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National Treatment Agency
for Substance Misuse

The impact of violence and abuse on engagement and retention rates for women in substance use treatment

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Reader information

Document purpose	To provide an overview of the evidence to inform the commissioning, design and delivery of drug treatment services
Title	The impact of violence and abuse on engagement and retention rates for women in substance use treatment
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Description	This document describes the available evidence and includes professional opinion from key informants on the impact of domestic violence and abuse on women's capacity to access, engage and benefit from drug treatment
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This publication is not a journal publication and does not constitute National Treatment Agency or Department of Health guidance or recommendations. The views expressed by this study are not necessarily those of the Department of Health or the NTA, but are based on externally refereed research.

Contents

“A woman that I am working with, her partner has been in prison for three years, and was very violent towards her and she has spent three years staying clean and dealing with a lot of the domestic violence issues and he’s come out and she’s dropped out, and for me it’s pretty … I know why she’s dropped out. [How do I] reach her now because an awful lot of the control is part of the abuse – it’s very controlling. The phones have been taken away, the post is intercepted, so it’s kind of how do I get a message to this woman who is now being completely isolated again? One of the things that we can do is for example, we could leave a message with her prescription – I know she is going to pick her prescription up and so therefore I know she will get a message as she will be the only one to get that. And that worked – she kind of got the message and rang and said ‘I’m OK’. But OK what’s the plan? How can we deal with this? How are you going to get in touch with me? What’s going to make this easier for you? And that’s what we did, but the first thing she did was stop treatment.”
(Project worker – substance use service)

“It’s often been going on for a long time before any sort of drug or alcohol problem develops and, you know, women are often very self-blaming. I was in an assessment last week where a woman was saying ‘Well if I wasn’t out of it he wouldn’t hit me’, and then we managed to establish that actually, he’s hit her when she’s been sober as well. And so, I think [substance use] is a fairly reasonable response in some ways to a horrendous situation in terms of the women clients here.”
(Manager – substance use service)

“Most of our women now, 99 per cent, are class A substance misusers. I think it’s like that in most cities now. They’re out there to pay for the drugs. So yes, that leads to lots of violence, it leads – there’s violence from the partner or pimp – because usually their partner is their pimp, they just don’t realise until later, you know, until they’re out of that relationship. There’s lots of violence there and that’s usually around not earning enough money, because they’ve got to provide his drugs as well.”
(Manager – sex work project)

1 Executive summary

1.1 Aims and principal research questions

The objective of this study was to explore what is known about the impact of violence and abuse towards women on their rates of engagement and retention in substance use treatment. Its aims were to explore the following issues:

1. The extent to which current violence and abuse prohibits women from entering treatment
2. Whether violence and abuse to women is a risk factor for women increasing their level of substance use during treatment
3. Whether current violence and abuse affects women's treatment completion
4. If violence and abuse is a risk factor for returning to problematic levels of substance use post-treatment (relapse).

1.2 Factors of interest

The main drivers for this research are threefold. First, there is increasing evidence that domestic abuse is ignored or overlooked in many aspects of health and social care, including substance use treatment. Second, there is increasing pressure from health and social care staff for guidance on how to work with women (and men) presenting for treatment with these issues. Third, there is evidence that these gaps in service provision are leaving women (and children) facing increased risks to their physical and psychological safety.

The overlap between substance use and domestic abuse is not a new issue. However, it has received almost no policy or practice attention in the UK in spite of its significance to the health and wellbeing of those involved and their families. In the last few years, national policy has given increasing attention to both domestic violence, alcohol and drug abuse, albeit as separate problems, with publication of alcohol and drug strategies and legislation in relation to domestic violence (see Humphreys *et al*., 2005, for review). However, only the Alcohol Harm Reduction Strategy for England (AHRSE) (Cabinet Office, 2004) called for recognition of the links between alcohol abuse and domestic violence, and for policy and services to respond. Further potential for development lies in the multi-agency community safety partnerships, which should now include members from drug and alcohol treatment services (DATs), police and primary care trusts (PCTs). What remains a challenge is how to extend this recognition to other relevant policy areas and to ensure that it is made operational within existing drug and alcohol treatment services.

1.3 Methods

There were two strands to the proposed study: a comprehensive literature review and interviews with key informants. The search aimed to identify literature that examined:

1. The existing evidence on the impact of domestic violence and abuse on women's engagement with treatment services
2. Whether domestic violence and abuse has been identified as a relevant factor in treatment uptake and completion

3 How significant domestic violence and abuse is as a factor in women's substance use treatment.

The study also aimed to interview ten to 15 key informants with practical experience in this area. The interviews were semi-structured in design to allow for in-depth discussion, with some flexibility in how such discussion was structured while maintaining a focus on the key issues. Minor adjustments were made to the wording of the interview schedules to ensure the questions remained relevant to the informant's area of practice.

1.4 Sample groups

1.4.1 Literature review

The literature search focused on sources that would meet the identified aims of the project. The search terms were predefined to maintain focus on domestic violence and abuse, due to the abundance of general literature on women and substance use, and substance use and engagement and retention issues. Search dates were unrestricted initially but were narrowed for half the databases searched, due to the amount of duplication and the volume of "hits" that were irrelevant. The literature search included a range of literary sources such as books, journals, "grey (largely unpublished) literature", conference proceedings, government reports and official publications, and alternative literature. The search focused on UK evidence before extending its remit to international research. Research and practice networks were used for consultation with academic and practice colleagues over grey literature or other possible literature sources. The literature was selected using set inclusion and exclusion criteria. For inclusion in the review, it needed to meet the following criteria:

- Empirical research (quantitative or qualitative)
- A substance-misusing population
- A treatment or intervention-based sample
- Have at least one form of domestic abuse as a focus or key variable
- Consider some aspect of treatment engagement, retention, completion and relapse.

Exclusion criteria included:

- Editorial comment
- Position papers, literature reviews, foreign language articles and such like
- Literature focusing on either domestic abuse or substance use only
- Reference lists, media reports and other sources not meeting the inclusion criteria.

1.4.2 Interviews

In new areas of practice, particularly within social care, practitioner experience is an important source of knowledge (Pawson *et al*., 2003). The key informants were accessed using "snowball" sampling techniques (Atkinson and Flint, 2003). This is a method of accessing hard-to-reach populations based on personal recommendation from initial informants. The selection of key informants was set against three criteria identified by Pawson *et al*. (2003): "the authenticity and credibility of the source", "the credibility of content, including evidence of traceable links to practice" and "the provision of sufficient detail for wider relevance and take up into others' practice". The resulting group of informants were therefore those practitioners that met these criteria and had also begun to identify and address the dual issues of substance use and domestic abuse among their client group. In total, 13 key informants were drawn from substance use treatment providers, organisations

providing domestic violence services or working with women in the sex industry, and specialist staff working with domestic violence and substance use.

1.5 Outcome measures

The empirical research was read using set criteria including:

- Type of treatment setting, single or mixed-gender treatment
- Number in the sample, methods used and key findings.

A small selection of broader studies on women's engagement and retention in treatment services were read with a view to determining whether or not domestic abuse was a factor identified during the research, or treatment, process. Any grey literature available was read for relevance, prevalence, practice experience and anecdotal evidence. The key themes were then extracted from the literature.

The key informant interviews were recorded (where permission was granted), transcribed and analysed using thematic coding (Flick, 1998, Strauss, 1987). This form of analysis is used where a purposive sample has been recruited for their views on a particular topic. It is designed to identify commonalities and differences among participants' views and to allow key themes to emerge from the data. For this research, the interview schedule had been designed to cover specific areas relevant to engagement and retention issues. Thus, not only was thematic coding applied to the responses about those particular topics, but it was also applied to data which had not been predefined but arose in the course of the interview.

1.6 Findings

The key finding emerging from this study is that there is a severe lack of research evidence on the impact of domestic abuse on the engagement and retention rates of women in substance use treatment. The research available is primarily from the US and often methodologically flawed. Further, it is devoid of qualitative research that seeks to represent service users' views. The practice-based experience of the key informants suggests that domestic abuse does have an impact on both engagement and retention rates for women living with domestic abuse, but the agencies have no way of quantifying that at present.

The following is a very brief summary of the findings in relation to the key aims of the research.

1.6.1 Engagement

The research literature was extremely limited and thus no reliable conclusions can be drawn from it. The grey literature evidenced a range of issues that prevented women experiencing substance use and domestic abuse from accessing treatment including:

- Increased stigma is attached to women suffering domestic abuse and misusing substances
- A lack of resources to address the dual issues
- Bad experiences of previous treatment seeking
- Denial of access to services by the abuser, or fear of the perpetrator finding out
- Fear of children being removed by social services and other professionals
- Ignorance about abuse issues.

Analysis of the key informant interviews identified five main themes that prevented women engaging with treatment:

- Concerns over childcare
- Perpetrator control
- Inflexible service structures, for example, lack of gender-specific provision
- Lack of refuge access for women using substances
- Time gaps between early stages of service delivery, for example, no fast tracking.

1.6.2 Retention

There was no UK and only limited US research on retention and completion rates for women suffering domestic abuse. On the surface, the majority of studies stated that a woman's history of domestic abuse did not appear to impact upon her treatment outcomes or completion of treatment. However, serious methodological flaws – for example, looking at physical or sexual abuse only and looking at past violence only – coupled with the small number of studies, suggest this finding should be treated with extreme caution. Of those that found no difference, half of them identified possible protective factors that helped keep women in treatment, for example, a women-only service, childcare facilities and holistic approaches to treatment.

