

Violence in the Lives of Women in Substance Abuse Treatment: Service and Policy Implications

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***If you take away substances and don't
deal with the trauma and pain
underneath, then you leave them
completely bare and exposed, with no
anesthesia.***

Angela Browne speaking at the Faces of
Family Violence and Trauma Conference,
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The relationship between substance abuse and the abuse of women by their partners is a complex one that needs to be better understood if women's lives are to become both substance and violence-free. It seems self-evident that women suffering with the dual burdens of substance use disorders and histories of abuse present complex challenges to conventional treatment approaches. What is less obvious is how women and their providers can work together effectively to meet and overcome these issues.

In an attempt to further knowledge in these areas, the Substance Abuse/Domestic Violence Committee of the Greater New Haven Domestic Violence Task Force, supported by the CT Women's Consortium, cooperated in a study to examine the prevalence and impact of domestic violence on women receiving substance abuse treatment in the New Haven area. This paper presents a brief review of the literature relating domestic violence, trauma, and substance abuse treatment; discusses the philosophical barriers

between providers of these services; and describes the results of the study. Policy and treatment implications and recommendations are offered.

Far from being the last or definitive word on this multifaceted subject, we hope this paper will spur discussion and prompt action. Through concerted efforts we can develop services for women whose bravery is unquestioned, but whose health is compromised by violence, addiction, and clinical and social misunderstandings about their lives.

Extensive literature documents a strong relationship among exposure to violence, psychological trauma, and substance use disorders. Research has consistently found that women who are victims of domestic violence have a prevalence of substance abuse that is higher than the general populationⁱ. For example, women diagnosed with alcoholism are more likely to report a history of childhood physical and emotional abuse than are nonalcoholic womenⁱⁱ. Women in substance abuse treatment are likely to have a history of violent traumaⁱⁱⁱ and the prevalence of PTSD among women with substance use disorders has been estimated to be as high as 2-5 times that of the general population. An estimated 50%-90% of women in substance abuse treatment are victims of current or past physical, emotional, or sexual abuse. ^{iv}

ETIOLOGY OF SUBSTANCE USE DISORDERS IN ABUSED WOMEN

Women exposed to abuse develop a variety of short and long term behavioral and psychological disturbances including depression, anxiety, anger, self-destructiveness, PTSD, suicidal behavior, substance abuse, and difficulties with interpersonal relationships. ^v These outcomes of trauma, particularly PTSD, can lead women to use substances as coping mechanism to relieve the pain. ^{vi} The social

isolation that often results from situations of domestic violence may also increase the likelihood that a woman will turn to alcohol or drug use. The coercive behavior of an abusive partner focuses on removal of a woman from her support systems like friends and family. This situation is compounded by the woman's shame, fear of blame, and her resultant withdrawal from social networks. In each case, the loneliness and lack of support create an additional risk that a woman will turn to drugs or alcohol for relief.

Furthermore, there is significant evidence that many women are introduced to drug use by a male partner.^{vii} Social isolation produces further dependence on her partner, establishing an opportunity for him to coerce her into using substances. A woman's addiction provides the abusive partner with even more control, either by taking advantage of her while she is under the influence or threatening to withhold the substances on which she is dependent if she does not comply.^{viii} Further, a woman's attempts to achieve sobriety are threatening to controlling partners, as these are correctly interpreted as important routes to her independence. Some violent men actively encourage women to leave treatment, or create situations that force a woman to choose to leave.^{ix}

BARRIERS BETWEEN SUBSTANCE ABUSE AND DOMESTIC VIOLENCE PROVIDERS

Given the strong connection between women's abuse and subsequent vulnerability to substance use disorders, it is not surprising that domestic violence and substance abuse

treatment providers often serve the same women. Unfortunately, they rarely coordinate services and in fact, these two systems are often in conflict.^x Historic differences in approach and emphasis continue to fragment services for women. Treatment models for substance abuse disorders have traditionally been based on the needs of men and too often use a disease model that emphasizes illness over strengths.^{xi} In contrast, domestic violence services grew out of a socio-political change movement with advocacy very much at the forefront. These services focus on the need for structural change and avoid models that imply women are "sick" or "dependent" because of someone else's behavior.^{xii}

