?”
- “Does anyone make it difficult for you to attend this service?”
- “Does your partner control who you can and cannot see?”

By adopting a non-judgemental approach clients will feel more comfortable disclosing to you. If you suspect a client is unwilling to talk about their experiences of domestic violence, you could revisit the screening questions at a later time once you have a more established rapport.

Evidence shows that women will often disclose abuse at different times during their substance use intervention, requiring practitioners to repeat questioning at different intervals of the therapeutic relationship.

A sample screening form can be found on pg 279.
3.4 Documentation for client files


It is important to keep accurate, concise, relevant and up to date records of all incidents of domestic violence that a client discloses. All notes should be written during the session with the client, agreed by the client, and signed and dated.

It is possible that these case notes may be used for legal purposes in the future, and thus will be beneficial for the client should they wish to pursue the abuse through legal channels.

These records will be stored with the agency. The client should be offered the option of receiving a copy. However, it is important to advise clients that it may not be safe to keep records at home or on their person as they may be discovered by the perpetrator.

Any documentation will include the record of the routine inquiry, the client responses (including types of abuse experienced with examples given by the client and any context).

The worker’s response including discussion of options and information-giving, risk assessment, any injuries that have been noted, any referrals made, any safety plans, and scheduled follow-up appointments.

Even if domestic violence is not identified as an issue, it should still be documented that the worker inquired about it, and the client response.

If the worker did not inquire about domestic violence as part of this Domestic Violence Routine Inquiry Policy, this should also be documented with the reasons why this did not occur.

Possible reasons could relate to issues of safety. For example, if the client was accompanied by the perpetrator or by anyone else, if it was not possible to speak in a confidential setting, or if the client left before the appointment was completed.

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

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

The answers to some of the TOP questions/monitoring could alert a practitioner to the possibility of domestic violence and therefore could provide the opportunity to explore the issue further.

Questions on mental, physical health, quality of life, social circumstances and offending could all open a window of opportunity to address domestic violence with service users.

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

Don’t be put off by not having all the domestic violence knowledge you would like. Your main concern should be making your client feel safe and comfortable.

The section below suggests approaches you can use to ensure you maintain a rapport with your client.

- Remind her that she is not alone: isolation is a key feature of domestic violence. Many women think they are the only one and are very relieved to discover that they are not alone.

- Remind the service user that your service is confidential. Under no circumstances should the perpetrator know about her disclosure, as this could put her in more danger. If the perpetrator also uses your service, make sure all sessions are conducted separately. Couples work is not usually a place a woman can safely disclose violence. Even if she does this may put her in increased danger and as such, should not be facilitated or encouraged by your agency.

- Don’t collude with the abuser by making remarks like “what did you say or do to provoke his anger?” or “what happens in the privacy of your home is none of my business”. We all have a responsibility to take a stand against violence. Introduce options into her life and give her the freedom to make decisions and exercise choice.

- If a survivor is also a parent, additional issues may exist. She may feel it is difficult to change her situation because of concerns her children may be removed from her care. Ask whether you can provide any support around her parenting and if necessary be prepared to advocate for her with social services. Work from the approach that supporting the mother to remain safe is the best way to support children.

- Her safety should be your paramount concern. Try to provide suggestions of ways she can increase her safety. This includes her use of drugs and alcohol and exploring the relationship between the two. It does not include telling her what to do, or telling her to leave. Safety planning will allow a woman to develop personal strategies to enable her to further increase her and her children’s safety. Safety planning is outlined on pg 133.

- Try to contact local domestic violence services. What are the options in your area? Are there safe places she can go? Would a worker be able to come visit the woman at your service? What advice can they give you about increasing her safety?

- Provide the service user with information on domestic violence services, which she may need to keep at your service or at a friend’s house. At a minimum, numbers should include the 24 Hour National Domestic Violence Helpline 0808 200 247. For male victims of domestic violence, you may also wish to give contact details for Men’s Advice Line 0808 801 0327 (but note this is not 24 hour service). Remind your service user of the emergency number 999.

- Respect her choices. Women have the right to choose when and how they make changes in their lives. If she decides to take no action now, remember that you have begun the support process.

3.6 Risk assessment and management

3.6.1 Assessing risk

If someone has problems with their substance use or is the victim of violence they are potentially at risk of harm. Harm can be experienced physically, emotionally, financially and socially.

A risk assessment can highlight potentially dangerous risks your client may be facing and indicate any areas of additional support they may require.
Domestic violence cases can be highly complex with fragmented information shared across several different services. Joint information sharing and development of a risk management strategy is far more effective and prevents you as a lone worker or agency carrying the sole responsibility for victim/survivor (and their children’s) safety.

Remember:
Risk assessments are not foolproof and they only give an indication of risk at that particular point in time. Victim/survivor assessment of danger is the most reliable indicator of risk. If she feels he will be violent again, chances are that he will.

Nevertheless, you should be aware that women often minimise the risk as a way of coping so a denial / hope that he will not be violent again is not as reliable. Other research suggests that assaults committed whilst intoxicated are also a relatively reliable indicator of future risk of serious violence.

An example of a risk assessment can be found on pg 282.

High Risk Cases - when should I override requests for confidentiality?
Upon initial assessment it is standard practice to explain the limits of confidentiality. Domestic violence comes under the duty to share information if a service user is deemed a risk to themselves or others.

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

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

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

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

Answering yes to any of these questions could mean your service user is at a high level of risk. It is important that you work with a domestic violence professional to complete a thorough risk assessment as soon as possible. If your service user does not wish to speak to a domestic violence worker you should respect these choices and not force this option. However, you should consider undertaking a full risk assessment to determine whether you should refer and share information to your local MARAC (see pg 130).
In all cases where there is indication of violence or abuse you should:

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

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

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

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

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

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

It is important that MARACs co-ordinate their work with Local Safeguarding Children Boards (LSCBs), Multi Agency Public Protection Agencies (MAPPAs) and local systems to safeguard vulnerable adults.

**Evaluation of MARACs:**

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

**Source:** Specialist Domestic Violence Courts Resource Manual, Home Office, 2006
3.6.3 Information sharing

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

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

3.6.4 Safety planning

By raising the issue of domestic violence practitioners can create opportunities to explore ways in which women and children can be safe. Safety planning involves more than assessing potential future risk; it can help create psychological safety, the space needed to recover and freedom from fear. A safety plan is a semi-structured way to think about steps that can be taken to reduce risk before, during and after any violent or abusive incidents. It is important to stress that although a safety plan can reduce the risks of violence they cannot completely guarantee safety.

Internet Chatroom

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

(Survivor’s voice)

http://messageboards.ivillage.co.uk/n/mb/message.asp?web-tag=iv-ukrlabuse&msg=27714.7
Developing a safety plan
Survivors will already have coping strategies they find effective in reducing/managing the abuse. It is essential to acknowledge these and use them as guidance for your work.

A safety plan is about allowing women to identify the options available to them within the context of their current circumstances. Safety plans can be developed in the context of a survivor choosing to leave, choosing to remain in the relationship or if they have already left.

Key Principles
• Keep the responsibility for the abuse explicitly with the perpetrator

• Provide consistency and continuity

• Never assume you know what is best for victims; they know their situation and the risks better than you do

• Recognise that victims will already be employing safety strategies, though they may not name them; recognise, validate and build on what they are already doing. Explore which strategies are effective and helpful, and which may not be so helpful and could be adapted

• Do not suggest or support anything that colludes with the abuse

Safety planning needs to be an on-going discussion as situations change, particularly when a victim is considering leaving.

It is also essential to think about the difference between ‘safe from’ (violence, threats of violence etc) and ‘safe to’ (engaging with services, develop friendships, study, work etc) to ensure that both needs are met effectively.

Some questions to ask in drawing up a safety plan:
• “What do you currently do to keep you and your children safe? What works best?”

• “Who can you tell about the violence who will not tell your partner/ex-partner?”

• “Do you have important phone numbers available e.g. family, friends, refuges, police?”

• “If you left, where could you go?”

• “Do you ever suspect when your partner is going to be violent? E.g. after drinking, when he gets paid, after relatives visit”

• “When you suspect he is going to be violent can you go elsewhere?”

• “Can you keep a bag of spare clothes at a friend’s or family member’s house?”

• “Are you able to keep copies of any important papers with anyone else? E.g. passport, birth certificates, benefits book”

• “Which part of the house do you feel safest in?”

• “Is there somewhere for your children to go when he is being violent and abusive?”

• “What is the most dangerous part of your house to be in when he is violent?”

• "Can you begin to save any money independently of your partner?"

• “Can you find ways to attend the drug/alcohol service without your partner finding out?”
It is also important to help the survivor to focus on the more positive things going on in their life and/or identify ways that they could access activities which would help improve confidence, self esteem, emotional wellbeing etc.

Further issues to consider in a safety plan if the victim/survivor is using substances can be found on pg 73 and a sample safety plan can be found on pg 288.

**Safety planning with children and young people**

You can advise children and discuss safety issues with them, but remember they do not have the power or resources to develop safety plans for themselves. Child protection requires adults to take responsibility for ensuring children’s safety.

**The following should be considered when assessing harm to children:**
- When was the most recent incidence of violence or abuse? Frequency and severity/when and where?
- Are the children present during abusive incidents?
- How do they respond? Do they ever try to intervene?
- How do the children describe what happens?
- Is the abuse connected with any other factors that may undermine parenting capacity (such as alcohol or substance misuse or mental health)?
- Is the non-abusing parent able to meet the child's needs effectively?
- Were weapons involved?
- Are the children forced to participate in the abuse?
- Was a pregnant woman and her unborn child threatened or abused?
- Does the child have contact with an abusive parent? What are the arrangements?

**From these questions you can then prepare a personal safety plan. This should include:**
- Helping children to identify a safe place to go in the event of violence
- How to contact emergency services, safe contacts
- Ensure children know their address and telephone number
- Make sure children know it is not their place to intervene
- Role-play calling the Police. Teach children the basic information to give name, address, and the fact that someone is hurting their mother and to leave the phone off the hook
- Familiarise the older children with the local services and community resources for dealing with domestic violence
4. Domestic violence service provision

The range of services available to survivors varies depending on the London borough in which they live. Also, they may wish to leave their home area, or even escape London altogether, in order to escape the violence. When you are considering referring women to a domestic violence service you should contact either your local Domestic Violence Co-ordinator or a refuge.

The national 24 hour domestic helpline can also offer support or refer to a refuge anywhere in the country 0808 2000 247. For support for male victims of domestic violence contact the Men's Advice Line on 0808 801 0327 which can provide tailored support and details of services which you can refer to.

The section below will cover the main forms of domestic violence service provision: refuges, advocacy, outreach services and counselling services.

4.1 Refuges

It is important to note that if your client has medium to high support needs resulting from their substance use that they are likely to be excluded from most mainstream refuge provision. In these cases other forms of accommodation and support will need to be sought.

What is a refuge?

A refuge is a safe house where women who are experiencing domestic violence (including sexual, mental, emotional, financial, and verbal abuse and physical violence) can live free from violence. A woman does not have to be living with the abuser to be offered help. Women residents of refuges must keep their location confidential. This means that they will not be able to tell friends or family where they are staying.
4.1.1 Refuges in London accepting women with problematic drug and alcohol use

the nia project
The nia project provides refuge places in Hackney and Haringey for women with problematic substance use subject to assessment. Nia employs a specialist domestic violence and substance misuse worker and a specialist worker for women involved in prostitution with problematic substance use.

Contact: 020 7683 1270 (admin)
Advice Line: 020 7683 1210
http://www.niaproject.info/

Solace Women’s Aid
Formerly Camden, Islington and Enfield Women’s Aid. Solace operate seven refuges in the boroughs of Camden, Islington and Enfield and will work with women survivors who also have problematic substance use subject to assessment.

Contact: 020 7428 9962 (advice)
020 7428 7656 (admin)
020 7267 5629 (legal)
www.camdenwomensaid.org
http://www.iwauk.org/

Chamlong House - Eaves Women’s Aid
Specialist crisis accommodation for survivors of domestic violence who are also experiencing problematic substance use. Women must be resident within Southwark for six months.

Contact: 020 7735 206

Elevate Refuge, Barnet
Contact: 0845 6000 331

N.B. Refuge addresses and phone numbers are confidential due to the concerns that violent partners will track down residents. Women are at greatest risk of being murdered when they plan to leave or have left a partner. It is therefore critical that you never, under any circumstances, give the address or location of a refuge to anyone, even when you think they are safe.

Children
Children can also stay in refuges with their mothers, though some refuges limit the number of children a woman can bring because children have to share a room with their mother. Some refuges are only able to take male children up to a certain age; this can be as young as eleven or twelve but each refuge varies. There are usually activities and specific workers for children.

How long can women stay?
Women can usually stay as long as they need to in refuges. This varies greatly depending on the individual woman. Re-housing can take a long time; refuge stays may therefore be fairly lengthy. An application for re-housing has to be submitted within one month of a woman entering a refuge due to Supporting People and Registered Social Landlord regulations. New accommodation is usually found via the Council, a Housing Association or through private means.

Specialist services
There are also some specialist refuges working with women from black and minority ethnic communities. In London, they exist for South Asian, Turkish, Iranian, African Caribbean, Latin American, Irish and Jewish women. They offer the chance to stay with other women who share their culture, language and background. A growing number of refuges also have disability access and workers who can assist women and children who have special needs.

Other communities may have support centres and advocacy which provide specialised support and information in community languages. To find out about services for specific communities contact Women’s Aid or Refuge – contact details are on pg 332/334.
How to access refuges
If your client needs a refuge space they can contact the 24 Hour National Domestic Violence Helpline, run in partnership between Women’s Aid and Refuge, on **0808 2000 247**.

You can also contact refuges through the Samaritans, the police, Social Services or the Citizens Advice Bureau.

The London Hostels Directory (**ris@ris.org.uk**) and the Women’s Aid “Gold Book” (**www.womensaid.org.uk**) are both useful referral resources. Places can be arranged quickly and often women can go into a refuge on the day that they contact the Helpline.

However due to the pressure on refuge spaces this may not always be possible. Refuge spaces cannot be booked in advance and there may not be space in the location of choice.

You can contact the Helpline on your client’s behalf and you will be given the public numbers and bed space information – you then need to contact the refuges direct.

If you find a space, refuge staff will need to speak to the client directly in order to ensure that refuge accommodation is appropriate and useful and also to explain the conditions of stay.

If it is preferable, your client can contact the Helpline herself and the Helpline staff will assist her with finding appropriate bed space.

Once a refuge space has been secured either you or your client will be given the details of a meeting point. You will not be given the address of the refuge because of the need to keep locations confidential. Your client will have to make her own way to the meeting point.

If a woman is in an extremely dangerous situation i.e. she and/or her children are expecting an immediate attack or have been threatened with murder, her and her children’s safety should be paramount.

If you cannot find a refuge space the following options may be helpful:

- Contact your local Homeless Persons Unit. Your client is eligible due to the risks posed by her experience, i.e. she is homeless due to violence/threats of violence. If she has children this will strengthen her case for eligibility, as she will be in “priority need”

- Citizen’s Advice Bureau also provide assistance to those who are eligible for housing

- Contact Shelter who offer a 24 hour phone line that can assist you finding hostel or supported accommodation. They can sometimes assist in advocating for individuals housing rights with local housing authorities. **Shelterline: 0808 800 4444**

- Out of office hours, contact emergency Social Services to see what support they can offer. They may be particularly useful in finding a safe place to stay if children are involved; they will NOT immediately assume that because the mother uses substances, she cannot care for her children, but will take into account her ability to parent, and the situation as a whole. During normal office hours, the duty social worker will fulfil the same role

- If all else fails, or if a safe place is needed urgently, go to the local police station and ask for protection while appropriate accommodation can be found. In many cases, when a woman and/or her children are in immediate danger, police officers will transport a woman and her children to a refuge or hostel

**Male drug or alcohol workers**
If you are a male worker contacting refuges on behalf of a client it is good practice to verify who you are: provide office details, address and phone number and suggest that a refuge worker may want to call the main office number and speak to another member of staff to verify your details. If you choose to accompany your client to a refuge meeting point, you will need to leave your client before she is collected.
4.2 Advocacy, outreach and counselling services

Outreach services
Some refuges and other agencies also run advocacy or outreach services which support women experiencing domestic violence in the community or living in other forms of temporary accommodation. This service may be more suitable for your service user who is not ready to leave a relationship or who does not wish to go to a refuge. It may be possible that the outreach worker could attend your service to provide advice.

Advocacy services
Advocacy services generally provide crisis intervention assistance to survivors of domestic violence with priority given to the safety of victims and their children. Often women will be assigned a dedicated worker who will support them through the crisis / high risk phase. In some areas these workers are called Independent Domestic Violence Advocates (IDVAs) who have a specific focus on managing high risk cases and who play a key role in MARACs (see above) and Specialist Domestic Violence Courts.

Counselling services
There are a small number of specialist counselling services which provide emotional support to women experiencing domestic violence. Some of these services are provided on a sliding scale of costs depending on the income of the women who wish to use their services. One London-based example is Woman’s Trust which can be found online at: http://www.womanstrust.org.uk/index.htm

Alternatively, your client could speak to their GP and ask for a referral to a counsellor or therapist on the NHS. Unfortunately, waiting lists are often lengthy. If your client can afford it, they could pay to see a counsellor or therapist privately. Ideally you should only refer survivors to counsellors that have been trained in domestic violence.

They should always check that the counsellor or therapist is registered /accredited with the British Association for Counselling and Psychotherapy. A list of registered therapists can be found online at: http://www.bacp.co.uk/seeking_therapist/index.html

A list of services can be found on pg 328.
Liz has been seeing an alcohol counsellor at your service for the past six months. She has been with her girlfriend for three years and her partner has been violent toward her for the past two years. Liz blames this primarily on her own drinking and feels guilty that she ‘fights back’ when she has been drinking. Liz feels that her partner is justified in being violent, due to the stresses of living with a problem drinker.

1. What are the issues or myths you might wish to discuss with Liz?

2. When is it okay for Liz to ‘fight back’?

3. What options are available to Liz?

Possible Solutions

Have you considered good practice guidelines when working with this client group (see pg 115)?

1. What are the issues or myths you might like to discuss with Liz?

Liz’s drinking does not cause violence. In fact she may drink as a way of coping with the violence she is experiencing. Although it may be stressful to live with Liz’s drinking her partner has no right to be violent.

As a worker you should reiterate this to Liz and offer her alternative ways to think about and understand the violence she is experiencing. It is important to explore with Liz the type of violence that she is experiencing from her partner and whether it is escalating – consider asking some risk assessment questions on pg 282. Make sure you record the information in Liz’s file.

2. When is it okay for Liz to ‘fight back’?

Women are not generally brought up to believe they should ever be violent. Therefore Liz may feel very guilty about being violent, even if she uses violence as a form of self defence. You should talk to Liz about the dangers of ‘fighting back’ when she is under the influence of alcohol.

Whilst substance affected she may not be able to gauge the level of danger or harm she could be in or may possibly inflict. You should ask Liz how her partner feels about her attending an alcohol service and whether she tries to interfere with her treatment. It is important that you continue encouraging Liz to access your service.

3. What options are available to Liz?

Liz should continue accessing your service in relation to her substance use. You should ask Liz if she would prefer to speak with an organisation that works directly with gay and lesbian domestic violence e.g. Broken Rainbow or Sola (see pg 329/333).

You could speak to Liz about the sorts of domestic violence services available, such as refuges or meeting with an outreach worker. At all times you should ensure that Liz feels safe, secure and that you are non-judgemental. Your job is to provide options and ideas to Liz; however Liz’s choice should be respected.
5. Working with domestic violence perpetrators within drug and alcohol services

In-depth work with perpetrators around their use of violence is a specialist field and holds potential for extreme danger. As such, it should only be attempted by trained professionals.

The links between domestic violence and substance misuse are controversial, complex and a much under-developed area of debate.

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

Why do this work?

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

If the project is working with both partners, there is a duty of care to ensure the safety and well-being of the service user who is a victim/survivor of domestic violence.

Challenging domestic violence could increase the ability to motivate change in a service user. One of the motivations for change is the perpetrator's awareness of the harm they are causing to others.

The actions of workers may help to improve the safety of a victim of domestic violence (including children) and ultimately prevent serious injury or death.

There is a responsibility to share information if a service user is deemed at risk of harm to others.

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

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

Any agencies which are funded from the statutory sector have a positive duty to uphold rights in the Human Rights Act (see pg 211).
5.1 Facts and statistics

- Findings from a review of the British Crime Surveys revealed that 44% of domestic violence offenders were under the influence of alcohol and 12% affected by drugs when they committed acts of physical violence.

- Home Office research on domestic violence offenders (n = 336) showed 73% had used alcohol prior to the offence, with 48% seen as ‘alcohol dependent’.

- Alcohol is likely to contribute to intimate partner violence in a variety of ways. Levels of consumption relate to the likelihood and severity of violence. Alcohol appears to be particularly important in escalating existing conflict.

- A number of studies have found that the perpetrators use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober.

- Evaluation of perpetrator programmes has also shown that a man committing violence whilst drunk is one of the most influential risk markers of future violence.

- A small scale study in the UK showed that all of the women interviewed about the role of alcohol in their partner’s abuse had also experienced violence and abuse from their partner when he had not been drinking.

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

5.2 Key messages

- Substance misuse does not excuse or justify domestic violence nor does it offer a sufficient causal explanation.

- Perpetrators must be held accountable for their violence, even if they are substance affected.

- Perpetrators have control and choice about their abusive behaviour.

- Perpetrators may help to create a dependency on, or even enforce the use of, drugs and alcohol by the victim as a tool of control.

- Most male perpetrators also claim to be the victim.

- Substance misusing men should normally be excluded from perpetrator programmes if they fail to address both issues simultaneously. In some cases it may be necessary for a perpetrator to address the substance misuse first.

- Workers can miss the dynamics of control in a violent relationship where there is also substance misuse because of the additional layers of complexity.

- Services should only refer to perpetrators programmes which have women’s services attached and meet the Respect guidelines.

“Drug and other services already work with clients to reduce other offending behaviour so arguably domestic violence perpetrating could also be addressed with appropriate support and practice development.”
Myth:
Alcohol misuse causes domestic violence

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

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

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

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

Reality:
A small scale study in the UK showed that all of women interviewed about the role of alcohol in their partner’s abuse had also experienced violence and abuse when their partner had not been drinking.

It is important to remember that even when physical violence only takes place with alcohol use, often emotional, psychological, financial and sexual abuse takes place in its absence.
5.3 Practice issues

5.3.1 Routine questioning for perpetrators of domestic violence

Perpetrators of domestic violence are unlikely to present to your service and disclose their violence as a problem with which they need help. In drug and alcohol services they are more likely to associate their violence as a negative effect of their substance use.

Alternatively perpetrators may refer to their violence as an ‘anger management issue.’ Within your general assessments under the sections which deal with risk of harm to others you should include some questions to ascertain whether your service user has ever been abusive towards a partner.

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

For example an opening question could be:

• “Has your drug or alcohol use affected your relationships with your partner and family?”

• “What do your partner and family think about your drug use?”