The key informant data resulted in four relevant themes:

- Women facing the "push-pull" of wanting to attend treatment but being pressured not to by perpetrators
- Women facing an increased risk of abuse if they attend treatment through perpetrator reasserting control
- The enormity of women coping with dual problems
- Practical barriers, for example, a male-oriented service.

1.6.3 Relapse

Again there was almost no data on this except two studies that suggested women with domestic abuse histories are more likely to relapse. However, the grey literature and key informants were clear that women often use substances to cope with their experiences of abuse, and thus if the abuse increases or a woman returns to an abusive partner she is more likely to drop out of treatment.

1.6.4 Practice issues

Two key issues arose from both data sources: the need for assessment of domestic abuse to inform practice responses and the need for staff training in order to identify and address domestic abuse in an informed way. The other key practice issues were the likelihood that treatment characteristics played a role in engaging and retaining women in treatment, and the role of psychopathology in non-completion of treatment. However, very few of the studies made the connection between women's experiences of domestic abuse and subsequent mental ill health.

1.7 Conclusions

As yet, there are no clear messages that can be formed on the relationship between women's experiences of domestic violence and abuse and its impact on their treatment for

substance problems. While a small amount of US research suggests it has no impact on engagement or retention, this needs to be viewed with caution in view of its methodological flaws and differences in treatment characteristics. What the key informant interviews provide is some practice-based evidence that suggests women's access to, and engagement with, treatment services is negatively affected by domestic abuse and that most service providers have not yet taken steps to identify and address domestic abuse, let alone reflect upon its impact on treatment effectiveness.

1.8 Implications for further research

- There is a need for UK data on the prevalence of domestic abuse among people in treatment for substance problems (both victim and perpetrator prevalence)
- There is also a need for research into the impact of domestic abuse on engagement and retention of women in substance treatment. It should identify characteristics of the treatment setting that are supportive of women who suffer domestic abuse.
- Future research in this area needs to use mixed methodologies that both demonstrate ethical research practice and are sensitive to the subject under study
- The research also needs to involve service users, as their views are not currently reflected in existing research
- The research needs to consider all types of abuse including emotional and psychological abuse, not just physical and sexual abuse
- It also needs to consider "current active" and "current impact" (past abuse but current trauma) abuse (see also section 13) – not just past abuse. This will have implications for how the research is conducted and by whom
- There is a need for research that focuses on establishing the needs of women in Black and minority ethnic communities and from different faith communities in relation to these dual problems
- There is a need to establish the existing knowledge base of substance use staff in order to focus training appropriately. This may also consider exploring attitudes towards working with domestic abuse perpetrators and victims.

1.9 Relevance to the NHS

The NTA leads national policy and guidance that is implemented at a local level. It is well placed to offer a strong lead in developing policy and practice in this area. This could be done in the following ways:

- Appoint a strategic lead to develop the response of substance use services to the subject of domestic violence and abuse
- Commit to training managers and staff in the knowledge and skills needed to work with these issues and to support staff through informed supervision
- Commit to producing policy guidance on working with domestic abuse for substance use service providers
- Ensure national and local policy documents on service provision and quality reflect the significance of domestic violence and abuse in relation to people's substance use
- Ensure close liaison between a representative from the NTA and relevant strategic fora, including the Community Safety Partnership and Domestic Violence Partnership (Forum) to ensure relevant issues on drug treatment

- Ensure partnership working includes formal working agreements with domestic violence service providers, backed by integrated care pathways that have been consulted and agreed with key stakeholders
- Develop good practice by building on existing models of good practice used by organisations within the voluntary sector and from other areas of the NHS, including health-based forums, such as Health Ending Violence and Abuse Now (HEVAN, formerly the National Domestic Violence Health Practice Forum).
- Commission substance use services that support women's needs though attention to treatment characteristics (see section 12.1), for example, gender-specific services that have childcare facilities or offer local, supportive and practical partnerships with supplementary service providers
- Review existing service philosophies to determine whether they offer a holistic service (thus maximising the chances treatment success) or one that treats the substance rather than the person.

2 Introduction

Women's experiences of violence and abuse,[1,2] have a profound effect on their physical and psychological wellbeing. UK prevalence rates for the general population show that one in four women will have suffered domestic abuse at some point in their lives (Walby and Allen, 2004). It also shows that women are the primary victims and their partners, or ex-partners, the primary perpetrators (Mirrlees-Black, 1999, Walby and Allen, 2004).

For women in substance use treatment,[3] the picture is even more concerning. US research figures consistently show that a high proportion of women have suffered recent domestic abuse and that approximately half of men in treatment admit to perpetrating such abuse (see also sections 7 and 11.2). This is not, therefore, a secondary issue for treatment services.

The link between substance use and domestic abuse is complex. There is no reliable evidence of a cause-effect link between the two. However, where problems with substance use exist, domestic abuse is often present too. The link clearly combines the effects of the substance with gender roles and expectations, cultural learning, the social environment, relationship dynamics and individual choice.

In the UK, little attention has been paid to this problem, nor to the overlap between women's experiences of domestic abuse and the impact of such abuse on their engagement and retention in treatment services. It is important to consider the impact of domestic abuse on delivering treatment that is effective, accessible and meets the needs of women service users. Further it has implications for staff training and support, and for developing partnerships with other specialist services.

[1] For the purposes of brevity, we will substitute "violence and abuse" toward women with the phrase "domestic abuse". This includes sexual violence and abuse, physical violence and abuse and other forms of abuse, including emotional, psychological and economic. It is not the intention of this research to look at stranger violence.

[2] While the findings include some references to childhood experiences of abuse, our focus in this study is primarily on adult experiences.

[3] Throughout this report substance use includes alcohol as well as drug abuse.

2.1 Definitions

2.1.1 Treatment

This term has been used to represent the wide range of interventions that are available to help and support someone with a drug or alcohol-related problem.

2.1.2 Substance use

For the purposes of this report, substance use refers to any use of drugs or alcohol that is deemed to cause problems for the individual to the extent that they receive treatment for such use.

3 Aims

The objective of this study is to investigate what is known about the impact of domestic abuse towards women on their rates of engagement and retention in substance use treatment. Its aims are to explore the following issues:

1. The extent to which current violence and abuse prohibits women from entering treatment
2. Whether violence and abuse to women is a risk factor for women increasing their level of substance use during treatment
3. Whether current violence and abuse affects women's treatment completion
4. If violence and abuse is a risk factor for returning to problematic levels of substance use post-treatment (relapse).

4 Background

The main drivers for this research are threefold. First, there is increasing evidence that domestic abuse is ignored or overlooked in many aspects of health and social care, including substance use treatment. Second, there is increasing pressure from health and social care staff for guidance on how to work with women (and men) presenting to treatment with these issues. Third, there is evidence that these gaps in service responses are leaving women (and children) facing increased risks to their physical and psychological safety.

The overlap between substance use and domestic abuse is not a new issue. However, it has received almost no policy or practice attention in the UK, in spite of its significance to the health and wellbeing of those involved and their families. In the last few years, national policy has given increasing attention to both domestic violence, alcohol and drug abuse, albeit as separate problems, with publication of alcohol and drug strategies and legislation in relation to domestic violence (see Humphreys *et al.*, 2005 for review). However, only the Alcohol harm reduction strategy for England (AHRSE) (Cabinet Office, 2004) called for recognition of the links between alcohol abuse and domestic violence and for policy and services to respond. Further potential for development lies in the multi-agency community safety partnerships which should now include members from DATs, police and PCTs.

What remains a challenge is how to extend this recognition to other relevant policy areas, and to ensure it is operated within existing drug and alcohol treatment services.

5 Methodology

There were two strands to the proposed study: a comprehensive literature review and interviews with key informants. Both strands were completed between mid-January 2005 and early March 2005.

5.1 Comprehensive literature review

The literature search focused specifically on sources that would meet the identified aims of the project. It therefore searched for literature using search terms specific to the issues of violence and abuse and substance use treatment (see appendix 1). The search terms were predefined to maintain focus on domestic violence and abuse, due to the abundance of general literature on women and substance use, and substance use and engagement and retention issues. Search dates were unrestricted initially but were narrowed for half the databases searched, due to the amount of duplicates and the volume of "hits" that were irrelevant.

The literature search included a range of literary sources, including books, journals, "grey (largely unpublished) literature", conference proceedings, government reports and official publications, and alternative literature. The search focused initially on UK research evidence before extending its remit to international research. In addition, research and practice networks were used for consultation with academic and practice colleagues (see appendix 2 for database and network details).

The search aimed to identify literature that examined:

- The existing evidence on the impact of domestic violence and abuse on women's engagement with treatment services
- Whether domestic violence and abuse has been identified as a relevant factor in treatment uptake and completion
- How significant domestic violence and abuse is as a factor in women's substance use treatment.

The literature was selected using set inclusion and exclusion criteria. For inclusion in the review, it needed to meet the following criteria:

- Empirical research (quantitative or qualitative)
- A substance-using population
- A treatment or intervention-based sample
- Have at least one form of domestic abuse as a focus or key variable, and
- Consider some aspect of treatment engagement, retention, completion and relapse.

Exclusion criteria included:

- Editorial comment, position papers, literature reviews, foreign language articles
- Literature focusing on either domestic abuse or substance use only
- Reference lists, media reports and others not meeting the inclusion criteria.

5.2 Interviews

The study also aimed to interview ten to 15 key informants with practical experience in this area. In new areas of practice, particularly within social care, practitioner experience is an important source of knowledge (Pawson *et al*. 2003). This is particularly so when there is a limited research evidence base. The role of the key informants is to activate their "latent" knowledge base (Pawson *et al*., 2003) via the research process, with a view to raising practice issues for wider consideration of their relevance to policy and practice development.

