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Research paper

“You can never work with addictions in isolation”: Addressing intimate partner violence perpetration by men in substance misuse treatment



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ABSTRACT

Background: Studies have shown rates of IPV-perpetration among men in substance misuse treatment at rates far higher than the general population. There is poor evidence for the effectiveness of IPV perpetrator programmes.

Methods: An analysis of drugs and alcohol policy documents 1998–2015 was conducted using discourse analysis to examine how English drug and alcohol policy has addressed IPV among substance misusers. Transcripts of interviews with 20 stake holders were analysed thematically.

Results: How policy ‘frames’ IPV-perpetration among drug and alcohol misusers has implications for service provision. IPV has increasingly been framed in terms of its implications for child safeguarding, and has been ‘folded in’ to policies targeting Troubled Families. With increasing ‘localism’ in English drug and alcohol policy there has been little specification of services for substance misusing IPV-perpetrators. Policy and literature produced by IPV perpetrator and victim organisations has framed IPV-perpetration as an individual choice with intoxication as a post hoc excuse for violence with limited implications for effective service development. Interviews with stake holders indicate a range of understandings/explanations for IPV among substance misusing men. Stake holders suggest that not all staff have the confidence or skills to ask men about their relationships and that there are few referral routes for substance misusing men who seek help for their IPV perpetration.

Conclusion: There are gaps and contradictions in the extent to which English drug and alcohol policy has sought to address IPV-perpetration among substance misusers. Recent National Institute for Health and Care Excellence guidance provide an opportunity to include domestic abuse training for all front line social care staff including in the substance misuse sector. There is a need for further research into effective services for substance misusing perpetrators and the development of training for front-line staff.

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Introduction

Intimate Partner Violence (IPV) is a recent term in public health discourse and describes physical, sexual, or psychological harm by a current or former partner or spouse. Such abuse is included for example in the UK government definition of Domestic Violence or Abuse:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality (Home Office, 2013)

This paper considers challenges and opportunities to addressing IPV in the context of substance misuse treatment. Throughout the paper we refer to IPV and Domestic Violence/Abuse interchangeably where these terms are used in policy. There is no doubt that the level of IPV among people receiving treatment for drug and alcohol misuse is a cause for concern. Studies suggest that reported rates of physical or sexual violence perpetration among men receiving treatment for substance misuse are four times higher (34–42%) (El-Bassel, Gilbert, Wu, Chang, & Fontdevila, 2007;

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Frye et al., 2007; Gilchrist, Radcliffe, McMurrin, & Gilchrist, 2015a; Gilchrist, Blazquez, et al., 2015; O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004) than among men in the general population (O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003), and that women receiving treatment for drug misuse experience IPV victimisation at rates far exceeding general population estimates (Feder et al., 2009).

There is little consensus in research regarding why people who misuse alcohol and drugs are more likely to perpetrate IPV (Gilchrist, Radcliffe, et al., 2015; Gilchrist, Blazquez, et al., 2015) and explanations and conceptualisations of IPV more generally are hotly contested. In the UK, Kelly (1988) has been influential in arguing that 'gendered violence' should be conceptualised as part of a continuum of violence within systems of patriarchal power (and see Morgan & Thapar Björkert, 2006). US activists and researchers, Pence and Paymar (1990) and Pence (1996) have similarly described male 'battering' in terms of a pattern of tactical behaviours that ensure the exertion of power and control over a female partner. Critics have argued though that this definition of IPV is based on the reports of women for whom IPV has been sufficiently severe that they had fled to refuges, and that general population samples show different types of IPV (Graham-Kevan & Archer, 2003; Johnson, 1995). Distinctions have been made between 'situational' violence that is lower in frequency, less likely to escalate over time and is more likely to be mutual (Johnson, 2008) and Intimate Terrorism, described as a coercive pattern of men's physical violence, intimidation, and control of their female partners (Kelly & Johnson, 2008). Alongside the dimensions of aggression, control and severity of violence, theorists have examined how substance misuse may interact with the effects of broader culture, subculture, family and individual characteristics in IPV perpetration (Dahlberg, Krug, Mercy, Zwi, & Lozano, 2002).

We currently know little concerning how substance misuse policy and practice has attended to this issue among men in treatment for substance misuse. This paper seeks to contribute to an understanding of the policy and practice response to the co-occurring social problems of substance misuse and IPV. We are taking England as a case study. To clarify, although England is part of the United Kingdom, the devolved administrations (Wales, Scotland and Northern Ireland) have their own drug strategies and responsibility for health policy. We also refer to legislation and non-statutory measures that pertain to England and Wales. We firstly present the findings of a policy mapping exercise that explores the specific ways in which drug and alcohol policy discourses have represented IPV as a problem (Bacchi, 2012). Secondly, with reference to interviews conducted with English policy makers and practitioners from both substance misuse and IPV sectors we examine their conceptions of IPV perpetration among men in treatment, their views of how and whether IPV perpetration should be identified and addressed in the context of substance misuse treatment.

Commentators have described a range of ways in which UK substance misuse policy documents have sought to establish links between substance misuse and other behaviours in order to change substance misusers' behaviour (Monaghan, 2012; Monaghan & Wincup, 2013; Seddon, 2000; Stevens, 2007). In this study, we have asked how IPV victimisation and perpetration has featured in drug and alcohol policy; how in other words, substance misusing perpetrators and victims of IPV have been constituted in policy and how, in turn, policy makers and practitioners conceptualise IPV perpetration in the context of substance misuse treatment. Bacchi (2012) argues that policy does not simply respond to social problems but shapes them according to how they have been selectively represented. Following Foucault, Bacchi argues that the purpose of studying problematizations is to

dismantle 'their taken for granted, fixed essences and show how they have come to be' (Bacchi, 2012). The aim of this paper is to better understand this complex area by investigating how IPV is made as a social problem by drug and alcohol policy and how this conceptualisation of IPV in drug and alcohol policy translates into practitioner and policy makers' knowledge and practice.