• “Has anyone in your family been frightened or harmed by you when you’ve been substance affected?”

Followed by one or two further questions:

• “Do you ever make decisions or rules about who your partner can or can’t see?”

• “Have you ever felt that your behaviour got out of hand when you’ve lost your temper or been violent? If yes, what happened?”

Myth:
Alcohol treatment alone will address the abuse adequately

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

Myths:
Abusers lose control when drunk

Reality:
The Stella Project does not support the view that abusers lose control when perpetrating abuse – whether this involves substances or not. Women report that even when their partners have seemed “uncontrollably drunk” during a physical assault they routinely exhibit the ability to stop the abuse when there is an outside intervention e.g. children, police.

Abusers exhibit control over which area of the bodies they direct their assault even when drunk. The majority of abusers only target their abuse and violence at one person – their partner.
5.3.2 What do I do if I know my client is perpetrating domestic violence?

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

Any discussions about abuse and violence should emphasise that there is no excuses for the behaviour. Any other approach is in danger of colluding and condoning the abuse.

It should be made clear that the substance use is not to blame, the violence and associated controlling behaviour is usually directed at his partner and/or children. No one deserves to be abused.

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

You may find the following approaches useful:

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

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

Phil Price, Domestic Violence Intervention Project (DVIP)
5.3.3 Safety and basic risk assessment

- If you are in contact with both partners, always see them separately when discussing violence and abuse.
- If your information about the man’s violence comes only from the woman, you MUST NOT use that to challenge the man. Her safety is paramount.
- Offer alternatives to ‘couple work’ as such interventions are unlikely to be effective and can even be dangerous (see pg 187).

Be constantly alert to indicators of risk
Risk is not a static process and he is unlikely to disclose the level and extent of violence (particularly sexual violence) through direct questioning. However, whilst completing your standard risk assessments and undertaking key working sessions with your service user you should be alert for the following indicators which have been found to be risk factors for domestic violence.

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

- History of violence and abuse
  The strongest predictor that violence will occur in the future is if it has happened in the past. Indicators of particularly high risk to the victim include affirmative answers to the following:
  § Has the violence caused injuries?
  § Have there been threats to kill, use of weapons?
  § Choking or strangulation? Is the violence escalating?
  § Has there been sexual violence/coercion/abuse?
  § Has there been stalking, harassment, isolation of the victim?
  § Jealous, controlling or obsessive tendencies?

- Ask him what effects his violence has upon himself and explore if this is how he would like to continue. Be aware that deep down he is somehow unhappy about the abuse.
- Ask him to focus on the effects the abuse has on his children and partner, their family and friends. Allow him to think of the issue from another point of reference.
- Does he show a desire to change? If not broach the subject with him in future sessions.
- Have you established whether there are child or adult protection issues that need reporting? Does your organisation have a protocol for dealing with this?
- Tell him that you may contact his partner and provide her with information and offer support.

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

- If he does wish to change encourage him to phone the Respect phone line on 0845 122 8609 or consider referring him to a perpetrator programme.
- Contact Respect for a list of perpetrator programs in your area. Contact a program and discuss the support they can provide to both the perpetrator and their partner.

The national Respect Phoneline is open Monday, Tuesday, Wednesday and Friday 10-1pm and 2-5pm 0845 122 8609. It offers a clear, non-collusive response to men concerned about their abusive behaviour and advice on short-term strategies to prevent further abuse. It also acts as a resource to practitioners who have any questions or concerns about their service users.
• **Separation**
  Have the couple recently separated or is a separation imminent? It is often assumed that once the abusive partner is no longer present that the risk of violence ends. Yet research has consistently shown that it is the period following a couple’s separation that poses the greatest threat to most women.

• **Alcohol/drugs**
  Few researchers think there is a simple causal link between substance misuse and violent behaviour. Nevertheless, men’s (especially recent and heavy) alcohol or drug misuse features among the most robust risk markers for violent recidivism and for inflicting serious injury to a victim.

• **Children’s exposure**
  In 90% of domestic violence incidents reported in the British Crime survey where children were present in the household, children were in the same or adjacent rooms.

  Whether or not children are directly exposed to the violence, we should also bear in mind that many men who assault their wives or partners are also directly physically or sexually violent to their children (estimates vary between 40-70% depending on the research).

• **Disputes over child contact**
  In domestic violence homicide reviews in London, child contact has been proven to be a major factor in the majority of murders.

• **Mental health problems**
  There is an established link between certain mental health problems such as attention deficits including ADHD, anxiety, depression, post-traumatic stress, and personality disorders (especially borderline and anti-social personality) and an increased risk of domestic violence (especially when associated with a history of substance misuse).

• **Major life stresses**
  E.g. bereavement, unemployment, homelessness, financial problems. The greater the number of individual, familial and social stressors individuals encounter, the greater the likelihood of domestic violence occurring.

• **Criminal record**
  Men who have a history of anti-social behaviour or prior arrests, criminal convictions, or imprisonment for offences unrelated to violence are at increased risk of perpetrating violence in general, and domestic violence in particular.

• **History of generalised aggression**
  Those who exhibit generally aggressive behaviour or who are violent to non-family members are among the most dangerous of domestically violent men; they are more likely to be severely and frequently violent, more likely to be sexually abusive, and more likely to murder their partner.

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

• **Victim perceptions**
  Is the victim afraid of further injury or violence? That the children will be hurt? Research has shown that victims’ perceptions of risk tend to be accurate – the victim is, after all, the person who has been most closely associated with the perpetrator. A possible exception is where victims may minimise risk, for instance out of fear of the perpetrator or social services intervention or as a coping strategy.

• **Other victim vulnerability factors**
  Pregnancy, poverty, health problems, imposed isolation by the perpetrator, disability, substance misuse, insecure immigration status, or dependency on the perpetrator in respect of these.
5.3.4 Consider sharing information

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

You should consider seeking advice from the Respect helpline and/or contacting your local MARAC Coordinator (see pg 130) if you are concerned about the risk posed by an abuser.

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

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

DVIP run perpetrator programmes and have a model agreement that can be adapted for drug/alcohol agencies.

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

Domestic Violence Intervention Project (DVIP) - Violence Prevention Programme

Statement of confidentiality limits

I understand that my confidentiality is limited on a number of counts:

1. That information will be available to my (ex) partner on my attendance on the programme, and whether I drop out or am suspended from it. Also that DVIP will inform her if they believe that I pose a particular risk to her or others.

2. That DVIP will provide information to any professionals involved with myself or my family if requested to do so, such as probation officer, CAFCASS reporter, police officer or court officials.

3. If DVIP are concerned that I or another member of my household is a threat to the welfare or safety of children we may take steps to increase the safety of those children by involving another agency. If there are times where we feel that we need to break confidentiality to protect the safety of yourself or others we will do so.

Signed

Date

Name

The Domestic Violence Intervention Project (DVIP) is a charity whose main aim is to increase the safety of women and children who experience domestic violence by providing a range of diverse services challenging men, supporting women, working in partnership, influencing policy and campaigning for change.

t: 020 8563 7983
info@dvip.org
5.3.5 Record disclosures

You should always make a note of when you asked and the response in the service user’s records. You should also note what action you took in response to a disclosure.

This information may be required if future criminal justice action is taken and could also be helpful in other circumstances (e.g. housing applications).

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

5.3.6 Referrals to perpetrator programmes

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

As an organisation you need to ensure you have contacts with your local perpetrator program, so that your referrals are appropriate.

When referring to perpetrator programmes you should look for programmes which are part of the Respect network as this will provide some reassurance about quality and safety.

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

Both victim and perpetrator?

You may come across cases where both partners claim to be victims. It is important to remember that domestic violence is a pattern of behaviour comprising various forms of controlling behaviour and not just an individual event. It is important to try and understand the dynamics in a relationship.

To put it in context, it is best to ascertain who is most fearful or frightened for their safety within a relationship where both partners claim to be abusers.

It’s worth exploring where the power and control in the relationship lies and you will often find that it lies with the man even if he discloses his partner has been violent towards him.

Many women who disclose hitting a partner are often lashing out or responding in frustration to the systematic emotional or physical control her partner has had over her over a period of time. This could be the case for male victims.

While no violence should be condoned, it is important to determine who is the predominate aggressor within such bi-directional violence.

If you are working with such cases, ring the Respect Phoneline 0845 122 8609 which can offer support and help to professionals and help clarify the patterns of abuse.
Angie and her partner Shawn are both in their early twenties, Black and new to London. Shawn is a crack cocaine and alcohol user and has been coming to your service for two months. Angie attends your service with Shawn, but is continually withdrawn. She has little interaction with staff or other service users and generally just waits for Shawn while he sees his counsellor. You have noticed that Angie often appears with physical health problems such as bruising or limping.

Shawn has told his counsellor that he has ‘anger management’ problems, sometimes losing his temper with Angie. Shawn says he feels people make unfair assumptions about him because he is a young, Black man. You are very concerned for Angie’s well being.

1. How could you provide support to Angie?
2. Should you address the possibility of domestic violence with Shawn?
3. Are you providing a culturally appropriate service for Shawn and Angie?

Possible Solutions

1. How could you provide support to Angie?

It is essential that, whatever support you give Angie, her safety is your paramount concern. Try talking to her when Shawn is meeting his counsellor. Do you have a female worker who could offer Angie a cup of tea and a chat? By building a rapport and making Angie feel safe you could ask some basic screening questions about the violence she may be experiencing (pg 121-122).

Case Study - Angie and Shawn

Angie and her partner Shawn are both in their early twenties, Black and new to London. Shawn is a crack cocaine and alcohol user and has been coming to your service for two months. Angie attends your service with Shawn, but is continually withdrawn.

She has little interaction with staff or other service users and generally just waits for Shawn while he sees his counsellor.

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"Why did you do it when you promised to care
You were always so happy at the moments we shared
You said that you loved me and it would never stop
Now it will be over with one short drop
Do you know the pain you cause when you clench up your fist
Why make the agony when it's more appealing to kiss
Why make me scream, why make me cry
Now 'Thank God' I’m saying ‘Goodbye’
I'm sure you're not aware when the alcohol flows the hurt that exists from one of your blows
It doesn't stop me, the bruises will go
The wounds will heal, blood ceases to flow
But look at the family, the scars on their hearts
It's for them I do this now that we part
I'll be free from your torment to live my own life
Shall it be drugs, a gun, a push of the knife
You're spaced again, I can see in your eyes
Today I'm not prepared to settle for lies
I'm not the one who's going, I've my baby to care for
So it's you who will scream and fall to the floor"

Anonymous
http://www.bbc.co.uk/health/hh/real45.shtml
3. Are you providing a culturally appropriate service for Shawn and Angie?

Ideally you should be able to give Shawn and Angie the option of a variety of workers. For instance Shawn may wish to have a Black man as a counsellor and Angie may feel more comfortable talking to a woman.

Never attribute Shawn or Angie’s actions to either their age or their ethnicity. Be willing to learn from Shawn and Angie what being Black and young means to them. This means taking into account any past experiences they have had of using services both positive and negative.

2. Should you address the possibility of domestic violence with Shawn?

Because Shawn has already expressed the fact he has an ‘anger management’ problem you are able to talk to him about this. You could explore the relationship his drug and alcohol use has with his violence. You could ask Shawn some basic screening questions to see if he is perpetrating violence against Angie. Make these questions quite direct. Sample perpetrator screening questions can be found on pg 155 alongside suggestions for how you can address the violence and abuse with Shawn in keyworking sessions.

You should also be alert to risk factors (see pg 159) and if you are concerned that Angie is at high level or risk, consider speaking to the MARAC Coordinator and/or the Respect phoneline for further guidance. Do not condone any of the violence Shawn may disclose. Give him the option to call the Respect phoneline who can offer short term strategies for dealing with his violence and give details of a suitable perpetrator programme.

Never indicate any information that Angie has disclosed to your service, as this will put her at an even greater risk. It is important that Shawn feels comfortable with you and will therefore return to the service, hopefully with Angie.

Outline the support you can give her and the options she has available to her. Reiterate to Angie that she is not alone and that you will not repeat any of your conversations to Shawn.

Are there any other activities she could become involved in while at your service? E.g. women’s groups or complementary therapies. Importantly, make sure Angie feels safe in your service and is able to return. Offer to keep any information she wants about domestic violence services at your project, it may put Angie at risk to take it home.
Section 3 footnotes

1 Please note that the evidence base for the information given in this section largely derives from research studies which have only focused on the needs of female survivors. Only a very limited amount of research has been undertaken into the needs of male survivors and we would be doing them a disservice to represent their needs as identical to those of women. This is supported by the evidence that we do have which clearly suggests that there are differences in support needs and that the support needs of men are clearly split along sexuality lines. In other words, gay, bisexual and transgender men are much more likely to want on-going support whereas heterosexual men tend to want a one-off information giving session. See Robinson, R. & Rowlands, J., 2006. The Dyn Project: Supporting Men Experiencing Domestic Abuse. Cardiff; and Donovan, C., Hester, M., Holmes, J., & McCarr, M., 2006. Comparing Domestic Abuse in Same Sex and Heterosexual Relationships. University of Sunderland and University of Bristol, London: ESRC.

2 An adult is defined as any person aged 18 years or over. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in laws or stepfamily.


6 This figure is based on the cost to key services only and of lost economic output and does not include human costs. The figure is based on national averages and does not, therefore, take into account the additional costs of London so the true figure is likely to be higher still. Greater London Authority, 2005. Second London Domestic Violence Strategy. London, available athttp://www.london.gov.uk/mayor/strategies/dom_violence/docs/2nd-dv-strategy.pdf


8 This research consisted of analysis of 1,889 incidents relating to the 692 perpetrator profiles using data collected by Northumbria Police. It also included semi-structured interviews with 17 perpetrators regarding their contact with the criminal justice system and experiences of help-seeking. Hester, M. & Westmarland, N., 2006. Service Provision for Perpetrators of Domestic Violence, University of Bristol.


14 ibid.


16 This section has been compiled from existing good practice guidance on working with female victims. However, much of the information it contains will also apply to male victims.


20 Gilchrist, E., Johnson, R., Takriti, R. Weston, S., Beech, A. & Kebbell, M., 2003. Domestic violence offenders: characteristics and offending related needs, Findings 217, London: Home Office. N.B. It is unclear from the Findings how ‘dependency’ was determined


26 The exception to this is the tiny minority of people who may experience psychotic episodes under the influence of substances. However there is no evidence to suggest that this group of people are over represented amongst domestic violence perpetrators.


1. Supporting children living with parental substance misuse and domestic violence

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

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

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

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

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

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

(Mother’s voice)
1.1 Key messages

• Women who experience domestic violence, including those who use substances, are rarely ‘bad’ parents. Many women are able to manage their parenting role despite their substance use and victimisation.

• In assessments, focus should remain on how the non-abusive parent is able to meet the physical and psychological needs of the child when they are using substances.

• Children’s services need to be an integral part of any responses rather than, as occurs far too often, an afterthought.

• Workers need to feel confident in discussing and reporting potential or actual child abuse and neglect that may be occurring.

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

• Over a one hundred day period an estimated 205,000 children will witness domestic violence and at least 14 children will die from cruelty.

• 29 children are known to have been killed in the last 10 years as a direct result of child contact arrangements.

• At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the ‘at risk’ register live in households where domestic violence occurs.

• It is estimated that there are between 250,000 - 350,000 children of problem drug users in the UK – about one for every problematic drug user.

• Children who grow up in families where there is domestic violence and/or parental alcohol or drug misuse are at an increased risk of...
### Parental alcohol problems
- Social isolation, stigma and keeping secrets
- Emotional neglect and abuse
- Behavioural changes or problems
- Developmental delay, including in utero
- Potential damage to the foetus from heavy drinking (Foetal Alcohol Spectrum Disorder – FASD)
- Psychological and/or psychiatric problems
- Poor supervision
- Inconsistent and poor quality care
- Overly punitive discipline
- Child feeling fearful and responsible
- Disrupted play and leisure time
- Disrupted routines, e.g. school attendances
- Low self esteem and confidence
- Disrupted attachment to parents
- Difficulties in their adult relationships

### Domestic abuse
- Social isolation, stigma and keeping secrets
- Emotional neglect and abuse
- Behavioural changes or problems
- Developmental delay
- Damage to foetus/miscarriage from physical abuse targeted at stomach
- Psychological and/or psychiatric problems
- Inconsistent and poor quality care
- Overly punitive discipline
- Child feeling fearful and responsible
- Disrupted play and leisure time
- Disrupted routines, e.g. school attendances
- Low self esteem and confidence
- Physical and sexual abuse
- Conflicting loyalties towards parents
- Difficulties in their adult relationships

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

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

Domestic violence is often associated with other risk factors such as poverty, substance abuse, child sexual and physical abuse, maternal depression and parenting style.

Galvani has outlined the numerous parallels between the potential negative effects of parental alcohol problems and domestic violence and abuse on children.

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

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Significant harm: Child Line report that 44% of children who called about a significant other’s alcohol misuse, had called primarily to talk about the physical abuse they had experienced. 29% who had called about significant other’s drug use reported physical abuse.

1 in 11 children are estimated to be living with a parent who is experiencing problems with their drinking.

Among the families that social workers have on their caseloads, 50-90% of cases include parents with drug, alcohol or mental health problems.

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

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

A clear distinction should be made between domestic violence and child abuse. Many children are themselves the direct target of abuse as well as experiencing indirect abuse through witnessing domestic violence. Both of these experiences can cause immense damage to children. This is further compounded when one or both parents have problematic substance use.

It is essential that organisations working with children have clear guidelines for dealing with disclosures of child abuse. Children need to feel they are being listened to and are safe. You need to be clear about what disclosure means in terms of child protection issues (see pg 196).

**Common Assessment Framework**

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

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

A sample form and further guidance for implementation can be accessed at [http://www.everychildmatters.gov.uk/deliveringservices/caf/](http://www.everychildmatters.gov.uk/deliveringservices/caf/)

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

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

*Parental Alcohol Use and the Common Assessment Framework, The Parenting and Alcohol Project, Alcohol Concern, 2006 available to download at [www.alcoholandfamilies.org.uk](http://www.alcoholandfamilies.org.uk)*
1.4 Protective factors and building resilience in children

In recent years focus has been on identifying why some children are able to be resilient to the impact of negative childhood experiences such as parental substance misuse and domestic violence. Research seems to indicate that some children can grow up with many forms of difficult circumstances without developing significant problems.14

Resiliency is defined as “...the ability to overcome adversity, survive stress and rise above disadvantage.” 15

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

“Protective factors make it more likely that a child can overcome this risk because they provide a more positive setting. Resilience makes this more likely because it equips the child with a set of skills and feelings that enable him (or her) to be forward looking and to bounce back from adversity.” 14

Studies have shown that a central key element of helping children thrive in difficult circumstances is feeling as though they have choices and are in control of their lives. This can be done through the identification of goals and aspirations and the strategies needed for achieving them. Resilient children may appear to be less vulnerable, however it is still important to offer services and support as levels of resilience and protective factors can change at various developmental stages and transitions.

Researchers have identified some key ways that practitioners can help children and young people develop the attributes associated with resilience.17

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

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

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

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

1.5.1 Practice guidance

The Advisory Council on the Misuse of Drugs states that assessing and meeting the needs of a client’s children should be an integral part of reducing drug related harm. It recommends that substance misuse agencies should become family friendly with an emphasis on meeting the needs of women and children.

A number of key tasks should remain the focus of work to support children affected by parental substance use:

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

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

- Be clear that the service users’ safety is the priority rather than their drinking or drug using goal. Practitioners may have fears that this will frighten their clients away from treatment but if it is a routine part of assessment alongside other personal questions involving health and risk then this is unlikely to be an issue
- Staff commitment to referring the adult and children to domestic violence specialists as well as a commitment to monitoring and supporting their progress. Once the safety of the children and parent is established it is more likely that they will feel able to talk about the links between domestic violence, abuse, their drug/alcohol use and subsequent thoughts, feelings and behaviour
- Be alert to possible domestic violence at all stages of your work with parents and/or families – not just at the assessment stage
- Be aware of the language of domestic abuse and ask for clarity from children who use phrases such as “I’ll be in trouble” or “daddy can get really angry”
- Be aware that children also fear that the information they disclose will lead to their removal from the home or may make their current situation worse. Children may fear the consequences of revealing violence or illegal activity such as drug use – particular if they have been threatened by the abuser

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

- Be aware that risk is not a static process and can change rapidly. Missed appointments, drug and alcohol relapse or disengagement with the service could indicate ongoing experiences of domestic violence
• Be aware that child contact where domestic violence is present can be potentially very dangerous as some fathers may use contact with the children as a route to further abuse them and their mother.

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

Interventions for adult and family orientated alcohol services

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

1.5.2 Child contact

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

- In more than one in eight domestic violence incidents the London Metropolitan Police note issues around child contact or residence.

- In 1995 6.7% of contact orders applied for were refused. In 2004 0.7% contact orders were refused.

- Women's Aid has compiled details of 29 children in 13 families who were killed between 1994 and 2004 as a result of contact (and in one case residence) arrangements in England and Wales.

- In 2001 a survey involving 127 refuge organisations found that contact orders were granted to parents convicted of offences against children and to parents whose behaviour caused children to be placed on the Child Protection Register. In some of these cases unsupervised contact was granted or visits were ordered to take place at contact centres which had no facilities for supervision.

Unfortunately there are a limited number of supervised contact centres in the UK.

Contact should not be presumed to be in the best interests of the child if there has been domestic violence towards the mother.

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

1.5.3 Couples and network therapies

The Stella Project believes that couples counselling or other network therapy is not appropriate if domestic violence is currently being perpetrated in the relationship. Many drug and alcohol agencies who are concerned about addressing domestic violence note that excluding such families from network therapies would exclude a significant proportion of their clients. The Stella Project welcomes the development of detailed guidance on this issue but until this has been developed, it is simply too risky to work with families where any domestic violence or abuse has been disclosed.

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

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

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

“It is critical that decisions about couple work be based not on faith or familiarity with couples therapy as a therapeutic modality but on concrete data obtained from the couple on the detailed knowledge of risk assessment and the intricate dynamics of violent relationships.”
It could still be beneficial to work with the child(ren) and the non-abusing parent. This could include the wider family if it is safe to do so and where family members are supportive of the non-abusing parent. This should be done ideally in partnership with a domestic violence agency.

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

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

1.6 Guidance for domestic violence agencies

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

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

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

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

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

- It is common for the victim to also minimise what is happening to them for fear of the consequences of disclosure and the hope that the relationship can be saved. In this context, such interventions will potentially unwittingly undermine rather than increase the safety of a vulnerable client.

- The work is unlikely to be useful when one partner is fearful about how much they can disclose about the relationship. However skilful the therapist they will be unlikely to gain the open and honest thoughts and feelings of a victim while the abuser is in the same room. This can apply equally to the children who may suffer the consequences of speaking openly.

- Reviewing violence and abuse with a couple in a session is not advisable due to the risks of retaliation if the victim discloses abuse.

- The couple have a history with each other which means subtle and exclusive methods of communication – including non-verbal - may have developed which are not discernible to the therapist.