The key informants were accessed using "snowball" sampling techniques (Atkinson and Flint, 2003). This is a method of accessing hard-to-reach populations based on personal recommendation from initial informants. As many services have not yet recognised or addressed this overlapping issue, a purposive sample of key informants was sought from agencies where the issues were beginning to be recognised and addressed. The initial list of informants was drawn from the researchers' expert knowledge of practice in this area and their involvement with the only specialist project on this subject in the UK (Stella Project, 2004). These individuals then recommended other people to contact, if known. Snowballing was appropriate for this research because there is no single body co-ordinating or monitoring this work, and anecdotal evidence of agency work on this subject is the key source of information outside Stella Project sources.

The selection of key informants was set against three criteria identified by Pawson *et al*., (2003): "the authenticity and credibility of the source", "the credibility of content, including evidence of traceable links to practice" and "the provision of sufficient detail for wider relevance and take up into others' practice".

While a number of contacts were made using this snowballing technique, few met the criteria stated. The resulting group of informants were therefore those practitioners that had begun to identify and address the dual issues of substance use and domestic abuse among their client groups. The initial selection of informants was geared towards accessing views from a range of professionals working with this issue, not solely treatment services.

As the initial informants were known to the researchers this could present a possible bias in terms of informant responses. However, arguably, such prior knowledge of the researchers allowed people to speak freely about the subject, and the attention it has or has not received within their agencies and practice experience. In addition, given the small pool of practitioners working in this field, and the researchers' involvement in developing related research and practice, prior knowledge was unavoidable.

The subsequent interviews were semi-structured in design to allow for in-depth discussion, with some flexibility in how such discussion was structured while maintaining a focus on the key issues (see appendix 3). Minor adjustments were made to the wording of the interview schedules to ensure the questions remained relevant to the informant's area of practice.

5.3 Analysis

The empirical research on the impact of domestic abuse on women's engagement and retention in substance use treatment were read using set criteria including:

- Type of treatment setting, single or mixed-gender treatment
- Number in the sample, methods used and key findings.

A small selection of broader studies on women's engagement and retention in treatment services were read with a view to determining whether or not domestic violence and sexual abuse were factors identified during the research or treatment process. Any grey literature

available was read for relevance, prevalence, practice experience and anecdotal evidence. Key themes were then extracted from the literature (see section 6).

The key informant interviews were tape recorded (where permission was granted) transcribed and analysed using thematic coding. This is a process of analysis based on the work of Strauss (1987) and is used where a predefined sample has been selected for their views on a particular subject. The views of the participants are compared and analysed for commonalities and differences. Using thematic coding each interview is analysed as a single case study and the key topics identified (Flick, 1998). These are placed within "thematic domains", that is, broad themes containing related topics drawn from each interview. The thematic domains are modified as necessary to ensure that as much data as possible is represented in the subsequent interpretation. For this research the interview schedule had been designed to cover specific areas relevant to engagement and retention issues. Thus, not only was thematic coding applied to the responses about those particular topics but it was also applied to data which had not been predefined but arose in the course of the interview.

5.4 Ethical approval

Ethical clearance was gained through University of Warwick ethics committee and through approval processes at the University of Birmingham. In addition, participants were provided with an informed consent form (appendix 4) and the ethical code for the research (appendix 5). Participants were asked routinely at the start of each interview whether they had any questions relating to the consent form or ethical code. The interview schedule was sent to key informants in advance to allow for consultation with colleagues or considered responses as appropriate.

5.5 Limitations

The key limitation for this research was the time limited nature of the project. This restricted the amount of interviews and extent of the literature review undertaken. It is possible that more data could be found by a comprehensive search of the general literature on women and substance use or on substance use treatment and retention. However, limited reading of this general literature suggests that it would add little beyond acknowledgement that childhood abuse or adult sexual abuse is an issue for many women in substance treatment. The time limit also restricted the range of research participants to those from voluntary sector agencies, which have different requirements in relation to research governance and approval processes.

6 Findings

6.1 Literature review

The literature search (detailed in appendices 1 and 2) resulted in nearly 2,000 hits. However, when these were sifted using the criteria described in section 5.1 this resulted in very little relevant empirical research. What there is comes primarily from US treatment samples.

6.1.1 UK research

There were 11 relevant pieces of UK research identified, only two of which specifically addressed the issue of substance use and domestic abuse (Humphreys *et al*., 2005, Barron,

2004). Some literature identified women's experiences of violence and abuse in the context of a broader focus on the treatment needs of women in different settings, for example, prison or sex work, while the remaining literature raised sexual and physical abuse in the context of looking at gender differences among men and women completing drug treatment. One study (Rathbone, 2004) specifically looked at the needs of drug-using mothers. These latter studies were selected because of their more recent publication but it is acknowledged that there is a broader base of literature that mentions sexual abuse and its relationship to adult substance problems.

6.1.2 US research

There were 22 relevant pieces of research found in the search outside the UK literature. Thirteen of these identified the impact of physical and sexual abuse on treatment outcomes, although not solely on women sample populations. A further two studies highlighted the potential impact of violence and abuse on treatment outcomes although this was not their primary focus. Five US studies and one Australian study addressed the issues of violence and abuse in treatment and raised practice and policy questions. Only two studies specifically mentioned the impact of domestic abuse on access and engagement with treatment with one offering no gender breakdown (Caetano *et al.,* 2002) and the other focusing on developing a model to explain women's entry into substance treatment (Brown *et al.*, 2000).

6.1.3 Grey literature

A small amount of relevant UK grey literature was identified (n=12). It consisted of unpublished prevalence data collected by organisations for in-house monitoring purposes, with very little detail about methods of data collection (n=4). Some key informants had more in-house data but felt it was not in a form to be useful to this project. There were five published reports, three of which had women's experiences of domestic abuse as the key focus, but for the remaining two it was mentioned as part of a broader project focus. Some of the samples were very small or did not specify the numbers of women on which the report was based. The information on which these reports were based had been collected from a range of respondents including staff and women (n=2), staff only (n=1), service evaluation (n=1), women only (n=1). The remaining three pieces of grey literature included one example of good policy (Nottinghamshire County Council and DAAT (2004)) and one example of good practice (Waltham Forest Drug and Alcohol Action Team (undated)), and a toolkit for working with these dual issues (Stella Project, 2004b).

6.2 Key informant interviews

In total, 13 key informants were drawn from substance use treatment providers, organisations providing domestic violence services or working with women in the sex industry, and specialist staff working with domestic violence and substance use. None of the key informants were aware of research evidence on the impact of violence and abuse on engagement or retention rates for abused women. Further, this is not something they had been able to evaluate formally within their agencies. The majority of them wanted data on this issue. What they were able to offer, and what is of value from the interviews, is their experience of working with women facing these dual problems and the challenges they face in doing so.

The literature and key informant interviews raised many wide-ranging issues relevant to policy and practice in this area. The primary focus of these findings will therefore be on the issues of engagement and retention but brief mention will be made of a few themes that consistently emerged from the data. First, there will be a summary of evidence relating to the

prevalence of women with the dual issues of using substances and living with experiences of domestic abuse.

7 Prevalence

The higher rates of prevalence of domestic abuse within the substance treatment population, relative to the general population are not in doubt. US research consistently shows between 60-80 per cent of women in treatment suffering sexual or physical abuse at some point in their lives (Gil-Rivas *et al*., 1997, Hien and Scheier, 1996, El-Bassel *et al*., 2000, Swift *et al*., 1996, Thompson and Kingree, 1998, Karageorge and Wisdom, 2001). A UK study which undertook a one week "snapshot" of women's services in three substance use agencies found rates of between 40 per cent and 62 per cent (Humphreys *et al*., 2005)[4]. This compares to a lifetime rate of 26 per cent of women in the general UK population suffering domestic abuse, threats or force (Walby and Allen, 2004). The figure at the lower end of the 60-80 per cent range falls, at its lowest, to approximately 33 per cent of all women in treatment when asked about current violence and abuse. However, some in-house and unpublished research studies show the top end of the range to be between 90-100 per cent when psychological abuse is considered (Downs, 1999, Stringer, 1998). These figures also vary according to the timeframes associated with "current" abuse.[5] Most often they are considerably higher. Again in comparison with the general UK population, only six per cent of women suffered domestic abuse in the last 12 months (Walby and Allen, 2004).

Even though these figures are high, they are still expected to be underestimates due to the obvious difficulties in researching such intimate experiences. For women abusing substances, suffering domestic abuse adds further layers of stigma and shame. The accuracy of the figures also appears to vary depending on the nature of who's asking, in what context, and how many times they are asked. In substance treatment there is evidence to show that people who disclose abuse during intake procedures may only be a percentage of those who have actually suffered (Burgdorf *et al.*, 2004, Titus *et al.*, 2003).

One of the key weaknesses in the majority of the prevalence data is its exclusion of forms of abuse other than physical and sexual abuse. Rarely are psychological, emotional, and economic forms of abuse considered in the data, in spite of women reporting psychological abuse as causing longer-term damage than physical abuse (Galvani, 2003, 2007, Swan *et al.*, 2001). As one key informant stated:

> *"We know that [women] often struggle with highly intrusive recollections about abuse. So, just two examples … a woman who just kept seeing her husband's fists coming towards her or another woman whose partner pinned her with his knees on her chest to the ground and repeatedly lifted a knife above her head and stabbed it into the carpet, so close to her head that it shaved hairs off her head. He did that nine or ten times, and each time she thought she was going to die. Every time she closed her eyes, she saw the knife coming towards her face again. So, I am just trying to illustrate the power of the flashback as intrusive events. I know that many women will use – particularly alcohol or marijuana – or other drugs, be they prescribed or otherwise, as well, to try and manage the effects of the flashbacks and the intrusive memories."*
> *(Psychologist – domestic violence service)*

This is an important issue for treatment services to consider, particularly if their work with clients uses cognitive-behavioural therapy or other psychological models of treatment, and is

[4] Care needs to be taken with this data as the numbers in each agency for a snapshot were small.
[5] "Current" has been defined variously as within the last 30 days, six months or 12 months preceding substance use treatment.

with clients presenting with co-occurring mental health problems. The invasiveness of such traumatic memories and their impact on people's substance use will need to be considered in relation to working with their thoughts and behaviour around their substance use. This, in turn, requires a level of knowledge and skill about domestic abuse and its relationship to substance use and the resistance people may have in discussing it with, or disclosing it to, treatment staff.