Further, services for battered women focus on safety first, reasoning that the chief priority is to prevent women from being killed or seriously injured. Substance abuse treatment providers focus on sobriety first, reasoning that nothing in a woman's life can be mended until sobriety is achieved. In fact, many substance abuse treatment programs consider violence and trauma issues to be distractions from the primary addiction problem.^{xiii}

Yet, there is increasing clinical evidence that many chemically dependent women experience a great deal of difficulty in sobriety and frequently relapse if violence and sexual abuse issues are not addressed in treatment.^{xiv}

Additionally, there is personal and anecdotal evidence from women themselves that they want to talk about their experiences of violence and trauma while in treatment. Many clinicians explain their reluctance to ask women about their histories with violence because of fears the women will relapse or decompensate psychologically.^{xv} However, women talk about their lives when they are ready and when there

is reason to do so. Many have found that speaking out about violence in their lives or in the lives of others is helpful in reclaiming a sense of mission, purpose, and place in the world that has largely rejected them and called them “sick”.^{xvi}

THE DOMESTIC VIOLENCE/ SUBSTANCE ABUSE STUDY

In a cooperative effort to overcome these barriers, experts in both fields began meeting together in New Haven in 1996. From these meetings emerged the Substance Abuse/Domestic Violence Subcommittee of the Greater New Haven Domestic Violence Task Force. A major effort of this collaboration has been to develop and execute a study to assess the prevalence of domestic violence among women in substance abuse treatment and to examine its relationship to treatment completion.

Eight substance abuse treatment agencies in the greater New Haven area participated in the study. Clinicians at these agencies completed a questionnaire that assessed the client’s current and past experiences of domestic violence, whether domestic violence was a focus of her treatment, and whether she completed treatment.

FINDINGS

A total of 360 questionnaires were returned from eight agencies during 1998-1999. Almost half of the clients were inpatients at a substance abuse unit for women of a large psychiatric hospital, one-third were in outpatient treatment, and one-fifth were in residential treatment. Following are salient findings:

➤ **The prevalence of domestic violence among women in substance abuse treatment is significant.**

- 60% of clients reported either current or past domestic violence.
- 47% reported current domestic violence at treatment intake.
- 39% of the women in this study reported that they had been hit, kicked, emotionally abused, or threatened in the past year.
- 30% reported that their partner tried to isolate them and control their choice of friends, activities, or use of money.
- 9% reported someone currently in their lives who made them feel unsafe.

➤ **Abusive men were often partners or spouses.**

- 46% of the women reported that the abuser was a current partner or spouse.
- 39% reported their abuser was an ex-partner or former spouse.

➤ **Rates of domestic violence were highest among users of crack/cocaine as compared to women who used alcohol and other drugs. This finding is consistent with other studies.^{xvii}**

➤ **The presence of domestic violence had a significant impact on treatment completion.**

Women in this study who were current victims of domestic violence were significantly less likely to complete treatment.

- 59% of the women who reported current domestic violence did not complete the prescribed treatment.
- 77% who did not report a violent relationship did complete treatment.

Therefore, based on this study, experience of violence, particularly current violence, should be expected to effect treatment experience and vulnerability to relapse.

➤ **Domestic violence was seldom a focus of treatment.**

25% of current victims of violence received treatment that included a focus on domestic violence. Only 33% of substance abuse treatment providers believed that the inability of women to complete treatment was due to domestic violence. However, almost twice as many providers (60%) predicted that violence would be somewhat likely to trigger a relapse.

Substance abuse clinicians may not have addressed domestic violence simply because they did not have the time, training, or resources to do so. Unfortunately whatever the reason, the failure to do so could have consequences even more serious than recidivism. 39% of the women in this study reported that their abuser was a former partner. Although some clinicians believe that domestic violence issues do not need to be a focus of treatment when a woman is no longer with her partner, women are actually at greater risk of extreme violence and death after they leave.