Methods

The research thus comprised two phases. Firstly, a review of policy was undertaken. Secondly, telephone interviews were conducted with 20 key stakeholders during June 2014. The data for this research were thus policy documents and qualitative interview transcripts. The analysis of policy documents 1998–2015 sought to investigate whether and how IPV victimisation and perpetration featured as a problem of drug and alcohol policy. This period includes 13 years of Labour government in which there was enormous investment in and a renewed faith in substance misuse treatment (Duke, 2012); the election of the Coalition government in 2010 with the emphasis upon Recovery and the emergence of a politics of 'localism' and in 2015, the election of a Conservative government, whose Drug Strategy, at the time of writing, we await.

The analysis of policy documents investigated how the relationships between substance misuse and IPV was presented; how the victims and perpetrators of IPV were defined and an exploration of the underlying theories and taken for granted assumptions contained in substance misuse policies concerning IPV perpetration. Following a search of grey literature, Department of Health, National Treatment Agency, Public Health England and archived government websites, twenty-three policy and guidance documents were examined for the period 1998–2015. Key word searches were made for reference to family, domestic abuse, domestic violence and gender. In addition, key IPV voluntary sector documents and websites were included in the analysis with a particular focus on the role of substance misuse in IPV perpetration. The documents and websites were read and reread by PR. Relevant passages were extracted and coded in terms of their constitution of substance misusing IPV perpetrator/victim. Texts were considered in relation to their overall intent, purpose and audience.

In-depth telephone interviews were carried out with 5 national policy makers and 15 practitioners in the substance misuse and IPV sectors in London and South East England. These were the key policy makers in England responsible for developing public sector drug and alcohol policy and the leading voluntary sector, IPV policy makers. They were identified through policy documents and GG's research networks. Practitioners represented the range of roles in treatment and IPV perpetrator services available. Interviews with practitioners were continued until data saturation had been achieved (Baker & Edwards, 2012). The interviews sought to examine the translation of policy into practitioners' knowledge. To determine how practitioners make decisions regarding the identification, care and referral of men in drug and alcohol treatment who perpetrate IPV and to identify the barriers and facilitators to this process, practitioners were asked the referral and care pathways for substance misusers in treatment who perpetrate IPV.

The research reported in this paper was conducted as part of a larger UK Economic and Social Research Council funded, cross-cultural, mixed method study that investigated the prevalence and social construction of IPV among men in drug and alcohol treatment services in England and Brazil. Practitioners were recruited for telephone interview from the services where we had also negotiated access in order to recruit male service users for questionnaire and qualitative interviews in London, towns in a southern county and a coastal city in England. Practitioners were based in National Health Service and voluntary (Non-Governmental Organisations) sector

drug and alcohol treatment agencies as well as from organisations that run programmes for IPV perpetrators and that lobby government and develop IPV policy. Ethical approval for this study was granted by the East Midlands–Northampton National Research Ethics Service in England (REC ref: 14/EM/0088).

A convenience sample was achieved by asking directors of services to provide contact details of staff at a range of levels from service managers to key workers. We targeted IPV specialists for interview who were working in both IPV and substance misuse sectors. This included those leading and managing voluntary sector perpetrator programmes as well as those taking a more strategic and training role in addressing the problem of IPV perpetration. They provided a perspective on joint working with substance misuse services.

Interviews were audio recorded and professionally transcribed, checked for accuracy, anonymised and entered into Nvivo 10, a package for coding qualitative data. Coding of the interview transcripts and documents was conducted using modified grounded theory methods (Glaser & Strauss, 1967) that allows an analytical framework to guide analysis of emerging concepts and the relations between them (see Charmaz, 2001, 2008). In our study, coding and analysis of the interview data was framed by the research and interview questions in which we were concerned to establish policy maker and practitioners' understandings of IPV, systems for and experience of identifying IPV perpetration and knowledge of referral practices. Thematic analysis was conducted by one researcher (PR) reading and re-reading the transcripts (Braun & Clarke, 2006). Provisional coding was checked by a second researcher (GG) with reference to the broad themes arising from the research questions. These 'fuzzy categories' (Pope, Ziebland, & Mays, 2000) were then refined and grouped together.

Findings

Prior to discussing drug and alcohol policy documents, we will briefly describe policy for IPV victims and perpetrators in England and Wales. Feminist activists, campaigners and academics have been successful in making the issue of IPV victimisation visible and its recognition as an offence in the UK (Hester, Pearce, & Westmarland, 2008). The Call to End Violence against Women and Girls Action Plan (VAWAG) launched by the UK Coalition government in 2010 followed the development of a victim-focused, safeguarding and advocacy system by the previous Labour government 1997–2010 including the development of Multi-Agency Risk Assessment Conferences (MARACs), Independent Domestic Violence Advocate (IDVA) services and Specialist Domestic Violence Courts. In England and Wales, custodial and community sentences for Intimate Partner Violence crimes were accompanied by court-ordered, cognitive behavioural, group programmes for perpetrators.