8 Engagement

8.1 Literature review

The literature search found only one UK research study that identified access and engagement issues for women with substance use problems who also suffered domestic abuse. The study by Humphreys *et al.* (2005) sought key informant views, interviewed service users and reviewed a selection of agency policy and practice in their exploration of the overlap between domestic violence and substance use. It found that the failure of services to meet these needs meant women were forced to choose between domestic violence services or substance use services. The lack of a co-ordinated pathway through linked services meant women's needs were not being met. This, in turn, has implications for the safety of women and their children from both their experiences of domestic abuse and their substance use.

No other UK research was found which explored the impact of domestic abuse on women's access to, or engagement with, substance use services. Some studies raised the issues of violence and abuse when discussing gender differences in treatment needs (Becker and Duffy, 2002, Neale, 2004), or in relation to drug using populations in prison or sex work (Borrill *et al.,* 2003, Hester and Westmarland, 2004, Roberts and Vromen, 2005). In addition, there is a small but growing literature on responding to domestic abuse as a single issue within health and social care settings, however it does not recognise, nor address, the overlap between substance use and domestic abuse.

One US study (Caetano *et al.*, 2002) looked specifically at the link between partner violence and seeking help for alcohol problems and found that where both issues coexisted, couples were 1.5 times more likely to seek help compared to couples with alcohol problems alone. However, it still found 74 per cent of the alcohol and intimate partner violence group and 80 per cent of the alcohol alone group did not seek help for alcohol problems. There was also no gender analysis of the sample stating who was help-seeking and who it was that had the alcohol problem.

A second US study (Brown *et al.*, 2000) found women's readiness to change their experiences of domestic violence predicted entry to residential substance use treatment. While this study was geared towards testing a model for practice (developed from DiClemente and Prochaska's (1998) Stages of Change model), it raises important questions about the role of residential substance use treatment acting as a safe environment and front-line service for women with substance problems fleeing domestic abuse.

There was greater indication of access and engagement difficulties in some of the grey literature (Almond *et al.*, 2004, Rathbone, 2004, Stringer, 1998, Taylor, 2003, Cornwall Women's Rape and Sexual Abuse Centre, 2004). To summarise, the grey literature identified that women found accessing services difficult for a range of reasons including:

- The need for safe accommodation that addressed drug issues

- Increased stigma attached to someone suffering both domestic abuse and problematic substance use
- A lack of resources to address the dual issues
- Bad experiences of previous treatment seeking
- Denial of access to services by the abuser, or fear of the perpetrator finding out
- Fear of children being removed by social services
- Fear of children being left in the perpetrator's care and abused
- "Threatening" environment of mixed-gender treatment settings
- Professionals' ignorance about abuse issues
- These issues were also reflected in the key informant interviews.

8.2 Key informant interviews

Five main themes were identified in relation to access and engagement:

- Childcare
- Perpetrator control
- Problems with service structures
- Refuge access
- Gaps between stages of service delivery.

8.2.1 Childcare

A consistent theme from the interviews that prevented women attending for treatment was inadequacy of childcare provision and fears around child protection issues. Commonly reported by women were concerns that social services might be involved or women would be perceived as being unfit mothers. While these are not new barriers to women's treatment, there was the added concern that disclosing domestic abuse would add to the argument for removing children from the mother's care or that children would be at risk from the perpetrator while the woman is in treatment.

> *"If it was a violent relationship then the women would not want to leave the children with the perpetrator [which raised] child access issues. So the need to have the children going with them was really high and that came up as a concern."*
> *(Specialist worker – Borough based)*

For agencies working with families the issue was that the perpetrator could control the children's attendance at family sessions even if he could not control the woman's. However, the two were often related.

> *" We have also had [experience of] where a woman is coming in and doing quite well and being very involved and then the partner, although he cannot control whether she attends, has got some control over when the children attend and prevent children from coming, which then in itself, can prevent a woman from continuing.".*
> *(Senior staff member – family service)*

8.2.2 Perpetrator control

All key informants acknowledged that part of the dynamics of domestic abuse is controlling women's movements. This included her access to treatment services, sabotaging her attendance, visible wounds preventing her from leaving the house and his attending the service as a prohibiting influence, that is, not as a support as might be perceived. Finally, the perpetrators exercised powerful control of her through the children or making threats about the children, for example, reporting her as an unfit mother.

> *"I have actively known of a number of women who have not been able to access services and who have been told, 'no you can't go there'. And sometimes we are accessing women who are lying about where they are going or we are meeting them in other places in order for them to receive the service and to do that anonymously."*
> *(Manager – women's drug service)*

> *"We have had the experience as well of male perpetrators using in many ways the woman's need for an alcohol service as part of their power and control, and the woman will avoid the service on that sort of level … feeling that if she attends and admits to an alcohol problem of her own, then that plays into his hands of him being in control of and in control of their family and in control of getting rid of her or whatever the underlying issues might be about."*
> *(Senior staff member – alcohol service).*

8.2.3 Problems with service structures

A further theme related to services lacking flexibility and therefore being unable to meet these women's needs in a number of ways. These included inflexible appointment systems and structures, lack of gender-specific provision and lack of fast tracking or quick access. The majority of key informants recognised the importance of women being safe, although this didn't always come before a focus on the substance use. The following manager was clear that safety was a priority:

> *"Quick access would be one of the things [we would do] for women where there are safety issues, so we can see them as quickly as possible. The first step would be around how we actually access women in a way which is safe for them and feels safe for them."*
> *(Manager – women's drug service)*

Other issues included lack of working with women on access and safety issues once they had entered treatment, for example, where and when it was safe to attend appointments, inappropriate service provision on offer, for example, mixed groups or community detox where the perpetrator is present at home, and a lack of recognition by staff of the demands they place on women attending services – even the women without domestic violence issues. Again the issue of a lack of childcare facilities was raised resulting in the woman choosing between not attending the service to look after the children or attending the service and leaving the children with the perpetrator.

8.2.4 Refuge access

The majority of key informants recognised the lack of refuge access or safe accommodation for women fleeing domestic abuse and abusing substances. Three main issues arose:

- Women in refuge accommodation and presenting to treatment services often need to hide their substance use and treatment from the refuge provider for fear of being excluded from the refuge.

- Refuge access is difficult in the first place if the woman is honest about her substance use as she is likely to be excluded.
- If a woman is in a refuge this may act as a prohibiting factor for accessing substance use treatment even if she wants it for fear of people finding out and her being excluded.

8.2.5 Gaps between stages of service delivery

The gap between referral and access, or access and engagement (depending on the structure of the service) was a final theme that arose. Key informants identified a number of ways they felt domestic abuse might lead to women dropping out of treatment between these two early stages:

- Fears were raised that asking about abuse at first screening might lead to the women not returning to the service.
- Some key informants felt that work needed to be done with the perpetrator to smooth access to treatment for the woman.
- There was also a view that the woman will have a hierarchy of needs and a safe space may be her priority.
- Women were reluctant to enter treatment because they do not believe the service will understand the domestic abuse issues.
- Women fear dealing with the feelings generated by the abuse if the substance use is removed.

Three of the substance use agencies reported increased numbers of women attending their service due to their approach to working with women. This included: domestic violence work; women-specific services and a holistic focus, rather than presenting their service as having a medical or treatment focus.

9 Retention and completion

9.1 Literature review

There was no UK research that explored women's experiences of domestic abuse and its relevance to their retention and completion rates in substance use treatment. Two studies recognised the issue within a broader research focus (MacGregor, 2003, Becker and Duffy, 2002). MacGregor, in her comparison of men's and women's completion rates, found that more women than men completed treatment and remained abstinent in spite of suffering more sexual abuse, more isolation, less family support, more suicide attempts and depression and living with more drug-using partners. However, the author points out this greater completion rate may have been helped by the fact the treatment setting was a day programme with gender-specific groups and a choice of a female counsellor.

Becker and Duffy (2002) identified the complex needs of women problem drug users and reported these were not met by some services. They too make the links between these needs and past sexual and physical abuse although do not recognise that such abuse is also likely to be current. As with many other studies, they identify aspects of current service provision that are inadequate in meeting women's needs or approaching women's needs in a holistic and client-centred way.

The importance of addressing staff attitudes, knowledge and training needs in relation to domestic abuse was a strong theme that came out of all the literature. This will be explored further under issues for practice.

The US research on the impact of domestic abuse on women's treatment completion rates was also limited. Only nine studies looked specifically at treatment outcome in relation to abuse of some kind, although 13 studies made linkages between the two issues. Two further studies mentioned the potential impact of domestic abuse on treatment outcomes.

On the surface, the majority of studies stated that a woman's history of domestic abuse did not appear to impact her treatment outcomes or completion of treatment. Eleven of 13 studies reported no impact. The two remaining studies found that abuse did have a negative impact on women's treatment outcomes (Swan *et al.*, 2001, Thompson and Kingree, 1998).