SERVICE AND PUBLIC POLICY IMPLICATIONS AND RECOMMENDATIONS

“We need a new model: for want of a better term, a social contextual advocacy-based model in which interventions are guided by an understanding that it’s the impact of a form of normative social pathology that causes the majority of mental health symptoms in battered women; and if we don’t deal with that reality of each woman’s situation, we are not going to be much help in addressing it. When we can expand our traditional pathology-in-the-patient model to include social context, we can see that the “problem” or “pathology” here is the abuse of women by a woman’s partner, the social beliefs that condone abuse, and the social, political, and economic structures that sustain and support it.”
(Carole Warshaw)^{xviii}

RECOMMENDATIONS FOR WOMEN’S ADDICTION TREATMENT & ADVOCACY SERVICES FOR DOMESTIC VIOLENCE

Central to all of the following recommendations is the need for providers and policymakers to listen and respond to the voices of women who have lived with violence and addiction and who know best what they need to become healthy and whole. The CT Women’s Trauma Initiative, a partnership of the CT Department of Mental Health and Addiction Service and The CT Women’s Consortium has begun this work. Five regional “Speak-Outs” for women were held in the Spring 2000. In response to the voices and messages of almost 100 women, a set of policies and recommendations is being developed to help guide the clinical and policy changes that need to be made. A formal Trauma Steering Committee and statewide Trauma Council have been established to implement these changes. Most importantly, women in treatment, in shelters, and in recovery must be the guides to a better treatment system for all women in need.

Treatment for substance use disorders and services for domestic violence need to focus on the complex realities of women's lives, not on single issues. They must use research-tested models that address the special needs of women. The theoretical differences between these two systems must be recognized and each accepted as legitimate. Rather than a rigid "either/or" approach, every woman's unique situation should be considered separately. The issue that serves as a bridge between both fields is women's health. Both violence and addiction compromise women's health and functioning and both should be treated as health issues. Empowering approaches that avoid labels of "illness" or pathology and include validations for a woman's efforts to free herself both from the violence and the addiction are crucial to her recovery. Approached from this perspective, the philosophic differences become less important and the overall goal, to improve women's health and health care, becomes a shared one.

Comprehensive, culturally competent, and integrated services are crucial to recovery.

Treatment approaches need to be comprehensive, integrated, and culturally competent in order to help ensure treatment retention, successful outcomes, and enhanced functioning. Many women with substance use disorders also face a myriad of unmet service needs^{xix}. Chief among what women most need to access treatment is child care. Other women seeking residential treatment need the opportunity to have their children with them. All their children may need to receive concurrent therapeutic services.

Cultural competence in treatment and service approaches should reflect the diversity among women in class, race, ethnicity, age, disability,

and sexual orientation. Rather than an "add-on" to existing services, culturally proficient services should include and recognize that each woman's cultural history and heritage is a central part of her healing and recovery.

Combine clinical and advocacy approaches.

Treatment models that focus on empowerment and validation for each woman's historical efforts to help herself and her relationships, combined with advocacy and safety planning hold the most promise. To be successful, these approaches will require on-going, collaborative and mutual partnerships by clinicians and battered women's advocates. These partnerships must be based on honest appraisals of the obstacles, successes, and failures of these systems in the past and must develop a realistic plan for resolution and progress. Comprehensive training about domestic violence, its effect on women's health, and the social and political issues that perpetuate its prevalence should be offered to all providers of mental health and addiction treatment. Also, cross training for staff of battered women's shelters, rape crisis centers, child protection workers, substance abuse and mental health providers is needed to help all these systems work more effectively.

Shelters are often unable to keep battered women with active addiction and mental health issues. The health and social service needs of many women require shelters to change these policies, but to do this they will need additional training, clinical services, supports, and resources.

Routine screening for coercion and violence by providers of substance abuse treatment is crucial.