- Research evidence from mediation, couple counselling and court welfare work all tells us that neither women or children fare well in any model which means they have to negotiate their safety in the presence of their abuser. Out of fear for the consequences if they do not, women frequently reach ‘agreements’ which are not in their best interests.

- If the victim/survivor is the one with the substance use problem it is not helpful for more information about the complexity of their problems to be passed onto the abuser. It will only give the abuser more ammunition with which to control his partner.

- It is noteworthy that in at least 20 US states, most of Australia and New Zealand, couple based interventions are expressly prohibited by law. In Australia, this was in part motivated due to the numbers of women killed by ex-partners when attending or leaving couple-based interventions.
• Children taking on the role of carer either for other siblings or
the parent(s)

• Effects of drugs/alcohol which may lead to uninhibited behaviours
e.g. inappropriate display of sexual and/or aggressive behaviour and
reduced parental vigilance

• Unsafe storage of alcohol or drugs and prescribed medication
could mean children having unsafe access to it

• Adverse impact of growth and development of unborn child e.g.
Foetal Alcohol Syndrome

The Stella Project sample assessment form for domestic violence
agencies contains some opening questions regarding children see
pg 264.

The situation in relation to these risks may indicate a need to ask
further questions. Workers should seek examples from the substance
using parent as to how the emotional and developmental needs of
children are being met.

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

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

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

Suggested questions to ask:

• Does the child have regular contact with a non-drinking/using
adult/carer?

• How discreet is the alcohol/drug misuse – do the children
witness the behaviour or have they stumbled upon it
by accident?

• How is the behaviour hidden or contained so that children are
not affected?

• Have there ever been accidents as a result of drug/alcohol
misuse and are the parents able to acknowledge risks and
accept responsibility?

• How much time, energy, money and organisation is directed
wards alcohol/drug related activity and what are the
consequences for the children?

• Who looks after the children when alcohol is being sought
or consumed?

• Are children ever taken to inappropriate places connected with
drugs/alcohol where they might be placed at risk?

• Is the home used as a base for the alcohol/drug misusing group
to which the parent may be attached?

• Does the alcohol/drug use lead to financial problems that mean
the children have to go without basics?

• Does the alcohol/drug use come first so that other financial
obligations are not met?
1.7 Specialist services and resources for children

1.7.1 Domestic violence specific

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

- **Talking To My Mum: A Picture Workbook for Workers, Mothers and Children Affected by Domestic Abuse**
  Children and young people and their mothers, who have lived with domestic violence often don’t talk about the distressing events they have lived through together. Mothers often underestimate how much children already know.


- **Community Group Treatment Programme**
  An integrated community group programme for children and their mothers who have experienced domestic violence. The 12 weekly sessions are held in a community-based setting in which children can meet other children in the same situation as themselves, explore their feelings and learn how they can best protect themselves. Core issues addressed are: validation of the children’s experiences; understanding abuse; reducing self blame; safety planning; managing appropriate and inappropriate expressions of emotion.

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

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

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**Children and Domestic Violence E-forum**

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

The e-forum provides:

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

To join the forum send an email to the address below (you do not need a yahoo account):
gldvp_frontlinechildrensworkers-subscribe@yahoogroups.co.uk

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1.7.2 Specialised services to support children around parental drug/alcohol misuse

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

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

- **Drug Alcohol Services London (DASL)** offers individual counselling to young people aged between 11-21 who have experienced both substance misuse & domestic violence in their family
  t: 020 8257 3068
  f: 020 8257 3066
  services@dasl.org.uk
1.8 Recognising diversity when supporting children

It is important to reflect on and respond to the additional needs that some children may have relating to their ethnicity, culture and/or religion. For example, in some cultures where alcohol is forbidden, this may induce extra shame and stigma for children, particularly if their mother is drinking or using drugs.

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

For many communities the home and community networks provide a shield from racism and discrimination. This can lead to problems at home remaining hidden in attempt not to bring the family and community into ‘disrepute’ and/or encouraging further discrimination and hostility.

Furthermore, choosing to leave the family home due to domestic violence or to overcome condemnation from the religious community can sometimes become a choice between different forms of abuse – domestic violence and racial harassment."
It is essential that a sense of safety and confidentiality is given to the client. Women are often worried that any disclosure of violence could lead to the removal of children. Workers should assure clients that Social Services will only be informed if there is a realistic fear for the child’s safety. Drug and alcohol services need to ensure they ask basic questions about their client’s family situation, such as children’s names and ages.

From this basis, workers are then able to further assess a child’s safety, over a period of time. Social Services are not always involved in families where there is domestic violence or substance misuse; their focus is largely on children who are at risk of ‘significant harm’. All practitioners have a duty to safeguard and promote the welfare of children.

In many cases, this is a subjective assessment so the point at which a Social Worker will intervene varies between different Social Service Departments. You will need to be aware of the risk factors associated with both domestic violence and substance misuse so that Social Services can be informed if a child is at risk. Harm includes physical, emotional and sexual abuse, as well as neglect. However, children do not have to be in imminent danger to be referred.

Section 120 of The Adoption and Children Act 2002 extended the legal definition of ‘significant harm’ to make it clear that harm includes “any impairment of the child’s health or development as a result of witnessing the ill-treatment of another person, such as domestic violence”. If you suspect a child is being abused or appears neglected you have a legal obligation to contact Social Services. You should:

• Discuss your concerns with your manager. You and your manager may also wish to speak to Social Services prior to a referral. Most social services departments will run a ‘duty social worker’ scheme where professionals can contact them for informal advice. If you do speak to Social Services you should emphasis your concerns for the welfare of a child, rather than allegations of harm or abuse

• If after this discussion you still have concerns, you should consider referrals for the child and family. If you believe the child is at risk of harm, you should refer them to Social Services. In addition to Social Services and the police, the NSPCC also have powers to intervene. NSPCC helpline: 0808 800 5000

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

• What is it like when their parent(s) is under the influence of alcohol or drugs or arguing? What it is like when they are not?

• Do they have fears, anxieties and hopes about their parent’s behaviour?

• What would they most like to be different or stay the same?

• Whom do they think is most affected by the alcohol/drug use or violence and how can they tell?

• To what extent do the children have caring responsibilities?

• What do they do when their parents are arguing, drinking or taking drugs?

1.9 Child protection and legal responsibilities

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

• Domestic violence policy and procedures (substance misuse agencies)

• Drug and alcohol policy and procedures (domestic violence agencies)

• Vulnerable adults policy and procedures

• Confidentiality and information sharing policy and procedures

This policy should clearly state the process involved for reporting any suspicions or disclosures of child abuse or perceived harm to a child.
It focused on 4 main themes:

- Increasing the focus on supporting families and carers
- Ensuring necessary intervention takes place before children reach crisis point and protecting children from falling through the net
- Addressing the underlying problems identified in the report into the death of Victoria Climbié (namely weak accountability and poor integration)
- Ensuring that the people working with children are valued, rewarded and trained

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

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

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

A key message from this inquiry from the ACMD states that reducing harm to children from parental drug use should become a main objective of policy and practice and effective treatment of the parent can have major benefits for the child.

By working together, services can take many practical steps to protect and improve the health and well being of affected children. The inquiry further recommends that drug and alcohol agencies should aim to become ‘family friendly’ with an emphasis on meeting the needs of women and children.

Local Safeguarding Children Boards
The establishment of local safeguarding children boards (LSCBs) is an important element of the improved safeguards for children put in place by the Children Act 2004. The LSCB and its activities are part of the wider context of children’s trust arrangements. Each local authority should have an LSCB in place.
1.11 Contact details for parental substance misuse workers across London

Camden
Alison Johnson  alison.johnson@camden.gov.uk
t: 020 7974 3378

Enfield
Ophelia Powell  ophelia.powell-brown@enfield.gov.uk

Greenwich
Andrea Breen  andrea.breen@greenwich.gov.uk
t: 020 8316 0951 / 07985 211 515

Hackney
Claire Allwood  claire.allwood@hackney.gov.uk
t: 020 8356 5608

Hammersmith & Fulham
Mo Mills  mo.mills@lbhf.gov.uk

Islington
Gill Watson  gill.watson@islington.gov.uk
t: 020 7530 086 / 07837 700 986

Lambeth
Suzanne Olsen  solsen@lambeth.gov.uk
t: 020 7926 7857

Sutton
Jim Meehan  james.meehan@sutton.gov.uk
t: 020 8770 5188

Tower Hamlets
Martin Berry  m.berry@addaction.org.uk

Wandsworth
Lydsey Strachan  lyndsey.strachan@wandsworth.gov.uk

Models of Care for Alcohol Misusers, National Treatment Agency (NTA), 2006
This document regularly acknowledges the need to assess for the impact of alcohol problems on children and families and refers to domestic violence and abuse as one of the additional interlinking issues that needs to be addressed through coordinated interventions.

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

Vision for services for children and young people affected by domestic violence
Produced in 2006 this guidance offers a valuable template for those commissioning children’s services.
1. What are the issues facing Mende?

It is likely that Mende feels incredibly lonely and often frustrated. She may find it hard to express herself and long to speak her first language. How important is marriage within Mende’s culture?

She may feel ashamed that she has left her husband despite the violence. Her use of prescription drugs and alcohol may also be something she feels self conscious about. Mende does not yet have a decision about her immigration status which may also be causing her concern. Without ‘leave to remain’ Mende will not have recourse to public funds for herself, which will be stressful particularly if she is the sole care giver to three children.

Mende is therefore likely to be very vulnerable and anxious at the moment and may feel a reliance on the alcohol and medication in order to cope.

2. How could you reduce Mende’s isolation?

You could consult with Mende about what options she would like, such as finding an African or Sudanese women’s group in London. Also be aware of cultural differences and nuances within her own culture. For instance does everyone speak the same language in Sudan? Are there religious or class differences to consider?

It is possible Mende will not want contact with her ethnic community, due to fear of rejection or shame about her substance use. Encourage Mende to be involved in any activities that the refuge is running and to increase her interaction with the other service users. Try and find out if Mende has any particular skills or talents she may wish to develop, which would also allow her self esteem to grow.

Case Study - Mende and her children

Mende is originally from Sudan and has three children. She fled from her violent relationship six months ago and has applied for leave to remain. It took Mende a long time to leave her husband, as she did not speak English and had no family or friends to turn to. Whilst with her husband Mende was made to use prescription drugs; these made Mende subdued and very withdrawn.

Her husband would often drink too much and fail to give any attention or support to the children. She was also forced to drink on occasions when her husband was drinking and feels she is becoming dependent on alcohol too.

Mende feels very isolated and would also like to reduce her reliance on prescription medication and alcohol. She is currently housed with her children in a refuge.

1. What are the issues facing Mende?

2. How could you reduce Mende’s isolation?

3. Can you assist Mende to reduce her use of prescription medication?

4. What support may her children need?

Possible Solutions

Have you considered the key points to remember when working with this client group (see pg 86/115).
Case Study - Mende and her children

3. Can you assist Mende to reduce her use of prescription medication and alcohol?

Obtain clear and precise details about how much and when Mende takes her medication. Do some basic research about the drugs she is taking and their effects on her system, especially in combination with alcohol. Consider phoning a substance misuse worker for further drug/alcohol information and advice on how to work with poly-substance use.

You could also consider doing a basic screening test to determine if Mende is drinking problematically (pg 267). You may need to do a full assessment to gain a true picture (pg 268).

You may need to conduct a risk assessment to see if there is any risk of Mende overdosing. This could be a risk if she is also feeling isolated and depressed. Offer Mende a referral to a drug and alcohol agency if necessary.

You could accompany Mende to her next doctor’s appointment if she wishes and support her in explaining her situation. It is possible for Mende to gradually reduce her reliance on prescription medication with support from yourselves and her GP.

Case Study - Mende and her children

4. What support may her children need?

What services does your refuge offer for children? If you have a children’s worker allow them to assess Mende’s children and their possible needs. Children who have witnessed violence often require additional emotional support.

You should also be aware that her children’s needs might be even greater due to their father’s alcohol misuse. Consider asking the children how their parents’ behaviour has affected them (pg 196) and explore what protective factors are available to foster resilience in the children (pg 180).

You could also consider contacting a project which offers therapeutic support to children living in families with parental drug/alcohol use (pg 193).

Also be aware that children of non-English speakers can often end up acting as interpreters for their parents. This places the children in an adult position which is inappropriate. If this is the case your organisation needs to provide interpreters for Mende when required.
2. Mental health, substance use and domestic violence

The following information is adapted from the GLDVP Sane Responses: good practice guidelines for domestic violence and mental health services (2007).

“"I don’t call it mental health I call it ‘symptoms of abuse’, because to me that’s what it is.” (Survivor of domestic violence) 31

There are links between substance use and mental health, and mental health and domestic violence. In your work you will come across victims of domestic violence who will be experiencing all three issues.

2.1 Key messages

- Domestic violence causes mental, emotional and/or psychological distress, not just physical injury
- Women with mental health problems have the same rights to be safe as anyone else
- If a perpetrator has a mental illness this is never an excuse for violence
- All of the skills you have as a domestic violence or drug and alcohol worker are helpful to women experiencing mental distress

2.2 Domestic violence and mental health

- Domestic violence and other abuse is the most common cause of depression and other mental health difficulties in women 32
- The BMA identifies that a child who has witnessed domestic abuse has an increased risk of experiencing mental health problems 33
- Among abused women the average rate of depression is 48%, 34 but ranges between 38% and 83% 35 depending on the setting; compared to 10-21% of women in the general population over their lifetime
- On average, 18% of women experiencing domestic violence are suicidal, but ranges between 18% and 40%; 36 compared to 1-16% of women in the general population that have suicidal thoughts and up to 4% make suicide attempts
- On average, 64% of abused women have Post Traumatic Stress Disorder (PTSD) compared to 1-12% in the general population over their lifetime
- Other psychological impacts of domestic violence, 37 include anxiety, changes in eating habits, sleep disturbances and self-harm
- Mental health symptoms occur after, not before, the domestic violence starts
- The more severe or frequent the violence, the greater the risk of mental distress
- When violence stops, mental health improves; and if violence returns, mental health gets worse 38
- Mental distress is often greater, the more recent the abuse. However, women may still have symptoms many years after the abuse has stopped
2.3 Substance use and mental health

- About 30% of people with mental health problems have current substance misuse problems. 
- For women with the dual issues of substance misuse and mental illness, both depression and PTSD usually precede rather than follow the misuse of drugs and alcohol.
- Adults who survive trauma report large increases in their use of alcohol, cigarettes, sleeping tablets, anti-depressants and tranquilisers for up to 30 months after a single event.

It is also important to bear in mind that discrimination faced by certain communities can compound mental ill-health and substance misuse and add additional layers of complexity to a survivor’s support needs. 

Survivors with mental health symptoms may find it more difficult to access services due to:

- The stigma that surrounds mental illness
- Isolation, fear or depression caused by mental distress or domestic violence
- Inappropriate responses from service providers, who may feel unequipped to deal with the issues
- The reluctance of services to acknowledge or address all of the issues they are experiencing

Survivors may be unable to engage in mental health or drug and alcohol recovery until they are safe. Mental health has been shown to improve when the abuse stops. Services should work to address all the issues experienced by the survivor.

2.4 What you can do

- Display information about mental distress, domestic violence and dual diagnosis in your workplace
- Ask about mental health when asking about domestic violence/substance use or when domestic violence/substance use is disclosed
- Give information about mental health and sources of support
- Acknowledge the impact of domestic violence on her mental health and drug and alcohol use
- Prioritise safety – all of the guidance in this toolkit is as relevant to a woman with mental health needs as any other woman
- Work in partnership with mental health trusts and voluntary sector providers to improve outcomes and reduce the risk of repeat victimisation

2.5 Accessing support

If you are concerned about a survivor’s mental health, or they would like support from NHS services, the first steps are to contact their GP or NHS Direct.

GPs are the gateway to mental health services in Primary Care and Secondary Care, which treat 90% of people with mental health problems in the community. GPs can make the initial diagnosis for any mental health problem, prescribe medication and make referrals to NHS services.

Out of office hours, a survivor in crisis could:

- Telephone a helpline such as Saneline: 0845 767 8000 (charged at local rates) which is open 1pm – 11pm every day and offers practical information, crisis care and emotional support to anybody affected by mental health problems www.sane.org.uk
3. Equalities and diversity issues

3.1 Legislation

3.1.1 Human Rights Act (1998)

The Human Rights Act (HRA) has serious ramifications for how organisations must deliver services, and therefore an individual’s duty to act in certain circumstances. If you are a public authority, you provide a statutory function or are publicly funded you must abide by the HRA.

Articles 3 and 7 of this Act state that it is necessary for agencies providing statutory services to act to prevent violent treatment or to protect against violent treatment. The HRA imposes positive obligations on public authorities to protect people from inhuman and degrading treatment (Article 3) and threats to their lives (Article 2). This means that authorities must take pro-active steps to protect a person when they are aware that they are at risk in these ways, no matter who or what is the source of the harm.\(^4\)

As experiences of domestic violence fall under these categories, agencies working with service users who are perpetrators of abuse, need to take positive steps in addressing the behaviour of their service users to enhance the safety of their partners. The responsibility of providing safety to vulnerable people is of critical importance under the HRA and this has been re-enforced by case law in the UK in a 2006 court judgement.\(^5\) The case sends a strong message to the police and other public authorities and should act as a driver of change because it now means that any agency charged with our care can risk losing in court and incurring a financial penalty.

Developing case law indicates it is more than possible that publicly funded charities or those delivering statutory services may be also held to account under the HRA. As an individual acting on behalf of your agency you must be able to demonstrate that you have acted legally in providing services for as wide as possible a range of clients.
You should ensure that you are prepared and equipped to work with a variety of clients, such as those practising a religion, those from ethnic minorities, those with disabilities and those with drug and alcohol problems.

3.2 Addressing diversity issues

3.2.1 General guidelines

- Do remember that domestic violence and substance misuse may be compounded by inappropriate reactions to a survivor’s race, culture, age, sexuality, disability or class.
- Do remember that language and cultural barriers impact on a survivor’s experience.
- Do think carefully about the needs of Black and ethnic minority women who want to leave a violent relationship: for example give them information about ethnic specific refuges/service providers.
- Do think about the cultural requirements of survivors and their children who have dual heritage.
- Do think carefully about who you ask to interpret if the survivor you are supporting speaks a language other than English and her level of understanding/speech requires an interpreter.
- Do think carefully about how to work with women who do not have leave to remain in Britain e.g. asylum seekers. These women are often particularly vulnerable as it can be especially difficult for women with no recourse to public funds to access services and financial support.
- Do think about a survivor’s ability to access services if they have a physical or learning disability (for example, if physical disability prevents a survivor from being able to travel to an appointment). Does your service meet standards laid out in the Disability Discrimination Act (2005)?
- Do think carefully about a survivor’s ability to access services if they have a physical or learning disability (for example, if physical disability prevents a survivor from being able to travel to an appointment). Does your service meet standards laid out in the Disability Discrimination Act (2005)?
- Do remember that lesbian, gay and transgender people experience domestic violence at similar rates to heterosexual people.

3.1.2 Gender Equality Duty (2007)

The Gender Equality Duty requires all public bodies to take action to eliminate unlawful discrimination and harassment and promote equality of opportunity between women and men. The duty applies to all public bodies, as well as private and voluntary organisations carrying out public functions.

The duty is a legal requirement which covers all the functions of public bodies, including policy making and providing services. Specific required duties include: develop a gender equality scheme and implement it within three years; gather information on the effect of its policies and practices on men and women, in employment, services and performance of its functions; and assess the impact of current and proposed policies and practices on gender equality.

The duty requires organisations to pay ‘due regard’ to men’s and women’s particular needs and the issues that affect them. In practice this means addressing the most significant gender inequalities within services.

Examples:

- For women drug and alcohol service users, this could include addressing the impact of domestic violence on their ability to access services or engage in treatment. One way to address these issues could be the provision of tailored services for women.

- Most drug and alcohol agencies do not collect data on domestic violence. In order to meet the specific required duties, agencies may need to change or improve data collection.

Information and guidance about whether the duty applies to your organisation and how to meet the requirements of the duty is available at: www.equalityhumanrights.com
Do think about and ask what is the most suitable format for your communication. For example, do not assume everyone is literate. You should ask how someone prefers to have information conveyed to them. You should also consider whether you need to provide information for someone in a different format for example, in large type, on audio tape.

“A lot of times husbands blackmail their wives by saying that if the women report anything, the government will kick them out of the country.”

Survivors Consultation - Women’s National Commission

3.2.3 Developing culturally specific services

Rugby House works across a range of London Boroughs with diverse communities addressing drug and alcohol use. It also operates New Roots - a specialist Black and Asian counselling service for people with drug and alcohol problems.


Rugby House has developed the following guidelines:

Service Development

- Services will consult with key local stakeholders in developing high quality information about local communities in order to plan and develop appropriate services
- The service should work with Commissioners and other local providers to develop Locality Community Forums that include local Community Groups and Service Providers for mutual sharing of information including cultural and religious issues
- The service environment should indicate a multi-cultural working philosophy e.g. images from other cultures
- Services should attempt to make contact and establish links with community and religious leaders and other respected people from the community
- Services will develop culturally sensitive and relevant marketing and publicity material
- Service development and treatment interventions and initiatives need to include supporting parents and significant others (including their own alcohol and drug use e.g. prescribed tranquillisers)
- Service users and ex-service users should be involved in the planning, implementation and evaluation of service development

3.2.2 Supporting disabled survivors

Disabled survivors are harmed by partners and relatives and experience additional abuses that use and exploit the impairment, for example threatening to have them institutionalised; controlling disability aids such as wheelchairs or medication; refusing to wash, toilet or feed them; refusing to help them until they consent to sex; making decisions on their behalf without their consent and restricting access to communication aids and their ability to contact others.

Disabled survivor’s experiences should be a mandatory part of any service planning and bear in mind that they may wish to speak to specialist disability groups which offer support around violence and abuse. There is one specialist refuge in London for women with learning difficulties (see pg 328).

A groundbreaking research project is investigating disabled women’s experience of domestic violence and exploring existing service provision for disabled women. The research is being conducted by the Violence Against Women Research Group, University of Bristol and the Centre for the Study of Safety and Wellbeing, University of Warwick. For information see:

http://www.bris.ac.uk/sps/research/fpcw/vawrg/current.shtml#rj4502
It is also important to recognise that most people think of domestic abuse as being perpetrated by someone’s former or current partner (some agencies only work with this type of domestic abuse).

However, abuse can also be perpetrated by other members of an individual’s family, for example, by parents or siblings when someone discloses their sexual orientation or gender identity.

**How many LGBT people experience domestic abuse?**

Estimates of prevalence vary, usually because of the methodological difficulties of conducting research within the LGBT communities. Within the UK, there is limited research into this issue:

- One national survey into prevalence among lesbians and gay men reported that 29% of and 22% of women had experienced domestic abuse. Of these, 24% and 19% had experienced some recurrent abuse.
- Most recently, Donovan et al carried out a national survey into the experience of domestic abuse among gay men and lesbians, in which around 38% of respondents reported they had experienced domestic abuse at some time in a same-sex relationship.
- An evaluation of a men’s domestic abuse project in South Wales reported that 31.2% of gay men referred were assessed as being at high or very high risk, with 27% of gay men being experiencing repeat victimisation.
- Our knowledge of the experience of trans community is limited, although one study found that one in ten transgender people had experienced domestic abuse, while another found that 50% of participants had been raped or assaulted by an intimate partner.