Importantly, however, these latter studies raised interesting methodological questions against which the findings of the other 11 need to be set. Thompson and Kingree, (1998) found "traumatic stress" rather than "traumatic exposure" had a negative impact on treatment outcomes. Swan *et al.* (2001) looked at current domestic abuse and its impact on treatment outcomes as well as past domestic abuse. These studies raise a number of questions:

1. What types of domestic abuse were assessed as part of the other research studies?
2. Was current abuse part of that assessment?
3. Was the current impact of abuse on the individual assessed regardless of whether the abuse was past or current?

Of the nine studies specifically looking at abuse and treatment outcomes, only three considered current abuse (Andersen Clark *et al.*, 2001, Swan *et al.*, 2001, Thompson and Kingree, 1998), two asked about lifetime abuse (Fiorentine *et al.*, 1999, Titus *et al.*, 2003), and four asked about past abuse only (Burgdorf *et al.*, 2004, Gil-Rivas *et al.*, 1997, Greenfield *et al.*, 2002, Karageorge and Wisdom, 2001). Further the vast majority of all the studies reviewed asked about physical and sexual abuse only. Thompson and Kingree's (1998) findings that traumatic stress effected treatment completion, suggests it is important to assess for emotional and psychological abuse, as well as the impact of all abuse on the individual's current mental health and patterns of substance use. This is further supported by research that has found emotional abuse has a significant negative impact on an individual's functioning in a range of behavioural domains (Rice *et al.*, 2001). The authors suggest this, in turn, will have negative impact on treatment outcomes as research shows higher functioning clients do better in substance use treatment.

In addition, the majority of the US research used either a battery of quantitative tests or secondary analysis of case records or both for their research methods. While it is not within the remit of this review to analyse all the tools used in such research (and there were many), limited methodological details suggest that most of them required evidence of exposure to sexual or physical abuse or not. Beyond this finding there appears to be little exploration. Thus the impact of the abuse, be it past or current, on the individual and their method of coping with the abuse were not subject to exploration. The issue of current trauma and stress speaks directly to findings that people with higher levels of depression, anxiety and "psychopathology" have poorer treatment outcomes (Green *et al.*, 2002, MacGregor, 2003, Moos *et al.*, 2002, Thompson and Kingree, 1998).

Finally, several of the studies suggest that their findings are looked at alongside protective factors such as gender-specific programming, treatment setting, gender of the counsellor, informal support systems among women in treatment, childcare provision in treatment agencies, and a more holistic approach to treating women's needs.

The grey literature did not address completion and retention issues directly although many of the issues it raised in relation to access and engagement difficulties are likely to remain challenges for women's successful completion of treatment. Other issues highlighted by the literature and relevant to treatment retention include staff ignorance about domestic abuse, concerns about confidentiality issues and "threatening" male treatment environments.

9.2 Key informant interviews

The initial response of the key informants was that they had no data on the impact of domestic abuse on completion rates. They did not know of any evaluative evidence and felt this was a gap in their knowledge and the research. The majority felt it was logical that with domestic abuse affecting access and engagement it must also have an impact on completion.

However, their practice experience raised additional issues relevant to retention and completion although some overlapped with the issues that prevent or inhibit women's engagement with services. Four key themes emerged from the practice experience of the key informants.

9.2.1 "Push-pull"

The majority of key informants spoke of women being caught between substance use treatment on the one hand, and a controlling and sabotaging partner on the other. Among the key informants who were managing services there was recognition here, and elsewhere, that safety for women (and their children) needed to be the priority and should be assessed and addressed before the substance use. A key informant recalls an experience of a woman experiencing domestic abuse who dropped out of treatment:

> *"I think if you were thinking about where you were going to intervene, if the perpetrator could have been hauled out of the equation, and given the sentence he deserved, then I think she would have been able to avail herself of both interventions. The problem was the perpetrator you know."*
> *(Manager – domestic violence service)*

Other informants spoke of perpetrators sabotaging treatment and experiences of women returning to treatment once the perpetrator was no longer around. In particular, several of the participants said they had experienced an increasing number of women reporting partners forcibly injecting them to sabotage their treatment or retain control.

9.2.2 Increased risk to women in substance treatment

Several key informants spoke of the perpetrator's control being threatened by her attending treatment, resulting in heightened levels of abuse in a bid to re-establish his control. The consequential impact for the woman would often be increased substance use or dropping out of treatment.

> *"You know we had one guy – partner – calling at the doorway here and shouting and bawling. If he's prepared to come all this way, shout at the door at representatives of authority, there's no way he's not going to be violent. She didn't last very long under that pressure."*
> *(Manager – day programme, drug and alcohol service)*

Other key informants raised this concern in relation to their practice, fearing that their intervention or heightening her awareness of the issues might heighten the risks to the woman's safety.

9.2.3 Coping with dual problems

The key informants who were leading practice initiatives on this issue often commented on the enormity of the task women faced dealing with both their substance use and domestic abuse. Comments ranged from recognising that services were "asking a lot" of the women to reflections on the impact of domestic abuse on the therapeutic relationship.

> *"What we feel we are asking women to enter into when they come here is a trusting relationship … we feel this is very difficult for a woman who has been violated by people or a person they trust in relationships."*
> *(Senior staff member – alcohol service)*

One service provider spoke about women's stories reflecting a sense of resignation to their situation as their victimisation and substance use emerged from an inherited environment where such behaviours were the norm. This had practice implications in terms of women needing a longer period of support and input from treatment services. Another commented that she felt women would find it easier to complete treatment if there was no time limit attached to it. Several people commented on the fact the two problems added complexity to the treatment process. One key informant stated:

> *"It's just one of those things when the two work off each other a bit. Her life became very chaotic because she was a strong alcohol user and was also suffering repeat violence from this guy who was also a strong alcohol user and I know she entered treatment for it at a local agency and wasn't able to maintain it and similarly found it very difficult to maintain contact with us, partly because of her alcohol use – so the two problems compound each other."*
> *(Manager – domestic violence programme)*

There was also the recognition from all informants that the shame and stigma is intensified for women who are both substance users and victims of domestic abuse. One respondent called it a "double whammy" and all made reference to the negative impact of both issues on women's self-esteem and self-effectiveness.

9.2.4 Practical barriers

As with engagement issues, many key informants stated there were practical barriers that did not support women staying in treatment. These included mixed-gender services, male-dominated and male-oriented services and services without childcare facilities. As previously acknowledged, while these are barriers to women needing treatment in general, the key informants pointed out that women facing domestic abuse need a service where they can feel safe, making such service characteristics even more important.

One solution to people dropping out of treatment was presented by a key informant who ran a project for women in the sex industry. Her response to the question about whether women's experiences of domestic abuse affected treatment completion was:

> *"No, because we provide a hell of a lot of support. … the women we're supporting through treatment, even though they're one of the hardest to reach [groups], they're actually doing better than the national average for all clients doing drug treatment, staying in treatment, so that's quite good. I think it's because of the support they're getting. It's okay people saying 'oh we want you off drugs' and 'go get a DTTO' and 'go and get tested' or whatever, then they're just left. They've got a script but they haven't got anything else you know, and there's loads that goes with it."*
> *(Manager – sex work project)*

Key informants also stated that, in general, treatment services did not understand the types of relationships domestic abuse has with a woman's substance use, nor did they know how to go about addressing the issue. As one service provider stated:

> *"You need to pitch [the questions] right to ensure women come back, and that's difficult."*
> *(Manager – substance use service)*

10 Relapse

10.1 Literature review

The search for research literature on the impact of domestic abuse on relapse found very little data. Evidently, there is overlap between issues raised in the research on retention and completion rates as non-completion of treatment will often be preceded by a return to problematic patterns of substance use. However, there were some exceptions. A small US study by Greenfield *et al*. (2002) found that women with a history of sexual abuse were significantly more likely to relapse and had lower abstinence rates (n=27/41). The majority of these women had been sexually abused pre age 16. However, when background characteristics were controlled for in multivariate analysis, sexual abuse history was no longer significant.

Physical abuse appeared to have no impact on relapse rates, although the research highlights psychiatric disorders, for example depression, as a factor leading to quicker relapse and heavier drinking. Again there appears to have been no connection made between women's experiences of abuse and its negative impact on their mental health. A second US study by Green *et al*. (2002) found that women with more "substance dependence diagnoses" and with more mental health problems led to worsening treatment participation. Women who have suffered domestic abuse are highly likely to present with both.

The grey literature also identified reports that women often use substances to cope with domestic abuse. Intuitively, if a woman's coping mechanism is using substances, treatment services will potentially see an increase (lapse or relapse) in the woman's use at times when she is experiencing increased domestic abuse. This is highlighted further by the key informants.

10.2 Key informant interviews

10.2.1 Increased substance use after domestic abuse

There was clear acknowledgement from the majority of key informants that women often increased their substance use to cope with the abuse they received. Several pointed out that there were other losses associated with domestic abuse which then added to the reasons to use substances as a coping strategy, for example, loss of self-esteem, loss of friends and family contact, loss of home. It was pointed out that such increased use can, in turn, lead to the woman being increasingly vulnerable to abuse. Several key informants, however, stated that for women to recognise the links between their abuse and their substance use certain conditions had to be in place:

> *"They almost never understand how their use of substances is being used as part of the abusive power and control until further down the line when they are feeling*

safer, or got cleaner or dryer and had time to reflect."
(Psychologist – domestic violence service)

One service manager reported women dropping out if they lapsed or relapsed because of their sense of failure.