Since the early 1980s, there has also been an expansion of voluntary-sector run perpetrator programmes in the United Kingdom, the accreditation for which is given by the membership organisation, Respect. Both voluntary sector and probation-run perpetrator programmes in the UK have been influenced by the feminist, psycho-educational programmes developed in the US. These include the Emerge and Man Alive programmes that were the forerunners for the programme developed in Duluth, Minnesota (Pence & Paymar, 1990; Pence, 1996). In these programmes, male 'battering' is explained in terms of a pattern of tactical behaviours (coercion and threats; intimidation; emotional abuse; isolation; using children; male privilege; economic abuse; and minimizing, denying and blaming) that ensure the exertion of 'power and control' over a female partner. Questions have been raised however regarding whether criminal justice sanctions are the most effective way of dealing with IPV

(Hester, 2013; Walklate, 2008). There is sparse evidence internationally that perpetrator programmes (either feminist, psychoeducational or cognitive behavioural therapy based programmes), within and without the criminal justice system are effective in reducing abuse (Akoensi, Koehler, Lösel, & Humphreys, 2012; Babcock, Green, & Robie, 2004; Brooks et al., 2014; Hester & Lilley, 2014; Smedslund et al., 2011) and a lack of information about which elements of perpetrator programmes may be effective and with whom (Gadd, 2004; Hudson, 2002). US research suggests too that substance misusers are frequently not deemed suitable for referral to or fail to complete perpetrator programmes (Klostermann, 2006). For poor and marginalised women, criminal justice measures may result in increased public health and social work surveillance (Stark, 2004; Walklate, 2008). Women who misuse drugs and alcohol, especially women involved in sex work may be less likely to access health and social care services (Bowpitt, Dwyer, Sundin, & Weinstein, 2011; Balfour & Allen, 2014; EMCDDA, 2009), to report sexual or physical violence to the police when it occurs (Phipps, 2013) or to be considered as credible witnesses in prosecutions of domestic violence crimes (Leonard, 2002). Questions about the effectiveness of perpetrator interventions, in conjunction with evidence of the lack of availability of programmes for people who misuse substances suggest women may continue to be put in danger if IPV is not identified and addressed among this group. There is thus a strong case for examining how substance misuse policy and practice treatment can better respond to IPV-perpetration by men engaged with substance misuse treatment.

Drug and alcohol policy documents 1998–2015

Despite evidence of extensive polydrug and alcohol use among those in treatment (MacManus & Fitzpatrick, 2007; Puigdollers, Domingo-Salvany, & Brugal, 2004; Stenbacka, Beck, Leifman, Romelsjo, & Helander, 2007), alcohol and illicit drug policy have remained separate in England, illustrating a commitment to defining them as separate kinds of problems. For this reason we will first describe how drug policy has responded to IPV and secondly how it has been attended to in alcohol policy.

Given the high prevalence of both victimisation and perpetration among this client group, it is striking that IPV has received very little attention in drug policy documents in particular. Here, turning Bacchi's question on its head, it may be more relevant to ask what is the problem represented **not** to be. IPV was not made visible as a concern for drug policy in the first Drug Strategy of the New Labour government (Home Office, 1998) for example and as Stevens has argued (2007), the crimes this policy document considered drug related (theft, burglary, fraud and shoplifting) did not include assault of intimate partners. In the subsequent drug strategy documents however there was an increasing focus on the impact of drug misuse on families. Violence was included as part of a range of adverse effects of drug misuse to which each family member, parent, child and partner of a drug misuser was considered vulnerable:

The impact of drug misuse on the parents, siblings, partners and children of drug misusers can include violence, neglect, mental illness as well as all the side-effects arising from the poverty associated with drug misuse (Updated Drug Strategy, 2002, 18)

This conception of the complex links between drug misuse and IPV alongside poverty and mental illness was not to be repeated in further drug policy. The 1990s had seen the rise of Child Safeguarding as the focus of children and family social work services (Parton, 2006) and the recommendations of the Updated 2002 Drug Strategy must be seen in the context of the proliferation of programmes seeking to target families deemed at risk of developing substance misuse, mental health problems and

antisocial behaviour (Gregg, 2010). Such complex problems, it was suggested, could be addressed through a range of multi-agency interventions that aimed to change the behaviour of individual drug misusers and to intervene in the lives of their children (Monaghan, 2012).

Parents' substance misuse and its impact upon their children was framed as a new problem when the Advisory Council on the Misuse of Drugs (ACMD), the expert body that makes recommendations to the UK government concerning the control and social harms of illicit drugs, produced the Hidden Harm report (ACMD, 2003) which focused on the risks that the estimated 250,000–350,000 children of drug misusing parents in the UK were subject to. The report emphasised the risks to children of witnessing parental violence, marking the link between substance misuse, child abuse and neglect. IPV thus increasingly came to be produced as a problem of child protection. The redrafted 2007, Drug Misuse and Dependence: Clinical Guidelines on Clinical Management (commonly known as the Orange Book) referred directly to the Hidden Harm report, stating that: 'Clinicians have an individual responsibility to the children of their patients' (Department of Health, 2007). In the same year, the National Institute for Health and Social Care Excellence (NICE) produced *Public Health Guidance on Interventions to Reduce Substance Misuse Among Vulnerable Young People* (2007). The 2008 Drug Strategy (Home Office, 2008) emphasised the need for a whole-family approach to drug policy including support and intervention in families where substance misuse might put children at risk of harm. As Campbell and Etorre have argued (2011), emphasis on the family as a site of drug policy concern has consistently obscured the particular needs of women. The emphasis on parenting education and 'supporting families [at risk] to stay together' evident in the 2008 drug strategy document (Home Office, 2008, p. 21) also appeared to decenter IPV as an effect of substance misuse. Where it was referred to in this Strategy document, IPV was framed in terms of intergenerational harm rather than a problem for victims and perpetrators of abuse and no recommendations were made for identifying or responding to IPV in the context of treatment. Again we see that drug policy is largely silent concerning IPV perpetration/victimisation. Meanwhile, following the publication of social work research investigating the co-occurrence of substance misuse in child protection case files (Forrester & Harwin, 2006; Taylor & Kroll, 2004; Taylor, Toner, Templeton, & Velleman, 2006), co-occurring substance misuse, domestic abuse and mental health disorders would increasingly be described as a 'toxic trio'; the combined presence of which represented an indicator of risk (Brandon, Bailey, & Belderson, 2010; Cleaver, Unell, & Aldgate, 1999; DoH, 2010b). Identifying domestic abuse as a static category of risk, inhering in substance misusing parents, removes both its gender dynamic or the possibility that change in victimisation/perpetration might be possible.