It is important to remember that these reports are descriptive: they do not mean that this is the prevalence at which domestic abuse occurs in the LGBT communities. What we do know is that LGBT domestic abuse is clearly a significant problem.

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**Cultural Knowledge and Understanding**

Rugby House believes it is essential that staff fully understand the communities with which they work. Staff need to be aware of the following:

- Knowledge of the socio-demographic, epidemiological and political makeup of the Borough in which they work and the cultural, educational, and socio-economic background of people within communities, including the issues affecting asylum seekers.
- Have a full understanding of heterogeneity and not homogenise communities.
- Have an understanding of the values, beliefs and attitudes of these culturally and ethnically diverse groups.
- Provide advice and information in the appropriate language and medium.
- Have knowledge and understanding of good practice in the field.

**3.2.4 Working with Lesbian, Gay, Bisexual and Transgender communities**

*This section has been written by the LGBT Domestic Abuse Forum: The LGBT Domestic Abuse Forum is a network of practitioners, activists and researchers working around the issue of LGBT domestic abuse. It exists to provide a forum in which to meet, network and exchange good practice. For more information email lgbtforum@glvp.org.uk or go to www.glvp.org.uk.*

**Defining LGBT domestic abuse**

While most definitions of domestic abuse include a reference to sexual orientation or gender identity, there is often a lack of specific information on the services available to members of these communities or some of the unique needs they may face.
Domestic abuse among the LGBT communities is often overlooked. At worst, members of the LGBT communities have received a hostile or ignorant response to their experience of domestic abuse. There is a lack of specialist service provision and many generic services are not geared to provide appropriate safety planning and support to LGBT people who have experienced domestic abuse.

Equally, the LGBT communities have been reluctant to address the issue of domestic abuse for fear of prompting, or exacerbating, homo/bi/transphobia. The reality is that domestic abuse can affect anyone, regardless of their sexual orientation, age, gender, race, religion or ability.

**LGBT domestic abuse and substance use**

Many of the issues for LGBT people will be the same as their heterosexual peers in terms of substance use and domestic abuse. There is controversy about reports of high levels of substance misuse among LGBT people. Some research has suggested that this is true, with people pointing to the central role that bars and clubs can occupy for many LGBT people.

Another explanation is the impact of homophobia and heterosexism, which may exacerbate the use of alcohol and other substances as a coping mechanism for dealing with discrimination.\(^5\) However, research on the levels of use and associated problems remain inconclusive. However, there are specific issues that can affect LGBT people which need to be addressed to increase safety and reduce risk around domestic abuse and substance use. These may include:

- Threats to ‘out’\(^5\)
- Fears that no-one will help because someone ‘deserves’ the abuse (perhaps because of a belief that service providers are either homo/bi/transphobic or heterosexist)
- Claiming that domestic abuse is a ‘normal’ part of LGBT relationships
- Undermining someone's sense of identity
- Controlling someone's access to social networks, particularly with regard to sexual orientation or gender identity

There are also specific barriers to accessing support in both sectors which include:

- Real or perceived homophobia from service providers
- The need to ‘out’ oneself to access services or to discuss how violence and ‘abuse is impacting on alcohol or drug problems
- The potential impact of internalised homo/bi/transphobia
- A lack of appropriate or specialist services (particularly access to crisis housing provision)
- A lack of training in relation to LGBT domestic abuse and/or substance use, including a failure to screen for alleged perpetrator and victim/survivor
- Unsafe practice in drug/alcohol agencies due to the fact that staff are unaware that an accompanying ‘friend’ of a service user could be an abusive partner
- A lack of confidence in the Criminal Justice System, which can be a barrier to getting advice and support

**For survivors with problematic substance use further issues arise:**

- Controlling substance use or remaining abstinent often requires staying away from the drug, alcohol or party ‘scene’ which the survivor may rely on to meet other LGBT people. In the immediate, this could lead to isolation and fears of not meeting a new partner or new LGBT friends
- Drug or alcohol use may be linked to stress and trauma associated with not being able to seek support mechanisms of family or colleagues for fear of being ‘outed’
3.2.5 Supporting male survivors

Men can also be victims of domestic violence at the hands of a female partner and adult children, siblings and carers.

Many men may feel embarrassed or ashamed about the abuse they are experiencing, as it does not fit common masculine stereotypes. This may make it difficult for them to disclose the violence and seek appropriate help.

There is limited research and work undertaken on the needs of male victims but what is clear is that it is not appropriate to develop services for male victims as a mirror image of female services.

Evidence also suggests there are different support needs for men and this differs between heterosexual and homosexual men.13

Men’s Advice Line are currently developing a needs assessment which aims to meet the needs of this group of survivors. This service also provides emotional and practical support for male victims through a national helpline. They also provide free publicity material.

Men’s Advice Line
t: 0808 801 0327
www.mensadviceline.org.uk

The Men’s Health Forum have developed a booklet for men involved and affected by domestic violence

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Michelle’s Story...

“She even told me that if I’d do more social drinking/recreational drugs, I’d be more fun and she could enjoy me more. There was never any physical abuse, but the emotional abuse was constant and extensive.”

Safety planning
For someone experiencing LGBT domestic abuse, recognising that they are experiencing domestic abuse is an important first act.

Some websites with information about safety planning include:

- Another Closet (http://ssdv.acon.org.au/): This Australian website deals with same-sex domestic abuse, but is beneficial to any LGBT person experiencing domestic abuse. It has information on assessing abuse, safety planning and advice for when the relationship has ended

- Broken Rainbow also has information on safety planning at http://www.broken-rainbow.org.uk/content/safetyplan.htm

Useful contacts
There are a number of organisations who provide support to LGBT people experiencing domestic abuse (see pg 328).

Locally, support and advice may also be available from:

- LGBT helplines or groups, as well as organisations like the Citizen’s Advice Bureau who may be aware of other resources

- Police forces should have a unit which works specifically with the LGBT communities and/or a domestic abuse unit (sometimes called a family support or community safety unit) which can offer direct advice and support, or refer on to other more appropriate organisations. In an emergency, always contact the police on 999
3.3 Guidelines for working with interpreters

For those whose first language is not English, you will need to ensure an interpreter is available on request/where needed. Talking about sensitive and emotional issues like domestic violence and/or substance misuse is very difficult to do in a second language.

Below are some guidelines to help you select and use an interpreter.

- Be sensitive to the fact that for some women, the use of a male interpreter may preclude any discussion of certain subjects so whenever possible, try to use a female interpreter. If, in an emergency, this is not possible don’t press for details if you sense a discomfort in talking about sensitive issues. Try to arrange another time when a female interpreter is available.

- NEVER use a child as an interpreter

- Try not to use interpreters from the client’s own local area or from community associations to which she, her husband, family or friends may belong. If in doubt, ask

- Make sure that interpreters sign a confidentiality clause in their contract with you and that they understand the necessity for such precautions

- Ensure that the interpreters have been trained in issues of domestic violence and that they don’t have strong beliefs about the ‘sanctity of marriage’ or that ‘outsiders’ should not interfere within ‘their’ community

- If you regularly use interpreters, include them in any training you may have on domestic violence

- Before any interpreting begins, ensure that language and dialect match between the interpreter and the client

- During the session, allow time for introductions, pause frequently so that the interpreter can easily remember and translate what you are saying

- Make sure the interpreter understands that their role is to interpret, not to advise, censor or summarise what either you or she is saying

- Look at the client and speak directly to them, not the interpreter

**National Interpreting Service (NIS)**

**t: 0800 169 5996 or 0800 023 4089**

NIS provide interpreting services by phone – this can be achieved by any telephone, though not mobiles. You must be registered and issued with an ID number in order to access the service.

By dialling a free phone number, you can request any language and specify a female interpreter via a three way conference call. In face to face situations, the service can be used with a speaker phone or by passing the handset back and forth.

Special NIS dual handset phones are also available. Interpreters are professional and bound by a strict code of confidentiality – the only time she might intervene is to seek clarification or make you aware of a cultural implication that may cause offence.

Some Local Authority’s may also provide translation services.
4. Partnership working

Many organisations find building partnerships a challenging but essential part of their client work. In reading this toolkit it is assumed you have identified dual or even multiple needs within your client group.

Often we assume partnership working is a formal and time consuming process, yet making an informal phone call to a service and asking for advice and information is an effective exercise in partnership.

Partnership working is logical; no one is an expert in every field or issue presented to us. As workers we are as diverse as our clients. It is an organisation’s responsibility to provide options, alternatives and hope to clients facing domestic violence and substance misuse issues.

4.1 Forming partnerships

Before looking at how you can form partnerships, consider who you might form partnerships with. Do you have a directory of local services? If not, it is a good idea to make a staff member responsible for collating a list of local services, both statutory and non-statutory.

As a team, make a list of what kind of services you might need and have telephone numbers for e.g. mental health, drug and alcohol, sexual health, childcare, local doctors, employment services, domestic violence and sexual assault services.

This list will help prepare you for all forms of disclosure. For example, if a client presents with a need you can begin quickly finding an appropriate service or information. Ideally your service should also stock a large range of leaflets and information on local support services to assist people in making informed choices.

This should include resources such as leaflets, flyers and posters. Most importantly - ask questions, pick up the phone, write a letter or send an email. Instigate the process rather than expecting another organisation to do so.

What Works: Phoenix House and Mayfield Centre (Birmingham Women’s Aid) (taken from the group evaluation written by Andy White and Heather Cole)

This project was the initiative of two innovative service managers who recognised a gap in services and agreed to discuss how they could work together to fill the gap.

After some discussion it became apparent that having staff from both services co-facilitating the women’s group within Phoenix House would be an exciting, innovative and effective way of supporting women to make the links between their substance misuse and their experiences of gendered violence.

The managers established a pilot group project called the ‘women-centred group’. Every woman who took part in the group had experienced domestic abuse.

Women identified that exploring and addressing the links between their experiences of abuse and their drug use was an essential part of their recovery from problematic drug use.

They identified that the work covered within these groups was incorporated within their action plans for preventing relapse and developing stable lifestyles in their futures outside services.

While women in their on-going evaluations identified their feelings in some sessions as ‘angry’, ‘sad’, ‘upset’, ‘difficult’, they were at the same time very clear that they wanted to explore those feelings and not avoid discussing issues that they found hard. Women were also explicit that they would not have been able to have these conversations in mixed groups, or with male facilitators.

A significant number of women participating in the groups accessed other specialist services through the signposting offered; for example refuge, rape and sexual violence services, domestic abuse helplines and so on.
Women also reported discussing these issues with other women in their lives outside Phoenix House services, and passing on the contact numbers of specialist services.

For Phoenix House, the women’s group has had a significant positive impact on the awareness of gender oppression and violence within the service as a whole; this has also created interest and awareness within the wider, national organisation.

For Birmingham Women’s Aid, within the Mayfield Centre services there has been significant learning around the issues that drug-using women face and the responses to women have improved.

As a result of this work, the Mayfield Centre has become more accessible to women who have previously experienced obstacles to accessing the services.

Both services have also benefited from the increased capacities and skills that staff have developed through facilitating the groups.

For more information contact:
Andy White
andy.white@phoenixhouse.org.uk

4.2 Informal methods of building partnerships

Training Swaps
Perhaps you have identified a need for training in basic drug awareness but can’t afford to send your whole staff team? Why not offer a training exchange? Meet with a local service and agree to provide a day of training in domestic violence, while they provide one day of training in substance use.

E-Groups
The most cost effective of all. Create a list of interested parties, allowing people to seek advice and clarity on issues pertaining to substance misuse and domestic violence. Send and answer questions at convenient times, allow the list to grow and shrink as required.

Inter-agency visits
Visits allow an organisation to send one member of staff to ask a variety of questions and get a ‘feel’ for a service. If the service is a domestic violence refuge, arrange to meet at your service. Once you have discussed your services, it is possible you can explore common issues and ways of working together.

Conferences/Seminars
Hold them yourself or if not contact a local authority or umbrella group and ask them to; you may be surprised at the response. Allow staff to attend as many seminar days as possible, as an ideal way of networking.

Away Days/Team Meetings
If you don’t have time for a comprehensive day of networking, invite individual services to speak at team away days or meetings. This allows workers to become aware of what is available to clients, and provides an opportunity for open debate about how your services can work together.
4.3 Formal methods of partnership building

Referrals
Some organisations have funding restraints which limit the numbers and places from which most referrals can arrive. However, many services are open to referrals from a variety of sources or extending their referral base.

It is always worth discussing this with appropriate agencies. Before referring clients you should always call a service, gaining an understanding of what information they need for a referral. The more information you give on a referral form the more effective response a service can provide and it will also help to prevent inappropriate referrals.

Care Plans
Clients with dual or multiple needs, often require a collaborative response. If several organisations are working directly with a client it is essential to provide a joint system of care.

If this is the case, key workers need to meet on a regular basis and devise a joint strategy. Clients must give consent for information to be shared within this forum.

Service Level Agreements:
If two organisations feel that they would benefit from each other’s services a formal written agreement may be developed to clarify roles and responsibilities. A service level agreement should clearly state what services are to be provided and how this will be measured or ensured.

For example, a domestic violence refuge may write an agreement to have a substance use worker facilitate workshops with women. In order for this to occur, an agreement, inclusive of associated costs, may have to be devised.

“From my experience, true joint working can make a huge difference in supporting women suffering domestic violence with drug/alcohol issues. I can say that without the regular support my service users received from housing, police, ourselves and the alcohol team locally, the outcomes would have been different. Support from non judgmental, respectful professionals for women who misuse alcohol/drugs can have a huge impact on outcomes. When users see the police, housing and other agencies taking their situation seriously they can gain the strength to leave their abusers.”

Theresa Ryan, Brent Irish Advisory Service (BIAS)
www.biasbrent.co.uk

Sample referral pathways can be found on pg 307-308.
4.4 Finding partners

If you have identified a specific need within your client group you may consider contacting an umbrella organisation. They will be able to assist you to finding the best service with which your organisation can jointly work.

You could also consider attending any local meetings or fora to allow for the development of partnerships. Groups to consider contacting in your local borough:

- Drug and Alcohol Action Teams (DAATs) - located in each borough, these groups oversee drug and alcohol service provision and project management. They are also responsible for drug and alcohol funding distribution from the government. DAATs should be able to give a clear rundown on services available in your area. You can find contacts for London DAATs at pg 319

- Domestic Violence Fora - almost every borough in London has a domestic violence forum and most also have a co-ordinator. This Forum is attended by variety of interested parties such as police, refuge staff and local authority departments. They develop borough initiatives and should have a clear view of all the domestic violence services available in your area. Contacts can be found on pg 311

- Multi Agency Risk Assessment Conference (MARAC)- these have been set up in a number of boroughs and are usually coordinated by either the local Police Community Safety Unit or Domestic Violence Coordinator. The multi-agency meetings usually meet once a month with the aim of managing the most high risk domestic violence cases

- Community Voluntary Action Councils – usually funded by the local authority and other local statutory agencies, there is a CVS working in several boroughs across London. These groups are run by local groups to support, promote and develop local voluntary and community action

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

The ARP Women’s Alcohol Service in partnership with the nia project (formerly Hackney Women’s Aid) is in its 3rd successful year of offering service users specific help, information and support around the dual issues of domestic abuse and alcohol misuse. The Project is funded by Safer Islington Partnership and consists of 2 workers – a DV and Alcohol Worker (2.5 days a week employed by ARP) and a DV Advocacy Worker (seconded from nia 1 day a week).

The DV and Alcohol Worker promotes partnership working and delivers training to agencies within Islington. This worker also maintains a small one to one caseload and facilitates a weekly group for WAS service users who are or have been affected by domestic violence. The DV Advocacy Worker provides weekly information and referral sessions at WAS and carries a small caseload of clients who require more specific advocacy and practical support.

Our experience of working in partnership has been a very positive one. The familiar presence and expertise of the nia project worker onsite has allowed women to be referred more easily to domestic violence agencies. The majority of clients who attend WAS have experienced domestic violence in their past but have never talked to anyone about this which has often to their alcohol misuse. Dealing with both issues in one place has enhanced clients’ recovery and served to prevent relapse with regards to domestic violence and alcohol.

The nia worker has benefited from being seconded to an alcohol agency in that she has undertaken alcohol awareness training and transferred learning back to staff at the nia project. Quarterly meetings between the line managers of the nia project worker are held in order to review progress and deal with any issues. ARP strongly acknowledges the need for a service for women who have the dual issues of domestic violence and substance misuse and is actively looking for funding to increase the amount of work that can be done in this area, as well as seeking partners in relevant fields and devising protocols for partnership work.

Contact: Cordelia Mayfield, Team Manager, ARP Women’s Alcohol Service, cmayfield@arp-uk.org
What Works: Camden Women’s Aid (CWA) and Margerete Centre (South Camden Drug Service)

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

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

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

Camden Women’s Aid responses

Immediate assessment and link with GP for immediate prescribing

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

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

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

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

Multi-Agency Protocols and Practice Guidance

Camden Domestic Violence Forum Substance Misuse Sub Group has created a set of policies, assessment forms and referral charts for use by drug, alcohol and domestic violence agencies. Refining the Routes, Domestic Violence and Substance Misuse can be downloaded from http://www.camden.gov.uk/domesticviolence

Nottinghamshire County Council in partnership with Nottinghamshire Drug and Alcohol Action Team have produced Good Practice Guidelines for Working with Survivors and/or Perpetrators of Domestic Violence Who Also Use Alcohol and Drugs which can be downloaded from the Nottinghamshire Domestic Violence Forum website http://www.ndvf.org.uk/resources_26.php

The Stella Project has created a sample Partnership Agreement document based on the model used by GLDVP and GLADA when the Stella Project began. This can be obtained by contacting the stellaproject@glvp.org.uk

• Domestic Violence Services - the National Domestic Violence Helpline 0808 2000 247. The helpline operates twenty four hours a day and in a range of languages. The Men’s Advice Line provides support to male victims of domestic violence 0808 801 0327. The RESPECT phoneline provides advice to perpetrators and details of services nationwide 0845 122 8609. Links to services in London can also be found at www.glvp.org.uk

• Drug and Alcohol services on-line - a full list of alcohol services is available from Alcohol Concern: www.alcoholconcern.org.uk A full list of drug and alcohol services is available from the London Drug and Alcohol network: www.ldan.org.uk
Jackie knew that she would not be evicted if she did start using and that she would constantly be encouraged to take one step at a time.

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

She had reduced her script to much lower levels and was also having regular access to her child who was living with her mother. She was clear that she needed to be re-housed somewhere where she would not be in contact with users or ex-users.

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

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

Camden Women’s Aid is now part of Solace - referrals can be made by telephoning 020 7428 9962
4.5 Challenges in partnerships

When contacting refuges be aware that the main priority for refuges is the safety of their residents and their location. Refuges will not give out their location over the phone, since anyone could ring and claim to be a service provider and of course, service providers can be abusers too.

Male staff should be particularly aware of this issue. In an effort to maintain this confidentiality you may not be invited to the actual refuge, so offer to meet elsewhere such as your own service.

Never tell a perpetrator of violence that his partner or ex-partner may be or has been referred to a refuge. Refuges are often wary about working with women who use substances. Don’t assume refuge workers have knowledge of drugs or alcohol symptoms or treatment models. Take time to explain individual client drug and alcohol use.

When contacting drug and alcohol services be aware that: the environment of drug and alcohol services often reflects the nature of drug use, that is, ever changing, fast paced and sometimes chaotic.

Most drug and alcohol services assess the whole lifestyle that is associated with substance use and therefore may welcome any inter-agency work. However due to the nature of services, you should be direct and straightforward about the needs your client has. The drug and alcohol field is full of terminology relating to treatment, diagnosis and theory.

Rather than pretending to understand, ask questions, otherwise you risk referring a client to an inappropriate service. Be aware that just as in domestic violence work, confidentiality is a major factor in successful drug and alcohol work. Services will be reluctant to share any information with you without client consent.

If they feel that this information will threaten someone’s housing or safety they will be wary of sharing it with you. This can be overcome by simply gaining a shared understanding of each other’s work with a client and having a confidentiality form signed by the client.

Funding is often an issue for services, especially those offering medical interventions, such as detox or prescribing. If you have difficulty accessing specialist services for clients due to funding you should jointly approach your local DAAT for further direction.

Most importantly don’t assume that substance use workers have knowledge about domestic violence. Be sure to explain the nature of violence your client is experiencing and the danger they may be facing. Explain how violence is not excusable because of their substance use. Allow workers the time to reflect and empathise with a survivor’s experience.
5. Supporting staff

Services are only as good as the people who provide them. No matter how experienced, trained or hardened a worker is, organisations need to recognise and value staff. Direct service delivery can be emotionally draining and personally challenging. Good workers are people with the ability to self reflect and analyse their responses to situations.

These are not innate skills, but rather skills that are learned and developed. Supported staff also tend to stay in their positions longer, leading to greater staff retention.

Methods to support employees include:

- **Supervision**: supervision is not simply about managing employees, but is also a way of developing employees. Services should acknowledge that staff may need additional supervision in times of stress, when their client base changes or if they have been involved in a crisis situation. Supervision can be a helpful tool in allowing workers to reflect on their day to day practice. It is also ideal when discussing particular client related issues, as a line manager may have greater clarity around these issues.

- **Clinical supervision**: specialist workers in either domestic violence or drugs/alcohol operating in the other sector can sometimes feel isolated and may benefit from clinical supervision from someone outside the organisation. This person would be able to give support around the specialism and address issues outside the remit of the worker’s immediate line supervisor.

- **Practice clarity**: continually revise what sort of framework you are operating under and how this impacts on your practice. Issues of good practice and theory can easily be explored in team meetings or group supervisions.

- **Group supervision/away days**: group days allow for clarity in job roles and highlight individuals input within teams. This allows for re-grouping and reflection on how as a team you consistently relate to your clients.

- **Personal and career development**: we all get tired of being in a rut. Staff should be encouraged to develop areas of interest. Perhaps that means allowing individuals to select particular clients to work with or duties to undertake.

- **Training**: allows workers to develop more skills and knowledge, especially in specific areas. On top of this workers are given the opportunity to reflect on relevant and sustainable practice.

- **Sensible working hours**: whilst commitment to your job is essential, so is having an outside life. Organisations should never place pressure on employees to continually and systematically work extended hours. This leads to overworked employees with high levels of stress, associated health problems and poor staff retention.
6. User consultation

There is simply no point in providing a service without consulting users. Services need to be designed to meet their needs. Services should ensure they have a mechanism for engaging clients that is both meaningful and effective. Clients want to be able to trust service providers and feel that change will occur in realistic timeframes.

User consultation varies widely and needs to be adapted for each organisation. Points to consider:

• Consult with your clients to find a format or strategy for consultation they feel comfortable with

• Be aware that questionnaires and suggestion boxes can exclude those from non-English speaking backgrounds and those with literacy problems

• Explore ways in which service users can be involved in the decision making processes of your agency e.g. as part of your management committee

• Service user meetings should be held on a regular basis and all action points should be completed to a specified time

• If possible you could conduct ‘exit interviews’ as clients leave your service

User consultation does not have to be a negative experience. People are often more concerned with complaining than complimenting. However, the latter is likely to occur if clients feel a service meets their needs and client consultation is taken seriously. Below are two innovative models of user involvement.