> *"We regularly see women lapse or relapse after suffering a domestic violence incident or threats. So someone who has actually made a move away from a partner, [when] they are somehow back in the frame in some way, and are threatening them in some way, and alcohol is back in the picture because of that, I think that…the woman at that time may deselect herself because she feels like a failure… and [in her mind] how can we possibly want her to continue if she has failed something?"*
> *(Senior staff member – family service)*

Other informants also spoke of women relapsing then returning to the abusive partner for support or women relapsing as a result of the "trauma and instability" in their environment. As with completion and retention, key informants said they needed more information on the relationship between abuse and relapse.

One informant highlighted the similarities between relapse in relation to substance use and returning to the abusive partner and how practice models have been developed:

> *"It's interesting we have developed as two separate sectors these two cyclical notions of essentially the same concept – the return to the violent relationship [cycle of violence] or return to substance misuse [cycle of change]. We have to stop thinking of them as two separate cycles when effectively for the individual … it's one cycle."*
> *(Specialist worker – city based)*

11 Issues for practice

This research has raised many issues for service management and staff practice. The following four themes have been drawn from the literature and key informant interviews.

11.1.1 Assessment

A theme that ran strongly and consistently through the range of literature reviewed, as well as the key informant interviews, was the need for staff to routinely ask about domestic abuse. Both the research and key informants found screening for, and assessment of, domestic abuse was rare and haphazard. Some of the grey literature and qualitative evidence shows some substance use staff will address the issue once it is disclosed but are not proactive in prompting this disclosure (Humphreys *et al*., 2005, Stella Project, 2004). Where people were asking routine questions these were usually inadequate, often consisting of a one-off question which asked only about whether or not they had experienced "domestic violence" and whether this was as a perpetrator or victim. One key informant stated:

> *"We do have this screening question which comes up at some point … but it is a very strangely worded question … in theory every client is asked this question because it is on the assessment form."*
> *(Specialist worker – agency based)*

The implied reservations about both the nature of the question and whether everyone was asking it consistently were reflected by other informants. Barron's (2004) survey of UK

agencies also found that although a high number of survey respondents said their agencies asked about domestic abuse, upon further interviewing it was found that this was not the case. Her study reflected views of key informants that most staff will await disclosure from clients:

> *"Generally they wait for a disclosure and that disclosure often happens after a period of rapport … or they will wait for the woman to talk about their relationship and then develop some sort of opinion about whether that's coercive or not coercive behaviour."*
> *(Specialist worker – city based)*

The research also suggests that women need to be asked about domestic abuse at different times during their treatment as additional people will disclose at different times in the treatment process, often once therapeutic relationships are established (Burgdorf *et al.*, 2004, Swan *et al.*, 2001, Titus *et al.*, 2003).

11.2 Staff training

Alongside this theme ran the issue of training for staff and ensuring their knowledge, skills and understanding were developed in relation to asking about, and responding to, disclosures of domestic abuse. As Becker and Duffy (2002) point out:

> *"A major challenge for drug workers was to acknowledge the extreme kinds of violence and trauma experienced by their clients, while maintaining the goals of the drugs treatment programmes. Some staff stressed how important it was to clarify to their clients that they could not provide counselling on these issues."*
> *(Becker and Duffy 2002, p32).*

This highlights clearly how many staff do not understand the relationship between their clients' substance use and their experiences of suffering or perpetrating domestic abuse. Nor do they feel it's their job to work with these issues.

Among the majority of the key informants there was a clear understanding of the complexity of the links and attempts to address the issues in practice in spite of a lack of guidance and other practice challenges. However, there was also a sense that, while practitioners understood the co-occurrence of domestic abuse and substance use, they did not always link past abuse to current abuse or did not consider the impact of domestic abuse on a woman's substance use. If they did, they felt it was not their job to address it.

Becker and Duffy's findings also pick up on the level of abuse women presenting to services are experiencing. This was supported by one British study (Humphreys *et al.*, 2005) that clearly identified women presenting to substance use services as suffering severe forms of domestic abuse:

> *"In this sample of men and women with substance use problems both survivors and perpetrators reported either perpetrating or being subjected to chronic violence and abuse at the severe end of the continuum … with reports of beatings, rape, sexual pressure, and strangulation. The severity of violence is exemplified by the fact that 74 per cent of survivors in this sample needed to seek medical help with their injuries on at least one occasion but with some reporting many visits to accident and emergency and hospitalisation."*
> *(Humphreys et al., forthcoming)*

Given these recent findings it highlights the importance of staff understanding the risks service users face and being prepared to prioritise their safety.

Some agencies for which key informants worked were more advanced in their knowledge and understanding of the links. However, this raised another challenge for which further training is required. The heightened level of awareness and sensitivity to the issue raised fears among practitioners that they might do more harm than good:

> *"We do not shy away from the links, but we are held back by a fear that intervening makes things worse rather than better and it feels like walking on eggshells … and also I realise that we feel … as a service … we are also in fear of the power of the perpetrator … so there is almost a feeling of someone sitting on your shoulder, stopping you trying to sort some things out, because it feels like life and limb if you make mistakes…children might get killed, women get killed."*
> *(Senior staff member – family service)*

This fear of making things worse was common. Some informants pointed out that staff might be putting women at risk of abuse if they were asking screening or assessment questions without being preceded by training.

Another risk factor is the treatment approach employed that might contradict good practice for working with women suffering domestic abuse or perpetrators of domestic abuse. One US study stated:

> *"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 traumatisation by providers."*
> *(Swan et al., 2001)*

Much of these concerns fed into requests for further research and policy and practice guidance.

11.3 Gaps

It is clear from the grey literature and from the key informant interviews that there are examples of good practice. Some agencies have been trying to address this issue for several years. However, practice is obviously inconsistent both in terms of whether and how the issue is addressed. The key informants were chosen specifically for their knowledge of this issue and their attempts to work with it, however even their practice was varied. They also reflected a sense of frustration at working with a difficult and sensitive issue without adequate policy and practice guidance. The following gaps were identified by the key informants.

11.3.1 Research

There was a request from many participants for UK prevalence data for:

1. Women survivors in treatment
2. Perpetrators in treatment
3. Numbers of women presenting to domestic abuse agencies (and how many are being turned away).

Although some prevalence data exists, it is primarily from the US and flawed in its methodology and its focus is on physical and sexual abuse only.

Beyond this, people clearly did not have any formal data on the issues addressed in this study, that is, engagement and retention (see also section 13).

11.3.2 Policies

It is apparent from the grey literature, key informant interviews and existing networks, for example, the Stella Project in London, that agencies in different parts of the UK have been attempting to develop policy and practice in this area. One key informant pointed out that, to date, this has been unco-ordinated. Thus, there is a need to draw together agencies' attempts at policy and practice in this area in order to identify current good practice and disseminate this widely. Further, informants wanted more guidance on policy development, and several suggested the development of a model policy for working with domestic abuse in substance use services and vice versa. Policies would also need to address staff experiences of suffering and perpetrating domestic abuse as well as that of service users. One key informant from a domestic abuse service suggested looking at existing policies, for example, substance use and post-traumatic stress disorder (PTSD) and adapting them for working with domestic abuse.

11.3.3 Practice

While most of the key informants had been working with this issue for some years, their experience was that most agencies had not even begun working with these dual problems. They asked for practice guidance in a range of areas including the development of an effective practical model for substance use service providers on how to work with perpetrators and victims in a substance use setting and guidance on how to work with related populations, for example, families, Asian communities, young people and so on. The experienced key informants identified particular challenges for practice. Key informants working with families wanted guidance on how to work with young people growing up with domestic violence, particularly boys who had started to mimic the abusive father's behaviour.

11.3.4 Service provision

Key informants also identified gaps in services. Already mentioned is the lack of refuge accommodation for women using substances (and their children). Further, they pointed out the lack of services available to perpetrators who use substances, the need for link workers to build partnerships locally between substance use and domestic abuse agencies, and the need for people to work with the partners of substance abusing perpetrators in treatment.

11.3.5 Good practice

Key informants were also asked about the policies or procedures that helped them develop their practice in this area. Interestingly, the front line only staff knew of nothing while the managers and specialist workers knew only of a limited range of literature. Mentioned by most key informants was the Stella Project Toolkit (2004b), as well as a range of tools adapted from domestic abuse service providers. A few mentioned published literature in this area including: Women's Aid Guidelines (WA, 2003), Making the Links report (Taylor, 2003), Seeking Safety: A Treatment Manual (Najavits, 2002), Nottinghamshire policies and procedures for substance use services working with domestic violence (Nottingham CC, 2004), Home Office guidance on domestic violence and confidentiality (Humphreys *et al*., 2005), the "power and control" model of working with perpetrators (Morran and Wilson, 1997), and publications by Jacobs (1998) and Galvani (2005). Some also mentioned developing their own model of best practice and developing local agreements with agencies to allow for fast tracking to services.

12 Discussion

The key finding emerging from this study is that there is a severe lack of research evidence on the impact of domestic abuse on the engagement and retention rates of women in substance use treatment. The research available is often methodologically flawed. Further, it is devoid of qualitative research that seeks to represent service users' views.

It may not be surprising therefore that the findings of the key informant interviews reflect how the majority of substance use service providers are often "travelling blind," in terms of developing policy and practice responses to domestic abuse. Their practice-based experience suggests that domestic abuse does have an impact on both engagement and retention but they have no way of quantifying that at present.

Their view is that most agencies are not yet acknowledging their role in working with domestic abuse as an element of a woman's substance use, let alone considering the impact of domestic abuse on engagement and retention rates. The interviewees believed the majority of services do not address the issue, a small number do in a limited and uninformed way, and there are few examples of good practice. Where good practice exists, agencies have not had the resources to evaluate their service nor disseminate their practice. There are practice initiatives in different parts of the UK that are working with the dual issue of substance use and domestic abuse but no co-ordination of these individual agency's attempts.