The coercive control that battered women suffer is an important factor that needs to be acknowledged. Even when violence is addressed, the specific issues of coercive control in a woman's relationship with a violent partner are often overlooked or ignored. The evidence from research suggests that the psychological and behavioral disturbances that result from domestic violence are often more related to the devastating disempowerment of coercive control rather than the physical violence itself.^{xx}

Further, structural discrimination and barriers to institutional access intensify traumatic responses to battering.^{xxi} For these reasons, traditional substance abuse treatment approaches that have emphasized confrontation, subordination, powerlessness, and isolation are unlikely to be effective and can in fact do additional harm. Women with histories of violence frequently report secondary traumatization by providers. One way to understand women's "resistance" to treatment is by understanding the multiple negative experiences they have encountered when they sought help for their health problems. Multiple admissions and premature discharges from treatment facilities could be a result of the realization by many women that their needs were not being met in treatment.^{xxii}

Assessments that address issues of coercion and control as well as physical, sexual, and emotional abuse hold the most promise. One model to consider is "*Triple A: Ask, Assess, and Advocate*" developed and taught by the CT Women's Consortium's Domestic Violence Training Project in New Haven.

Treatment models must understand and reflect the importance of relationships in women's recovery.

Research on treatment for substance abuse disorders has shown that the longer a client remains in treatment, the better the outcome.^{xxiii} Therefore, the high drop-out rates for all modalities of substance abuse treatment are of serious concern. The few studies that compare retention and recidivism rates of men and women have identified significant differences in the factors that determine outcomes.

Models that have significant promise in meeting the special needs of women understand the central role relationships play in women's lives and in the development of their sense of self.^{xxiv} These approaches differ from traditional treatment models that recommend a woman isolate from her relational context so that she can focus on her sobriety.^{xxv} For many women, the impetus to enter treatment is to improve her interpersonal relationships. To ignore this as a valid reason worthy of notable attention is a sure prescription for poor treatment outcomes.

One promising treatment model is the Trauma Recovery and Empowerment intervention for victims of violence, developed by Maxine Harris and The Community Connections Trauma Work Group in Washington, DC.^{xxvi} This model, in conjunction with case management or individual therapy, focuses on substance abuse, domestic violence, and other traumas as well as issues such as homelessness and mental illness. It addresses the multiple, complex problems women face in their recovery.

Networking opportunities and structured team-building efforts to coordinate and link the fields of substance abuse and domestic violence are important for the success of both.

Based on this work, the Domestic Violence/Substance Abuse Committee of the Greater New Haven Domestic Violence Task Force is currently recruiting additional treatment providers to its membership. This collaboration has already had a significant impact on the ability of interdisciplinary groups to work effectively together and is an important model to consider for replication in other areas. For example, the Committee has brought domestic violence resources to substance abuse treatment agencies. These include staff training, a domestic violence screening poster, and a bilingual Domestic Violence Resource Guide, which is currently in its second edition and has been used as a national model. Further, as a result of this study, the New Haven Fighting Back project has agreed to use screening for domestic violence in substance abuse treatment as an indicator for its Community Report.

RECOMMENDATIONS FOR PUBLIC POLICY

Public policy must be changed to address the conflicting demands placed on women by social, health, and child welfare services.

Loss of children is by far the most overarching fear and loss for women in and out of treatment. While it is primarily men who abuse both their partners and their children, it is women who are most often held responsible. A woman who is unable to protect herself will also find it difficult to protect her children. Her dilemma then becomes whether to expose her violent partner and risk losing her children or

hide the violence and run the risk that he will abuse her child.

Furthermore, the multiple service systems that are supposed to help battered and addicted women often require contradictory behaviors and measures of “success” or “compliance”. For example, the welfare system requires a woman to work. The treatment process typically requires a woman to focus only on her sobriety. The child protection system requires a woman to stay home, spend more time with her child, and take parenting classes. Even when the child protection system requires a woman to enter addiction treatment, she still has no guarantee that this will result in the return of her child. Given these very real non-choices, it is not surprising that some women opt for silence and prefer to handle the violence on their own.

Two models are attempting to address the needs of women and their children struggling with domestic violence and substance abuse. Rather than the traditional approach of holding a woman responsible for protecting her children from a man against whom she cannot even defend herself, these non-punitive programs and services help women obtain safety and health care for themselves and their children.

The first is the nationally recognized Project SAFE (Substance Abuse Family Assessment and Evaluation). Jointly administered by the CT Department of Children and Families and The CT Department of Mental Health and Addiction, Project SAFE contracts with a statewide network of providers to ensure access to evaluation and treatment for parents involved with the child welfare system who are suspected to have a substance use disorder. Now entering Phase II, the project is developing a comprehensive assessment that includes screening for trauma and domestic violence. Training for staff focuses on motivational and empathic approaches to

engagement and melds the need for safety of children with treatment for their parents. This multi-dimensional approach promotes thoughtful planning and the provision of family support services that protect children and promote the health of their parents.