What Works: Barnet Service User Group and the Domestic Violence Poster Project

Following a survey of the domestic violence experiences of women using Barnet’s drug and alcohol services, Barnet Service User Group (BSUG) members expressed an interest in leading on the development and design of posters to encourage women accessing the borough’s substance misuse services to take the first step in getting support for domestic violence.

The Domestic Violence Coordinator worked with the DAAT Manager and was given funding for BSUG members to work together with a graphic designer, Helen Spiby, to develop the poster.

It is with the particular commitment of Fay and Rosemma and the feedback of the BSUG members that bought this project together.

Alison Lawrence, Barnet’s Service User Involvement Coordinator and BSUG member, and Foziha Raja, a Domestic Violence Counsellor from Ethnic Alcohol Counselling Hounslow (EACH), facilitated the poster group.

Helen has transposed the ideas and concepts of the group and designed a poster which everyone involved in is very proud of.

We look forward to seeing the poster displayed in substance misuse and domestic violence services and in other sectors such as health, housing and education.

The poster can be found overleaf.
When consulting with domestic violence survivors you should consider:

- The information sought must not jeopardise the safety of abused women and children
- Allow for anonymous contributions either in writing or via the telephone
- The impact of women’s unique situations and individual differences. Do not, for example, only consult with women whose first language is English or who are living on benefits
- Holding consultation sessions on women’s safety rather than on domestic violence
- Holding women-only consultation sessions
- Consulting specifically with refuge residents (but be absolutely clear that a refusal to participate will not impact in any way on services she may currently be using or seeking to use such as permanent housing)
- Providing childcare facilities while the consultation is taking place
- Providing a ‘follow-up’ session for those individuals who distressed by recounting their experiences. For example, ensure women are given numbers of appropriate local support services
- Detailing who will have access to any information given and whether or not individuals will be identifiable
- Ensuring that all safety considerations are integrated into the consultation process. For example, do not hold public meetings in poorly lit places which are inaccessible by public transport
7. Working at a strategic level – guidance for managers, service directors and commissioners

In order to encourage agencies from both sectors to develop this work and ensure it is embedded into practice, it is important that domestic violence, drugs and alcohol issues are addressed at a strategic level. Local drug treatment plans, alcohol, domestic violence and community safety strategies should all feature commitments to address the dual issues.

Local Area Agreements have become the main conduit for identifying funding priorities for local boroughs and it is therefore a key process with which to engage. This section aims to give examples of good practice which could be emulated in your own boroughs.

7.1 Local Area Agreements

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

They are driven by Local Strategic Partnerships who negotiate the targets and outcomes, in conjunction with central government, and are responsible for their delivery and monitoring.

In order to ensure that the domestic violence and drug and alcohol agendas receive sustained priority in the future it is essential that specific indicators and targets are incorporated into LAAs. Having specific indicators that address alcohol and drug related domestic violence would prove an efficient way for local boroughs to meet several of the new targets featured in the new National Performance Indicators which replace all existing performance indicators."

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

For more information see the Women’s Aid briefing Local Area Agreements – what’s next? http://www.womensaid.org.uk/landing_page.asp?section=00010001000900050017
7.2 Alcohol, domestic violence strategies and drug treatment plans

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

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

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

A multi-agency partnership training day was held shortly after where agencies were asked to consider ‘signing up’ to a negotiated set of standards.

A monitoring system was put in place to determine which agencies were able to meet the standards and identify where further resources and support were needed.

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

What Works: Camden Local Area Agreement
Camden has used LAA funding for a specialist Domestic Violence and Substance Misuse Development Worker. Camden’s LAA includes an indicator which commits the borough to achieve level three of the London Domestic Violence Strategy. This includes improving joint working between the domestic violence and substance misuse sectors.

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

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

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

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

Refining the Routes, Domestic Violence and Substance Misuse can be downloaded from [www.camden.gov.uk/domesticviolence](http://www.camden.gov.uk/domesticviolence)

For hard copies and additional information on the group contact: Domestic Violence Strategy and Services Manager Community Safety and Drugs Team t: 020 7974 6138 catriona.scanlon@camden.gov.uk

You can also find some of the documents reproduced in Section 5.
Ongoing discussions between the DAAT and individual agencies have lead to the following developments:

- The DAAT Data Officer supporting the development of a drug and alcohol recording spreadsheet for Greenwich Women’s Aid

- DAAT visits to all domestic violence agencies to distribute information

- Agreements to record victim and perpetrators of domestic violence within three substance misuse agencies (with this being formalised into an service level agreement with one agency)

- Networking lunch organised for both sectors

- The commissioning of a package of further advanced training for 2008

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

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

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

The link between domestic violence and substance misuse is identified and is a key priority with pathways to appropriate provision to be developed.

This commitment within the treatment plan resulted in the DAAT funding a substance misuse worker for the local domestic violence advocacy project and a further amount pledged for training and development work.

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

7.3.1 Monitoring impact of work

Any work undertaken with individual agencies and at a multi-agency level should include clear procedures for monitoring the impact of new initiatives.

One method of doing this would be to audit the local services to assess what they are currently doing and to form the basis of agreeing a set of practice standards against which each service can be measured.

Examples of such standards can be found at pg 303-306 and can be adapted to the specific needs of the Local Authority.

Some standards can be implemented quickly with limited resources (e.g. displaying posters and agency position statement) whilst others may need further resources and this could form the basis of a discussion between strategic partnerships and individual agencies.

Agencies could then be periodically reviewed against the agreed set of practices.

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What Works: Aquarius Experience (taken from a summary of the agency’s work to date written by Sheila Raby)

Aquarius is the UK Midlands based alcohol and drugs charity. It has the aim of reducing alcohol and drug related harm and promoting informed and responsible choices about the use of alcohol and other potentially addictive substances and behaviours.

Between 2002-2006 Aquarius employed a development worker for the women, alcohol and domestic abuse initiative. This part-time post was originally funded by Comic Relief, and then continued by Birmingham PCTs. The post came to an end in December 2006.

Action within Aquarius

An audit of Aquarius services was conducted, to ascertain how these looked from the perspective of a woman affected by domestic abuse.

Issues highlighted by this include: leaflets not mentioning domestic abuse; lack of women-only appointment times; lack of women-only groups (most services); lack of crèche facilities; restricted availability of evening appointments; lack of a defined service for partners of drinkers; no training provided for staff in domestic abuse.

The results of the audit were presented to Aquarius managers and agreement reached for all Aquarius projects to work towards attaining a ‘Basic Level Response’, as outlined in Sarah Galvani’s paper: Grasping the Nettle. (Alcohol Concern, Acquire, Winter 2005).

The development worker visited each Aquarius project to help develop and revise the wording of a position statement on domestic abuse which will be acceptable to all projects and will not alienate any service users, whether male or female, perpetrator or survivor.

An Aquarius Domestic Abuse Forum has been established to continue to highlight and progress this area of work.

In order to bring about sustainable change which is embedded in Aquarius policies and practice, it was important to motivate all staff members, rather than just managers.
7.3.2 Data collection

Collecting data on the number of service users disclosing the dual issues can provide an evidence of need and help in obtaining funding from your local Community Safety Partnership to develop this work further.

Agencies may wish to capture data within their current forms or spreadsheets or alternatively a separate sheet or form could be created to go alongside existing ones.

An ideal evidence collection would comprise the following points (in addition to more generic data that agencies already gather about user demographics and children).

- Total number of service users questioned about domestic violence/substance use*
- Total number of service users questioned about domestic violence/substance use and who disclosed domestic violence/substance misuse*?
- Substance misuse by the abuser disclosed?
- Disclosed upon assessment or during working relationship?
- Current or past domestic violence/substance misuse*?
- Type of substance use/domestic violence* experienced?
- Referral made to a dv/drug/alcohol* agency AND did the service user follow through?
- Referral received from a dv/drug/alcohol agency* AND did the client consequently engage with your service?

*delete as appropriate*

Presenting the results of the audit combined with national statistics to all staff increased their perceived importance of making changes, whereas using Galvani’s ‘Basic Level Response’ gave people confidence that they could make changes.

Following this a domestic abuse policy for the organisation was developed which will help to integrate best practice in domestic abuse into all existing policies see pg 291.

Partnership work has also been developed between Aquarius and local domestic abuse agencies leading to training swaps and regular partnership meetings.

The first stage of this work is complete. The challenge for the organisation is to embed the change. A service manager and the practice development manager are now developing a work plan to ensure that this change in practice occurs.

For more information contact Annette Flemming at whitehouse@aquarius.org.uk
Where domestic violence is identified this should be addressed in the care plan ideally working in partnership with a specialist domestic violence agency which can provide psycho-social support, access to safe housing and in some cases, children's support services. Integrated care pathways should be able to provide access to a range of services and interventions that meet individual's needs in a comprehensive way. Therefore, partnership working with domestic violence agencies should automatically form part of a response to a service user who is a victim or perpetrator of domestic violence.

- **Aftercare**
  For survivors of domestic violence who have left structured treatment, it is essential for their safety, and in order to avoid relapse, that the wider issues of partner and family abuse are addressed. The safety of the service user should be paramount in any aftercare initiatives particularly where they are returning to an abusive relationship.

Domestic violence services also have a key role to play in providing aftercare through psychosocial interventions which cater for the variety of survivors’ needs.

Drug/alcohol agencies can play a key role in delivering thorough and holistic aftercare if staff are appropriately trained on the issues of domestic violence from the perspective of both the survivor and the perpetrator. This requires knowledge of positive screening and effective responses to disclosures of violence.

Models of Care also recommends that it may be beneficial to have link professionals from specialist drug services who can train and support Tier 1 professionals, in this case domestic violence services.

Where the prevalence of substance use in domestic violence services is high, it may be beneficial to have a specialised liaison service to provide a co-ordinated response.

Further guidance and detail from Models of Care can be found at [http://www.nta.nhs.uk/areas/models_of_care/default.aspx](http://www.nta.nhs.uk/areas/models_of_care/default.aspx)
Models of Care for Alcohol Misusers (MoCAM) builds on the foundations of the models for drug treatment and recognises the particular needs of drinkers with complex problems.

Guidance regarding the stepped care model states that particular needs may be identified in relation to the alcohol use requiring more complex and co-ordinated interventions. Domestic violence is specifically mentioned in this context.

Psycho-social treatments should include targeted interventions for certain groups (as reflected by the needs of the local population) and should respond to specific cultural and gender issues.

- **Brief Interventions**
  Some simple steps can be taken to address the link between alcohol use and domestic violence in brief interventions and advice services. Practitioners need to be alert to the fact that a person’s drinking may be related to their experiences of domestic violence which may affect the type of advice that is given.

  At a minimum, all clients should be issued with information about local domestic violence services alongside alcohol information.

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

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

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

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

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


### 7.5 Guidance for domestic violence service managers

**Supporting People Strategy**
The government’s Supporting People initiative is one of the primary sources of funding for the majority of refuges. Supporting People has identified the difficulty refuges often have with accommodating women with drug and alcohol issues.

Models of good practice that have been highlighted by Supporting People include:

- Establishing and commissioning integrated services e.g. employing combinations of floating support and supported housing services with specialist support from Drug and Alcohol Action Teams (DAATs)

- Service user involvement in developing services

- Joint working to ensure that support needs are met and to avoid service users being ‘passed around’

- Joint assessments, working through shared processes and forms
If you are working across domestic violence and substance misuse and funded by Supporting People, you may find the following information useful:

- There is a requirement of services funded by Supporting People to work towards continuous improvement and strategic relevance in order to sustain funding.
- Supporting People research shows difficulties in providing accommodation for women with drug and alcohol issues in refuges. Any attempt to fill this gap effectively would be seen as positive.
- Ideally you would include multi-agency partnerships that are progressive and effective.
- Floating support for housing related needs is a method of service provision which is eligible for Supporting People funding. It is cost effective, flexible and user-focused. Working across the sectors provides refuges with an opportunity to develop innovative practice, respond to client need, and possibly assist in securing future funding.

**Outcome form for short term services**

The Department for Communities and Local Government has recently introduced a new monitoring tool which will apply to refuge and other services funded by Supporting People such as outreach.

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

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

### Section 4 footnotes

2. This is a calculation based on the statistic that ‘at least one child a week dies from cruelty’ Home Office, 2007 Homicides, Firearms Offences and Intimate Violence 2005/2006.
15. ibid
20 For five out of seven families this was the case (one lesbian and four heterosexual couples); Taylor, A., Toner, P., Templeton, L. & Velleman, R., 2006. Parental Alcohol Misuse in Complex Families: The Implications for Engagement. *British Journal of Social Work*.
28 Adapted from Parental Alcohol Use and the Common Assessment Framework, The Parenting and Alcohol Project, Alcohol Concern, 2006 available to download at www.alcoholandfamilies.org.uk
44 Van Colle v Chief Constable of Hertfordshire Police [2006] EWHC 360(QB) case. For further information see the GLDVP briefing http://www.glvdp.org.uk/C2B/document_tree/ViewAdocument.asp ?ID=160&CatID=130&Search=true (July 2007). In this case the police were held liable for failing to ‘discharge their positive obligations’ towards a murdered man, by failing to respond to the threats he had received against his life. By failing to take action where they should have known that there was a real risk to the life of a witness, the police were in breach of their duty.


52 i.e. to disclose someone's sexual orientation or gender identity without their consent, for example to their employer or family.


54 From 2008/09, LAAs will contain 17 statutory education and early years targets and up to 35 improvement outcomes taken from a set of 198 National Performance Indicators.

5. Sample Documents

This section displays sample policies and tools that you may find useful within your service. These have been generously donated by a variety of organisations across both sectors. You may find the documents are useful within your practice as they stand or you may need to adapt them so they are appropriate to your service. If you would like copies of the original documents please contact us at the Stella Project.

1. Stella Project sample drug and alcohol screening tool for use by domestic violence agencies 264
2. Dependency screening tool 267
3. Substance misuse routine inquiry procedures (for survivors and perpetrators) 268
4. Drug and alcohol risk assessment 276
5. Domestic violence screening tool 279
6. Domestic violence risk indicator checklist 282
7. Sample safety plan 288
8. Domestic violence and abuse sample agency policy 291
9. Domestic violence policy for employees 296
10. Stella Project practice standards for domestic violence agencies 303
11. Stella Project practice standards for substance misuse agencies 305
12. Referral pathway (substance misuse to domestic violence agency) 307
13. Referral pathway (domestic violence to substance misuse agency) 308
14. Sample domestic violence policy statement 309
1. Stella Project sample drug and alcohol screening tool

Date: ______________

First Name: _______________ Surname: _______________

Ideally the first two questions should be asked to all women who contact your service. If you are uncomfortable asking them or do not know how to begin you could try starting with the following:

“Many people come to use this service and all of them have different needs. Because of this we have to ask you a variety of different questions. We will not exclude you from our services because of the answers you give us. Our interest is in finding you the best kind of support possible for you.”

Screening questions:

1. Many people find it hard to cope with domestic violence. Some people use drugs or alcohol as a way of coping, has this ever happened to you?

2. Has your partner ever made you feel you had to use drugs or alcohol? If so, how often and when has this occurred? Where and to whom does this occur with?

If a woman has answered ‘yes’ to the above questions please ask the following two questions:

3. Some domestic violence projects/refuges can provide a safe place to stay as well as support with drug and alcohol use. Do you think you could benefit from this?

4. Are you currently working with any other services in relation to your substance use? Would you be happy for us to contact them if we need more information about your substance use? Include contact details if necessary

Screening questions (continued):

If a woman does recognise her drug or alcohol use as a support need it maybe helpful to ask the following questions to ascertain the sort of assistance she may need. It is essential that if you work in partnership with a local drug and alcohol agency, who will be able to provide a comprehensive assessment of her drug and alcohol use.

<table>
<thead>
<tr>
<th>Question</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the main substance or combination of substances that you use?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel you need to use drugs and alcohol?</td>
<td></td>
</tr>
<tr>
<td>Could any of your drug or alcohol using habits be risky for you? E.g. sharing injecting equipment, drinking to the point of losing consciousness, using a variety of substances at one time?</td>
<td></td>
</tr>
<tr>
<td>Sometimes women’s partners can control her money or access to substances. Has this happened to you? If a woman answers ‘yes’ this could mean she is unable to use substances without him. For some women this may mean it is difficult to leave. For some women leaving may mean going into withdrawal from her substance use.</td>
<td></td>
</tr>
<tr>
<td>Have you had arguments or been violent with people other than your partner when substance affected?</td>
<td></td>
</tr>
<tr>
<td>Do you have any involvement with the police or courts in relation to your substance use? If so please document and consider this when care planning.</td>
<td></td>
</tr>
</tbody>
</table>
2. Dependency screening tool

These questions could be used when assessing a service user’s substance use. They may be particularly valuable if you have a service user who finds it difficult to discuss their substance use. If a service user answers ‘yes’ to the majority of the questions, it may be appropriate to consider referring your service user to a drug/alcohol agency for further assessment. Alternatively you may wish to conduct a basic drug/alcohol assessment within your service.

In the last six months have you…

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Needed to drink/use more to get the desired effect or has your usual amount given you less effect than before?</td>
<td></td>
</tr>
<tr>
<td>2. Felt sick or unwell when the effect of the substance has worn off, have you used more to relieve these feelings?</td>
<td></td>
</tr>
<tr>
<td>3. Drunk/used large amounts for longer than you had anticipated</td>
<td></td>
</tr>
<tr>
<td>4. Had a desire to cut down or control how much and how often you use?</td>
<td></td>
</tr>
<tr>
<td>5. Spent large amounts of time drinking/using and recovering from the effects?</td>
<td></td>
</tr>
<tr>
<td>6. Given up work, social and recreational activities as a result of your drinking/usage?</td>
<td></td>
</tr>
<tr>
<td>7. Continued to use/drink despite the effects on your health and well being?</td>
<td></td>
</tr>
</tbody>
</table>


Screening questions (continued):

Children

The following questions are designed for women who have children. Before asking them you should be clear that you will only contact the authorities if you believe a child is at risk of harm. Ensure that you will, if she requests, assist her in developing skills in relation to her parenting.

<table>
<thead>
<tr>
<th>What plans do you make for your children when you are using or buying substances?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do your children do while you are using substances?</td>
</tr>
<tr>
<td>How does violence at home and the drug and alcohol use impact on your children?</td>
</tr>
</tbody>
</table>
3. Substance misuse routine inquiry procedures (for survivors and perpetrators)

Substance Misuse Sub Group Camden Domestic Violence Forum: procedures for substance misuse routine inquiry

WHO TO ASK

It is best practice to ask every individual over 16 years of age who accesses the service. There are no criteria, therefore, for either asking, or not asking, as substance misuse will be routinely inquired about for all individuals. This will be explained to the client upon asking about the issue.

WHEN TO ASK

Ideally, substance misuse will be specified as an issue at the stage of referral. However, as this does not occur routinely between agencies, because the client may have self-referred, and also because, for a myriad of reasons, someone who experiences substance misuse may not have yet disclosed their experience of this, it is best practice to ask at the stage of assessment for the service, along with other issues that are inquired about in order to assess need, risk and the appropriate nature of service delivery. This will inform how best to devise a working action plan to ensure safety as priority, and to consider which services should be involved and in what capacity.

Ideally substance misuse routine inquiry will form a part of the agency’s initial assessment and thus happen as part of procedure without the need for prompting. However, if this is not the case it is still possible to routinely inquire about substance misuse alongside the assessment, perhaps in the health and/or safety section.

If this is not incorporated into the assessment module per se, it may be worthwhile to create a special form that goes alongside the assessment form so that it will prompt the worker to ask.

It is also best practice to ask at any stage during the working relationship if the worker becomes aware of any signs or symptoms of substance misuse. (Please see Substance Misuse Policy: Need for Training). The worker should use their discretion to inquire about substance misuse in the context of the working relationship and to prioritise safety and support.

HOW TO ASK

It is important to know why you are asking the client about substance misuse and the philosophy behind this – this will enable workers to be clear on what the agency approach is, as well as being able to fully inform the client of why you are asking, and to be able to adequately answer any client questions about this.

Clients will feel extremely vulnerable about the thought of disclosing, wondering why you want to know and what you will do with the information, which can be a very real barrier to receiving support. It is vital to routinely fully inform clients of this information as procedure.

This will help build a foundation of trust so that clients have the confidence to disclose and discuss difficult issues and work with these. Most clients will not ordinarily voluntarily disclose to professionals that they are experiencing substance misuse.

By directly asking clients about substance misuse this gives them ‘permission’ to discuss the issue. It is best practice to introduce the policy as an all-of-agency procedure and to explain why this is so.

This will also be reinforced by the display of the Health/Safety/Substance Misuse Policy statement in the client waiting area. Inquiry should be carried out in a respectful, non-judgmental manner, and in a way where the client feels fully informed and reassured about the reasons why the issue is raised.
Confidentiality Policy, and the Limits of Confidentiality should also be explained as procedure (see Confidentiality Policy), in order to lay a foundation for trust, and to respect the client’s rights and safety.

It should also be explained to the client that it is not the intention of the worker/agency that the service be withheld if such issues arise, but rather that if the person is experiencing substance misuse this will affect the way the agency should best support them, and also that it may be important to discuss referrals to other appropriate agencies to best support them.

As such, to routinely inquire about substance misuse is carried out in a non-discriminatory manner, and with a focus on the client’s safety and well-being.

EXAMPLES OF FRAMING QUESTIONS

There is no one ‘right’ way of inquiring about substance misuse. However, it is crucial to introduce the issue first, explaining the reasons for asking, and then to actually begin to ask. Please see some examples below:

INTRODUCTION

a) We at [insert name of agency] recognise that many people use drugs and alcohol and for lots of different reasons. Often, domestic violence can be linked with substance use as well. Because of this, and because it affects people’s safety, health and well-being, we have started asking everyone who comes into our service about what drugs and alcohol they use.

You may have seen our Health/Safety/Substance Misuse Policy statement in the waiting area while you were waiting for your appointment. You don’t have to talk about anything that you really don’t want to, but it would help to be able to talk with you about things so that we can understand what is happening for you and work with you in the best possible way, with your permission.

b) Because so many people who experience domestic violence use drugs and alcohol to try and cope with the abuse we now ask everyone who comes into our service if they experience this.

c) You may have seen our policy and some posters out in the waiting area. As so many people use drugs and alcohol we now ask everyone about it as part of our every day procedure.

d) Because we care about your well-being we will ask you about whether you or anyone in the home uses drugs or alcohol. We ask everyone this just because we want everyone to be as safe as possible.

e) As well as talking about domestic violence we are also asking all clients about drug and alcohol use because this is very common. You may have seen our posters out in the waiting room.
DIRECT QUESTIONS

Questions should cover substance misuse of the client as well as substance misuse of the perpetrator, in order to assess risk.

SUBSTANCE MISUSE OF CLIENT

ALCOHOL and DRUGS (legal, illegal and prescription medication)
How many different types of drugs and/or alcohol do you use?