The Drug Strategy (Home Office, 2010) of the incoming Conservative/Liberal Democrat government focused on the objective of Full Recovery. The term Recovery has been described as both vague and contested (Neale et al., 2014) yet increasingly refers to the personal change and social re/integration of people who misuse substances via a range of community resources and opportunities (Best & Laudet, 2010). The increasing dominance of recovery in UK drug policy discourse replaced the focus on *harm reduction* that critics argued had trapped people who misuse substances in stigmatised identities and failed to move them into the world of work (McKeganey, 2014; Monaghan & Wincup, 2013). As McKeganey pointed out (2014), the 2010 Drug Strategy made no reference to harm reduction – the sets of practical strategies and ideas aimed at reducing the negative consequences associated with drug use – which had been a central plank of UK drug policy since 1988. Although the 2010 Drug Strategy document emphasised that recovery is an 'individual, person-centred journey' which

will 'mean different things to different people' (p. 18) the discourse of personal choice was belied with the policy document's specifications of the sorts of Recovery orientated outcomes that treatment services must deliver including 'improved relationships with family members, partners and friends' (p. 20).

Though there is scant reference to domestic violence in this document, continuity was provided with previous strategy documents with the emphasis on child safeguarding and the need for services to identify and respond to children's needs in relation to their parents drug use:

Whilst some services do have effective practices and integrated approaches to safeguarding the welfare of children, it is still the case that children are sometimes 'invisible' to services that do not take action to identify and respond to the impact of the parents' behaviour on the child (Drug Strategy, 2010, p.21)

Evidence was cited in this document that the Family Intervention Projects targeting families with complex needs, were leading to reductions in a range of offending behaviours including domestic violence (p.11; see Garrett, 2007 for a critique of the evaluations of the Family Intervention Projects). Families of drug and alcohol misusers were paradoxically portrayed in this Drug Strategy as afflicted by offending behaviours at the same time that the support of family members and strengthened relationships with family members were promoted as vital aspects of Recovery.

We will now turn to a consideration of alcohol strategy documents which have meanwhile made a much more direct link between alcohol misuse and IPV.

Alcohol policy documents

The first (and according to Drummond (2004), much delayed) Alcohol Harm Reduction Strategy of the New Labour government referred directly to both the social harms and financial costs of domestic violence arising from alcohol misuse. The salience of cost was included in the £20 billion pounds a year that the alcohol strategy stated had been lost to the public purse as a consequence of alcohol misuse, citing evidence that an estimated one third or approximately 360,000 incidents of domestic violence per year, were linked to alcohol misuse. The document was also careful to note that alcohol has a non-causal association with domestic violence, drawing upon sets of research evidence:

Alcohol is not the cause of domestic violence, but it can exacerbate the effects – for example increasing the severity of injuries sustained by the victim. It is a fact that substance misuse and domestic violence often co-exist: rates of alcohol misuse and dependence among perpetrators may be up to seven times higher than in the general population (PMSU, 2004, p. 64)

Formulating the relationship between domestic violence and alcohol misuse as non-causally related in this way focuses responsibility on the individual perpetrator. As a point of action however the document promised that work would be undertaken that:

takes account of the need to ensure that perpetrators and victims of domestic violence receive help from both domestic violence and alcohol treatment services, as appropriate to their needs (p. 89)

A second strategy document, *Safe, Sensible, Social. The next steps in the National Alcohol Strategy* was published in 2007 (H.M. Government). This document introduced the idea of 'alcohol related domestic violence' and cited research evidence of high prevalence of alcohol intoxication among men convicted of (more severe) domestic violence crimes. The document stated that:

Half of relationship breakdowns and one-third of all domestic violence are alcohol related. The children of alcohol misusers are more likely to drink earlier and to experience behavioural problems and poor outcomes at school (p. 43)

This document thus made direct reference to the impacts of alcohol related IPV on the adult perpetrators and victims in addition to its impacts on the children of alcohol misusers. Following on from this strategy document, a guidance document for commissioners of alcohol services (DoH, 2009) described the concept and purpose of addressing treatment pathways for 'vulnerable service users with complex needs, including people affected by domestic violence'. With the change in government, in 2010, the Coalition government produced its own Alcohol Strategy H.M. Government, 2012 in which alcohol misuse was described as a driver in some cases of domestic abuse, concurring with the previous government's estimate of the cost of alcohol related domestic violence. This Alcohol Strategy referred to alcohol misuse along with anti-social behaviour and truancy as one of the problems that was being addressed in the government's Troubled Family initiative.

Despite the identification of a need for services for both victims and perpetrators of IPV within alcohol policy, the introduction of the decentralising policies of Localism by the Coalition government in 2010 brought significant changes in the funding, planning and delivery of drug and alcohol treatment services in England. Many of the structures introduced by the Labour government of 1997 including the National Treatment Agency and local Drug and Alcohol Teams were abolished and commissioning of drug and alcohol services was now transferred to local Health and Wellbeing boards. While Drug and Alcohol Teams had previously commissioned services based on the assessment of treatment needs, the new local Well-being Boards were now being asked to assess need across all public health domains in Joint Strategic Needs Assessments (JSNA). Both domestic abuse and substance misuse could be brought together among a range of diverse public health indicators in the Public Health Outcomes Framework developed by the Department of Health (2012). A 'whole family' approach to drug and alcohol treatment was built into the outcome framework. For example the Joint Strategic Needs Assessments Support Pack (NTA, 2011) for commissioners had asked a range of questions for consideration in the commissioning of services including:

Can multi-agency practices identify the needs of vulnerable young people and troubled families? Can agencies work collaboratively to build resilience via whole family interventions and to minimise harm via effective safeguarding protocols? (NTA, 2011)

The 'folding-in' of IPV within the Troubled Family agenda is notable here as is the absence now of reference to poverty as an aspect of adverse circumstances that was seen in the 2002 Updated Drug Strategy. No specific questions were asked of commissioners concerning IPV. An examination of Joint Strategic Needs Assessment (JSNA) plans published in 2015, for the four areas in which we conducted research revealed a wide variation in the extent to which local JSNA documents were able to focus on IPV at all or had sought to link substance misuse and domestic abuse service provision or training for frontline staff in their documents. We turn now to an analysis of voluntary sector, IPV policy.