As the implications of these findings for research and the NHS are dealt with in later sections, the following discussion will identify ways to improve engagement and retention based on both the findings of the literature, and key informant data.

12.1 Treatment characteristics

A range of targeted service provision appears to be supportive of women remaining in treatment, including gender-specific services or groups, fast tracking procedures for women identified as suffering domestic abuse, residential facilities that can accommodate children, safe spaces to meet women for counselling or screening interviews, giving women greater choice over where and when to meet. More intensive treatment over a longer period of time may also be required.

Providing women with a holistic service appeared to positively influence women's completion of treatment. Smith and Marsh's (2002) work on the impact on treatment outcomes of matching services to identified needs, found it was the total number of services provided for women that resulted in better outcomes rather than matching particular services to identified need. They also said that few of these needs were met currently by substance treatment services.

Other research suggests that more women are likely to succeed in treatment, whatever level of abuse they have experienced, if supplementary services are provided (Ashley *et al*., 2003, Becker and Duffy, 2002, Karageorge and Wisdom, 2001). The importance of supportive social and other protective environmental factors have long been recognised as an important factor in the success of an individual's substance use treatment (Azrin, 1976; Copeland, 1998; Costello, 1980; Dobkin *et al*., 2002; Eldred and Washington, 1976; Powell *et al*., 1998; Ravndal and Baglum, 1994) and in the development of some practice models (Christo *et al*., 2000; McCarthy and Galvani, 2004). What has not been adequately considered is the impact of negative or destructive environments and relationships, such as those characterised by domestic abuse, on the failure of an individual's substance use treatment.

Further, the key informant data suggests that the way services are presented, that is, medical and prescriptive structures, as opposed to holistic and client-centred approaches, can also have an impact on increasing women's involvement and retention. This may have a particular impact on Black and minority ethnic women and the particular issues of shame and dishonour which many of them face (Taylor, 2003) and which are inadequately addressed under models structured to provide prescribing services plus some individual counselling.

12.2 Childcare

The literature and the key informant interviews repeatedly raise childcare concerns as a key barrier to women accessing or staying in treatment. Children can clearly act as a motivator for treatment, particularly when threats of removal of children by authorities are considered. They can also act as a demotivator when threats of removal or abuse of children by perpetrators of domestic abuse are considered, or when the woman is faced with being the primary or sole parent responsible for childcare (Powis *et al*., 2000). Both sources of information clearly suggest services working with women suffering domestic abuse need to consider childcare concerns in terms of providing childcare facilities.

12.3 The change process

Many treatment approaches are underpinned by an understanding of the difficulties people face when deciding to change their patterns of substance use. Women living with violence and abuse face equally hard, if not harder, decisions. Treatment providers could use current thinking about change, for example Prochaska and DiClemente (1984), to help them understand the enormity of change faced by women living with both issues. Hester and Westmarland (2004) developed a model from their work with prostitutes which describes four stages of need and support: "vulnerability, chaos, stabilisation, and exiting (moving on)". Using a similar model within a treatment setting could help staff to assess the woman's level of need – be it related to domestic abuse, substance use (or both) – and help them to respond appropriately.

12.4 Refuge access

It is clear that the lack of refuge space to accommodate women using substances means that treatment services may be acting as front line services for women with nowhere else to go, particularly if there is residential treatment that accommodates children. Joint initiatives between substance use services and domestic violence service providers could develop both residential and outpatient care to serve this group of women and their families.

12.5 Staff training

There are existing training initiatives running that specifically address the overlap of issues between substance use and domestic abuse. This training remains an essential part for all managers and staff considering screening for, and working with, domestic abuse. The key informant interviews clearly identified the need for all treatment staff to be well trained in this issue. This goes beyond domestic violence awareness training to addressing practice challenges and policy development.

The training needs to address the following issues:

- Managers and front line staff need a good understanding of the relationship between domestic abuse and substance use and why domestic abuse is the concern of the substance use professional.
- There needs to be an acceptance that a woman's safety is the key priority, that is, addressed before the substance use where appropriate, and that failure to ensure she is safe is likely to impact her treatment progress.
- Staff need to understand the dynamics of perpetrator control in relation to women's substance treatment. While the perpetrator's behaviour is an unmanageable issue for treatment providers, staff can still reflect on how women might respond to his behaviour and develop procedures or strategies for follow up if they drop out of services, particularly if staff feel their safety is at risk.
- Staff also need support and guidance in working with perpetrators in treatment settings.
- There also needs to be understanding about how women's substance use may increase to deal with current trauma resulting from domestic abuse.

12.6 Assessment

Both the literature and the key informant interviews identified the importance of routine screening for abuse. While the types of abuse assessed in the research varied, a combination of the research and key informant data highlights the importance of not just focusing on physical violence or sexual abuse.

Assessment needs to consider current as well as past abuse. This refers to both "current active" domestic abuse, that is, on-going domestic abuse, as well as "current impact" domestic abuse, that is, past abuse but current trauma. Further, practitioners need to be able to explore the woman's method of coping with this abuse and consider how this might relate to treatment plans and progress. Where substance use is the coping mechanism, working to remove the mechanism is not advisable unless staff are able to offer something in its place.

Assessment questions also need to be formed carefully. Single questions asking whether or not domestic abuse is an issue are likely to be less effective than sets of questions that avoid labelling and being too emotionally intrusive. Examples of good practice already exist and these could be disseminated more widely.

Consideration also needs to be given to when to ask about domestic abuse, together with clear follow up procedures for staff resulting from a range of possible responses. As there is evidence that some people will not disclose at intake, there needs to be procedural allowances made for later enquiry once the therapeutic relationship is more established. Assessment procedures need to ensure that domestic abuse is not just "screened out" if there is a negative response at intake and there should be follow-up at a later stage.

12.7 Agency policy and practice

Treatment providers need to develop policy and practice guidance for working with domestic abuse alongside staff training. It is a sensitive and difficult area to work with and staff need to feel clear about the agency's position and supported by practice guidance and supervision processes. Staff need to feel confident about when and how they are going to ask the questions and how they can respond. Agencies also need to demonstrate that they will address the issue and take it seriously. This will likely involve being explicit with women about their domestic abuse policy and practice so women's concerns about safety and confidentiality can be addressed.

Again there are examples of good practice. One London-based agency displays position statements, posters and leaflets about domestic abuse on the walls of the agency as well as in the toilets. Sets of questions are asked about domestic abuse in such a way that women suffering abuse feel they are not alone in disclosing their experience and will not be judged because of it.

Partnership working with providers of domestic abuse services is one way of securing cost effective training (training exchanges) and having a contact for advice and support with policy and practice development. One borough of London has taken this further and established "safety panels" made up of multi-agency staff, including substance use services, to provide a holistic approach to women's safety and needs and to avoid the woman having to present to a range of services repeatedly.

12.8 "Psychopathology" and domestic abuse

The literature clearly identifies mental ill health as having a negative impact on treatment completion. However, it failed repeatedly to "join up the dots" between women's experiences of domestic abuse and the impact of this abuse on her mental wellbeing. This is probably because of the research focus on physical and sexual violence at the expense of psychological and emotional abuse. Domestic abuse and mental ill health are not separate issues. There is clear evidence of the links between domestic abuse and psychiatric disorders, including depression, anxiety and suicide attempts (Barron, 2004, Golding, 1999), as well as evidence of links between mental ill health and relapse or treatment failure. Experience of the key informants firmly supports the need to recognise and work with the psychological and psychiatric damage resulting from domestic abuse.

13 Implications for further research

The following gaps in the research have been identified during this feasibility study:

- There is a need for UK data on the prevalence of domestic abuse among people in treatment for substance problems (both victim and perpetrator prevalence)
- There is also a need for research into the impact of domestic abuse on engagement and retention of women in substance treatment. This needs to identify the characteristics of treatment settings that are supportive of women who suffer domestic abuse
- Future research in this area needs to use mixed methodologies that demonstrate ethical research practice and are sensitive to the subject under study
- The research also needs to involve service users, as their views are not currently reflected in existing research
- The research needs to consider all types of abuse including emotional and psychological abuse, not just physical and sexual abuse.
- It also needs to consider "current active" and "current impact" abuse (see section 7) – not just past abuse. This will have implications for how the research is conducted and by whom
- There is a need for research that focuses on establishing the needs of women in Black and minority ethnic communities and from different faith communities in relation to these dual problems

- There is a need to establish the existing knowledge base of substance use staff in order to focus training appropriately. This may also consider exploring attitudes towards working with domestic abuse perpetrators and victims.

14 Implications for the NHS

Health services across the UK have begun to respond to the growing recognition of domestic abuse among its client groups. Initiatives have been running in A&E departments, maternity services and GP surgeries, to name a few. Thus there are good foundations elsewhere in the NHS on which to build a national response from drug and alcohol treatment services.

The NTA seeks to improve access to treatment and build a professional workforce that is underpinned by knowledge and awareness of why people use substances. Further, it aims to have efficient service provision that is both effective and evidence based. While it is acknowledged that more research is needed to provide a solid evidence base, the findings of this study suggest that to achieve these targets, women need to have their experiences of abuse identified and addressed by an informed workforce in a safe, single-gendered environment that addresses key motivators for completion and relapse, for example, childcare needs.

While we are waiting for such evidence, however, it needs to be acknowledged that women, and their children are at risk and that treatment staff who recognise this are calling for support in terms of how to address the issue.