Please state type of alcohol/drugs being used (beer, wine, spirits, cider, cocaine, crack cocaine, heroin, LSD, amphetamines, cannabis, ketamine, methadone, benzodiazepines, MDMA ecstasy, khat, magic mushrooms, anabolic steroids, any other prescription medication).

Do you ever use any of these substances at the same time, or in the same day?

Frequency of use: how often do you use alcohol/drugs?
- All day every day
- Several times per day
- A few times per day
- Once per day
- A few times per week
- Once per week
- Once per month
- Other (please state)

Amount used: how much alcohol/drugs do you generally use?

Has your alcohol/drug use increased recently? (increased in frequency or amount or both?)

Why do you think you use alcohol/drugs? (eg. Social drink, block out bad things, to feel better, to cope with abuse, etc). Please state.

Does anyone make you use drugs and/or alcohol?

Do you have any concerns about your use?
YES/NO

If yes, please state
- Physical health (e.g. blackouts, nausea, heart/liver, lethargy, etc)
- Mental health (e.g. depression/feeling down, anxiety, sleep disorder, etc)
- Spirituality
- Relationships (intimate, family, friends, children, work colleagues, etc)
- Financial issues
- Legal issues

Is there anything you would like to change about your alcohol use?
YES/NO

If yes, please give details.
SUBSTANCE MISUSE OF ABUSER

ALCOHOL and DRUGS (legal, illegal and prescription medication)
How many different types of drugs and/or alcohol does abuser use?

Please state type of alcohol/drugs being used (beer, wine, spirits, cider, cocaine, crack cocaine, heroin, LSD, amphetamines, cannabis, ketamine, methadone, benzodiazepines, MDMA ecstasy, khat, magic mushrooms, anabolic steroids, any other prescription medication).

Does abuser ever use any of these substances at the same time, or in the same day?

Frequency of use: how often does the abuser use alcohol/drugs?
- all day every day
- several times per day
- a few times per day
- once per day
- a few times per week
- once per week
- once per month
- other (please state)

Amount used: how much alcohol/drugs does the abuser generally use?

Has the abuser’s alcohol/drug use increased recently? (increased in frequency or amount or both?)

Are there any other concerns regarding the abuser’s use?

Does the abuser ever blame the violence on the alcohol/drug use?

Taken from Refining the Routes, Domestic Violence and Substance Misuse: Policies, Procedures and Protocols for Partnership Work in Camden (2007). This can be downloaded from www.camden.gov.uk/domesticviolence
### 4. Drug and alcohol risk assessment form

**Client No:**

**Assessors Name:**

**Assessors Signature:**

**Date Of Assessment:**

**CPA (care programme approach) Status:**

### Trigger Risk (always inform a manager)

**To self:** Current plans of suicide, self harm, overdose.

**To others:** GBH, murder, sexual crime, pregnancy, carries weapon, reports violence or threats of violence.

**From others:** Reports threats of violence, falls out of contact with services.

### Self:

**Suicide**

- Thoughts or plans which indicate a current risk of suicide
- History of suicide attempts
- Suffers from a major mental illness
- Previous violent method used
- Self harming behaviour
- History of impulsive behaviour
- Suffers from depression

### Substance use issues

- Regular injector
- History of substance use overdose
- Chaotic injector (neck or groin)
- Current poly-substance use
- Alcohol dependence
- History of seizures or DT’s

### Treatment Issues

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent abstinence from substances (illicit or prescribed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of erratic engagement with services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has injecting related virus infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of accidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk sexual behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious physical issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressed paranoid delusions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### To others / from others:

**Children**

- Has parental responsibility
- Is currently pregnant
- Problems with childcare
- Social services involvement

**Violence and Criminality**

- History of Grievous Bodily Harm (GBH)
- History of murder
- History of rape or sexual crime
- History of prison or secure unit
- Is at risk of violence from others
- Current thoughts or plans indicating risk of violence to others
- History of arson
- Known to carry a weapon
- Concern expressed from others
4. Drug and alcohol risk assessment form (continued)

<table>
<thead>
<tr>
<th>Social</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current major financial problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently homeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently living in unstable housing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Self neglect</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Recent traumatic life event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiences social isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is driving or operating machinery</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Complete at:**
1. Triage or initial contact
2. Assessment
3. At careplan review
4. When making changes to treatment or presentation
5. On discharge

The reviews of the risk assessment should be at minimum six monthly.

Drug Alcohol Services London exists to respond to the needs of the growing number of people experiencing alcohol and drug problems in London whilst aiming to reduce the impact of alcohol and drug misuse and its consequences.

**DASL contacts**
Women's Domestic Violence & Substance Misuse Worker
Counselling & Domestic Violence Services Manager

t: 020 8257 3068  f: 020 8257 3066
services@dasl.org.uk

5. Domestic violence screening tool

<table>
<thead>
<tr>
<th>Current Rel.</th>
<th>Past Hist</th>
</tr>
</thead>
</table>

Client Name or ID: __________________________________________

Screen Completed by: _________________________________________

Date: ___________________________________________________________________

As part of our interview with everyone who comes to us for help, we always include questions about other issues besides substance misuse. We feel it is really important to help you with as many of your problems as we can. We understand that sometimes in order to help with one problem other problems must also be addressed. In most homes where there is substance misuse, families have other problems too. I’m going to ask some questions to see whether any of these things have happened to you or your family. If we find that you need help, we will take whatever actions are necessary to ensure your safety and recovery, if you wish.

1. Are you currently experiencing conflicts with your family or partner that cause you stress?  
   | YES | NO | YES | NO |
2. Are you currently experiencing, or have experienced any of the following in your relationships with your family or partner?  
   a) being called names, being put down, told you are worthless  
      | YES | NO | YES | NO |
   b) pushing, grabbing, shoving, hitting or restraining  
      | YES | NO | YES | NO |
   c) being kept away from family and friends, prevented from leaving your home, or going where you wanted to go  
      | YES | NO | YES | NO |
7. Do you believe your partner will be supportive of your present treatment?  

8. Do you have any concerns or fears of physical harm?  

If YES, can you give me an example?

9. Do you believe that the abuser will be at the treatment facility or in the area of the facility during your treatment?  

If YES, please give his name and description:

Suggestion: ____________________________  
Reason: ____________________________  
Client Agreeable: YES NO MAYBE  
Comments and/or observations of client:

6. Domestic violence risk indicator checklist

This form includes all the questions that are included on the official risk assessment form for referral to Multi Agency Risk Assessment Conferences (MARACs). The recommended risk assessment checklist was devised by the Co-ordinated Action Against Domestic Abuse (CAADA) based on the South Wales Police checklist using non-police language. The questions were designed for use by Independent Domestic Violence Advisers (IDVAs).

In addition to the questions for referral to the MARAC three agencies - Respect, Children and Family Court Advisory and Support Service (CAFCASS) and Relate have added some further questions to assist assessment for safety within our agency settings. These questions are noted as Extra and have been shaded for ease of reference. They should not be used for the CAADA scoring process (i.e. adding up the number of ticks in the unshaded boxes) but they should be used in considering answers to the final questions about the worker’s perception.

Terminology: for CAFCASS use, ‘perpetrator’ and ‘victim’ need to be read as ‘alleged perpetrator/victim’ unless there has been a judicial finding of fact. In Relate the terms used are More Powerful Partner and More Vulnerable Partner.

### Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes (tick)</th>
<th>No/Don’t Know (tick)</th>
<th>Significant Concern</th>
<th>Source of Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the perpetrator have a criminal record for violence or drugs?</td>
<td></td>
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<tr>
<td>If ‘yes’, is the record domestic abuse related?</td>
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</tr>
<tr>
<td>Extra Q a) Does the perpetrator have a history of violence?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Extra Q b) Does the perpetrator have a history of domestic violence?</td>
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</tbody>
</table>

### Extra Questions

Extra Q c) has previous violence resulted in injuries?
Extra Q d) if yes, does this cause significant concern?
Extra Q e) has the perpetrator ever used an object to attack the victim?
Extra Q f) if yes, does this cause significant concern?

### 2. Has the current incident resulted in injuries?

If ‘yes’, does this cause significant concern?

### 3. Has the incident involved the use of weapons?

If ‘yes’, does this cause significant concern?

### 4. Has the perpetrator ever threatened to kill anybody?

If ‘yes’, which of the following?
- Client
- Children
- Other Intimate Partner
- Others

If ‘yes’, does this cause significant concern?

### 5. Has the perpetrator expressed/behaved in a jealous way or displayed controlling behaviour or obsessive tendencies?

If ‘yes’, give details:

If ‘yes’, does this cause significant concern? Give details:

(some questions highlight significant concern and the format steers you to note your response in that column)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes (tick)</th>
<th>No / Don't Know (tick)</th>
<th>Source of Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Has there been going to be a relationship separation between victim and ex/partner?</td>
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<tr>
<td>Extra Q g) Is there conflict around the separation?</td>
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<tr>
<td>7. Is the abuse becoming worse and/or happening more often?</td>
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<tr>
<td>8. Is the victim very frightened? Give the client’s perceptions of the situation indicating what they think their partner/ex-partner will do.</td>
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<tr>
<td>9. Is the perpetrator experiencing/recently experienced financial problems?</td>
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<tr>
<td>Extra Q h) Is the perpetrator experiencing other major life stresses (e.g. bereavement, unemployment, homelessness)?</td>
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<tr>
<td>If yes, please specify:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Does the perpetrator have/had problems with the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Alcohol</td>
<td></td>
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<tr>
<td>☐ Mental Health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>☐ Drugs</td>
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<tr>
<td>11. Is the victim pregnant?</td>
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<tr>
<td>Extra Q i) Does the victim have young children (under age 2)?</td>
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<tr>
<td>Extra Q j) Are there step-children in the family?</td>
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<tr>
<td>12. Is there any conflict with partner/ex-partner over child contact?</td>
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<td></td>
</tr>
<tr>
<td>If yes give details:</td>
<td></td>
<td></td>
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<tr>
<td>12. Extra Q k) Do children visit the house for contact?</td>
<td></td>
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<tr>
<td>13. Has perpetrator attempted to strangle/choke victim or past partner?</td>
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<tr>
<td>14. Have victim or perpetrator ever threatened / attempted to commit suicide? If ‘yes’, which of the following?</td>
<td></td>
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</tr>
<tr>
<td>☐ Victim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Perpetractor</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>15. Has perpetrator said or done things of a sexual nature that makes victim feel bad or that physically hurts the victim? Give details:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>16. Is the victim afraid of further injury or violence?</td>
<td></td>
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<tr>
<td>17. Is the victim afraid that they may be killed by their partner/ex-partner? (See note on victim’s perception of risk in Guidance at end of form.)</td>
<td></td>
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<tr>
<td>18. Is the victim afraid that perpetrator will harm child/ren?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>19. Are there concerns about stalking and harassment?</td>
<td></td>
<td></td>
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<tr>
<td>20. Is the victim isolated from family/friends?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give details:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. has the perpetrator made it difficult for the victim to keep up relationships with others)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Questions (some questions highlight significant concern and the format steers you to note your response in that column)

<table>
<thead>
<tr>
<th>Yes (tick)</th>
<th>No/Don’t Know (tick)</th>
<th>Source of Info</th>
</tr>
</thead>
</table>

20. Extra Q 1) Are there other victim vulnerability factors such as poverty, health problems, childcare issues, language, disability, substance abuse, immigration status, cultural issues, or dependency on the perpetrator in respect of these? Give details:

Worker’s perception (please complete this section with your observations about the client’s risk especially where there are lower numbers of ‘yes’ responses.)

<table>
<thead>
<tr>
<th>Total</th>
<th>Total Significant Concerns</th>
</tr>
</thead>
</table>

Extra ‘Perception’ Questions

- do you believe the victim is likely to experience domestic violence in the next 6 months?
- If yes, do you believe that the victim or others could be injured through this?
  If yes, state whether you believe this harm would be emotional, physical or sexual – or by a self-harm or suicide attempt
- do you believe that the child/ren are likely to be harmed in the next 6 months?
  If yes, state whether you believe this harm would be emotional, physical or sexual

Note: If ‘yes’ then a referral to Local Authority Children’s Social Care should be made

The guidance below is based on the experience of the South Wales Police force and the Women’s Safety Unit in Cardiff.

Guidance on classifying risk levels

| Very High Risk | 10 ticks in the yes box OR 4 significant concerns (Q1-5) OR If there are 3 police call-outs in 12 months |
| High Risk      | 6-9 ticks in the yes box OR 3 significant concerns (Q1-5) OR 2 police call-outs in 12 months |
| Medium Risk    | Up to 6 ticks in the yes box OR 1 or 2 significant concerns (Q1-5) |
| Standard Risk  | Where no question in ticked in the yes box |
| Maximum number of ticks = 20 (do not include ‘significant concern’ questions in this total) |

In all cases, IDVAs should take the victim’s perception of their risk very seriously and should use their professional judgement if a client appears to be at high or very high risk even if they do not meet the criteria outlined above.

This form, originally developed by South Wales Police, has been updated to reflect the research on its use by IDVAs both at the Women’s Safety Unit in Cardiff and the ASSIST advocacy service in Glasgow. CAADA has added a ‘don’t know’ option as there is a risk of ticking ‘no’ when information is not known, which might be incorrect and give a false low risk level. The levels of risk are useful in clarifying the different response that a service will offer to a client depending on the severity of their situation.

Health Warning

Anyone using this must be aware that this is a risk indicator checklist and not a full risk assessment. It is a practical tool that can help you to identify which of your clients should be referred to MARAC and where you should be prioritising the use of your resources. Risk is dynamic and anyone using this checklist needs to be alert to the fact that risk can change very suddenly.

Risk indication is more about balancing information with current practice, knowledge and previous experience and then making a judgement about whether there is a strong possibility that a person is at risk of serious harm1.

1 South Wales Police risk indicator checklist guidance for officer
7. Sample safety plan

Suggestions for increasing safety - in the relationship

• I will have important phone numbers available to my children and myself.

• I can tell ___________ and ___________ about the violence and ask them to call the police if they hear suspicious noises coming from my home.

• If I leave my home, I can go (list four places):
  ____________________________________________________.
  ____________________________________________________.
  ____________________________________________________.
  ____________________________________________________.

• I can leave extra money, car keys, clothes, and copies of documents with ____________.

• When I leave, I will bring ____________________.

• To ensure safety and independence, I can: keep change for phone calls with me at all times; ensure my phone is charged; use a panic alarm; open my own savings account; alter my routes to/from the drug/alcohol agency; go to __________ to use/drink; rehearse my escape route with a support person; and review safety plan on __________________________(date).

• When the violence begins which areas of the house should I avoid? e.g. bathroom (no exit), kitchen (potential weapons)
  ____________________________________________________.

Suggestions for increasing safety - when the relationship is over

• I can: change the locks; install steel/metal doors, a security system, smoke detectors and an outside lighting system.

• I will inform ___________ and ___________ that my partner no longer lives with me and ask them to call the police if s/he is observed near my home or my children.

• I will tell people who take care of my children the names of those who have permission to pick them up. The people who have permission are: ________________, ________________ and ________________.

• When I make phone calls I can use 141 so my number cannot be traced.

• I can tell ___________ at work about my situation and ask ___________ to screen my calls.

• I can avoid shops, banks, and ___________ that I used when living with my abusive partner.

• If I feel down and ready to return to a potentially abusive situation, I can call ___________ for support. I can alter the route and/or times of drug/alcohol appointments at the drug/alcohol service or attend ___________ as an alternative.

Important Phone Numbers
Police __________________________________________
Helpline __________________________________________
Friends __________________________________________
Refuge __________________________________________
Drug/Alcohol Service __________________________________________
8. Domestic violence & abuse sample agency policy

Aquarius Domestic Abuse Policy

Background

Domestic abuse is defined as abuse perpetrated by a partner or other family member(s) as part of a pattern of controlling behaviour. This may include emotional, psychological, sexual or financial abuse, or physical violence. Aquarius recognises that domestic abuse will commonly be the experience of our service users and some staff members, but that this issue may remain undisclosed due to the nature of abusive relationships.

For service users who are survivors, the abuse is likely to be a factor in their substance use and may be one of the underlying causes. If the abuse is not addressed, relapse is more likely and there may be difficulties in attending and engaging in their appointments.

For service users who are perpetrators, addressing their substance use may lead to a decrease in the severity of any physical violence they perpetrate, but will not otherwise decrease perpetration of domestic abuse. In fact, it is reported that domestic abuse may increase during treatment for substance use, possibly due to the physical and psychological discomfort experienced during withdrawal and the change process.

For children, witnessing domestic abuse is considered to be an abuse in itself, and subject to child protection legislation.

Items to Take Checklist

- Identification
- Birth certificates for me and my children
- Benefit books
- Medical cards
- Phone card, mobile or change for a pay phone
- Money, bankbooks, credit cards
- Keys - house/car/office
- Keys to a friend or relative’s house
- Medicine, medication or drugs
- Driver’s license
- Change of clothes
- Passport(s), Home Office papers, work permits
- Divorce papers
- Lease/rental agreement, house deed
- Mortgage payment book, current unpaid bills
- Insurance papers
- Address book
- Pictures, jewellery, items of sentimental value
- Children’s favourite toys and/or blankets
- Any proof of abuse, notes, tapes, diary, crime reference numbers, names and numbers of professionals
Aims of the policy

The aims of this policy are:
To ensure that survivors of domestic abuse do not face an increased risk as a result of interventions by Aquarius.

To validate the experience of survivors of domestic abuse, and to create a safe environment, which will encourage disclosure by service users and staff members in order to be better supported and informed.

To encourage service users and staff members who are perpetrators of domestic abuse to acknowledge and address their abusive behaviour.

1. Environment

In order to create an environment which demonstrates that Aquarius takes seriously the issue of domestic abuse, projects should:

1.1 Display the Aquarius position statement within the project and on agency literature as appropriate. The statement, (agreed at the Management meeting of 7 December 2005) is:

Abuse within any kind of relationship is a common concern for many people who attend Aquarius, and our staff are experienced in helping people discuss these issues. At Aquarius we take seriously the issue of domestic abuse, which may consist of emotional, psychological, sexual or financial abuse or physical violence. We believe that alcohol or drug use – by anyone – can be a factor but is never an excuse for violent or abusive behaviour.

1.2 Display posters and other literature about domestic abuse services in waiting areas, toilets and other areas as appropriate.

1.3 Keep a resource box or folder on domestic abuse for easy access by all staff (and service users as appropriate), to include details of services for women and men, survivors and perpetrators of abuse, and specialist domestic abuse services for people from black and minority ethnic and the lesbian, gay, bisexual and transgender communities.

1.4 Establish a system for keeping all the above information up to date, and check this at least annually.

1.5 Consideration should be given to the fears and anxieties of women survivors attending a mixed gender service, and how these can be allayed, eg by women-only sessions or waiting areas, or showing women directly to the counselling room.

2. Staff awareness and training

2.1 All staff must attend basic domestic abuse awareness training as a minimum requirement. This will be provided as part of the Aquarius training programme.

2.2 Aquarius will periodically provide additional training for practitioners, to include:
- How to recognise signs of domestic abuse
- How to ask about domestic abuse during assessment
- Safety planning
- Working with perpetrators
- Working with couples and families.

3. Liaison

3.1 Each project should nominate an interested staff member to take the lead on domestic abuse for that project. That person will normally attend the Aquarius Domestic Abuse Forum and disseminate information to their service.

3.2 Each project should make links with the local domestic abuse forum and local domestic abuse service providers, with the aim of improving and eventually formalising referral pathways.

3.3 Aquarius will nominate a lead person for domestic abuse, who will convene the Aquarius Domestic Abuse Forum and represent Aquarius at other meetings and fora as appropriate.
4. Practice issues

4.1 All assessment interviews should include screening questions for domestic abuse – both as survivor or perpetrator. The replies and subsequent action should be recorded, and numbers of disclosures included in service reports to the Executive committee.

4.2 Domestic abuse work should always be raised in supervision. Supervisors should recognise that working with survivors and perpetrators of domestic abuse can be particularly draining and provide appropriate support.

4.3 Working with couples and families where there is domestic abuse is considered unsafe practice, therefore - before undertaking such work - family members should be seen individually and screened for domestic abuse. If domestic abuse is revealed at this stage or subsequently, then joint work must cease, unless to do so would place the survivor at risk. All decisions made where domestic abuse is known or suspected must put the safety of survivors and children first.

4.4 Anger management to address domestic abuse is considered an inappropriate intervention, and therefore – before undertaking such work – service users should be screened for domestic abuse.

4.5 Any work with perpetrators designed to address their domestic abuse should be in accordance with the following document: Statement of Principles and Minimum Standards of Practice, published by Respect, the UK association for domestic violence perpetrator programmes.

5. Staff issues

5.1 A staff member who discloses that they are experiencing domestic abuse will be supported and have their right respected to make their own choices about what to do about the situation.

5.2 A disclosure of perpetration of domestic abuse by a staff member should be acted on in accordance with the appropriate agency policies regarding the safety of individuals and staff conduct.

6. Procedures

6.1 Aquarius will draw up a separate procedures document, containing guidelines about what to do in the case of disclosure of domestic abuse by a service user or a staff member.

Aquarius is the UK Midlands based alcohol and drugs charity. It has the aim of reducing alcohol and drug related harm and promoting informed and responsible choices about the use of alcohol and other potential addictive substances and behaviours.

Aquarius Action Projects
2nd Floor, 16 Kent Street, Birmingham B5 6RD
t: 0121 622 8181
f: 0121 622 8189
whitehouse@aquarius.org.uk
www.aquarius.org.uk

For more information see pg 251
9. Domestic violence policy for employees

DISC Domestic Violence Policy 1 for employees
Domestic violence is unfortunately common and has a serious impact on those who experience it.

As part of the commitment to promote equality of opportunity and a safe and healthy working environment, DISC will support any appropriate initiatives to tackle domestic violence.

Aim
DISC has taken the important step of developing a clear and effective response to minimise the impact and effects of domestic violence on its employees.

The aim of the Domestic Violence Policy is to ensure that any employee who is the victim of domestic violence is treated promptly, fairly and with due regard to personal safety and confidentiality.

It informs all employees of our intention to deal with problems that affect work performance, health and safety, in an effective and appropriate manner, and gives guidance to any employee seeking support.

This policy applies equally to all employees who require support and advice.

Definition
Whilst adopting the Home Office definition DISC also recognises that there may be cases that fall outside this definition and fall within the scope of this policy.

The Home Office definition of domestic violence is:
“Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”

Examples can include:
• Physical assault/or threats of physical assault
• Sexual abuse
• Verbal abuse
• Systematic criticism
• Degradation
• Deprivation
• Isolation
• Harassment

The abuse is repeated and can escalate and intensify, often over many years. The long-term effects of domestic violence include feelings of guilt and shame, depression, stress, lack of confidence and low self-esteem.
DISC’s Responsibilities
DISC will ensure that disclosures of domestic violence are dealt with in accordance with the workplace policy.

The policy’s objectives are to:

• Provide support to employees by the provision of designated personnel

DISC will provide the necessary assistance and support to employees by identifying a named person as Domestic Violence Contact Officer and by ensuring that all designated personnel representatives receive training.