Voluntary sector IPV policy

IPV voluntary sector policy and guidance focuses on holding male perpetrators to account for their violence, in spite of any co-occurring intoxication. In its standards for Accreditation of Perpetrator Programmes (2012), Respect, the membership

organisation for voluntary sector perpetrator programmes in the UK positions the perpetrator as a wholly rational actor who is responsible for choosing violent behaviour:

The perpetrator is 100% responsible for his use of abusive behaviour and the use of such behaviour is a choice (Respect, 2012, 28)

This concern to exclude any external causes of IPV is evident too in the Home Office funded online toolkit, produced by the voluntary sector organisation, AVA (Against Violence and Abuse) which outlines a series of myths surrounding partner violence including:

¹Myth: Perpetrators abuse their partners or spouses because of alcohol or drug misuse.

Fact: Alcohol or substance misuse does not cause perpetrators of domestic violence to abuse their partners, though it is frequently used as an excuse. Substance use may increase the frequency or severity of violent episodes in some cases (AVA, 2010)

Such assumptions can also be found in Women's Aid's (the federation of organisations providing services to victims of domestic violence in England) online Survivors' Handbook which is also preoccupied with the individual responsibility of the perpetrator

Abusers who use alcohol or drugs may use this as an excuse for their behaviour, saying "I was drunk" or "I don't remember". Even if they genuinely do not remember what they did, it does not remove responsibility for their behaviour. Sometimes abusers may deliberately become intoxicated in order to blunt their inhibitions against the use of violence. There is never an excuse for domestic violence and the causes of domestic violence are far more deeply rooted than simply being an effect of intoxication or alcohol or drug dependency. (Women's Aid Survivor's Handbook, 2015)

These statements reflect the Responsible Disinhibition Theory advanced by Galvani (2004) that any disinhibiting effect of alcohol does not, on its own, explain or excuse violence. In this view, indeed intoxication is sometimes used strategically by perpetrators, in order to justify violence after the fact. This view is consistent with the IPV voluntary sector focus on individual responsibility.

Drug policies have typically conceptualised IPV perpetration/victimisation as an aspect of but not caused by substance using behaviour and perpetrated by a mentally disordered or anti-social substance member of a Troubled Family. More recently the discourse of 'person centred' Recovery holds a paradoxical view of substance misusers' families both as a source of support and of intergenerational harm. With the introduction of Localism policies, the impetus to develop care pathways for 'vulnerable service users with complex needs' that were developing in alcohol policy documents in particular (DoH, 2009) has been lost. Meanwhile IPV voluntary-sector policy views violence and substance misuse as separate and distinct problems; the co-occurrence of which may obfuscate individual responsibility. These 'framings' of IPV by substance misusers provide little guidance for how treatment providers might respond to men who disclose or who are identified as perpetrating IPV in the context of substance misuse treatment.

Interviews with practitioners and policy maker

Knowledge of prevalence

Substance misuse staff were not on the whole knowledgeable about IPV perpetration among substance misusers; there was

uncertainty expressed for example as to whether IPV perpetration was more common among men in treatment

I've no idea because I don't know how common it is among the general public, my sense is it probably is but I'm not entirely sure (Substance Misuse Practitioner ID1)

A common view among staff from substance misuse treatment was that more may be known about the relationships of people who misuse substances because they are generally more subject to interventions and the surveillance that that entails:

I think it probably gets exposed a lot more, because you'll have someone coming in to services so you may get to hear about it (Substance Misuse Practitioner ID11)

I suppose, I think, we might hear about it more because we're asking those kinds of questions (Substance Misuse Practitioner ID3)

There was also caution expressed about stigmatising generalisations about the relationships of people who misuse substances that were not universally abusive:

we have many service users in treatment where there's clearly loving and caring relationships between the [couple], where there's no suggestion of any violence going on so I wouldn't want to stigmatise the whole cohort of service users (Policy ID3)

Although these statements suggest that staff in services ask questions which mean that they hear about IPV perpetration, as will be described, interviews with staff suggest that such knowledge and practice is uneven.

Identifying IPV perpetration and referral pathways

The identification of IPV-perpetration by substance misuse treatment staff was reported to be opportunistic, for example where IPV victims whose partners also attended services reported victimisation to key workers. IPV sector policy informants reported that substance misuse services as a whole had been very slow to refer victims of IPV to Multi-Agency Risk Assessment Conferences but that this is now improving and substance misuse staff confirmed knowledge of referral and care pathways for female victims of IPV. There was less information on the part of practitioners of provision and care pathways for perpetrators of IPV outside the criminal justice system however:

In some boroughs, where we've got really good connections with MARAC [Multi-Agency Risk Assessment Conference], referring somebody to MARAC, would be one of the pathways so that there's a joined up response, in terms of care. And in other services, the pathways are not very good at all, and we would probably refer them to people like Respect, or, you know, if they're already on probation orders, talk to probation about what probation could provide (Substance Misuse Practitioner ID3)

I do have a sense that services for the perpetrator's partner violence, where it's needed, I'm not sure they exist outside of the criminal justice setting (Policy3)

This was consistent with a report from an IPV sector policy maker who suggested that perpetrators were generally invisible:

IV: as you'll be well aware, drug and alcohol services are, their clients are predominantly male.