The NTA leads national policy and guidance that is implemented at a local level. It is well placed to offer a strong lead in developing policy and practice in this area. This could be done in the following ways:

- Appoint a strategic lead to develop the response of substance use services to the subject of domestic violence and abuse
- Commit to training managers and staff in the knowledge and skills needed to work with these issues and to support staff through informed supervision
- Commit to producing policy guidance on working with domestic abuse for substance use service providers (including addressing the issues of safety during treatment)
- Ensure national and local policy documents on service provision and service quality reflect the significance of domestic violence and abuse in relation to people's substance use
- Ensure close liaison between a representative from the NTA and relevant strategic forums including the Community Safety Partnership and Domestic Violence Partnership (Forum) to ensure relevant issues on drug treatment and domestic violence are progressed
- Ensure partnership working includes formal working agreements with domestic violence service providers, backed by integrated care pathways that have been consulted and agreed with key stakeholders
- Develop good practice by building on existing models of good practice used by voluntary sector organisations and other areas of the NHS, including health-based forums such as Health Ending Violence and Abuse Now (HEVAN, formerly the National Domestic Violence Health Practice Forum)
- Commission substance use services that support women's needs though attention to treatment characteristics, for example, gender-specific services that have childcare

facilities or offer local, supportive, and practical partnerships with supplementary service providers.

- Review existing service philosophies to determine whether they offer a holistic service (thus maximising the chances treatment success) or one that treats the substance rather than the person.

15 Conclusion

This study set out to explore what is known about the impact of domestic abuse towards women on their rates of engagement and retention in substance use treatment. The literature revealed wide ranging issues that need to be considered in research and practice. However, this breadth has also evidenced a lack of quality, quantity (UK), consistency and cohesion in the research.

As yet, there are no clear messages that can be formed on the relationship between women's experiences of violence and abuse and its impact on their treatment for alcohol or drug problems. While a small amount of US research suggests it has no impact on engagement or retention, this needs to be viewed with caution and in the context of its methodological flaws and differences in treatment characteristics.

What is evident from the US and small amount of UK literature is that the prevalence of the dual issues of substance use and domestic abuse is widespread and is clearly raising issues for treatment practice and policy.

What the key informant interviews provide is some practice-based and anecdotal evidence that suggests women's access to, and engagement with, treatment services is negatively affected by domestic abuse, and that most service providers have not yet taken steps to identify and address domestic abuse, let alone reflect on its impact on treatment effectiveness.

The UK policy context in relation to substance use has changed dramatically in recent years and is now firmly linked to primary care and the criminal justice agenda. There is evidence that both sectors are seeing women with substance use and domestic violence problems. The prison service has recognised the need to respond to women with these needs (Home Office, 2004, Roberts and Vromen, 2005), and there is some evidence that the probation service is reviewing its response to domestic abuse (Barnish, 2004). There are also moves within primary healthcare to improve its response to domestic abuse through training and guidance to healthcare practitioners (Agnew-Davies, 2004, Taket, 2004, Taket *et al.*, 2004). In addition, increasing political attention is also being paid to families and young people affected by someone else's or their own substance use (DfES,HO and DH, 2005, DfES, 2005).

Although many of these initiatives are primarily focusing on one issue or the other, strategic moves towards integrated care pathways provide a fitting context for developing partnerships with domestic violence services and meeting the needs of a significant number of women presenting to substance use services with these dual issues.

While we await improved research evidence and strategic partnerships, the findings of this study have shown there is still much that can be done to develop the workforce and offer them support in working with these issues. Further, the findings suggest that attention to treatment characteristics and screening for domestic abuse will help deliver services that are geared towards meeting the needs of women, and their children, living with the double difficulties of domestic abuse and substance use.

16 Appendix 1

Search record with predefined search terms

Database name Date of search

Search dates

Search terms	*Total hits*	*Relevant hits and if not why not*
Alcohol treatment and domestic violence		
Drug treatment and domestic violence		
Substance use and domestic violence		
Alcohol treatment and domestic abuse		
Drug treatment and domestic abuse		
Substance use and domestic abuse		
Alcohol treatment and abuse		
Drug treatment and abuse		
Substance use and abuse		
Alcohol treatment and violence		
Drug treatment and violence		
Substance use and violence		
Completion and women and drug treatment		
Completion and women and alcohol treatment		
Completion and women and substance use		
Retention and women and drug treatment		
Retention and women and alcohol treatment		
Retention and women and substance use		
Engagement and women and drug treatment		
Engagement and women and alcohol treatment		
Engagement and women and substance use		
Relapse and women and drug treatment		
Relapse and women and alcohol treatment		
Relapse and women and substance use		

17 Appendix 2

Search strategy

The following electronic databases were searched:

- Applied Social Sciences Index and Abstracts (ASSIA) (unrestricted)
- CareData (unrestricted)
- Cochrane Library (unrestricted)
- Social Science Information Gateway (SOSIG)
- System for Information on Grey Literature in Europe (SIGLE) (1980–2004/12)
- Social Science Citation Index (1995–2005)
- MEDLINE (1999–2005)
- PsychINFO (2000–2005)
- EMBASE (1996–2005)

Email and calls for information were sent to the following networks:

1 Joint Information Systems Committee (JISC) mailing lists including:

   - European Working group On Drug Oriented Research (EWODOR)
   - Alcohol misuse
   - Violence research
   - Domestic violence research.

2 European Network on Gender, Conflict and Violence

3 Network News

4 Personal contacts researching in this area, including Professor William Downs, University of Northern Iowa, USA

5 Contacts established through discussion with key informants.

18 Appendix 3

Interview schedule: treatment staff

Note to participants: You may wish to, or find it helpful to, talk to colleagues about these questions prior to the interview.

Project title

The impact of violence and abuse on engagement and retention rates for women in substance use treatment

Interviewee's name:	
Interviewee's job title:	
Agency and location:	
Permission to be recorded:	
Permission to be quoted anonymously in final report:	

1. In what ways do you address issues affecting women's safety in your organisation?
2. What has been your (and/or your colleagues) experience of working in a treatment setting with women who suffer, or have suffered, violence and abuse from a partner and/or close family member?
3. To what extent do you/your colleagues **ask** about violence and abuse within your women client group?
4. How far have you been able to **establish a link** between violent or abusive experiences and the use of alcohol or drugs?
5. If any, what has been the **nature** of this link?
6. In speaking to your colleagues and/or clients, how far have you been able to establish whether a woman's receipt of violence and abuse has sometimes prevented her from **entering** treatment for substance problems?
7. Can you recall any particular examples of this?
8. To what extent have you been able to establish whether women drink or use drugs **more** when they have recently suffered violence and abuse?
9. If a woman's use of alcohol or drugs increases during her treatment, have her experiences of violence and abuse been discussed as a possible trigger for this increase?
10. Have you any evidence, anecdotal or formal, to suggest that women's receipt of current violence and abuse affects whether or not they **complete** treatment, that is, do they dropout at an earlier stage in your experience?
11. Do you have any experience of, or views on, whether women who **relapse** into problematic alcohol or drug use link this to their experiences of violence and abuse?
12. Are there any policies or protocols, either locally or nationally, that you have found useful in progressing your work or thinking on these issues?
13. Is there any guidance or research evidence that you would like to see in order to help you develop your work with these issues?
14. To what extent does your service identify and address men's experiences of suffering or perpetrating violence and abuse within the treatment setting, for example, is it routinely asked about during screening or initial assessment?
15. Do you routinely collect statistical data relating to domestic violence, and if so, what is currently done with it?
16. To what extent have you been able to determine how **significant** a factor violence and abuse is in a woman's substance use and subsequent treatment?

19 Appendix 4

Informed consent

This research is being conducted by Sarah Galvani, University of Birmingham and Cathy Humphreys, University of Warwick, through funding from the National Treatment Agency, London.

We would like to thank you for agreeing to be interviewed for this project. Before we start we would like to emphasise that:

- Your participation is entirely voluntary
- You are free to refuse to answer any question
- You are free to withdraw at any time.

With your permission, we would like to record the interview. The interview data will be confidential. Recordings and any notes taken during the interview will be destroyed once the final report and related articles are complete.

Excerpts from the interview may be made part of the final research report, but under no circumstances will your name be included in the report.

Please sign this form to show you that you have read, or have had read to you, a) the contents of this consent form, b) the accompanying ethical code, and c) that you give your consent to taking part in the research.

Alternatively, you can return this form electronically with an email stating you consent to take part.

_____ (signed)

_____ (printed)

_____ (date)

Return to: **Sarah Galvani**
Email: s.a.galvani@bham.ac.uk
Fax: 0121 414 5726
Post: Institute of Applied Social Studies, University of Birmingham, Edgbaston, Birmingham B31 3UH

19 Appendix 5

Ethical code

Social Research Association

Ethical guidelines

December 2003

1 Obligations to society

If social research is to remain of benefit to society and the groups and individuals within it, then social researchers must conduct their work responsibly and in light of the moral and legal order of the society in which they practice. They have a responsibility to maintain high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings.

2 Obligations to funders and employers

Researchers' relationship with and commitments to funders and/or employers should be clear and balanced. These should not compromise a commitment to morality and to the law and to the maintenance of standards commensurate with professional integrity.

3 Obligations to colleagues

Social research depends upon the maintenance of standards and of appropriate professional behaviour that is shared amongst the professional research community. Without compromising obligations to funders/employers, subjects or society at large, this requires methods, procedures and findings to be open to collegial review. It also requires concern for the safety and security of colleagues when conducting field research.

4 Obligations to subjects

Social researchers must strive to protect subjects from undue harm arising as a consequence of their participation in research. This requires that subjects' participation should be voluntary and as fully informed as possible and no group should be disadvantaged by routinely being excluded from consideration.

NB: This summary has been taken from the full code which is available from Sarah Galvani or you can access it direct at http://www.the-sra.org.uk/ethics03.pdf.

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