• Provide information and guidance on help and support available

Where an employee discloses domestic violence, DISC will provide information on a range of services that can provide specialist help and will give assistance to access these services if required. (Please refer to the Practical Guidance and Resource Directory within your project). Ensure confidential and sympathetic handling of the situation.

In all cases the named person or any other appropriate personnel employed by DISC will maintain confidentiality in line with company policy with regard to the information disclosed. Records of any employee who is a victim of domestic violence are to be kept confidential, as are any changes made to the working environment of the employee, e.g. relocation.

Any breaches of confidentiality will be dealt with by way of the company disciplinary procedure. DISC will ensure that work problems related to domestic violence issues are dealt with in a sympathetic manner. They will be addressed appropriately without prejudice to benefits and rights laid down in the contract of employment and not by way of a disciplinary procedure.

• Offer stress consultant and ongoing support

DISC will offer any employee the opportunity to talk to a qualified stress consultant about their personal difficulties and will provide information about in-house and external counselling and support services.

Access to the stress consultant can be via the Health and Safety Manager or your Line Manager or the Domestic Violence Contact Officer.

• Put in place where necessary, special measures to enable the employee to access appropriate help and advice

In order to provide work-based support, DISC, as the employer, will have the discretion to:

• Allow special leave/time off for re-housing, childcare arrangements or appointments, with e.g. support agencies, solicitor, and doctor

• Allow for paid leave, extended unpaid leave and for their salary to be paid in advance without the specific reasons for such absences or arrangements appearing on the employee’s file or affecting their work record

• Consider flexible working arrangements

• Treat sympathetically any request for relocation/redeployment

• Provide the necessary training and publicity to ensure that the issue of domestic violence maintains its importance within the workplace e.g. Basic Awareness and dealing with Disclosures

DISC will ensure that the policy is widely publicised to achieve maximum impact. Managers and staff representatives will receive awareness training on domestic violence as a workplace issue, and the subject of the effect of domestic violence in the workplace will be included on induction, the DISC Intranet website and other training courses as appropriate.

• Take appropriate action to support the employee if they are subjected to further abuse from the perpetrator or other employees
With regard to the safety and well being of employees in the workplace, DISC undertakes to investigate and take appropriate action against any member of staff who victimises, intimidates or harasses an employee suffering domestic violence.

DISC will take all reasonable steps to guard against the threat of domestic violence and will make special provision to deal effectively with the situation of a victim and perpetrator having close contact in the workplace.

Appendix 2

Line Manager’s Responsibilities

It is unlikely that an employee who experiences domestic violence will tell people at work of their situation or approach their Line Manager in the first instance.

It is far more likely that the Line Manager will become aware of the situation through associated issues (e.g. supervision).

Line Managers should be aware of some of the signs that may indicate domestic violence.

Some signs may include:

- Employee becoming withdrawn/depressed
- Frequent submissions of self-certified sickness periods
- Reduced quality/quantity of work
- Conduct out of character
- Employee’s partner frequently contacting them at work
- Visible bruising

Managers should be aware of other possible causes or signs and need to develop a sensitive and non-judgemental approach when dealing with employees who have experienced domestic violence.

This will include:

- Taking the employee seriously, taking time to listen to them, and accept what they tell you. Ensuring that any discussion about the employee’s situation takes place in private and that confidentiality is respected as far as is possible.

- Being aware that there may be additional issues faced by the employee.

- Understanding that a member of staff may or may not wish to involve their Line Manager and may prefer to involve a Third Party and that their choice should not be regarded as a reflection on the Line Manager.

- A Line Manager will need to make the individual aware of the Domestic Violence Contact Officer in the company.

- Being aware – the employee may need some time to decide what to do, and may try many different options during this process. It should not be assumed that because an individual returns to, or stays in a violent relationship that the violence was not severe or did not take place.

- Being aware of what support is available - if however the employee does not want other agency involvement then their wishes must be respected.

- Contacting their Line Manager or a contact from within DISC, who will be able to advice on what special measures, can be taken if required.

Contacting their Line Manager or a contact from within DISC, who will be able to advice on what special measures, can be taken if required.
10. Stella Project practice standards for domestic violence agencies

<table>
<thead>
<tr>
<th>Level One</th>
<th>Currently doing</th>
<th>Could do (3-6 mths)</th>
<th>Could do but need resources</th>
<th>No Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training of all staff on basic drug and alcohol awareness</td>
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<tr>
<td>Positive routine screening for drug and alcohol problems</td>
<td></td>
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<td></td>
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<tr>
<td>Ensuring information about drug and alcohol services are available in waiting rooms, toilets etc</td>
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</tr>
<tr>
<td>Ensuring that all service users are given information about drugs, alcohol and links to local services regardless of whether they disclose abuse or alcohol problems</td>
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</tr>
<tr>
<td>Making sure all staff are aware of the local drug and alcohol treatment and referral procedures/times. Ensure awareness of which local treatment services and support groups offer the highest level of physical and psychological safety for victims/survivors of domestic violence</td>
<td></td>
<td></td>
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<tr>
<td>Addressing the impact of substance use in safety planning and risk assessment. Help victim/survivor to understand how the substance use is linked to experiences of domestic violence and how their partner may attempt to sabotage attempts to stop using. Assist in finding alternative means of empowerment as a replacement for the sense of power induced by substances.</td>
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<tr>
<td>Monitoring disclosures of problematic substance use, collating statistics and reviewing periodically</td>
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<tr>
<td>Implementing a drug &amp; alcohol policy and/or practice guidelines and procedures and having review procedures in place to consider impact</td>
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</tr>
</tbody>
</table>

DISC undertakes to monitor any reported incidents, and to evaluate the effectiveness of this policy and its procedures, initially at 12 months and then every 3 years via a Working Party.

DISC is an independent charity which has been committed to tackling deprivation and exclusion since 1984.

Working across the northern region of the UK we are a specialist agency dedicated to enabling disadvantaged and excluded people to realise their potential. We work with people facing complex issues of discrimination, deprivation, educational failure and loss of hope.

We are committed to using our experience to find integrated solutions to the issues of employment, drugs, housing, criminal justice and independent living.

Contact:
Judith Tuck
t: 0191 384 2785
judith.tuck@disc-vol.org.uk

DISC is an independent charity which has been committed to tackling deprivation and exclusion since 1984.

Working across the northern region of the UK we are a specialist agency dedicated to enabling disadvantaged and excluded people to realise their potential. We work with people facing complex issues of discrimination, deprivation, educational failure and loss of hope.

We are committed to using our experience to find integrated solutions to the issues of employment, drugs, housing, criminal justice and independent living.

Contact:
Judith Tuck
t: 0191 384 2785
judith.tuck@disc-vol.org.uk
### Domestic Violence Agencies - Drug/Alcohol Practice Standards

#### Level Two

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Currently doing</th>
<th>Could implement (3-6 mths)</th>
<th>Could do but need resources</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced training around drugs and alcohol which looks further at issues of risk assessment and safety planning</td>
<td></td>
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<td></td>
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<tr>
<td>Specialist worker based onsite</td>
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<tr>
<td>Arrangements for a drug and alcohol outreach worker to visit site</td>
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<tr>
<td>Developing a budget to implement comprehensive support services for women affected by problematic substance use</td>
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<tr>
<td>Formal partnership agreements and referral protocols between domestic violence agency and substance misuse agency e.g. Service Level Agreements between refuge and drug/alcohol agency</td>
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</tr>
</tbody>
</table>

These standards have been adapted from Sarah Galvani's Basic and Enhanced Level Response (2005).

### Drug and Alcohol Agencies - Domestic Violence Practice Standards

#### Level One

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Currently doing</th>
<th>Could implement (3-6 mths)</th>
<th>Could do but need resources</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff and managers to receive basic domestic violence awareness training</td>
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<tr>
<td>Displaying domestic violence posters, leaflets, business cards in waiting areas, toilets and meeting or interview rooms. Resource folder/box file available to all staff and service users</td>
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<tr>
<td>Information given to all service users about domestic violence services regardless of whether they disclose</td>
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<tr>
<td>The agency's position statement on domestic violence displayed in these areas, and where appropriate, included in the agency information given to or discussed with service users</td>
<td></td>
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</tr>
<tr>
<td>Ensuring all staff are aware of the domestic violence services available within the borough, the services available for domestic violence perpetrators and which refuges in London accept women with drug and alcohol problems</td>
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<tr>
<td>Routine enquiry for domestic violence (victims and perpetrators) in one to one appointments</td>
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<tr>
<td>Staff to ensure domestic violence support needs are addressed in care plans</td>
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<tr>
<td>Ensuring couples and/or family therapy which includes the abuser is not a treatment option where domestic violence has been identified</td>
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<td></td>
</tr>
<tr>
<td>Monitoring disclosures of domestic violence, collating statistics and reviewing periodically</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

These standards have been adapted from Sarah Galvani's Basic and Enhanced Level Response (2005).
12. Sample referral pathway:
Substance Misuse Agency to a Domestic Violence Agency

Issue of domestic violence raised by worker or client

Discussion about domestic violence risks/concerns – e.g. are there any immediate risks to client upon returning home.
Worker provides information about support services available and offers a referral

Client declines offer of referral

Client accepts offer of referral

Discussion of options for appointment – outreach, drop in, in-agency or immediate referral to a refuge, etc.

Is the domestic violence putting client or children at high risk of harm?

YES
Raise concerns with both client and service manager. Follow appropriate agency procedures e.g. child protection, vulnerable adults, referral to MARAC

Follow up with client periodically reviewing domestic violence issues, safety and possibility of referral

NO
Acknowledge client wishes and invite to discuss again at any time. Discussion of fears/anxiety client may have around engaging with a dv service e.g. fear of criminal justice system

Client does not attend appointment.
Discussion of fears / anxiety client may have around engaging with a dv service e.g. fear of criminal justice system. Systems in place to assess and monitor risk to client and children; conduct basic safety planning. Revisit possibility of referral at later date

Client attends appointment. Drug/alcohol agency to make arrangements to check up on progress and record in care plan

Adapted from the Camden Domestic Violence Forum Substance Misuse Subgroup Protocols (2007)
13. Sample referral pathway: Domestic Violence Agency to a Substance Misuse Agency

- **Domestic Violence Agency**
  - Issue of drug/alcohol use raised by worker or client

- Discussion about current use/risks/concerns and previous experiences of treatment services; discussion of drug and alcohol support services available and referral offered

- Client declines offer of referral

- Is the substance use putting client or children at risk of harm?
  - **YES** Raise concerns with both client and service manager. Follow appropriate agency procedures e.g. child protection, vulnerable adults
  - **NO** Acknowledge client's wishes and invite to discuss again at any time. Discussion of fears/anxiety client may have around engaging with treatment services

- Client accepts offer of referral

- Initial telephone conversation with drug/alcohol agency to discuss referral in consultation with client; discussion of options for appointment – outreach, drop in, in-agency etc. Is the substance use putting client or children at risk of harm?

- Discussion between agencies of info-sharing procedures; confidentiality practices; and how the agencies can provide 'shared care' to client; discussion of harm minimisation techniques if needed

- Client does not attend appointment. Discussion of fears/anxieties of why client does not wish to engage with treatment and re-visit possibility of referral in later sessions

- Client attends appointment. Dv agency to make arrangements to check up on progress

- Follow up with client periodically reviewing substance use issues, impact and possibility of referral

Adapted from the Camden Domestic Violence Forum Substance Misuse Subgroup Protocol (2007)

14. Sample domestic violence policy statement

**DOMESTIC VIOLENCE**

**DRUG MISUSE IS NO EXCUSE**

WDP is committed to challenging domestic violence in all its forms. We provide support and advice to victims and perpetrators who use drugs.

24 Hour National Domestic Violence Helpline: 0808 200 0247
Men’s Advice Line: 0808 801 0327
Broken Rainbow: 0845 260 4460

www.wdp-drugs.org.uk

Reaching out to drug users and communities
1. Domestic violence fora and domestic violence coordinators – Greater London

NB: We are using the term ‘Domestic Violence Co-ordinator’ (DVC) collectively. However, the named person may be a Community Safety Officer or Projects Officer based in the Community Safety Team or associated department but will have responsibility for domestic violence within their borough.

Barking & Dagenham Domestic Violence Forum
c/o Community Safety Team,
Room B8, Civic Centre,
Dagenham, Essex RM10 7BN
t: 020 8227 2809
DVC: Emma Gray
emma.gray@lbbd.gov.uk

Barnet Domestic Violence Forum
c/o Safer Communities Team,
Room 203, Colindale Police Station,
Grahame Park Way, Collindale, London NW9 5TW
t: 020 8733 4416
DVC: Rachel Smith
rachel.smith@barnet.gov.uk

Bexley Domestic Violence Forum
c/o Bexley Community Safety Partnership,
Civic Offices, Broadway,
Bexleyheath, Kent DA6 7LB
t: 020 8294 6034
DVC: Post currently vacant
community.safety@bexley.gov.uk
Brent Domestic Violence Forum
Brent Community Safety Team,
Quality House, 249 Willesden Lane,
London, NW2 5JH
t: 020 8937 1139
DVC: Catherine Kane
catherine.kane@brent.gov.uk

Brent Domestic Violence Forum
Brent Community Safety Team,
Quality House, 249 Willesden Lane,
London, NW2 5JH
t: 020 8937 1139
DVC: Catherine Kane
catherine.kane@brent.gov.uk

Bromley Domestic Violence Forum
Civic Centre, Stockwell Close,
Bromley BR1 3YH
t: 020 8313 4290
DVC: Dave Gaywood
david.gaywood@bromley.gov.uk

Bromley Domestic Violence Forum
Civic Centre, Stockwell Close,
Bromley BR1 3YH
t: 020 8313 4290
DVC: Dave Gaywood
david.gaywood@bromley.gov.uk

Camden Multi-Agency Domestic Violence Forum
Bidborough House, 20 Mabledon Place,
London WC1H 9BF
t: 020 7974 6138
DVC: Caitriona Scanlan
caitriona.scanlan@camden.gov.uk

Camden Multi-Agency Domestic Violence Forum
Bidborough House, 20 Mabledon Place,
London WC1H 9BF
t: 020 7974 6138
DVC: Caitriona Scanlan
caitriona.scanlan@camden.gov.uk

City of London Domestic Violence Forum
c/o Community Safety Team,
Suite 48, London Fruit & Wool Exchange,
Brushfield Street, London E1 6EX
t: 020 7456 9815
DVC: Emma Davies
emma.davies@corpoflondon.gov.uk

City of London Domestic Violence Forum
c/o Community Safety Team,
Suite 48, London Fruit & Wool Exchange,
Brushfield Street, London E1 6EX
t: 020 7456 9815
DVC: Emma Davies
emma.davies@corpoflondon.gov.uk

Croydon - Family Violence Strategic Partnership Group
Family Justice Centre,
69 Park Lane, Croydon, CR0 1JD
t: 020 8688 0100
DVC: Ann Crosthwaite
ann.crosthwaite@croydon.gov.uk

Croydon - Family Violence Strategic Partnership Group
Family Justice Centre,
69 Park Lane, Croydon, CR0 1JD
t: 020 8688 0100
DVC: Ann Crosthwaite
ann.crosthwaite@croydon.gov.uk

Ealing Domestic Violence Task Group
Community Safety Team,
London Borough of Ealing, Perceval House,
14-16 Uxbridge Road, London W5 2HL
t: 020 8825 7914
DVC: Joyce Parker
parkerj@ealing.gov.uk

Ealing Domestic Violence Task Group
Community Safety Team,
London Borough of Ealing, Perceval House,
14-16 Uxbridge Road, London W5 2HL
t: 020 8825 7914
DVC: Joyce Parker
parkerj@ealing.gov.uk

Enfield Domestic Violence Forum
Community Safety Unit,
First Floor, Civic Centre, Silver Street,
Enfield, Middlesex, EN1 3XN
t: 020 8379 4310/4184
DVC: Keri Abbadi
keri.abbadi@enfield.gov.uk

Enfield Domestic Violence Forum
Community Safety Unit,
First Floor, Civic Centre, Silver Street,
Enfield, Middlesex, EN1 3XN
t: 020 8379 4310/4184
DVC: Keri Abbadi
keri.abbadi@enfield.gov.uk

Greenwich Domestic Violence Forum
c/o Community Safety & Integrated Enforcement,
Riverside House East, Mezzanine Floor,
Woolwich High Street, London SE18 6BU
t: 020 8921 4909
DVC: Katie Howell
domestic-violence@greenwich.gov.uk

Greenwich Domestic Violence Forum
c/o Community Safety & Integrated Enforcement,
Riverside House East, Mezzanine Floor,
Woolwich High Street, London SE18 6BU
t: 020 8921 4909
DVC: Katie Howell
domestic-violence@greenwich.gov.uk

Hackney Domestic Violence Forum
Community Safety Team,
London Borough of Hackney,
2nd Flr, Maurice Bishop House,
17 Reading Lane, London E8 1HH
t: 020 8356 2418 or 0800 056 0905
DVC: Nazia Matin
nazia.matin@hackney.gov.uk

Hackney Domestic Violence Forum
Community Safety Team,
London Borough of Hackney,
2nd Flr, Maurice Bishop House,
17 Reading Lane, London E8 1HH
t: 020 8356 2418 or 0800 056 0905
DVC: Nazia Matin
nazia.matin@hackney.gov.uk
Hammersmith & Fulham Domestic Violence Forum
c/o Community Safety Unit,
Town Hall, King Street,
London W6 9JU
tel: 020 8753 2817
DVC: Siuta Julita
Julita.Siuta@lbhf.gov.uk

Hillingdon Domestic Violence Forum
Civic Centre, High Street,
Uxbridge, Middlesex, UB8 1UW
t: 01895 277 147
DVC: Erica Rolle
erolle@hillingdon.gov.uk

Hounslow Domestic Violence Forum
c/o Community Safety & Crime Reduction Unit,
London Borough of Hounslow,
Civic Centre, Lampton Road,
Hounslow TW3 4DP
t: 020 8583 2483
DVC: Permjit Chadha
Permjit.Chadha@hounslow.gov.uk

Islington Domestic Violence Project Team
c/o Domestic Violence Co-ordinator,
Community Safety Partnerships Unit,
Room 116, Municipal Offices,
222 Upper Street,
London N1 1XR
t: 020 7527 2184
DVC: Harriet Wilkins
harriet.wilkins@islington.gov.uk

Kensington & Chelsea Domestic Violence Forum
Community Safety Team, Whitlock House,
c/o Kensington Police Station,
72-74 Earls Court Road,
London W8 6EQ
t: 020 7795 6660
DVC: Samantha De Silva
samantha.desilva@rbkc.gov.uk

Harrow Domestic Violence Forum
Harrow Council,
Civic Centre, Station Road,
Harrow, Middlesex HA1 2XF
t: 020 8424 1326
DVC: Hazel Waters
hazel.waters@harrow.gov.uk

Havering Domestic Violence Forum
Community Safety,
London Borough of Havering,
Room 515, 5th Floor,
Mercury House, Mercury Gardens,
Romford RM1 3SL
t: 01708 779 412
DVC: Tarjinder Sehanger
Tarjinder.sehanger@havering.gov.uk

Haringey Domestic Violence Forum
c/o Equalities & Diversity Unit,
London Borough of Haringey,
Civic Centre, High Road,
Wood Green, London N22 8LE
tel: 020 8489 2694 / 3152
DVC: Deirdre Cregan
deirdre.cregan@haringey.gov.uk

Hounslow Domestic Violence Forum
c/o Community Safety & Crime Reduction Unit,
London Borough of Hounslow,
Civic Centre, Lampton Road,
Hounslow TW3 4DP
t: 020 8583 2483
DVC: Permjit Chadha
Permjit.Chadha@hounslow.gov.uk

Islington Domestic Violence Project Team
c/o Domestic Violence Co-ordinator,
Community Safety Partnerships Unit,
Room 116, Municipal Offices,
222 Upper Street,
London N1 1XR
t: 020 7527 2184
DVC: Harriet Wilkins
harriet.wilkins@islington.gov.uk

Kensington & Chelsea Domestic Violence Forum
Community Safety Team, Whitlock House,
c/o Kensington Police Station,
72-74 Earls Court Road,
London W8 6EQ
t: 020 7795 6660
DVC: Samantha De Silva
samantha.desilva@rbkc.gov.uk
Kingston Upon Thames Domestic Violence Forum  
c/o Domestic Violence Co-ordinator,  
Kingston Crime & Disorder Reduction Partnership,  
Room 47, Guildhall,  
Kingston-Upon-Thames KT1 1EU  
t: 020 8547 5040  
DVC: Kelly Whitehead  
Kelly.Whitehead@rbk.kingston.gov.uk

Lambeth Domestic Violence Forum  
c/o Communications & Customer Relations Team,  
Adult & Community Services,  
Phoenix House,  
10 Wandsworth Road,  
Vauxhall, London SW8 2LL  
t: 020 7820 0007  
DVC: Post currently vacant

Lewisham Domestic Violence Forum  
Community Safety Team,  
23 Mercia Grove,  
London SE13 6BT  
t: 020 8314 9120  
DVC: Joanne Marshall  
joanne.marshall@lewisham.gov.uk

Merton Domestic Violence Forum  
Safer Merton,  
3rd Floor, Athena House,  
86-88 London Road,  
Morden, Surrey, SM4 5AZ  
t: 020 8545 4146  
DVC: Post currently vacant

Newham Domestic Violence Forum  
Newham Domestic Violence & Hate Crime Unit,  
London Borough of Newham,  
328 Barking Road,  
East Ham,  
London E6 2RT  
t: 020 8430 2000  
DVC: Frances Martineau  
frances.martineau@newham.gov.uk

Redbridge Domestic Violence Forum  
Community Safety Team,  
Room 35, Perth Terrace,  
Perth Road, London IG2 6AT  
t: 020 8708 5081  
DVC: Post currently vacant

Richmond Upon Thames Domestic Violence Forum  
Community Safety Team,  
Room 42, York House,  
Richmond Road,  
Twickenham  
t: 020 8891 7155  
DVC: Post currently vacant

Southwark Domestic Violence Forum  
c/o Community Safety Unit,  
Alpha House, 5th Floor,  
Borough High Street,  
London SE1 1LB  
t: 020 7232 6237  
DVC: Nahid Chowdhury  
nahid.chowdhury@southwark.gov.uk
2. Drug (and alcohol) action teams (DAATs) - Greater London

**Barking & Dagenham**
Roecraft House,
15 Linton Road,
Barking IG11 8HE
t: 020 8227 5669
Ann Griffiths - DAAT Team Co-ordinator
ann.griffiths@lbbd.gov.uk

**Barnet**
Barnet Safer Communities Team,
Room 204,
Colindale Police Station,
Grahame Park Way,
London NW9 5TW
t: 020 87334531
Peter Fernandez - DAAT Co-ordinator
DAT.Co-ordinator@barnet.gov.uk

**Bexley**
Bexley Community Safety Partnership,
2 Nuxley Road,
Belvedere,
Kent DA17 5J
t: 020 8284 5513
Graham Lettington - DAAT Co-ordinator
graham.Lettington@bexley.gov.uk