I: Sure. And do you see there being a gap of policy around provision for perpetrators?

IV: Yes, and that's across the board and not just in drug and alcohol services. You wouldn't believe how invisible perpetrators are in the domestic violence world (IPV-sector policy ID2)

Where there were services for perpetrators, it was reported that probation-run perpetrator programmes might not always be suitable or made available to substance misusers and that offenders might be expected to address their substance misuse issues separately despite evidence that such non-integrated interventions may be less effective (Schumacher, Fals-Stewart, & Leonard, 2003).

I think the ones who had severe, substance misuse problems wouldn't have got referred on to [probation run perpetrator programmes] actually, because they would have been seen as not being able to do it (Policy1)

Aside from an integrated programme, located in a drug service, there were few examples of perpetrator programmes that treatment providers could refer into and as a whole, practitioners did not seem to be well versed in services for perpetrators with vague references made to websites and helplines as possible referral routes. Staff from substance misuse treatment had little experience of referring men to voluntary perpetrator programmes and suggested that such programmes might not be suitable for those with ongoing substance misuse problems:

I think a lot of our kind of clients, possibly, aren't, you know, in that right space, you know, they can't even do addictions programmes, most of them, you know, if things are that chaotic, let alone something that's, kind of, even more emotional than that. So I don't know if that's why but, yeah, I haven't seen anybody complete it. (Substance Misuse Practitioner ID1)

This perception that substance misusers may not be able 'to do' perpetrator programmes has been highlighted elsewhere (Klos-termann, 2006). An IPV perpetrator programme leader confirmed that substance misuse treatment clients do not tend to access perpetrator programmes, the make-up of which is different from the programme run in a substance misuse service;

By and large they're a more stable group; they're less damaged as a group. There are more people in work and there are less criminogenic needs in the group as a whole. (IPV practitioner ID2)

What's difficult about asking a man how is relationship is?

Lack of policy and services for substance misusing IPV perpetrators and a perception that substance misusers cannot 'do' perpetrator programmes was reflected in a lack of confidence to ask questions about IPV perpetration in the context of treatment. Substance misuse service managers emphasised however that although staff may not always have the confidence to raise issues of IPV, IPV perpetrators were no more complex than other drug and alcohol service users more generally whom practitioners did have the skills to work with:

When we were training the [borough] substance misuse staff the other day, they said that this was specialist work and that they couldn't do this. I said, 'You sit there with a client and ask them about their groin injecting. You ask them about what

needles they use. You may ask them to show you their injecting sites; to make sure it's clean or if not then clean the wound or get the nurses to clean the wound. What's difficult about asking a man how his relationship is?' (Substance Misuse and IPV practitioner ID5)

An IPV sector policy officer suggested that substance misuse staff were well placed to address and identify IPV perpetration:

there's so much overlap in what perpetrator workers do and substance misuse workers do. I think it would be very easy for substance misuse workers to do a lot more than they currently do, and that would leave them feeling so much more skilled and confident and able (IPV policy ID3)

Despite this, policy makers and service managers suggested that key working staff in substance misuse treatment services needed to be 'upskilled' and didn't always have the confidence to ask questions about IPV perpetration or to identify IPV perpetration:

I think our key workers are a bit concerned about asking questions around domestic violence and what to do with disclosures – is some of the feedback that I'm hearing (Policy ID2)

I think some more specialist training. And a chance to think about how we identify better but I think we've only got as far really as identifying in perpetrators I think in victims we're probably slightly better (Substance Misuse Practitioner ID1)

These accounts suggest staff in substance misuse treatment may not always have the skills, confidence or consider it their job to ask questions about IPV-perpetration (Loughran et al., 2010). Previous research has also found that staff avoid asking questions about IPV victimisation (Rose et al., 2011), child sexual abuse (Hepworth and McGowan, 2013) or trauma (Mills, 2015) even when they are required to by policy. Without clear protocols of how to respond to disclosure of IPV perpetration or an organisational culture that supports its identification, staff may be justified in feeling that it is beyond their remit. Reluctance on the part of staff to ask questions about IPV perpetration, may in the view of some staff, be matched in substance misusers' own narrow interest in accessing substance misuse treatment:

they come in the door to deal with their substance, so they, some clients are not always open to the other aspect of working with them, you know, so you know, they might be very focused on ooh you know, I've got a heroin addiction, I want a script, and that's all I want to do in a way, I don't want to talk about my relationship, I don't want to talk about, you know (Substance Misuse Practitioner ID9)

This view is contradicted by findings that the treatment aspirations of people who misuse substances entering treatment frequently include the desire to improve relationships (Neale & Stevenson, 2015). Indeed this is supported by the view expressed in our interviews that responding to IPV-perpetration as part of a holistic response in was likely to improve recovery from substance misuse:

So I think you can, you know, you can never work with addictions in isolation, and the more you iron out the rest of somebody's life, the better chances they have of, kind of, meaningfully engaging in treatment and making changes. So, yeah, all of their risks go down, and all of their, kind of, you know, the hope that you have for someone goes up, if they're, kind of, ticking things off the list of social issues. So this is up there, for sure, yeah (Substance Misuse Practitioner ID4)

Attribution and responsibility

Questions about prevalence and identification of IPV perpetration among substance misusers raised the issues of blame and responsibility. A number of staff expressed the view – described above in the IPV voluntary sector material – that individual men and not the substance misuse itself were responsible for IPV perpetration:

Well, I mean, in some ways I possibly do think it's more common, but it just would be, it's not because I think drug and alcohol would be the cause. I certainly know statistics will be going up every year, of how many are, you know, are also, kind of, known to have drug and alcohol problems (Substance Misuse Practitioner ID4)

Rather than attributing blame to individuals, a number of informants expressed the view that violence in substance misusers' relationships was coextensive with damage and abuse experienced from childhood, with multiple morbidity or vulnerabilities that will also – although not inevitably – affect intimate relationships

people who are attending [drug services and day programmes] are very damaged and potentially very damaging as well. So I can't see that drug and alcohol abuse wouldn't impact on relationships really (IPV practitioner ID2)

people in addiction treatment settings are people who are multiply morbid and at multiple social disadvantages and you're concentrating them in one place, they're poor, they're badly educated, they've been victims of abuse themselves, they've got significant psychological distress so there's a range of things going on (Policy ID3)

it's because of all the vulnerabilities that come with drug and alcohol. there's instability and possibly emotional neglect and therefore poor attachments, and poor outcomes in life (Substance Misuse Practitioner ID4)

Several informants suggested that there is a gender dynamic to vulnerability and that women who misuse substances in relationships with others who misuse substances have needs that are more complex.

a lot of women in drug using relationships are exceptionally vulnerable anyway, but certainly that vulnerability shows in drug using relationships really (Policy ID1)

For some drug misusing partnerships in particular, there was reported to be a gendered division of labour, with male partners very often in control of arrangements for raising money for, purchasing and accessing substances as well as controlling their partner's access to treatment services

There are often quite complicated dynamics at work there, if one partner's initiated the other into use or if one partner – if it's primarily their economic ability that's funding the use; whether that be sex work (Policy ID4)

It is quite often the man that's doing the scoring and supplying the drugs to the woman, rather than the woman independently getting her own drugs. So I think that that creates vulnerabilities for the woman because she's dependent on the man (Substance Misuse Practitioner ID3)

These statements refer to complex power relations within some substance-misusing intimate partnerships. The view that IPV in

substance misusers was linked to a range of complex needs, contrasted with the view that IPV perpetrators should not be absolved of responsibility for their actions. This was a view expressed particularly by practitioners and policy makers from the substance misuse sector who had received domestic violence training from an IPV sector organisation in their current or previous roles who provided statements using the ‘power and control’ discourse:

they may well have had lots of other issues and insecurities going on with them and a lot of them had poor family backgrounds and everything and had poor male models to have learned anything from in lots of ways but it was about power and control definitely (Policy ID1)

I’m asking how substance misuse might affect relationships.

IV: Well, it depends, really, I think, because substance misuse can make people quite aggressive, but power and control in domestic abuse, it’s different, completely, and substance misuse is used as an excuse. It’s not a reason. It’s not a cause for violence towards a partner. It’s an excuse, and what it does is, it escalates the situation. (Substance misuse practitioner ID7)

they will say, ‘Well, I would never normally do it. I wouldn’t do this if I wasn’t drinking,’ but evidence has shown that, actually, they do, but it just becomes worse, and the injuries that the victims sustains are much worse when the perpetrator is drinking or using drugs (Substance Misuse Practitioner ID5)

In these statements, male power and control is understood as the central driver for IPV perpetration. Substance Misuse Practitioners refer to evidence supporting the Responsible Disinhibition Theory (Galvani, 2004) described above that alcohol and drug intoxication is a post hoc ‘excuse’ masking individual responsibility for violence that would take place anyway. Meanwhile a practitioner in the IPV sector who leads perpetrator programmes referred to a different set of research evidence as to the differential impact of intoxication leading to ‘more overt expressions of violence’

And what about the role of alcohol and drugs?

IV: And alcohol and drugs, yeah because we know that with alcohol you’re going to get much more overt expressions of violence with. . . just kind of spill things out. I think other drugs, yes, cocaine, amphetamines, all those stimulants, with cannabis there’s a sort of myth that it makes people more. . .

I: Relaxed?

IV: a bit more chilled out but there is a backlash and there is more paranoia and I think leads to a lot more difficulties in a relationship which can then result in some violent action and with heroin we used to think there was less violence but I think there’s a whole kind of environment that is about violence and control and sometimes in more subtle ways. (IPV practitioner ID1)

IPV practitioner ID1’s statements complicate the notion of intoxication as a post hoc excuse for IPV, with consideration of the impact of intoxication in context, described here as the ‘whole..environment’ in which violence takes place. This extract is consistent with substance misuse practitioners’ statements described above of complexity and gendered disadvantage providing a context for IPV perpetration and victimisation.

Normalisation of violence

The view of IPV perpetration in a context of complex vulnerabilities and disadvantage was linked to a view of sub-cultural acceptability of violence in drug using relationships in which forms of violence may be ‘normalised’. These observations are presented as derived directly from working with substance misusers rather than from research:

People [] may be being told what to wear and when to wear it, when to be around, when not to be around, not having a lot of say about when you have sex. and actually slapping and hitting is probably part of that as well because it can be normalised (Substance Staff Practitioner ID6)

There might be some kind of behaviours, including violence, so, for example, pushing, you know, that they just may not even, it may not even be on their radar, in terms of it being unacceptable (Substance Staff Practitioner ID4)

‘Normalised’ violence was reported to be particularly prevalent among homeless, often poly-drug users, whose needs were reported to be the most complex and who were as likely to be victims of violence as perpetrators. This is a view that is also reflected in research with substance misusers with complex needs (Gadd, 2004; Hammersley & Dalgarno, 2013; Neale, Bloor, & Weir, 2005):

people who live in the street, that community, particularly women are very vulnerable to abuse and sexual violence and experience a lot of it and actually the men experience a lot of violence as well mostly from other men I should say (Substance Misuse Practitioner ID2)

These accounts suggest an everyday experience of victimisation/perpetration of violence among street homeless substance misusers particularly. The ‘power and control’ model for explaining perpetration that was evident among those who had received training from the IPV-sector, thus contrasted with more ‘situated’ (Johnson, 2006) accounts of IPV linked to substance misuse, homelessness and gendered relations of inequality.