Another promising approach on the policy level in Connecticut is the *Hard To Serve Collaborative*, an interagency work group convened to help provide services to women leaving welfare and for women who have left, but who have significant and complex personal and health issues. This group includes representatives from the CT Department of Labor, The CT Department of Social Services, the Bureau of Vocational Rehabilitation, The CT Department of Children and Families, The CT Department of Mental Health and Addiction, The CT Women's Consortium, CT Legal Services, and the CT Women's Education and Legal Fund. The primary areas of focus are domestic violence, mental health, and access to treatment for addiction.

CONCLUSIONS

This study underscores the need for additional research to better understand the relationship between trauma, domestic violence, substance abuse, and appropriate treatments and interventions for women. Like most research, it has perhaps elicited more questions than answers. Despite that not uncommon occurrence, this research study has had other extremely important outcomes. It has strengthened the relationship between advocates for battered women and substance abuse treatment providers; it has established a forum and a model for others to replicate that facilitates open discussions about the historic divisions in philosophy and beliefs about domestic violence and how to resolve them; it has provided an opportunity for the women who are victims of violence to have their needs

and experiences confirmed and addressed; and it has paved the way to advocate for and establish the services and help that can save the lives of countless women and their children.

Endnotes

- ⁱ Foa, Cascardi, Zoellner, & Feeny, 2000
- ⁱⁱ Hein & Schier, 1996
- ⁱⁱⁱ Fullilove, Fullilove, Smith., Winkler, Panzer, & Wallace, 1993
- ^{iv} Finkelstein, 1993
- ^v Beitchman, 1992; Ireland & Windo, 1994; Lisak & Luster, 1994; Malinosky-Rummell & Hansen, 1993; Mullen, Martin, Anderson, Romans & Herbison, 1993; Widom & Ames, 1994
- ^{vi} SAMHSA, 1997; Stark & Flitcraft, 1996; New York State Office for the Prevention of Domestic Violence
- ^{vii} Rosenbaum, 1981.
- ^{viii} New York State Office for the Prevention of Domestic Violence
- ^{ix} New York State Office for the Prevention of Domestic Violence
- ^x SAMHSA, 1997
- ^{xi} Minnesota Coalition for Battered Women, 1992
- ^{xii} SAMHSA, 1997
- ^{xiii} Finkelstein, 1993
- ^{xiv} Kovach, 1986
- ^{xv} CT Women's Consortium, 2000
- ^{xvi} Salasin, 1986
- ^{xvii} Bennett, Tolman, Rogalski, & Srinivasaraghavan, 1994.
- ^{xviii} Warshaw, 1995
- ^{xix} Gil-Rivas., Fiorentine., Anglin., & Taylor, 1997
- ^{xx} Stark & Flitcraft, 1996
- ^{xxi} Stark & Flitcraft. 1996.
- ^{xxii} CT Women's Consortium, 2000
- ^{xxiii} Simpson, 1979
- ^{xxiv} Markoff, 1996
- ^{xxiv} Harris, 1998.
- ^{xxv} Allison & Hubbard, 1988

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HISTORY OF THE SUBSTANCE ABUSE /DOMESTIC VIOLENCE COMMITTEE

The Substance Abuse / Domestic Violence Committee is a collaborative effort of two regional organizations: The Greater New Haven Domestic Violence Task Force (The Task Force) and The Connecticut Women's Consortium. Created in 1986, the Task Force promotes public awareness of domestic violence, monitors and improves existing

domestic violence treatment programs, and supports legislative reform.

The CT Women's Consortium grew out of a New Haven effort begun in 1990 to improve services available to women with substance use disorders and their children. The Consortium is now a statewide independent organization dedicated to improving behavioral health care for women and their children. It does this through its Women's Services Institute providing education and training, through its initiatives offering technical assistance and consultation in gender-competent services, consumer empowerment and support, and the development of concrete products and technology that help build comprehensive approaches for women's health needs.

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