**Sutton Domestic Violence Forum**
Safer Sutton Partnership,
PO Box 227, London Borough of Sutton,
6 Carshalton Road, Sutton SM1 4XY
t: 020 8770 5126
DVC: Jean Chinery
jean.chinery@sutton.gov.uk

**Tower Hamlets Domestic Violence Forum**
Town Hall, Mulberry Place,
5 Clove Crescent,
London E14 2BG
t: 020 7364 4438
DVC: Victoria Hill
victoria.hill@towerhamlets.gov.uk

**Waltham Forest Domestic Violence Forum**
c/o Community Safety Team,
1 Cecil Road, Leytonstone,
London E11 3HF
Tel: 020 8496 5084
DVC: Mee Cheuk
Mee.Cheuk@walthamforest.gov.uk

**Wandsworth Domestic Violence Forum**
c/o Domestic Violence Co-ordinator,
PO Box 620, London SW15 6QN
t: 020 8871 6418
DVC: Jenny Iliff
jiliff@wandsworth.gov.uk

**Westminster Domestic Violence Forum**
c/o NCH, 14-18 Newton Road,
London W2 5LT
t: 020 7229 0333
DVC: Venesha Patel
Venesha.Patel@nch.org.uk
Brent
Wembley Centre for Health & Care,
116 Chaplin Road,
Wembley,
Middlesex HA0 4UZ
t: 020 8795 6193
Andy Brown - DAAT Co-ordinator
andy.brown@brentpct.nhs.uk

Bromley
London Borough of Bromley,
W83A West Wing,
Civic Centre,
Stockwell Close,
Bromley BR1 3UH
t: 020 8461 7926
Colin Newman - DAAT Co-ordinator
colin.newman@bromley.gov.uk

Camden
2nd Floor, Clifton House,
83-117 Euston Road,
London SW1 2RA
t: 020 7974 2915
Mark Morton - DAAT Co-ordinator
mark.morton@camden.gov.uk

City of London
Room 421 Fruit and Wool Exchange,
Brushfield Street,
London E1 6EX
t: 0207 456 1440
Golda Behr - DAAT Co-ordinator
golda.behr@corpoflondon.gov.uk

Croydon
Carolyn House,
22-26 Dingwall Road,
Croydon CR0 9XF
t: 020 8726 7750
Andy Opie - DAAT Co-ordinator
andy.opie@croydon.gov.uk

Ealing
58 Uxbridge Road,
5th Floor, West Wing,
Ealing, London W5 2TL
t: 020 8799 2144
Anna Johnston - Head of Drugs and Alcohol Strategy
ajohnston@ealingdaat.org.uk

Enfield
Winchmore Hall Police Station,
687 Green Lanes,
Winchmore Hill,
London, N21 3RT
t: 020 8345 4640
Roger Cornish - DAAT Co-ordinator
Roger.cornish@enfield.gov.uk

Greenwich
3rd Floor,
47 Woolwich New Road,
London SE18 6EW
t: 020 8921 6904
Rachel Karn - DAAT Co-ordinator
rachel.karn@greenwich.gov.uk
Hackney
2nd Floor,
Maurice Bishop House,
Reading Lane, London E8 1HH
t: 020 8356 2285
Laurence Wrenne - DAT Co-ordinator
Laurence.Wrenne@hackney.gov.uk

Hammersmith & Fulham
London Borough of Hammersmith and Fulham,
Community Safety Unit,
Town Hall, Room 42,
King Street, Hammersmith,
London W6 9JU
t: 020 8753 2459
Patricia Cadden - DAT Co-ordinator
Patricia.Cadden@lbhf.gov.uk

Haringey
Room G14B,
Civic Centre, High Road,
Wood Green, London N22 8LE
t: 020 8489 6962
Marion Morris - DAAT Co-ordinator
marion.morris@haringey.gov.uk

Harrow
London Borough of Harrow,
PO Box 57, Civic Centre, Harrow,
Middlesex HA1 2FX
t: 0208 424 7541
Lizzie Reid - DAT Co-ordinator
lizzie.reid@harrow.gov.uk

Havering
Whitworth Centre,
Noak Hill Road,
Harold Hill, Romford,
Essex RM3 7YA
t: 01708.434 338
Dominic Brown - DAAT Co-ordinator
dominic.brown@havering.gov.uk

Hillingdon
c/o Hillingdon Primary Care Trust,
Kirk House, 97-109 High Street,
Yiewsley, West Drayton,
Middlesex UB7 7HJ
t: 01895 452 084
Lizzie Reid - DAT Co-ordinator
gareth.jones@hillingdon.nhs.uk

Hounslow
Social Services & Health Partnerships,
Civic Centre,
Lampton Road,
Hounslow TW3 4DN
t: 020 8583 3015
Simon Gunn - DAAT Co-ordinator
simon.gunn@hounslow.gov.uk

Islington
Islington Drug & Alcohol Action Team,
Room 105,
Municipal Offices,
222 Upper Street,
London N1 1XR
t: 020 7527 3406
Clare Brighton - DAAT Co-ordinator
clare.brighton@islington.gov.uk
### Kensington & Chelsea
Community Safety Team,
Whitlock House,
c/o Kensington Police Station,
72-74 Earls Court Road,
London W8 6EQ
t: 020 7938 3013
Linda Oola - Community Safety Officer – Drugs
linda.oola@rbkc.gov.uk

### Kingston Upon Thames
c/o Royal Borough of Kingston,
Guildhall, Kingston-upon-Thames,
Surrey KT1 1EU
t: 020 8547 6011
Peter Nightingale - DAAT Co-ordinator
peter.nightingale@rbk.kingston.gov.uk

### Lambeth
Lambeth Council, 2nd Floor,
205 Stockwell Road,
London SW9 9SL
t: 020 7926 2684
Megan Jones - DAAT Manager
mjones2@lambeth.gov.uk

### Lewisham
Crime Reduction Service,
23 Mercia Grove,
Lewisham,
London SE13 6BJ
t: 020 8314 9738
Fizz Annand - DAAT Co-ordinator
fizz.annand@lewisham.gov.uk

### Merton
c/o Housing and Social Services,
Fourth Floor,
Merton Civic Centre,
London Road,
Morden, Surrey SM4 5DX
tel: 020 8545 3439
Ali Young - DAAT Co-ordinator
Ali.Young@merton.gov.uk

### Newham
407-409 High Street,
2nd Floor,
Stratford,
London E15 4QZ
t: 0208 430 6725
Fran Barry - DAAT Co-ordinator
fran.barry@newham.gov.uk

### Redbridge
c/o Redbridge & Waltham Forest HA,
Becketts House,
2/14 Ilford Hill,
Ilford IG1 2QX
tel: 020 8708 7846
Shaheen Mughal - DAAT Co-ordinator
Shaheen.Mughal@redbridge.gov.uk

### Richmond Upon Thames
Room 42, York House,
Richmond Road,
Twickenham TW1 3AA
tel: 020 8831 6195
Anne Lawtey - DAAT Co-ordinator
a.lawtey@richmond.gov.uk
Southwark
Community Safety Unit,
Suite 51,
Alpha Business Centre,
100 Borough High Street,
London SE1 1LB
t: 020 75250805
Kate Sinar - DAAT Co-ordinator
kate.sinar@southwark.gov.uk

Sutton
Sutton Police Station,
PO Box 277,
Sutton SM1 4XY
t: 020 8649 0672
Michael Pierce - DAAT Co-ordinator
michael.pierce@sutton.gov.uk

Tower Hamlets
London Borough of Tower Hamlets,
Chief Executives Office,
2nd Floor,
Mulberry Place,
5 Clove Crescent,
London E14 2BG
t: 020 7364 4594
Gilly Cottew - DAAT Co-ordinator
gilly.cottew@towerhamlets.gov.uk

Waltham Forest
London Borough of Waltham Forest,
Rowan House,
1 Cecil Road,
London E11 3HF
Tel: 020 8496 1775
Alastair Macorkindale - DAAT Co-ordinator
alastair.macorkindale@walthamforest.gov.uk

Wandsworth
Policy Unit,
Wandsworth Borough Council,
The Town Hall,
Wandsworth High Street,
London SW18 2PU
t: 020 8871 6020
Richard Wiles - DAAT Co-ordinator
rwiles@wandsworth.gov.uk

Westminster
Westminster City Hall,
64 Victoria Street,
London SW1E 6QP
t: 020 7641 3466
Davina Firth - DAT Co-ordinator
dfirth@westminster.gov.uk
3. Domestic violence and associated services

- **Action on Elder Abuse**
  - t: 020 8765 7000; Helpline: 0808 808 8141
  - www.elderabuse.org.uk
  - A national organisation aims to prevent abuse in old age by raising awareness, providing education and promoting research.

- **Al-Aman**
  - t: 020 8748 2577 / 020 8563 2250

- **Ashiana Project**
  - t: 020 8539 0427
  - www.ashiana.org.uk
  - Provides advice, support, and temporary housing for young South Asian, Turkish and Iranian women experiencing domestic violence. Outreach service available at home and community level. Refuge provision for women fleeing forced marriage. Takes referrals nationally.

- **Beverley Lewis House**
  - t: 020 7473 2813 (24 hours)
  - Specialist refuge for women with learning difficulties.

- **Broken Rainbow**
  - t: 020 8558 8674; Helpline: 08452 60 44 60
  - www.broken-rainbow.org.uk
  - Provides information and a support service to lesbian, gay, bisexual and transgender people experiencing domestic violence.

- **Eaves Women’s Aid & Eaves Supported Housing**
  - t: 020 7735 2062
  - www.eaves4women.co.uk
  - Provides homeless women across London with high quality supported housing. The organisation also delivers domestic violence services, and undertakes campaigning and development work around violence against women, prostitution and trafficking.

- **Ending The Silence - LGBT Domestic Abuse Project**
  - t: 0141 548 8121
  - www.lgbtdomesticabuse.org.uk
  - A website for all service providers currently supporting, working with or planning services for people experiencing domestic abuse.

- **Forced Marriage Unit**
  - t: 020 7008 0151
  - www.fco.gov.uk/forcedmarriage
  - The Forced Marriage Unit is a single point of contact for confidential advice and assistance for those at risk of being forced into marriage overseas.

- **Galop**
  - t: 020 7704 6767; Helpline/Shoutline: 020 7704 2040
  - www.galop.org.uk
  - Provides advice, support and advocacy to lesbians, gay men, bisexual and trans people that have experienced sexual assault or abuse in the Greater London area.
Greater London Domestic Violence Project (GLDVP)
t: 020 7785 3860
www.gldvp.org.uk
GLDVP is a second tier charity that works to ensure that good practice in domestic violence work is transferred across London, bringing together key agencies to develop London-wide policies, raise awareness about domestic violence and increase the effectiveness of multi-agency work. The Stella Project is a partnership project between GLDVP and GLADA.

The Havens – Specialist Sexual Assault Referral Centres
www.thehavens.co.uk
Providing medical examination, care and support to people who have recently experienced sexual violence. This service is available to adults, children and young people in London. Services are available in Camberwell (020 3299 1599); Paddington (020 7886 6666); and Whitechapel (020 7247 4787).

Hidden Hurt - Domestic Abuse Information
www.hiddenhurt.co.uk
This site has been written by a survivor of domestic violence, and provides advice and information to those who are in an abusive relationship.

Imkaan
t: 020 7250 3933
www.imkaan.org.uk
Imkaan is a national research and policy project, initiated by Asian women’s projects. Imkaan profiles and advocates on behalf of the specialist refuge sector nationally, through accredited training programmes, publications and strategic liaison with government, statutory and community organisations.

Jewish Women’s Aid
t: 020 8445 8060;
Helpline: 0800 591 203
www.jwa.org.uk
Provides advice and refuge for Jewish women and children experiencing domestic violence. Also provides counselling and outreach. Takes referrals nationally.

Kingston Asian Women’s Refuge (Bhavan)
Refuge: 020 8399/020 8786 2259;
Outreach: 020 8786 2128
Refuge for Asian women and children and may accept women from similar cultural backgrounds (African/Arab/Turkish). May accept women on a methadone programme.

Kiran Asian Women’s Aid
t: 020 858 1986
www.rdlogo.com/cwp/kawa/
Provides support and safe temporary accommodation for Asian women and their children escaping domestic violence. Also offers outreach services and resettlement. Takes referrals nationally.

Latin American Women’s Aid
Outreach: 020 7275 0321;
Referrals: 07958 536 242
Advice, support and temporary accommodation to Latin American women fleeing domestic violence. Staff speak Portuguese and Spanish. Takes referrals nationally.

Men’s Advice Line
Helpline: 0808 801 0327
www.mensadvice-line.org.uk
A national helpline which provides practical and emotional support for men experiencing domestic abuse.
**Newham Asian Women’s Project (NAWP)**

* t: 020 8472 0528  
* www.nawp.org  

Advice and support for Asian women and children experiencing domestic violence. Also provides legal advice and counselling. Takes national referrals for their refuges.

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**Samaritans**

* Helpline: 08457 90 90 90  
* www.samaritans.org.uk  

A national helpline providing 24-hour confidential emotional support for anyone in a crisis.

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**Southall Black Sisters**

* t: 020 8571 9595  
* www.southallblacksisters.org.uk  

Specialist campaigning, advice, information, advocacy, practical help and counselling to women experiencing domestic violence, forced marriages, honour crimes and immigration issues. Takes referrals primarily from the London Borough of Ealing but may consider referrals from other boroughs.

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**SOLA (Survivors of Lesbian Abuse)**

* t: 020 7328 7389  
* solalondon@hotmail.com  

Support for any woman that has experienced abuse (past or present) from a female partner. Email support is available, and evening phone appointments are available by arrangement. Also has a weekly support group for survivors of rape (women only).

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**Victim Support**

* Helpline: 0845 30 30 900  
* www.victimsupport.org  

Offers information and support to victims of crime, whether or not they have reported the crime to the police.

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**Women & Girls Network**

* t: 020 7610 4678;  
* Helpline: 020 7610 4345  
* www.wagn.org.uk  

A pan-London service offering a holistic healing centre for women and girls overcoming the experience of violence whether physical, sexual or emotional. Also provides counselling and body therapies.
Women’s Aid Federation of England
Helpline: 0808 2000 247 (24 hours)
www.womensaid.org.uk
Runs the 24 hour National Domestic Violence Helpline (in partnership with Refuge). Women’s Aid is the national charity working to end domestic violence against women and children. They can offer support, advice, accommodation and information on all aspects of domestic violence.

Women’s Therapy Centre
Tel: 020 7263 6200
www.womenstherapycentre.co.uk
Provides psychotherapy by women for women in London.

Woman’s Trust
East: t: 020 8522 7856/7455;
West: t: 020 7034 0303/0304
www.womanstrust.org.uk
A pan-London service that provides independent, confidential, women-only services to women who have been or are affected by domestic violence.

4. Drug and alcohol agencies

Addaction
t: 020 7251 5860
www.addaction.org.uk
Addaction is a leading UK charity working solely in the field of drug and alcohol treatment. They have over fifty projects within communities and prisons. Services in London include the Women’s Centre and an Ethnic Community Development Worker (Hackney) as well as a residential service specifically targeted at BME women and their children.

Alcohol Concern
t: 020 7928 7377
www.alcoholconcern.org.uk
www.alcoholandfamilies.org.uk
Alcohol Concern is the national agency on alcohol misuse. They work to reduce the incidence and costs of alcohol-related harm and to increase the range and quality of services available to people with alcohol-related problems.

Dazz-Elle
www.dazz-elle.org.uk
A drugs and alcohol information service for young lesbian and bisexual women run by Drug Alcohol Services London.

Drug and Alcohol Services for London (DASL)
t: 020 8257 3068
www.alcoholeast.org.uk/
Provide a specialist domestic violence and substance misuse worker across a number of London boroughs and services to the Bengali community in Tower Hamlets including an Asian women’s group.
Drug and Alcohol Action Programme (DAAP)
t: 020 8843 0945
www.daap.org.uk
DAAP works with BME communities against addiction and promotes education, community cohesion and service provision.

DrugScope
t: 020 7928 1211
www.drugscope.org.uk
DrugScope aims to inform policy development and reduce drug-related risk. They provide quality drug information, promote effective responses to drug taking, undertake research at local, national and international levels, advise on policy-making, encourage informed debate and speak for member organisations working on the ground.

Ethnic Alcohol Counselling in Hounslow (EACH)
t: 020 8577 6059
Offers advice, information, support and counselling for people with alcohol, drug and mental health problems from BME communities. Workers are available in a number of languages including Arabic, Farsi, Kurdish, Polish and Asian languages. Operate a specialist domestic violence project taking referrals from a number of London boroughs.

Greater London Alcohol & Drug Alliance (GLADA)
t: 020 7983 4100
www.london.gov.uk/mayor/health/drugs_and_alcohol/glada/index.jsp
GLADA is the Mayor of London’s strategic partnership network that aims to improve collective responses to alcohol and drug problems, and to provide a mechanism to address tackle London wide priorities. The Stella Project is a partnership project between GLDVP and GLADA.

The Hungerford Drug Project
t: 020 7287 8743
http://www.thehungerford.org/
The Hungerford provides advice, support, information and treatment for people in London who are experiencing problems with drug-use and for their families and friends. They also operate the pan London Antidote Project providing specialist support for LGBT people.

London Drug and Alcohol Network (LDAN)
t: 020 7704 0004
www.ldan.org.uk
LDAN is a London-wide voluntary organisation. The network provides advice, information and support to frontline services in London.

Mainliners
t: 0207 378 5480
www.mainliners.org.uk
Delivers services in the areas of substance use, harm minimisation, blood borne viruses and sexual health in London, Edinburgh and Glasgow.

National Treatment Agency (NTA)
t: 020 7261 8801
www.nta.nhs.uk
The NTA aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England. The NTA also has a full list of services available throughout England.

New Roots
t: 020 8983 9646
New Roots is a branch of Rugby House and has a mix of projects across Camden, Islington, Westminster and Kensington & Chelsea. Their services include counselling, community engagement and work with young people from BME communities.
5. Housing services

**Crisis**
t: 0870 011 3335
www.crisis.org.uk
Crisis is a national charity that provides services and programmes to empower homeless people. Works with single homeless people.

**Gay Men’s Shared Housing**
t: 020 8743 2165
www.thresholdsupport.org.uk/gaymensshared.html
Provides accommodation based medium term temporary housing and support to gay men who have been the victims of same-sex domestic violence, homophobic violence and/or gay related hate crimes in the London Boroughs of Wandsworth and Hammersmith & Fulham.

**Homelessness Link**
tt: 020 7960 3010
www.homeless.org.uk
Homeless Link is the national membership organisation for frontline homelessness agencies in England.

**Resource Information Service (London Hostels Directory)**
tt: 020 7939 0641
www.ris.org.uk
A national resource for advice workers, hostel staff, day centre, Social Services and anyone in contact with people with housing problems. Also produce publications and manage various housing and advice related websites.

**Phoenix Futures**
t: 020 7234 9740
www.phoenix-futures.org.uk
A national provider of care and rehabilitation services for people with drug and alcohol problems in the UK in community, prison and residential settings. Also provide residential services where children can stay with their parent(s).

**Turning Point**
t: 020 7553 5500
www.turning-point.co.uk
Turning Point is a social care organisation working with individuals and their communities across England and Wales in the areas of drug and alcohol misuse, mental health and learning disability.
Shelter
Shelterline: 0808 800 4444
www.shelter.org.uk
A national organisation providing telephone housing advice and information. Issues include finding accommodation, hostel referrals, housing benefit/rights, illegal eviction, domestic violence and emergency accommodation.

Stonewall Housing
t: 020 7359 5767
www.stonewallhousing.org
Provides supported housing, advice and advocacy for the lesbian, gay, bisexual and transgender communities in London.

6. Legal services

Community Legal Service
t: 0845 345 4345
www.clsdirect.org.uk
Government organisation providing information on where and how to access legal help in England and Wales.

Criminal Injuries Compensation Authority
t: 020 7842 6800;
Freephone: 0800 358 3601
www.cica.gov.uk
Administered in England, Scotland and Wales, this agency operates the Criminal Injuries Compensation Scheme for survivors who are no longer living with their partner.

Joint Council for the Welfare of Immigrants
t: 020 7251 8706
www.jcwi.org.uk
A national organisation that provides free advice and case work.

The Law Centres Federation
t: 020 7387 8570
www.lawcentres.org.uk
This national network of community based law centres will refer you to your local law centre for free legal advice.

Release
t: 020 7729 5255;
Helpline: 0845 4500 215
www.release.org.uk
Release operate a Legal Helpline and Specialist Drugs Helpline. You can also contact the organisation by email at ask@release.org.uk
Children and young people’s services

Childline
- t: 020 7650 3200;
- Helpline: 0800 1111
- www.childline.org.uk
- The free 24 hour confidential helpline for children and young people.

Gingerbread for Lone Parents
- t: 020 7488 9300;
- Advice Line: 0800 018 4318
- www.gingerbread.org.uk
- A national membership organisation providing advice and information for lone parents.

The Hideout
- www.thehideout.org.uk
- The Hideout is the first national domestic violence website for children and young people. The website has been designed to inform children and young people about domestic violence, help them identify whether it is happening in their home and signpost them to additional support and information.

Rights of Women
- Legal Advice Line: 020 7251 6577;
- Sexual Violence Legal Advice Line: 020 7251 8887
- www.rightsofwomen.org.uk
- A national organisation that provides advice and information for women on a range of legal issues including relationship breakdown, childcare, lesbian parenting, domestic and sexual violence.
8. Additional services for Black and minority ethnic and refugee communities

**Akina Mama Wa Afrika**  
t: 020 7716 5166  
www.akinamama.org  
A national organisation that provides advice, training, counselling and information services for African women.

**Chinese Information and Advice Centre (CIAC)**  
t: 020 7323 1538  
www.ciac.co.uk  
A national charity that provides information on family issues, domestic violence and immigration.

**IMECE Turkish Speaking Women’s Group**  
t: 020 7354 1359  
www.imece.org.uk  
Culturally sensitive services for Turkish, Kurdish, Turkish Cypriot women. Advice and information on domestic violence, welfare benefits, housing, immigration and an outreach service.

**Latin American Women’s Rights Service (LAWRS)**  
t: 020 7336 0888  
www.lawrs.org.uk  
Offers advice on housing, housing and welfare benefits for the elderly, counselling and a domestic violence project.
9. Perpetrator services

Respect

t: 020 7022 1801;
Phoneline: 0845 122 8609
www.respect.uk.net
Respect is a registered charity and national membership organisation promoting best practice for domestic violence perpetrator programmes and associated support services in the UK. Respect also provides a directory of perpetrator programmes throughout London.

Domestic Violence Intervention Project

www.dvip.org
Provides perpetrator programmes and partner support services in London to Respect standards.

London Irish Women’s Centre

t: 020 7249 7318
www.liwc.co.uk
Offers advice for women in housing need including women fleeing domestic violence in London. Also offers training and support services.

Naz Project London (NPL)

t: 020 8741 1879
www.naz.org.uk/index.html
Provides sexual health and HIV prevention and support services to targeted BME communities in London.