Discussion

In tracing how IPV perpetration has been problematized in English drug and alcohol policies we have found lacunae. Aside from the 2002 Updated Drug Policy in which violence in the family was considered as an effect of substance misuse alongside mental health problems and poverty, there has been scant reference to victims or perpetrators of IPV in drug policy. This is despite the fact that research has demonstrated that men in treatment for substance misuse report higher levels of IPV perpetration than in the general population (El-Bassel et al., 2007; Frye et al., 2007; Gilchrist, Radcliffe, et al., 2015; Gilchrist, Blazquez, et al., 2015; O’Farrell et al., 2004). Drug policy has been framed instead in relation to offending behaviours, social disorder and troubled families. We have described the increasing prioritisation of child safeguarding in drug policy in which domestic violence represents one risk indicator alongside mental health and substance misuse. More recently the discourse of ‘person centred’ recovery holds a paradoxical view of drug users’ families as both supportive and toxic; a source of recovery capital and risk factors that are linked to intergenerational harm.

While IPV perpetration and victimisation have more explicitly been presented as aspects of alcohol policy this has been couched in terms of the associated public service costs linked to alcohol related domestic violence. The impetus to develop care pathways

for 'vulnerable service users with complex needs' (DoH, 2009) appear to have been lost with the introduction of Localism policies. Meanwhile IPV voluntary-sector policy – which has considerable influence on the social care sector in England – views violence and substance misuse as separate and distinct problems; the co-occurrence of which is considered to obfuscate the perpetrator's individual responsibility. These 'framings' of IPV perpetration by substance misusers provide little guidance for how treatment providers might respond to men who disclose or are identified as perpetrating IPV in the context of substance misuse treatment. There is an apparent vacuum in the social care responses to IPV among substance misusers (and see Hanson and Patel, 2014 for a discussion of the child welfare lens in the social work response to IPV).

We found no straightforward translation of drug and alcohol policy to practitioner and policy makers' conceptualisation of IPV perpetration among men in treatment. Two broad explanations for IPV perpetration among men who misuse substances could be distinguished. Firstly, IPV was explained by the 'power and control' model in which violence perpetrated upon an intimate partner is considered as coercive, strategic and tactical. In this view, substance misuse is considered as a post hoc excuse used by perpetrators for their IPV perpetration. Secondly, IPV perpetration was explained as an aspect of multiple complexities and adversities. In this view, women who misuse substances were considered particularly vulnerable to forms of (sometimes coercive) IPV. Homeless people who misuse substances are considered to be victims as well as perpetrators of all forms of violence. This view that men who misuse substances are vulnerable, socially disadvantaged and are themselves frequently victims of abuse (Bellis, Lowey, Leckenby, Hughes, & Harrison, 2013; Stevens, 2011; EMCDDA, 2003; Hammersley & Dalgarno, 2013) challenges both the criminalisation of offending drug users and the responsabilising discourse of IPV sector theory.

Limitations

Our research took place with substance misuse practitioners in one region of England although these included National Health Service staff and staff working for a voluntary sector organisation which has national reach. We interviewed practitioners involved in an integrated IPV programme within a substance misuse service that as far as we know is not replicated elsewhere. IPV and substance misuse policy makers who took part in our research also work nationally and we have no reason to believe that findings from interviews with policy makers are not generalizable. Although requests were made to interview generic key-working staff, the substance misuse practitioner sample was biased towards staff who took a special interest or had a responsibility for IPV and/or 'safeguarding' within their organisations. It is possible that the substance misuse key working staff we interviewed were therefore more knowledgeable about IPV perpetration than are most substance misuse practitioners.

Conclusions

These findings clearly have implications for the development of policy and practice in England and elsewhere. An international review of continued education in the substance misuse field found a 'highly diverse, unsystematic, and insufficiently supported transfer of research evidence and good practice guidelines into the everyday work of professionals' (Uchtenhagen, Stamm, Huber, & Vuille, 2008). We therefore welcome the recent visibility given to IPV by the National Institute for Social Care Excellence (NICE) guidelines for Domestic Abuse (2014) with their recommendations that the 'health needs and behaviour' of perpetrators are included

in mapping services and in training of front line staff. Our research interviews indicate the value of interrogating the tacit knowledge that informs the work of frontline staff (and see Orford, 2008). A recent Capabilities Framework has specified the knowledge, values and skills that substance misuse staff need to work effectively and safely in the substance misuse treatment setting with men who perpetrate IPV (Hughes, Fitzgerald, Radcliffe, & Gilchrist, 2015). Organisations need a shared understanding of and approach to IPV perpetration and a protocol with specific actions at each stage of the process. Teams need policy on responding to the perpetration of IPV that matches statutory and non-statutory safeguarding systems. Clear referral pathways to other relevant services are needed for perpetrators and victims. Furthermore, training on IPV perpetration for substance misuse staff should be based on an ecological model that considers how substance misuse may interact with the effects of broader culture, subculture, family and individual characteristics (Dahlberg et al., 2002).

Given the limited evidence for the effectiveness of current approaches to working with perpetrators there is a clear case for re-viewing models of IPV perpetrator work and to establish effective approaches to work with substance misusing IPV perpetrators as part of an integrated treatment approach. Service providers' reports of their own work may not always capture what takes place in practice. Further qualitative research with naturally occurring data, examining what takes place in key working and group work sessions is likely to be revealing.

Conflict of interest statement

The authors declare that there is no conflict of interest.

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